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CLIENT'S COPY

INSPECTION COPY

UNRELATED BUSINESS INCOME

CARRYOVER DATA TO 2015

Name CARROLL HOSPITAL CENTER, INC.	Employer Identification Number 52-1452024
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Based on the information provided with this return, the following are possible carryover amounts to next year.

FEDERAL NET OPERATING LOSS	544,324.
FEDERAL AMT NET OPERATING LOSS	546,511.
CA NET OPERATING LOSS	1,062.
IN NET OPERATING LOSS	426.

INSPECTION COPY

Dixon Hughes Goodman LLP
1410 Spring Hill Road
5th Floor
Tysons, VA 22102
703-970-0400

Carroll Hospital Center, Inc.
200 Memorial Avenue
Westminster, MD 21157

Dear Kevin,

Enclosed are the organization's 2014 Exempt Organization returns. The state Exempt Organization returns are also enclosed. These should be signed, dated, and mailed.

Specific filing instructions are as follows.

FORM 990 RETURN:

Please sign and mail on or before May 16, 2016.

Mail to - Department of the Treasury
Internal Revenue Service Center
Ogden, UT 84201-0027

FORM 990-T RETURN:

No amount is due on Form 990-T.

Please sign and mail on or before May 16, 2016.

Mail to - Department of the Treasury
Internal Revenue Service Center
Ogden, UT 84201-0027

CALIFORNIA FORM 199 RETURN:

Mail to - Franchise Tax Board
P.O. Box 942857
Sacramento, CA 94257-0500

Please sign and mail Form 199 on or before May 16, 2016.

No payment is required.

CALIFORNIA FORM 109 RETURN:

Mail to - Franchise Tax Board
P.O. Box 942857
Sacramento, CA 94257-0500

Please sign and mail Form 109 on or before June 15, 2016.

No payment is required.

GEORGIA FORM 600-T RETURN:

Mail to - Georgia Department of Revenue
P.O. Box 740397
Atlanta, GA 30374-0397

Please sign and mail Form 600-T on or before May 16, 2016.

No payment is required as there is a refund in the amount of \$3,213.

INDIANA FORM IT-20NP RETURN:

Mail to - Indiana Department of Revenue
P.O. Box 7228
Indianapolis, IN 46207-7228

Please sign and mail Form IT-20NP on or before May 16, 2016.

No payment is required.

MINNESOTA FORM M4NP RETURN:

Mail to - Minnesota Revenue
Mail Station 1257
St. Paul, MN 55146-1257

Please sign and mail Form M4NP on or before June 15, 2016.

Enclose a check for \$638.

Make check payable to Minnesota Revenue.

The Minnesota Form M4NP includes a penalty for underpayment of estimated tax of \$15.

The Maryland Form 500 should be mailed on or before May 16, 2016 to:

Comptroller of Maryland
Revenue Administration Div.
110 Carroll Street
Annapolis, MD 21411-0001

No payment is required with this return when filed.

The North Carolina Form CD-405 should be mailed on or before May 16, 2016 to:

NCDOR
P.O. Box 25000
Raleigh, NC 27640-0500

No payment is required with this return when filed.

Copies of all the returns are enclosed for your files. We suggest that you retain these copies indefinitely.

We have furnished instructions regarding the above form(s) for easy reference. The original return(s) should be signed and dated where indicated. The copy should be retained for your files. If applicable, we have enclosed an additional copy of Form 990 for filing with the state authorities.

Federal law requires that every organization which files Form 990 must make it available for public inspection. However, information regarding the name and address of any contributor to the organization should not be made available. For your convenience, we have enclosed an extra copy of Form 990 to be used for public inspection. This copy does not contain any contributor information.

Please note that we have provided your copy of the return and the copy for public inspection in CD-ROM format. We have enclosed separate instructions for accessing the CD-ROM.

We recommend that you file your return using certified mail with a postmarked receipt for proof of timely filing. You should write the certified mail receipt number on the return in the margin near your signature prior to filing. You should also retain the certified mail receipt with your copy of the return.

Kind regards,

Tamara Vineyard

TAX RETURN FILING INSTRUCTIONS

** FORM 990 PUBLIC DISCLOSURE COPY **

FOR THE YEAR ENDING

June 30, 2015

Prepared for	Carroll Hospital Center, Inc. 200 Memorial Avenue Westminster, MD 21157
Prepared by	Dixon Hughes Goodman LLP 1410 Spring Hill Road, 5th Floor Tysons, VA 22102
Amount due or refund	Not applicable
Make check payable to	Not applicable
Mail tax return and check (if applicable) to	Not applicable
Return must be mailed on or before	Not applicable
Special Instructions	<p>This copy of the return is provided ONLY for Public Disclosure purposes. Any confidential information regarding large donors has been removed.</p> <p>We recommend that you file your return using certified mail with a postmarked receipt for proof of timely filing. You should write the certified mail receipt number on the return in the margin near your signature prior to filing. You should also retain the certified mail receipt with your copy of the return.</p>

Form **990**

Return of Organization Exempt From Income Tax
Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

OMB No. 1545-0047

2014

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ Do not enter social security numbers on this form as it may be made public.
▶ Information about Form 990 and its instructions is at www.irs.gov/form990.

A For the 2014 calendar year, or tax year beginning **JUL 1, 2014** and ending **JUN 30, 2015**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization <p align="center">CARROLL HOSPITAL CENTER, INC.</p> Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite <p align="center">200 MEMORIAL AVENUE</p> City or town, state or province, country, and ZIP or foreign postal code <p align="center">WESTMINSTER, MD 21157</p> F Name and address of principal officer: LESLIE SIMMONS <p align="center">200 MEMORIAL AVE, WESTMINSTER, MD 21774</p>	D Employer identification number <p align="center">52-1452024</p> E Telephone number <p align="center">410-871-6859</p> G Gross receipts \$ 232,375,074. H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) H(c) Group exemption number ▶
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		
J Website: ▶ WWW.CARROLLHOSPITALCENTER.ORG		
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		L Year of formation: 1957 M State of legal domicile: MD

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: OUR COMMUNITIES EXPECT AND DESERVE SUPERIOR MEDICAL TREATMENT, COMPASSIONATE CARE, AND EXPERT		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	17
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	12
	5 Total number of individuals employed in calendar year 2014 (Part V, line 2a)	5	2038
	6 Total number of volunteers (estimate if necessary)	6	348
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	2,645,858.
	b Net unrelated business taxable income from Form 990-T, line 34	7b	-232,849.
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	3,054,000.	3,347,840.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	222,597,736.	227,964,993.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,094,568.	471,761.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	533,617.	575,633.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	229,279,921.	232,360,227.
	14 Benefits paid to or for members (Part IX, column (A), line 4)	105,000.	173,000.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	0.	0.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	104,572,998.	107,497,742.
	b Total fundraising expenses (Part IX, column (D), line 25) ▶	0.	0.
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	106,936,658.	113,474,480.
	18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	211,614,656.	221,145,222.
	19 Revenue less expenses. Subtract line 18 from line 12	17,665,265.	11,215,005.
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21 Total liabilities (Part X, line 26)	369,751,968.	352,894,518.
	22 Net assets or fund balances. Subtract line 21 from line 20	220,555,142.	189,476,490.
		149,196,826.	163,418,028.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here	Signature of officer <p align="center">KEVIN KELBLY, CFO</p> Type or print name and title	Date
Paid Preparer Use Only	Print/Type preparer's name <p align="center">TAMARA VINEYARD</p> Preparer's signature Date Check if self-employed <input type="checkbox"/> PTIN <p align="right">P01775208</p> Firm's name ▶ DIXON HUGHES GOODMAN LLP Firm's address ▶ 1410 SPRING HILL ROAD, 5TH FLOOR <p align="center">TYSONS, VA 22102</p> Firm's EIN ▶ 56-0747981 Phone no. 703-970-0400	

May the IRS discuss this return with the preparer shown above? (see instructions) Yes No

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III [X]

1 Briefly describe the organization's mission: OUR COMMUNITIES EXPECT AND DESERVE SUPERIOR MEDICAL TREATMENT, COMPASSIONATE CARE, AND EXPERT GUIDANCE IN MAINTAINING THEIR HEALTH AND WELL-BEING. AT CARROLL HOSPITAL CENTER, WE OFFER AN UNCOMPROMISING COMMITMENT TO THE HIGHEST QUALITY HEALTH CARE

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? [] Yes [X] No

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? [] Yes [X] No

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses \$ 184,616,647. including grants of \$ 173,000.) (Revenue \$ 225,313,054.) CARROLL HOSPITAL CENTER, A 189 LICENSED BED ACUTE CARE FACILITY LOCATED IN WESTMINSTER, MARYLAND OFFERS THE LATEST IN MEDICAL TECHNOLOGY AND SERVICES, COMBINED WITH A STATE-OF-THE-ART FACILITY AND TOP-NOTCH, SKILLED MEDICAL PROFESSIONALS, CARING FOR PATIENTS WITH COMPASSION. CURRENTLY, THERE ARE MORE THAN 450 PHYSICIANS REPRESENTING 38 SPECIALTIES ON OUR MEDICAL STAFF IN ADDITION TO OVER 2,038 INDIVIDUALS EMPLOYED BY THE HOSPITAL - MAKING CHC THE SECOND LARGEST EMPLOYER IN CARROLL COUNTY. THE ORGANIZATION OPERATES AN ACUTE CARE HOSPITAL SERVING THE COMMUNITIES LOCATED IN CARROLL AND SURROUNDING COUNTIES AS WELL AS PARTS OF PENNSYLVANIA. IN ACCORDANCE WITH OUR TAX-EXEMPT FUNCTION THE ORGANIZATION OPERATES AN EMERGENCY ROOM OPEN TO ALL PERSONS REGARDLESS OF THEIR ABILITY TO PAY AND HAD 53,302 PATIENT

4b (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4c (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4d Other program services (Describe in Schedule O.) (Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses 184,616,647.

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ?	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	X	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? <i>If "Yes," complete Schedule C, Part III</i>		X
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		X
9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>		X
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>	X	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	X	
b Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>	X	
c Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i>	X	
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i>		X
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>	X	
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14a Did the organization maintain an office, employees, or agents outside of the United States?		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>	X	
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>		X
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I</i>		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>		X
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	

Part IV Checklist of Required Schedules (continued)

	Yes	No
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	X	
22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>		X
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	X	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	X	
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		X
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		X
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		X
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>		X
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>		X
26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i>		X
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>		X
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	X	
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	X	
c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	X	
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>		X
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		X
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		X
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>		X
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>	X	
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	X	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	X	
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>	X	
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		X
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>		X
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19?	X	

Note. All Form 990 filers are required to complete Schedule O

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V

Input box for Schedule O

Main table with columns for question numbers (1a-14b), Yes/No, and numerical responses (356, 0, 2038, etc.). Includes questions about Form 1096, Form W-2G, Form W-3, and various IRS forms.

Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.

Check if Schedule O contains a response or note to any line in this Part VI

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.		
	1a 17		
b	Enter the number of voting members included in line 1a, above, who are independent		
	1b 12		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	X	
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		X
6	Did the organization have members or stockholders?		X
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?		X
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?		X
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
a	The governing body?	X	
b	Each committee with authority to act on behalf of the governing body?	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		X

Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)

		Yes	No
10a	Did the organization have local chapters, branches, or affiliates?		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?		
10b			
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
12a	Did the organization have a written conflict of interest policy? If "No," go to line 13	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	X	
12c		X	
13	Did the organization have a written whistleblower policy?	X	
14	Did the organization have a written document retention and destruction policy?	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
a	The organization's CEO, Executive Director, or top management official	X	
b	Other officers or key employees of the organization	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).		
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	X	
16b		X	

Section C. Disclosure

- 17** List the states with which a copy of this Form 990 is required to be filed **CA, MD, IN, MN**
- 18** Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
 Own website Another's website Upon request Other (explain in Schedule O)
- 19** Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records: **DAVID MCCORMICK - 410-871-6859**
200 MEMORIAL AVE, WESTMINSTER, MD 21157

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) CHARLES O FISHER JR BOARD MEMBER	1.00 1.00	X					0.	0.	0.	
(2) DR. SOHAILIA ALI BOARD MEMBER	1.00 1.00	X					0.	0.	0.	
(3) ETHAN SEIDEL PHD BOARD MEMBER	1.00 1.00	X					0.	0.	0.	
(4) GERALD LEE STURGILL EX-OFFICIO	1.00 2.00	X					0.	0.	0.	
(5) HELEN W WHITEHEAD CHAIR	1.00 1.00	X		X			0.	0.	0.	
(6) JASON BLAVATT, ESQUIRE BOARD MEMBER	1.00 2.00	X					0.	0.	0.	
(7) JEFFREY A WOTHERS BOARD MEMBER	1.00 1.00	X					0.	0.	0.	
(8) JOHN STEERS MD BOARD MEMBER	1.00 1.00	X					0.	0.	0.	
(9) KIMBERLY JOHNSTON, MD BOARD MEMBER	1.00 1.00	X					0.	0.	0.	
(10) LARRY VAN SANT SR BOARD MEMBER	1.00	X					0.	0.	0.	
(11) LESLIE SIMMONS CHIEF EXECUTIVE OFFICER	37.00 3.00	X		X			539,559.	0.	30,839.	
(12) MARCUS PRIMM BOARD MEMBER	1.00 1.00	X					0.	0.	0.	
(13) MARTIN HILL BOARD MEMBER	1.00 1.00	X					0.	0.	0.	
(14) MIRIAM BECK SECRETARY	2.00 1.00	X		X			0.	0.	0.	
(15) NEIL MELTZER BOARD MEMBER	1.00	X					0.	1,500,322.	359,290.	
(16) THOMAS WELLS BOARD MEMBER	1.00 1.00	X					0.	0.	0.	
(17) W DENNIS THOMAS BOARD MEMBER	1.00 1.00	X					0.	0.	0.	

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) KEVIN KELBLY SR VP FINANCE CFO	35.00 5.00			X				432,142.	0.	45,334.
(19) BOB EDMONDSON VICE PRESIDENT	40.00				X			312,132.	0.	38,290.
(20) CRIS COLEMAN VICE PRESIDENT	40.00				X			225,512.	0.	39,721.
(21) DAVID LOUDER VICE PRESIDENT	39.00 1.00				X			370,696.	0.	27,496.
(22) JED ROSEN CHIEF MEDICAL INFO OFFICER	40.00				X			486,262.	0.	10,146.
(23) JOYCE ROMANS VICE PRESIDENT	40.00				X			250,804.	0.	31,523.
(24) M ELLEN FINNERTY MYERS CHIEF DEVELOPMENT OFFICER	20.00 20.00				X			284,067.	0.	18,538.
(25) MARK OLSZYK VICE PRESIDENT	40.00				X			435,333.	0.	19,078.
(26) ROBERT WHITE VICE PRESIDENT	40.00				X			212,611.	0.	24,798.
1b Sub-total								3,549,118.	1,500,322.	645,053.
c Total from continuation sheets to Part VII, Section A								4,859,690.	0.	347,963.
d Total (add lines 1b and 1c)								8,408,808.	1,500,322.	993,016.

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization 109

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual	X	
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
CENTRAL MD REHABILITATION 4259 HARNEY RD, TANEYTOWN, MD 21787	REHABILITATION SERVICES	3,397,001.
CARROLL CO ANESTHESIA ASSOC PA PO BOX 75193, BALTIMORE, MD 21275	ANESTHESIA SERVICES	1,950,462.
MDICS, 7250 PARKWAY DRIVE SUITE 500, HANOVER, MD 21072	PHYSICIAN SERVICES	1,297,375.
DEVANEY & ASSOCIATES INC., 135 VILLAGE QUEEN DRIVE, OWINGS MILLS, MD 21117	ADVERTISING	1,211,426.
BRENDA RAY CCS 674 LAKE SANTEE DR, NORTH AUGUSTA, SC 29841	TRANSCRIPTION/CODING	740,995.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization 37

SEE PART VII, SECTION A CONTINUATION SHEETS

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d	3,303,940.			
	e Government grants (contributions)	1e				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	43,900.			
	g Noncash contributions included in lines 1a-1f: \$					
	h Total. Add lines 1a-1f		3,347,840.			
	Program Service Revenue	2 a NET PATIENT SERVICE REVENUE	Business Code 621300	223,685,430.	223,685,430.	
b NONPATIENT LAB		621500	2,651,939.	2,651,939.		
c CAFETERIA/VENDING		999999	880,618.	880,618.		
d OTHER OPERATING REVENUE		999999	747,006.	747,006.		
e						
f All other program service revenue						
g Total. Add lines 2a-2f			227,964,993.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		486,608.	-118,956.	605,564.	
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
	6 a Gross rents	(i) Real	473,100.			
		(ii) Personal				
		b Less: rental expenses	0.			
		c Rental income or (loss)	473,100.			
	d Net rental income or (loss)		473,100.	22,875.	450,225.	
	7 a Gross amount from sales of assets other than inventory	(i) Securities				
		(ii) Other				
		b Less: cost or other basis and sales expenses	14,847.			
		c Gain or (loss)	-14,847.			
	d Net gain or (loss)		-14,847.		-14,847.	
	8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a				
		b Less: direct expenses	b			
c Net income or (loss) from fundraising events						
9 a Gross income from gaming activities. See Part IV, line 19	a					
	b Less: direct expenses	b				
	c Net income or (loss) from gaming activities					
10 a Gross sales of inventory, less returns and allowances	a					
	b Less: cost of goods sold	b				
	c Net income or (loss) from sales of inventory					
Miscellaneous Revenue		Business Code				
11 a CARROLL COUNTY MED SERVICES MGMT	541610	90,000.		90,000.		
	b OTHER REVENUE	999999	12,533.	12,533.		
	c					
	d All other revenue					
e Total. Add lines 11a-11d		102,533.				
12 Total revenue. See instructions.		232,360,227.	225,325,587.	2,645,858.	1,040,942.	

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX X

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	173,000.	173,000.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	6,216,968.		6,216,968.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	83,948,115.	78,012,680.	5,935,435.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	2,363,220.	2,084,124.	279,096.	
9 Other employee benefits	7,729,503.	6,542,530.	1,186,973.	
10 Payroll taxes	7,239,936.	6,384,902.	855,034.	
11 Fees for services (non-employees):				
a Management				
b Legal	13,659.		13,659.	
c Accounting	245,988.		245,988.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	481,896.		481,896.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	25,829,144.	19,779,950.	6,049,194.	
12 Advertising and promotion	782,324.	750,487.	31,837.	
13 Office expenses	2,102,328.	2,047,616.	54,712.	
14 Information technology	94,692.	65,464.	29,228.	
15 Royalties				
16 Occupancy	4,098,068.	2,529,668.	1,568,400.	
17 Travel	506,594.	206,205.	300,389.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	91,074.	59,186.	31,888.	
20 Interest	5,894,245.	4,731,587.	1,162,658.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	15,186,189.	14,548,369.	637,820.	
23 Insurance	2,491,078.	1,578,487.	912,591.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	35,453,495.	35,444,443.	9,052.	
b CONTRACTED SERVICES	11,134,640.	4,141,342.	6,993,298.	
c DUES BOOKS AND SUBSCRIP	2,215,529.	373,049.	1,842,480.	
d OTHER PURCHASED SERVICE	1,905,343.	1,376,753.	528,590.	
e All other expenses	4,948,194.	3,786,805.	1,161,389.	
25 Total functional expenses. Add lines 1 through 24e	221,145,222.	184,616,647.	36,528,575.	0.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				
Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X

		(A)		(B)	
		Beginning of year		End of year	
Assets	1 Cash - non-interest-bearing	10,340.	1	2,480.	
	2 Savings and temporary cash investments	22,314,068.	2	11,466,277.	
	3 Pledges and grants receivable, net		3		
	4 Accounts receivable, net	23,389,282.	4	19,510,699.	
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5		
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6		
	7 Notes and loans receivable, net		7		
	8 Inventories for sale or use	3,041,830.	8	3,018,003.	
	9 Prepaid expenses and deferred charges	5,660,075.	9	6,017,164.	
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 296,940,518.			
	b Less: accumulated depreciation	10b 178,479,720.			
	11 Investments - publicly traded securities	151,175,891.	10c	118,460,798.	
	12 Investments - other securities. See Part IV, line 11	53,795,622.	11	52,419,933.	
	13 Investments - program-related. See Part IV, line 11	33,614,935.	12	24,864,195.	
	14 Intangible assets	42,701,587.	13	94,534,542.	
	15 Other assets. See Part IV, line 11	3,050,000.	14	12,600,000.	
16 Total assets. Add lines 1 through 15 (must equal line 34)	30,998,338.	15	10,000,427.		
	369,751,968.	16	352,894,518.		
Liabilities	17 Accounts payable and accrued expenses	28,868,635.	17	23,278,070.	
	18 Grants payable		18		
	19 Deferred revenue	303,287.	19	211,663.	
	20 Tax-exempt bond liabilities	139,094,739.	20	96,060,517.	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21		
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22		
	23 Secured mortgages and notes payable to unrelated third parties		23		
	24 Unsecured notes and loans payable to unrelated third parties		24		
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	52,288,481.	25	69,926,240.	
	26 Total liabilities. Add lines 17 through 25	220,555,142.	26	189,476,490.	
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27 Unrestricted net assets	137,821,978.	27	103,620,476.	
	28 Temporarily restricted net assets	10,202,084.	28	58,624,788.	
	29 Permanently restricted net assets	1,172,764.	29	1,172,764.	
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.				
	30 Capital stock or trust principal, or current funds		30		
	31 Paid-in or capital surplus, or land, building, or equipment fund		31		
	32 Retained earnings, endowment, accumulated income, or other funds		32		
	33 Total net assets or fund balances	149,196,826.	33	163,418,028.	
	34 Total liabilities and net assets/fund balances	369,751,968.	34	352,894,518.	

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI

1	Total revenue (must equal Part VIII, column (A), line 12)	1	232,360,227.
2	Total expenses (must equal Part IX, column (A), line 25)	2	221,145,222.
3	Revenue less expenses. Subtract line 2 from line 1	3	11,215,005.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	149,196,826.
5	Net unrealized gains (losses) on investments	5	723,234.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	2,282,963.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	163,418,028.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII

		Yes	No
1	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other		
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?		X
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:			
<input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis			
2b	Were the organization's financial statements audited by an independent accountant?	X	
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:			
<input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis			
2c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	X	
If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?		X
3b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits		

Form 990 (2014)

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.

▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2014

Open to Public
Inspection

Name of the organization

CARROLL HOSPITAL CENTER, INC.

Employer identification number

52-1452024

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E.)
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8 A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9 An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)
- 10 An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 11 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**. Check the box in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

f Enter the number of supported organizations

g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see Instructions)	(vi) Amount of other support (see Instructions)
			Yes	No		
Total						

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge ...						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources ...						
9 Net income from unrelated business activities, whether or not the business is regularly carried on ...						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2014 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2013 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2014. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
b 33 1/3% support test - 2013. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
17a 10% -facts-and-circumstances test - 2014. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
b 10% -facts-and-circumstances test - 2013. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions	<input type="checkbox"/>	

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**

Section C. Computation of Public Support Percentage

15 Public support percentage for 2014 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2013 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2013 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2014. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

b 33 1/3% support tests - 2013. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions

Part IV Supporting Organizations

(Complete only if you checked a box on line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No" describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>		
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2) (B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below.</i>		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations; (b) individuals that are part of the charitable class benefited by one or more of its supported organizations; or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
b Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
c Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
10a Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer (b) below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

Part IV Supporting Organizations (continued)

	Yes	No
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?		
b A family member of a person described in (a) above?		
c A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in Part VI .		
11a		
11b		
11c		

Section B. Type I Supporting Organizations

	Yes	No
1 Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.		
2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.		
1		
2		

Section C. Type II Supporting Organizations

	Yes	No
1 Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).		
1		

Section D. Type III Supporting Organizations

	Yes	No
1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).		
3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.		
1		
2		
3		

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):			
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.			
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.			
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).			
2 Activities Test. Answer (a) and (b) below.		Yes	No
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.			
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.			
3 Parent of Supported Organizations. Answer (a) and (b) below.			
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI .			
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.			
2a			
2b			
3a			
3b			

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations

1 Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970. See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt-use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).		

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations (continued)

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions.	
7 Total annual distributions. Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	
9 Distributable amount for 2014 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2014	(iii) Distributable Amount for 2014
1 Distributable amount for 2014 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2014 (reasonable cause required-see instructions)			
3 Excess distributions carryover, if any, to 2014:			
a			
b			
c			
d			
e From 2013			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2014 distributable amount			
i Carryover from 2009 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2014 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2014 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2014, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6 Remaining underdistributions for 2014. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7 Excess distributions carryover to 2015. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a			
b			
c			
d Excess from 2013			
e Excess from 2014			

Schedule B

(Form 990, 990-EZ, or 990-PF)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2014

Name of the organization

CARROLL HOSPITAL CENTER, INC.

Employer identification number

52-1452024

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

501(c)(3) (enter number) organization

4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

4947(a)(1) nonexempt charitable trust treated as a private foundation

501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of (1) \$5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ▶ \$ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2014)

Name of organization CARROLL HOSPITAL CENTER, INC.	Employer identification number 52-1452024
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	<hr/> <hr/> <hr/> <hr/>	\$ <u>3,303,940.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	<hr/> <hr/> <hr/> <hr/>	\$ <u>43,900.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization CARROLL HOSPITAL CENTER, INC.	Employer identification number 52-1452024
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____
	_____ _____ _____	\$ _____	_____

Name of organization CARROLL HOSPITAL CENTER, INC.	Employer identification number 52-1452024
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Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this info. once.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2014

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.**

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization CARROLL HOSPITAL CENTER, INC.	Employer identification number 52-1452024
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
- 2 Political expenditures ▶ \$ _____
- 3 Volunteer hours _____

Part I-B Complete if the organization is exempt under section 501(c)(3).

- 1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ \$ _____
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$ _____
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? Yes No
- 4a Was a correction made? Yes No
- b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ \$ _____
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ \$ _____
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ \$ _____
- 4 Did the filing organization file **Form 1120-POL** for this year? Yes No
- 5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule C (Form 990 or 990-EZ) 2014

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10-21-14

Part II-A Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).

- A** Check if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).
- B** Check if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)														
b Total lobbying expenditures to influence a legislative body (direct lobbying)														
c Total lobbying expenditures (add lines 1a and 1b)														
d Other exempt purpose expenditures														
e Total exempt purpose expenditures (add lines 1c and 1d)														
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width:65%;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>	If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:													
Not over \$500,000	20% of the amount on line 1e.													
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.													
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.													
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.													
Over \$17,000,000	\$1,000,000.													
g Grassroots nontaxable amount (enter 25% of line 1f)														
h Subtract line 1g from line 1a. If zero or less, enter -0-														
i Subtract line 1f from line 1c. If zero or less, enter -0-														
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No												

4-Year Averaging Period Under section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Schedule C (Form 990 or 990-EZ) 2014

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		8,166.
j Total. Add lines 1c through 1i			8,166.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

	Yes	No
1 Were substantially all (90% or more) dues received nondeductible by members?	1	
2 Did the organization make only in-house lobbying expenditures of \$2,000 or less?	2	
3 Did the organization agree to carry over lobbying and political expenditures from the prior year?	3	

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."

1 Dues, assessments and similar amounts from members	1	
2 Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
a Current year	2a	
b Carryover from last year	2b	
c Total	2c	
3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5 Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV Supplemental Information

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions); and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

ATTORNEY FEES RELATED TO LOBBYING ACTIVITIES

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.

▶ Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization **CARROLL HOSPITAL CENTER, INC.** Employer identification number **52-1452024**

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year)		
4 Aggregate value at end of year		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

- 1 Purpose(s) of conservation easements held by the organization (check all that apply).
 Preservation of land for public use (e.g., recreation or education) Preservation of a historically important land area
 Protection of natural habitat Preservation of a certified historic structure
 Preservation of open space
- 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.
- | | Held at the End of the Tax Year |
|--|---------------------------------|
| a Total number of conservation easements | 2a |
| b Total acreage restricted by conservation easements | 2b |
| c Number of conservation easements on a certified historic structure included in (a) | 2c |
| d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register | 2d |
- 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____
- 4 Number of states where property subject to conservation easement is located ▶ _____
- 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?
- 6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____
- 7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ \$ _____
- 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?
- 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

- 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.
- b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:
- (i) Revenue included in Form 990, Part VIII, line 1
- (ii) Assets included in Form 990, Part X
- 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:
- a Revenue included in Form 990, Part VIII, line 1
- b Assets included in Form 990, Part X

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

- a Public exhibition
- b Scholarly research
- c Preservation for future generations
- d Loan or exchange programs
- e Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

	Amount
c Beginning balance	1c
d Additions during the year	1d
e Distributions during the year	1e
f Ending balance	1f

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	13,894,871.	12,400,252.	10,859,176.	10,086,170.	7,900,509.
b Contributions	50,512,667.	192,482.	405,024.	735,458.	690,978.
c Net investment earnings, gains, and losses	410,422.	1,322,825.	1,147,052.	48,548.	1,503,183.
d Grants or scholarships	11,500.	20,688.	11,000.	11,000.	8,500.
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	64,806,460.	13,894,871.	12,400,252.	10,859,176.	10,086,170.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

- a Board designated or quasi-endowment 19.00 %
- b Permanent endowment 2.00 %
- c Temporarily restricted endowment 79.00 %

The percentages in lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

- (i) unrelated organizations
- (ii) related organizations

	Yes	No
3a(i)		X
3a(ii)	X	
3b	X	

b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,983,973.		1,983,973.
b Buildings		115,345,793.	49,088,365.	66,257,428.
c Leasehold improvements		8,488,827.	8,488,827.	0.
d Equipment		141,381,536.	110,541,996.	30,839,540.
e Other		29,740,389.	10,360,532.	19,379,857.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				118,460,798.

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) SHORT TERM INVESTMENT	6,907,545.	END-OF-YEAR MARKET VALUE
(B) LONG-TERM INVESTMENTS	17,922,674.	END-OF-YEAR MARKET VALUE
(C) L-T INVESTMENTS IN EXEC		
(D) OPTION PLAN	33,976.	END-OF-YEAR MARKET VALUE
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	24,864,195.	

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) INVESTMENTS IN FOUNDATION	71,455,110.	END-OF-YEAR MARKET VALUE
(2) INVESTMENT IN PREMIER	195,176.	END-OF-YEAR MARKET VALUE
(3) INVESTMENT IN MT AIRY		
(4) HEALTH SERVICE	288.	END-OF-YEAR MARKET VALUE
(5) INVESTMENT IN COLONIAL	7,362.	END-OF-YEAR MARKET VALUE
(6) INVESTMENT IN CMOA	523,192.	END-OF-YEAR MARKET VALUE
(7) INVESTMENT IN HOSPICE	10,218,291.	END-OF-YEAR MARKET VALUE
(8) INVESTMENT IN CARROLL		
(9) COUNTY RADIOLOGY	5,802,522.	END-OF-YEAR MARKET VALUE
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶	94,534,542.	

Part IX Other Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	

Part X Other Liabilities.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ADVANCES FROM THIRD PARTY	6,731,774.
(3) ACCRUED PENSION	7,742,535.
(4) CAPITAL LEASE	743,156.
(5) MOB DEBT	17,192,397.
(6) DEFERRED COMPENSATION	33,976.
(7) DUE TO CENMAR	10,128,937.
(8) DUE TO AFFILIATES	27,353,465.
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	69,926,240.

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements		1
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains (losses) on investments	2a	
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIII.)	2d	
e	Add lines 2a through 2d		2e
3	Subtract line 2e from line 1		3
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	
c	Add lines 4a and 4b		4c
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)		5

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements		1
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIII.)	2d	
e	Add lines 2a through 2d		2e
3	Subtract line 2e from line 1		3
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	
c	Add lines 4a and 4b		4c
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)		5

Part XIII Supplemental Information.

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

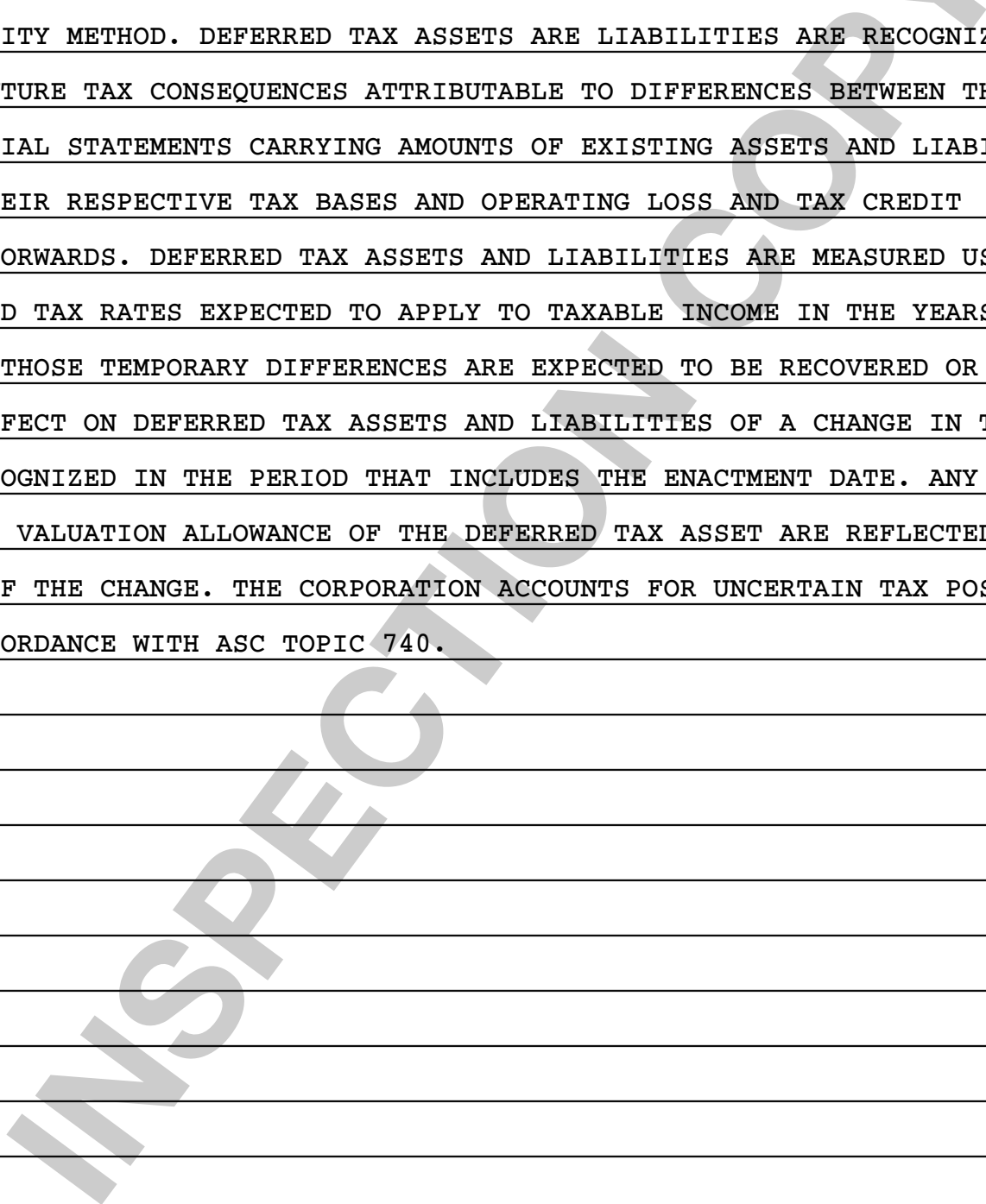
PART X, LINE 2:

EFFECTIVE ON APRIL 1, 2015, CARROLL COUNTY HEALTH SERVICES CORPORATION (CCHS), TOGETHER WITH ITS SUBSIDIARIES CARROLL HOSPITAL CENTER INC AND OTHER CARROLL ENTITIES, BECAME AFFILIATED WITH LIFEBRIDGE HEALTH INC. (LHI), A 501(C)(3) EXEMPT ORGANIZATION. BEGINNING ON THAT DATE THE FINANCIAL POSITIONS AND RESULTS OF CCHS WERE CONSOLIDATED IN THE LHI AUDITED FINANCIAL STATEMENTS. THE FOLLOWING IS THE FIN 48 STATEMENT DISCLOSED IN THE FOOTNOTE TO LHI'S AUDITED FINANCIAL STATEMENTS:

LIFEBRIDGE AND ITS NOT-FOR-PROFIT SUBSIDIARIES HAVE BEEN RECOGNIZED BY THE INTERNAL REVENUE SERVICES AS TAX-EXEMPT PURSUANT TO SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE.

Part XIII Supplemental Information (continued)

LIFEBRIDGE'S INCORPORATED FOR-PROFIT SUBSIDIARIES ACCOUNT FOR INCOME TAXES IN ACCORDANCE WITH FINANCIALS ACCOUNTING STANDARDS BOARD (FASB) ASC TOPIC 740, INCOME TAXES. INCOME TAXES ARE ACCOUNTED FOR UNDER THE ASSET AND LIABILITY METHOD. DEFERRED TAX ASSETS ARE LIABILITIES ARE RECOGNIZED FOR THE FUTURE TAX CONSEQUENCES ATTRIBUTABLE TO DIFFERENCES BETWEEN THE FINANCIAL STATEMENTS CARRYING AMOUNTS OF EXISTING ASSETS AND LIABILITIES AND THEIR RESPECTIVE TAX BASES AND OPERATING LOSS AND TAX CREDIT CARRYFORWARDS. DEFERRED TAX ASSETS AND LIABILITIES ARE MEASURED USING ENACTED TAX RATES EXPECTED TO APPLY TO TAXABLE INCOME IN THE YEARS IN WHICH THOSE TEMPORARY DIFFERENCES ARE EXPECTED TO BE RECOVERED OR SETTLED. THE EFFECT ON DEFERRED TAX ASSETS AND LIABILITIES OF A CHANGE IN TAX RATES IS RECOGNIZED IN THE PERIOD THAT INCLUDES THE ENACTMENT DATE. ANY CHANGES TO THE VALUATION ALLOWANCE OF THE DEFERRED TAX ASSET ARE REFLECTED IN THE YEAR OF THE CHANGE. THE CORPORATION ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH ASC TOPIC 740.



**SCHEDULE F
(Form 990)**

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 14b, 15, or 16.

▶ Attach to Form 990.

▶ Information about Schedule F (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2014

Open to Public
Inspection

Name of the organization **CARROLL HOSPITAL CENTER, INC.** Employer identification number **52-1452024**

Part I General Information on Activities Outside the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

- 1 For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No
- 2 For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.
- 3 Activities per Region.** (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e.g., fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
CENTRAL AMERICA AND THE CARIBBEAN - ANTIGUA & BARBUDA, ARUBA, BAHAMAS,			INVESTMENTS		17,898,527.
3 a Sub-total	0	0			17,898,527.
b Total from continuation sheets to Part I	0	0			0.
c Totals (add lines 3a and 3b)	0	0			17,898,527.

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than \$5,000. Part II can be duplicated if additional space is needed.

1 (a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)

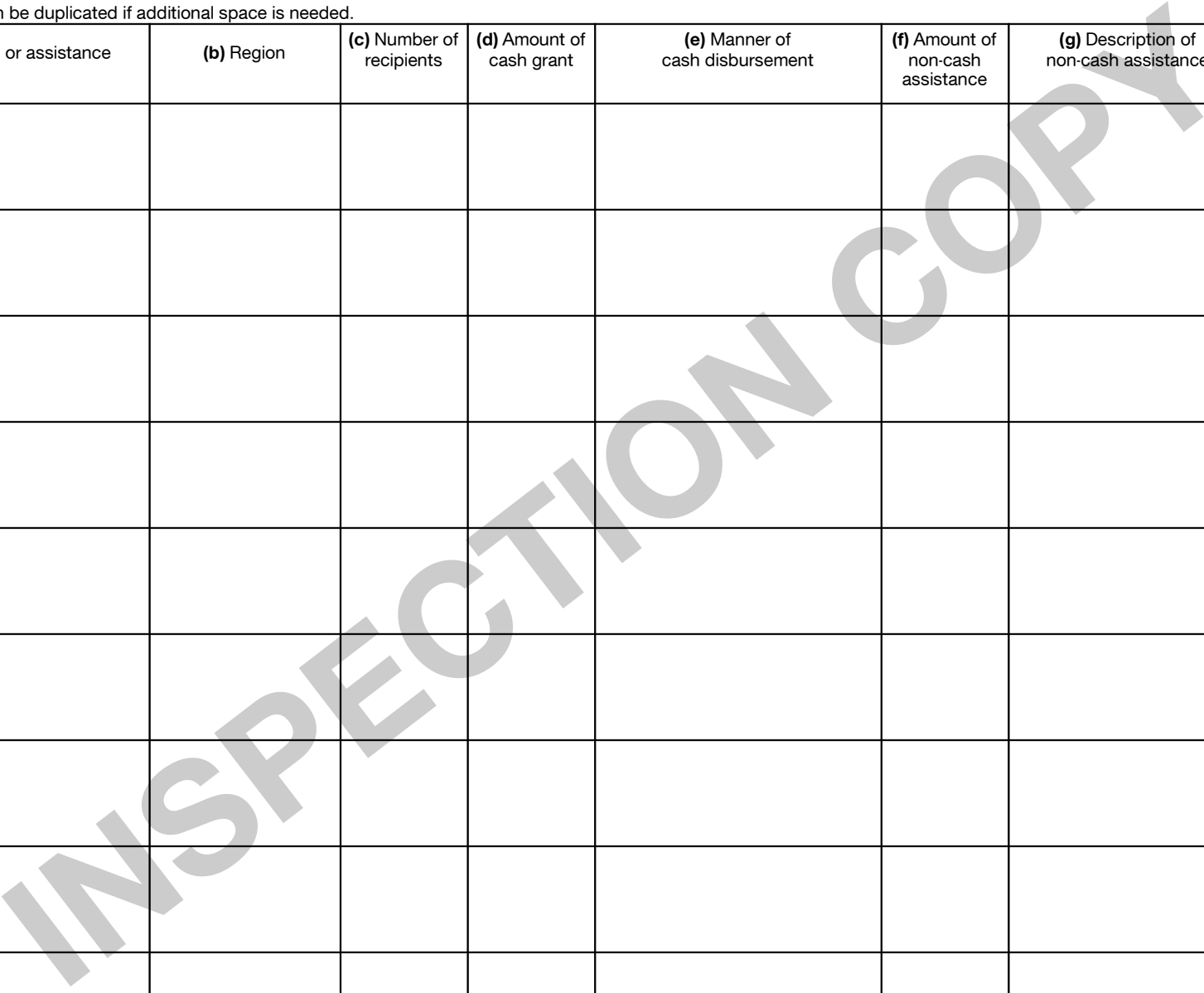
2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter ▶ _____

3 Enter total number of other organizations or entities ▶ _____

Part III Grants and Other Assistance to Individuals Outside the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 16.

Part III can be duplicated if additional space is needed.

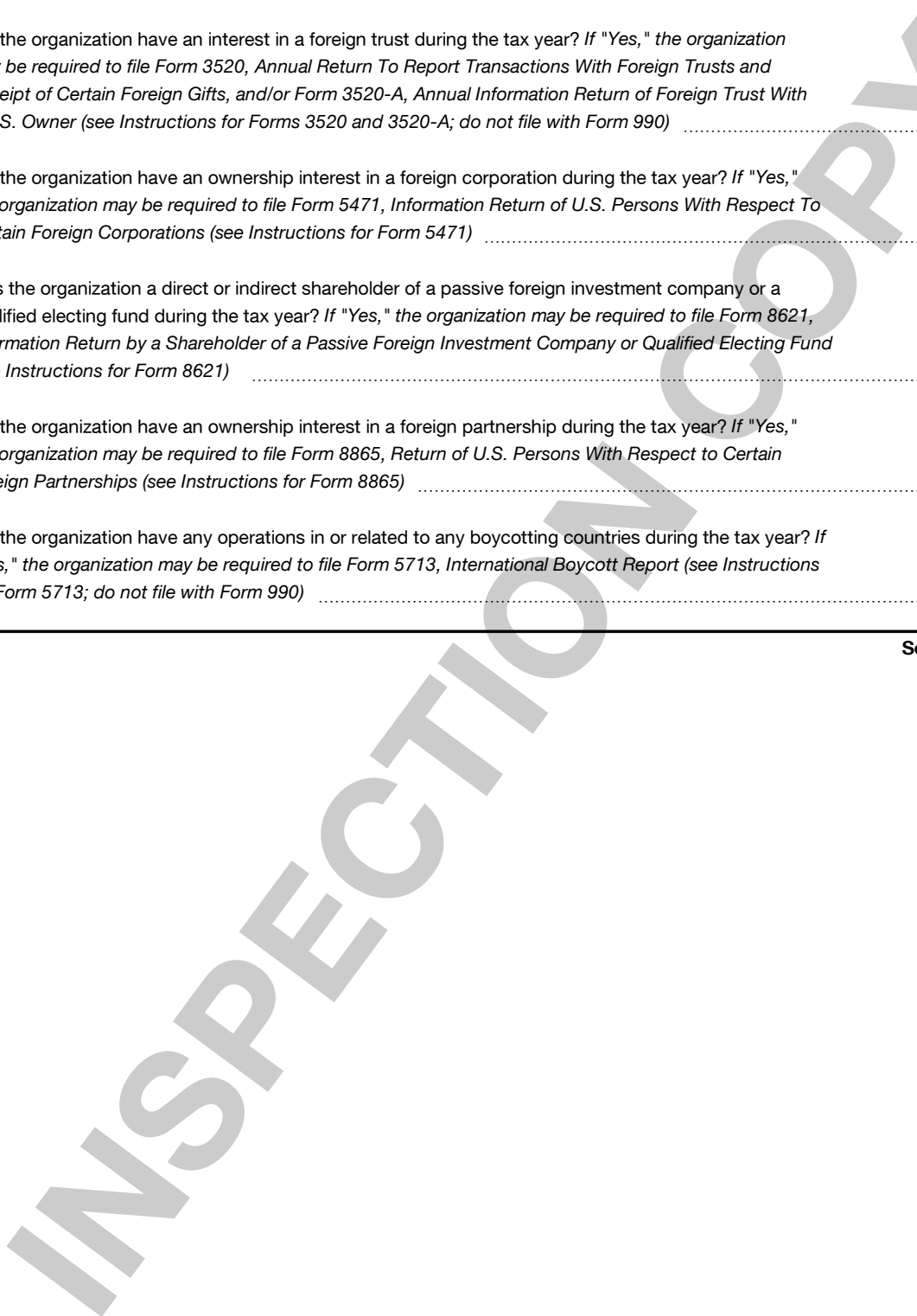
(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)



Part IV Foreign Forms

- 1 Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)* Yes No
- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to file Form 3520, Annual Return To Report Transactions With Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; do not file with Form 990)* Yes No
- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations (see Instructions for Form 5471)* Yes No
- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)* Yes No
- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons With Respect to Certain Foreign Partnerships (see Instructions for Form 8865)* Yes No
- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to file Form 5713, International Boycott Report (see Instructions for Form 5713; do not file with Form 990)* Yes No

Schedule F (Form 990) 2014



Part V Supplemental Information

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information.

Multiple horizontal lines for supplemental information.

INSPECTION COPY

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2014

Department of the Treasury
Internal Revenue Service

- ▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
- ▶ Attach to Form 990.
- ▶ Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.

Open to Public Inspection

Name of the organization **CARROLL HOSPITAL CENTER, INC.** Employer identification number **52-1452024**

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>300</u> %	X	
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>375</u> %	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		X
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a Did the organization prepare a community benefit report during the tax year?	X	
b If "Yes," did the organization make it available to the public?	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			936,883.		936,883.	.42%
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			936,883.		936,883.	.42%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			3,467,095.	171,927.	3,295,168.	1.49%
f Health professions education (from Worksheet 5)			531,839.		531,839.	.24%
g Subsidized health services (from Worksheet 6)			6,351,077.		6,351,077.	2.87%
h Research (from Worksheet 7)			198,904.		198,904.	.09%
i Cash and in-kind contributions for community benefit (from Worksheet 8)			223,194.		223,194.	.10%
j Total. Other Benefits			10,772,109.	171,927.	10,600,182.	4.79%
k Total. Add lines 7d and 7j			11,708,992.	171,927.	11,537,065.	5.21%

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy			552,314.		552,314.	.25%
8 Workforce development						
9 Other						
10 Total			552,314.		552,314.	.25%

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		X
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	95,562,236.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	89,294,983.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	6,267,253.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year?	9a	X
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	X

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 CARROLL COUNTY RADIOLOGY LLC	IMAGING CENTER	60.00%		40.00%

Part V Facility Information

Section A. Hospital Facilities

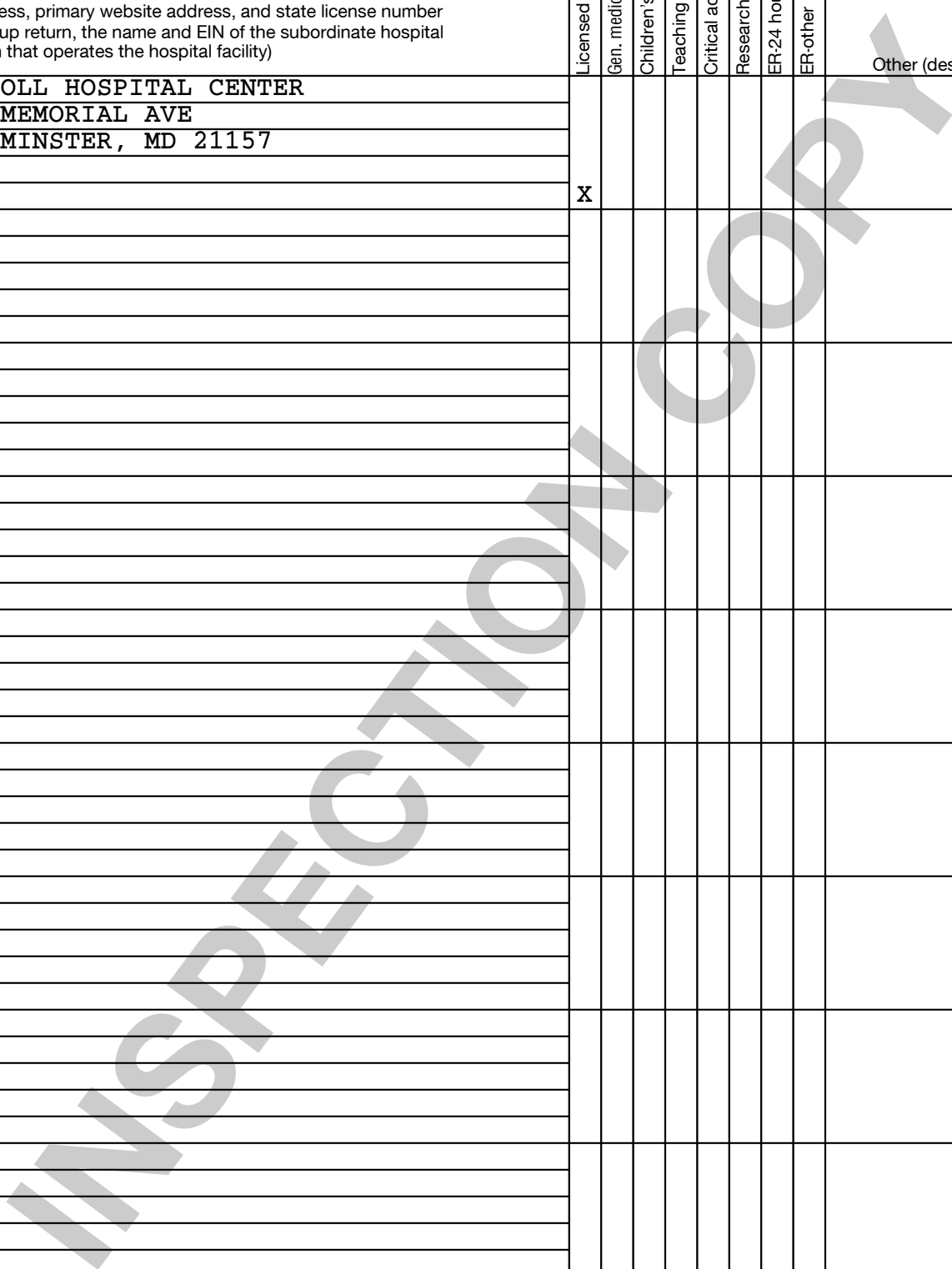
(list in order of size, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

1 CARROLL HOSPITAL CENTER
200 MEMORIAL AVE
WESTMINSTER, MD 21157

Table with columns: Licensed hospital, Gen. medical & surgical, Children's hospital, Teaching hospital, Critical access hospital, Research facility, ER-24 hours, ER-other, Other (describe), Facility reporting group. Row 1 has an 'X' in the 'Licensed hospital' column.



Part V Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group CARROLL HOSPITAL CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>12</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		X
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C		X
7 Did the hospital facility make its CHNA report widely available to the public?	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>CARROLLHOSPITALCENTER.ORG</u>		
b <input checked="" type="checkbox"/> Other website (list url): <u>HEALTHYCARROLL.ORG</u>		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>13</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a If "Yes," (list url): <u>HEALTHYCARROLL.COM</u>		
b If "No", is the hospital facility's most recently adopted implementation strategy attached to this return?		X
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group CARROLL HOSPITAL CENTER

	Yes	No
<p>Did the hospital facility have in place during the tax year a written financial assistance policy that:</p> <p>13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?</p> <p>If "Yes," indicate the eligibility criteria explained in the FAP:</p> <p>a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300</u> % and FPG family income limit for eligibility for discounted care of <u>375</u> %</p> <p>b <input type="checkbox"/> Income level other than FPG (describe in Section C)</p> <p>c <input checked="" type="checkbox"/> Asset level</p> <p>d <input checked="" type="checkbox"/> Medical indigency</p> <p>e <input type="checkbox"/> Insurance status</p> <p>f <input type="checkbox"/> Underinsurance status</p> <p>g <input type="checkbox"/> Residency</p> <p>h <input type="checkbox"/> Other (describe in Section C)</p>	X	
14 Explained the basis for calculating amounts charged to patients?	X	
15 Explained the method for applying for financial assistance?	X	
<p>If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):</p> <p>a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</p> <p>b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</p> <p>c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process</p> <p>d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</p> <p>e <input type="checkbox"/> Other (describe in Section C)</p>		
16 Included measures to publicize the policy within the community served by the hospital facility?	X	
<p>If "Yes," indicate how the hospital facility publicized the policy (check all that apply):</p> <p>a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>CARROLLHOSPITAL.ORG</u></p> <p>b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>CARROLLHOSPITAL.ORG</u></p> <p>c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>CARROLLHOSPITAL.ORG</u></p> <p>d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</p> <p>g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility</p> <p>h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</p> <p>i <input type="checkbox"/> Other (describe in Section C)</p>		

Billing and Collections

17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	X	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Actions that require a legal or judicial process		
d <input type="checkbox"/> Other similar actions (describe in Section C)		
e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V Facility Information (continued)

Name of hospital facility or letter of facility reporting group CARROLL HOSPITAL CENTER

	Yes	No
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?		X
If "Yes", check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Actions that require a legal or judicial process		
d <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	21	X	
If "No," indicate why:			
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions			
b <input type="checkbox"/> The hospital facility's policy was not in writing			
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d <input type="checkbox"/> Other (describe in Section C)			

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d <input checked="" type="checkbox"/> Other (describe in Section C)			
23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	23		X
If "Yes," explain in Section C.			
24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	24		X
If "Yes," explain in Section C.			

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

CARROLL HOSPITAL CENTER:

PART V, SECTION B, LINE 5: THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) TOOK INTO ACCOUNT INPUT FROM REPRESENTATIVES OF THE COMMUNITY SERVED BY THE HOSPITAL FACILITY, INCLUDING PERSONS WITH SPECIAL KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH, AS WELL AS LEADERS AND REPRESENTATIVES OF MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS. THE CHNA WRITTEN REPORT INCORPORATED EXPERTISE AND PARTICIPATION FROM SUCH COMMUNITY LEADERS AND REPRESENTATIVES, AS WELL AS LEADERS IN PUBLIC HEALTH, INCLUDING REPRESENTATIVES FROM THE CARROLL COUNTY HEALTH DEPARTMENT. AS PART OF THE CHNA, A KEY INFORMANT SURVEY OF 54 COMMUNITY LEADERS FROM A BROAD RANGE OF ACADEMIC, BUSINESS, GOVERNMENT, NON-PROFIT, PUBLIC HEALTH AND HEALTH CARE FIELDS WAS UNDERTAKEN. AMONG THE INDIVIDUALS WHO COMPLETED THE KEY INFORMANT SURVEY WERE REPRESENTATIVES FROM SUCH COMMUNITY ORGANIZATIONS AS THE ARC CARROLL COUNTY, CHANGE, INC., Y OF CENTRAL MARYLAND, AND THE WOMEN'S PLACE, AS WELL AS PUBLIC HEALTH EXPERTS INCLUDING A WIDE RANGE OF PHYSICIANS AND NUMEROUS MEMBERS OF THE CARROLL COUNTY HEALTH DEPARTMENT. IN ADDITION, THE CHNA INCLUDES FINDINGS FROM THE MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP), CARROLL COUNTY SHIP PROFILE AND CARROLL COUNTY LOCAL HEALTH IMPROVEMENT PLAN. FURTHERMORE, LEADERS FROM THE CARROLL COUNTY HEALTH DEPARTMENT AND THE PARTNERSHIP FOR A HEALTHIER CARROLL COUNTY ARE MEMBERS OF A COMMITTEE THAT HELPS OVERSEE THE DEVELOPMENT AND EXECUTION OF THE CHNA PLAN.

CARROLL HOSPITAL CENTER:

PART V, SECTION B, LINE 11: PURSUANT TO THE CHNA UNDERTAKEN BY CARROLL

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

HOSPITAL CENTER, 20 COMMUNITY HEALTH NEEDS WERE IDENTIFIED. THEN, WORKING COLLABORATIVELY, HOSPITAL AND COMMUNITY PUBLIC HEALTH LEADERS, AS WELL AS THE HOSPITAL'S COMMUNITY BENEFIT PLANNING COMMITTEE, BEGAN PRIORITIZING THE FOCUS FOR ACTION IN THE NEXT THREE YEARS. IN PARTICULAR, A JOINT STRATEGIES MEETING WAS CONVENED TO HELP DETERMINE THE PRIORITIZATION OF THE IDENTIFIED COMMUNITY HEALTH NEEDS.

DURING THE JOINT STRATEGY MEETING, EACH OF THE 20 IDENTIFIED COMMUNITY HEALTH NEEDS WAS ADDRESSED. TAKING INTO CONSIDERATION THE LIMITED FINANCIAL RESOURCES AVAILABLE TO THE HOSPITAL, THE 20 IDENTIFIED NEEDS WERE PRIORITIZED BY HOSPITAL AND COMMUNITY PUBLIC HEALTH LEADERS ON THE FOLLOWING CRITERIA: COMMUNITY IMPACT, URGENCY, SIZE, SEVERITY, ALIGNMENT WITH CARROLL HOSPITAL CENTER/ THE PARTNERSHIP FOR A HEALTHIER CARROLL COUNTY AND RETURN ON INVESTMENT. FINAL CRITERIA SELECTION WAS DETERMINED BY THE EXECUTIVE COUNCIL MEMBERS OF CARROLL HOSPITAL CENTER, IN COLLABORATION WITH THE PARTNERSHIP FOR A HEALTHIER CARROLL COUNTY BOARD.

PURSUANT TO THIS PRIORITIZATION PROCESS, IT WAS DETERMINED THAT THE NEEDS THE CARROLL HOSPITAL CENTER HOSPITAL FACILITY WOULD ATTEMPT TO ADDRESS WOULD BE NARROWED DOWN TO SEVEN (7) KEY COMMUNITY BENEFIT ISSUES, SO AS TO MAXIMIZE THE HOSPITAL'S RESOURCES TO ADDRESS NEEDS THE HOSPITAL FELT IT WAS IN THE BEST POSITION TO ATTEMPT TO MEET. AMONG THOSE NEEDS THAT THE HOSPITAL FACILITY DETERMINED IT WOULD NOT SPECIFICALLY FOCUS UPON ADDRESSING WERE: HEALTH CARE TRANSPORTATION, MOTOR VEHICLE DEATHS, AGE DISCRIMINATION, ARTHRITIS, ASTHMA, FLU, AND ORAL HEALTH CARE.

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

CARROLL HOSPITAL CENTER:

PART V, SECTION B, LINE 20E: THE HOSPITAL FACILITY OR AN AUTHORIZED THIRD PARTY DID NOT UNDERTAKE ANY OF THE COLLECTION ACTIONS NOTED IN PART V, SECTION B, LINE 17 BEFORE MAKING REASONABLE EFFORTS TO DETERMINE ANY PATIENTS ELIGIBILITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY. IN ORDER TO HELP DETERMINE PATIENTS' ELIGIBILITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL UNDERTAKES A NUMBER OF ACTIONS, INCLUDING NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY ON ADMISSION, NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY PRIOR TO DISCHARGE, NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY IN COMMUNICATIONS WITH THE PATIENTS' BILLS, AND DOCUMENTING ITS DETERMINATION OF WHETHER PATIENTS WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY.

CARROLL HOSPITAL CENTER:

PART V, SECTION B, LINE 22D: THE HOSPITAL FACILITY PROVIDES A DISCOUNT OF AT LEAST 25% OFF OF GROSS CHARGES FOR THE PROVISION OF EMERGENCY AND OTHER MEDICALLY NECESSARY CARE TO ANY INDIVIDUAL THAT IS ELIGIBLE FOR DISCOUNTED CARE UNDER THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY AND AT LEAST 15% OFF OF GROSS CHARGES FOR THE PROVISION OF EMERGENCY AND OTHER MEDICALLY NECESSARY CARE TO ANY INDIVIDUAL THAT QUALIFIES UNDER THE MEDICAL HARDSHIP PROVISIONS OF THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY. PURSUANT TO THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) ALL-PAYOR SYSTEM FOR HOSPITALS IN THE STATE OF MARYLAND, THE GREATEST DISCOUNT OFF OF GROSS CHARGES FOR THE PROVISION OF EMERGENCY AND OTHER MEDICALLY NECESSARY CARE PERMITTED TO ANY COMMERCIAL INSURER OR

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

MEDICARE IS ONLY 6% AS A RESULT, THE HOSPITAL FACILITY WAS ABLE TO DETERMINE THAT THE MAXIMUM AMOUNT CHARGED TO INDIVIDUALS THAT WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY WAS NOT GREATER THAN THE AMOUNT GENERALLY BILLED TO INDIVIDUALS WHO HAVE INSURANCE COVERING SUCH CARE.

CARROLL HOSPITAL CENTER:

PART V, SECTION B, LINE 24: THE HOSPITAL FACILITY DOES NOT CHARGE ANY INDIVIDUALS THAT IT KNOWS ARE ELIGIBLE FOR FINANCIAL ASSISTANCE AN AMOUNT EQUAL TO THE GROSS CHARGE FOR ANY SERVICE. THE HOSPITAL USES THE CHARGE MASTER RATES FOR A SERVICE AS A STARTING POINT AGAINST WHICH THE DISCOUNTS MANDATED IN THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY ARE APPLIED TO DETERMINE THE AMOUNT ACTUALLY BILLED TO PATIENTS ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY. THE HOSPITAL FACILITY WILL NOT COLLECT PAYMENT FROM ANY PATIENT ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY IN EXCESS OF THE REDUCED AMOUNT THAT IS ACTUALLY BILLED TO SUCH FINANCIAL ASSISTANCE PATIENT. IN ADDITION, IF THE HOSPITAL CHARGED AN INDIVIDUAL THAT HAD NOT YET BEEN DETERMINED TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE AT THE TIME OF THE CHARGE AN AMOUNT EQUAL TO GROSS CHARGES, THEN UPON DETERMINING THE INDIVIDUAL WAS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL PROMPTLY CORRECTS THE BILL.

Part V Facility Information (continued)

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 5

Name and address	Type of Facility (describe)
1 CARROLL COUNTY RADIOLOGY 7253 AMBASSADOR ROAD BALTIMORE, MD 21244	IMAGING CENTER
2 CARROLL COUNTY RADIOLOGY 1430 PROGRESS WAY, STE 108 ELDERSBURG, MD 21784	IMAGING CENTER
3 CARROLL COUNTY RADIOLOGY 193 STONER AVE, STE 200 WESTMINSTER, MD 21157	IMAGING CENTER
4 CARROLL COUNTY RADIOLOGY 1 VILLAGE SQUARE WESTMINSTER, MD 21157	IMAGING CENTER
5 CARROLL COUNTY RADIOLOGY 844 WASHINGTON ROAD, STE 102 WESTMINSTER, MD 21157	IMAGING CENTER

Part VI Supplemental Information

Provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 3C:

FOR PATIENTS THAT EXPERIENCE A MEDICAL HARDSHIP (MEDICAL DEBT THAT EXCEEDS 25% OF HOUSEHOLD INCOME), CARROLL HOSPITAL CENTER ALSO PROVIDES DISCOUNTED CARE FOR EMERGENCY OR OTHER MEDICALLY NECESSARY SERVICES TO INDIVIDUALS EARNING UP TO 500% OF THE FEDERAL POVERTY GUIDELINES. IF A PATIENT HAS RECEIVED REDUCED COST MEDICALLY NECESSARY CARE DUE TO A MEDICAL HARDSHIP, THE PATIENT OR ANY IMMEDIATE FAMILY MEMBER OF THE PATIENT LIVING IN THE SAME HOUSEHOLD SHALL REMAIN ELIGIBLE FOR REDUCED COST MEDICALLY NECESSARY CARE WHEN SEEKING SUBSEQUENT CARE AT THE SAME HOSPITAL DURING THE 12 MONTH PERIOD BEGINNING ON THE DATE ON WHICH THE REDUCED COST MEDICALLY NECESSARY CARE WAS INITIALLY RECEIVED.

IN ADDITION, SOME PATIENTS ARE PRESUMED TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE DISCOUNTS ON THE BASIS OF LIFE CIRCUMSTANCES. THESE PATIENTS THAT THE HOSPITAL HAS DETERMINED PRESUMPTIVELY QUALIFY FOR FINANCIAL ASSISTANCE ARE NOT REQUIRED TO COMPLETE ADDITIONAL FORMS OR PROVIDE ADDITIONAL INFORMATION AND ARE GRANTED 100% FINANCIAL ASSISTANCE DISCOUNTS. THE HOSPITAL INTERNALLY DOCUMENTS ANY AND ALL RECOMMENDATIONS

Part VI Supplemental Information (Continuation)

TO PROVIDE PRESUMPTIVE FINANCIAL ASSISTANCE DISCOUNTS FROM PATIENTS AND OTHER SOURCES, SUCH AS PHYSICIANS, COMMUNITY OR RELIGIOUS GROUPS, INTERNAL OR EXTERNAL SOCIAL SERVICES OR FINANCIAL COUNSELING PERSONNEL.

THE FOLLOWING ARE EXAMPLES OF PATIENT SITUATIONS THAT MAY REASONABLY ASSIST IN THE DETERMINATION OF PRESUMPTIVE ELIGIBILITY FOR FINANCIAL ASSISTANCE: (1) PATIENT HAS RECEIVED CARE FROM AND/OR HAS PARTICIPATED IN WOMEN'S, INFANTS AND CHILDREN (WIC) PROGRAMS, (2) PATIENT IS HOMELESS AND/OR HAS RECEIVED CARE FROM A HOMELESS CLINIC, (3) PATIENT'S FAMILY IS ELIGIBLE FOR AND IS RECEIVING FOOD STAMPS, (4) PATIENT'S FAMILY IS ELIGIBLE FOR AND IS PARTICIPATING IN SUBSIDIZED SCHOOL LUNCH PROGRAMS, (5) PATIENT QUALIFIES FOR OTHER STATE OR LOCAL ASSISTANCE PROGRAMS THAT ARE UNFOUNDED OR THE PATIENT'S ELIGIBILITY HAS BEEN DISMISSED DUE TO A TECHNICALITY (I.E. MEDICAID SPEND-DOWN), (6) FAMILY OR FRIENDS OF A PATIENT HAVE PROVIDED INFORMATION ESTABLISHING THE PATIENT'S INABILITY TO PAY, (7) THE PATIENT'S STREET ADDRESS AND DOCUMENTATION EVIDENCING STATUS IN AN AFFORDABLE OR SUBSIDIZED HOUSING DEVELOPMENT, (8) PATIENT/GUARANTOR'S WAGES ARE INSUFFICIENT FOR GARNISHMENT, AS DEFINED BY STATE LAW, OR (9) PATIENT IS DECEASED, WITH NO KNOWN ESTATE.

PART I, LINE 7G:

CARROLL HOSPITAL CENTER INCURRED \$6.4 MILLION OF NET COMMUNITY BENEFIT EXPENSE AS A RESULT OF UNDERTAKING SUBSIDIZED HEALTH SERVICES.

A SHORTAGE OF PRIMARY OR SPECIALTY PROVIDERS HAS PERHAPS POSED THE MOST SIGNIFICANT CHALLENGES IN INPATIENT CARE DELIVERY. SUBSTANTIAL PHYSICIAN SUBSIDIES HAVE BECOME NECESSARY TO ENSURE THAT ALL PATIENTS REQUIRING ANESTHESIA AND PEDIATRIC, PSYCHIATRIC, OBSTETRICAL AND CRITICAL AND GENERAL MEDICAL CARE HAVE THE ACCESS THEY NEED ONCE ADMITTED TO THE

Part VI Supplemental Information (Continuation)

HOSPITAL, INCLUDING 24/7 COVERAGE. CARROLL HOSPITAL CENTER HAS HOSPITALIST PROGRAMS IN EACH OF THESE AREAS AND ALLOCATES A SIGNIFICANT AMOUNT OF RESOURCES SUSTAINING THE PROGRAMS. IN FY15, APPROXIMATELY \$7.7 MILLION WAS SPENT IN ENSURING CARE FOR ALL PATIENTS AND RECRUITING AND RETAINING PHYSICIANS.

EQUALLY IMPORTANT IS ACCESS TO PHYSICIANS ON AN OUTPATIENT BASIS, NOT JUST FOR THE UNINSURED, BUT ALSO FOR ALL PATIENTS IN OUR GROWING COMMUNITY. TO ENSURE OUR COMMUNITY HAS ACCESS TO QUALITY PHYSICIANS, CARROLL HOSPITAL CENTER CONTINUALLY MONITORS STATISTICALLY CALCULATED NEED BY DEVELOPING A COMPREHENSIVE MEDICAL STAFF DEVELOPMENT PLAN BASED ON THE HEALTH CARE NEEDS OF OUR MEDICAL SERVICE AREA. THE REPORT INCLUDES BOTH AN ANALYSIS OF THE HOSPITAL'S SERVICE AREA AND SPECIFIC RECOMMENDATIONS REGARDING APPROPRIATE STAFFING LEVELS IN A VARIETY OF MEDICAL SPECIALTIES. THE PHYSICIAN NEEDS ASSESSMENT METHODOLOGY USED IS BASED ON A QUALITATIVE STANDARD ESTABLISHED BY THE INTERNAL REVENUE SERVICE (IRS). THE REPORT GUIDES THE HOSPITAL'S RECRUITING STRATEGY, HELPS US TO PRIORITIZE RECRUITING EFFORTS AND ALLOWS THE HOSPITAL TO PLACE CONTINGENCIES ON RECRUITED PHYSICIANS TO ENSURE THEY SEE MEDICALLY UNDERSERVED, UNINSURED, MEDICARE AND MEDICAID PATIENTS.

WHILE CARROLL HOSPITAL CENTER CARES FOR PATIENTS WITH NO MEANS TO PAY THEIR MEDICAL EXPENSES THROUGHOUT THE HOSPITAL, IT IS SEEN MOST ACUTELY IN THE EMERGENCY DEPARTMENT (ED), WHERE MANY UNINSURED PATIENTS OFTEN COME FOR PRIMARY AND EMERGENT CARE. SINCE ALL PATIENTS PRESENTING TO THE ED ARE TREATED FOR ANY MEDICAL CONDITION REGARDLESS OF THEIR ABILITY TO PAY FOR CARE, THE UNINSURED POPULATION POSES A SIGNIFICANT CHALLENGE NOT ONLY TO THE HOSPITAL, BUT ALSO TO PHYSICIANS PROVIDING CARE IN THE HOSPITAL AND IN

Part VI Supplemental Information (Continuation)

THE ED. DUE IN PART TO A LACK OF, OR MINIMAL REIMBURSEMENT, IT HAS BECOME INCREASINGLY DIFFICULT TO FIND SPECIALISTS TO PROVIDE ON-CALL SERVICES FOR THE ED AROUND-THE-CLOCK. THE MORE SERIOUS ISSUE IS THAT THIS TREND AFFECTS NOT ONLY OUR UNINSURED PATIENTS, BUT ALL PATIENTS SEEKING TREATMENT IN OUR ED.

THE LIKELIHOOD THAT PATIENTS PRESENT MORE ACUTELY IN THE UNINSURED POPULATION AND THE ACCOMPANYING INCREASED POTENTIAL FOR MALPRACTICE CLAIMS ALSO HAS CONTRIBUTED TO SPECIALISTS CHOOSING NOT TO COVER NONPAYING PATIENTS IN THE ED. THAT GAP IS MOST SIGNIFICANT IN SURGICAL SPECIALTIES INCLUDING, ORTHOPAEDICS, OTOLARYNGOLOGY (ENT), GENERAL SURGERY AND PLASTIC SURGERY. THERE ALSO HAS BEEN INCREASING RELUCTANCE FROM OTHER SPECIALTIES WITH SIGNIFICANT ED VOLUMES, INCLUDING VASCULAR SURGERY, NEUROSURGERY AND NEUROLOGY.

TO HELP EASE THE EFFECTS OF UNCOMPENSATED CARE ON PHYSICIANS AND ADDRESS THE GAP IN CARE FOR OUR PATIENTS, CARROLL HOSPITAL CENTER HAS CONTINUED TWO MAJOR, COSTLY INITIATIVES TO ADDRESS THE GAP PROACTIVELY. FIRST, THE HOSPITAL CONTRACTS WITH 10 MEDICAL SPECIALTIES TO ENSURE 24/7 COVERAGE IN THE ED. IMPLEMENTED IN 2006, THOSE SPECIALTIES INCLUDE NEUROSURGERY; GENERAL, PLASTIC, VASCULAR AND ORAL SURGERY; ORTHOPAEDICS; UROLOGY; PODIATRY; OPHTHALMOLOGY AND ENT. ADDITIONALLY, THE GROWING VOLUMES OF UNINSURED PATIENTS HAS CAUSED THE HOSPITAL TO RECENTLY INSTITUTE AN ADDITIONAL POLICY WHICH ALLOWS PHYSICIANS WHO SEE PATIENTS WITHOUT A PAYMENT SOURCE IN THE ED TO BE REIMBURSED FOR PHYSICIAN SERVICES BY THE HOSPITAL AT CURRENT MEDICARE RATES. WHILE PAYMENT FOR ED CALL MAY HELP WITH THE GAPS IN COVERAGE FOR THE UNINSURED, IT BEARS A SIGNIFICANT FINANCIAL TOLL ON THE HOSPITAL. THE EXPENSE TO PAY PHYSICIANS FOR ED CALL

Part VI Supplemental Information (Continuation)

HAS COST THE HOSPITAL \$854,602 IN FY15.

ALL THE INITIATIVES AND SUPPORT LISTED ABOVE WOULD NOT BE PROVIDED IF CARROLL HOSPITAL CENTER DID NOT PROVIDE THEM. AS THE ONLY HOSPITAL IN THE COUNTY, IT IS OUR PRIMARY RESPONSIBILITY TO PROVIDE THESE SERVICES FOR THE UNINSURED AND UNDERINSURED, AS WELL AS ALL COMMUNITY MEMBERS. NO OTHER ORGANIZATION OR INDIVIDUAL IN THE COUNTY WOULD BE ABLE TO PROVIDE ALL OF THESE COMPREHENSIVE SERVICES IN THE AREAS THAT THE HOSPITAL DOES.

PART I, LINE 5A

CARROLL HOSPITAL CENTER DOES NOT DENY FINANCIAL ASSISTANCE TO ANY PATIENT ELIGIBLE FOR FREE OR DISCOUNTED CARE UNDER ITS FINANCIAL ASSISTANCE POLICY REGARDLESS OF WHETHER OR NOT THE FINANCIAL ASSISTANCE BUDGET WAS EXCEEDED.

PART I, LINE 6A

MARYLAND HOSPITALS ARE REQUIRED TO SUBMIT AN ANNUAL COMMUNITY BENEFIT REPORT TO THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) THAT DESCRIBES THE PROGRAMS AND SERVICES OFFERED THAT ARE DESIGNED TO PROMOTE THE HEALTH AND WELLNESS OF THE COMMUNITIES SERVED. THESE REPORTS ARE AVAILABLE TO THE PUBLIC ON THE HSCRC WEBSITE (WWW.HSCRC.STATE.MD.US). ADDITIONALLY, CARROLL HOSPITAL CENTER MAKES AVAILABLE ITS COMMUNITY BENEFIT REPORT ON ITS WEBSITE (WWW.CARROLLHOSPITALCENTER.ORG)

PART I, LINE 7A

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES

Part VI Supplemental Information (Continuation)

COST REVIEW COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYOR'S RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELTED TO UNCOMPENSATED CARE.

PART I, LINE 7A, COLUMN C

THE METHODOLOGY USED TO CALCULATE CHARITY CARE COST WAS A COST-TO-CHARGE RATIO DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE-TO-CHARGES.

PART I, LINE 7B

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYOR'S RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELTED TO UNCOMPENSATED CARE. COMMUNITY BENEFIT EXPENSES ARE EQUAL TO MEDICAID REVENUES IN MARYLAND, AS SUCH, THE NET EFFECT IS ZERO. THE EXCEPTION TO THIS IS THE IMPACT ON THE HOSPITAL FOR ITS SHARE OF MEDICAID ASSESSMENT. IN RECENT YEARS THE STATE OF MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING HOSPITALS THROUGH THE RATE-SETTING SYSTEM. FOR TAX YEAR 2012 CARROLL HOSPITAL CENTER'S

Part VI Supplemental Information (Continuation)

MEDICAID BUDGET DEFICIT UNFUNDED ASSESSMENT AMOUNTED TO \$929,190

PART I LINE 7F

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYOR'S RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

PART III, LINE 4:

CARROLL HOSPITAL CENTER INCURRED \$4,345,000 BAD DEBT EXPENSE DURING THE TAX YEAR 2015. THIS REFLECTS THE AMOUNT OF GROSS PATIENT CHARGES UNCOLLECTED FROM PATIENTS THAT DID NOT QUALIFY FOR FINANCIAL ASSISTANCE. PER AUDIT REPORT (IN "PROVISION FOR BAD DEBTS"): "PATIENT ACCOUNTS RECEIVABLE ARE REDUCED BY PROVISION FOR BAD DEBTS. IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE, THE HEALTH SYSTEM ANALYZES HISTORICAL COLLECTIONS AND WRITE-OFFS AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE PROVISION FOR BAD DEBTS AND PROVISION FOR UNCOLLECTIBLE ACCOUNTS. MANAGEMENT REGULARLY REVIEWS ITS ESTIMATE AND EVALUATES THE SUFFICIENCY OF THE ALLOWANCE FOR BAD DEBTS. THE HEALTH SYSTEM ANALYZES CONTRACTUAL AMOUNTS DUE FROM PATIENTS WHO HAVE THIRD PARTY COVERAGE AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS. FOR PATIENT ACCOUNTS

Part VI Supplemental Information (Continuation)

RECEIVABLE ASSOCIATED WITH SELF-PAY PATIENTS, WHICH INCLUDES THOSE PATIENTS WITHOUT INSURANCE COVERAGE EXISTS FOR A PORTION OF THE BILL, THE HEALTH SYSTEM RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS FOR PATIENTS THAT ARE UNABLE OR UNWILLING TO PAY FOR THE PORTION OF THE BILL REPRESENTING THEIR FINANCIAL RESPONSIBILITY. ACCOUNT BALANCES ARE CHARGED OFF AGAINST THE ALLOWANCE FOR BAD DEBTS AFTER ALL MEANS OF COLLECTION HAS BEEN EXHAUSTED.

BAD DEBT EXPENSE REPORTED ON LINE 2 REFLECTS ACTUAL PATIENT CHARGES THAT HAVE BEEN DETERMINED TO BE UNCOLLECTIBLE FOR PATIENTS THAT HAVE NOT QUALIFIED FOR CHARITY CARE. BAD DEBT EXPENSE MAY ALSO INCLUDE ADDITIONAL "BAD DEBT PROVISIONS" FOR DOUBTFUL ACCOUNTS BASED ON MANAGEMENT'S ESTIMATES OF FUTURE ACCOUNT COLLECTIONS BASED ON CHARGES IN SERVICE MIX AND PAYOR MIX.

CARROLL HOSPITAL CENTER INC. DETERMINES ELIGIBILITY FOR FINANCIAL ASSISTANCE THROUGH OTHER VARIOUS MEANS (CREDIT REPORTS, DEBT AND ASSET REVIEWS, AND REFERRALS FROM THE HOSPITAL'S BILLING AGENTS) WHEN THE PATIENT HAS NOT COMPLETED THE FINANCIAL ASSISTANCE APPLICATION. IF A DETERMINATION IS MADE REGARDING THE PATIENT'S INABILITY TO PAY, THE ACCOUNT CAN BE APPROVED FOR FINANCIAL ASSISTANCE ON A PRESUMPTIVE BASIS RATHER THAN BE REFLECTED AS BAD DEBT EXPENSE. OF THE REMAINING BAD DEBT EXPENSE, IT IS ESTIMATED THAT \$332,000 AT COST MAY BE ATTRIBUTABLE TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE/CHARITY CARE.

PART III, LINE 8:

CARROLL HOSPITAL CENTER'S TAX YEAR 2014 (FISCAL YEAR 2015) MEDICARE COST REPORT SUBMISSION WAS UTILIZED AS THE SOURCE DOCUMENT TO REPORT MEDICARE

Part VI Supplemental Information (Continuation)

TOTAL REVENUE AND ALLOWABLE COSTS.

PART III, LINE 9B:

FOR THOSE PATIENTS THAT DO NOT INITIALLY APPLY OR QUALIFY FOR FINANCIAL ASSISTANCE, THE ORGANIZATION CONTINUES TO MONITOR WHETHER THE PATIENT MAY QUALIFY FOR FINANCIAL ASSISTANCE. IF THE PATIENT IS FOUND TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE, AT ANY POINT (INCLUDING ONCE COLLECTION EFFORTS HAVE BEGUN), THE ORGANIZATION WILL APPROVE THE PATIENT FOR FINANCIAL ASSISTANCE. COLLECTION EFFORTS WILL BE STOPPED IMMEDIATELY ONCE THE PATIENT IS FOUND TO QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY. PATIENTS DETERMINED TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE SUBSEQUENT TO THE DATE OF SERVICE MAY BE ELIGIBLE FOR A REFUND OF PAYMENTS MADE IF IT IS DETERMINED THAT THE PATIENT WAS ELIGIBLE FOR FINANCIAL ASSISTANCE AT THE TIME OF SERVICE.

PART VI, LINE 2:

MONITORING THE HEALTH STATUS OF THE COMMUNITY IS AN ONGOING AND INTERACTIVE PROCESS ENGAGED IN BY THE HOSPITAL, WITH SUBSTANTIAL INVOLVEMENT FROM OUR COMMUNITY VIA THE PARTNERSHIP FOR A HEALTHIER CARROLL COUNTY, INC. ("THE PARTNERSHIP"), AN ENTITY ESTABLISHED BY THE HOSPITAL AND THE CARROLL COUNTY HEALTH DEPARTMENT SPECIFICALLY TO ASSESS UNMET HEALTH NEEDS IN THE COMMUNITY, EXPAND THE CAPACITY FOR HEALTH AND QUALITY OF LIFE IMPROVEMENT IN THE COMMUNITY, SERVE AS A COLLABORATIVE VEHICLE FOR INTERACTION WITH THE COMMUNITY, AND WITH OUR COMMUNITY, TO DRIVE THE EFFORT TO CREATE A HEALTHIER CARROLL COUNTY. THE PARTNERSHIP IS A RELATED SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION OF THE HOSPITAL, WHICH RECEIVES A MAJORITY OF ITS OPERATING FUNDS FROM CONTRIBUTIONS MADE DIRECTLY BY THE HOSPITAL.

Part VI Supplemental Information (Continuation)

IMPROVEMENT IN THE CORE HEALTH IMPROVEMENT AREAS (C.H.I.A.S) IS ONE OF THE HOSPITAL'S GOALS. THE C.H.I.A.S ARE THE NEED AREAS REQUIRING INDIVIDUAL AND ORGANIZATIONAL ACTION TO ACHIEVE TARGETED IMPROVED STATUS USING THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' HEALTHY PEOPLE 2020 TARGETS AS THE BENCHMARK. THE HOSPITAL PARTICIPATES ACTIVELY IN MANY OF THE C.H.I.A. LEADERSHIP TEAMS COMPRISED OF DIVERSE INDIVIDUALS AND ORGANIZATIONS FROM THROUGHOUT THE HOSPITAL'S SERVICE AREA, WHO SHARE EXPERTISE AND INTEREST IN THE CHIA. WITH SUPPORT AND GUIDANCE FROM THE PARTNERSHIP, THOSE LEADERSHIP TEAMS DEVELOP AND IMPLEMENT ACTION PLANS SPECIFICALLY INTENDED TO ACCOMPLISH TARGETED RESULTS. "HEALTHY CARROLL VITAL SIGNS" (DESCRIBED BELOW) ARE THEN AFFIRMED, ARE SPECIFIC TO EACH CHIA LEADERSHIP TEAM AND SERVE AS ONE OF THE PRIMARY TOOLS FOR MEASURING AND REPORTING RESULTS TO THE HOSPITAL LEADERSHIP AND TO THE COMMUNITY.

RECENTLY THE HOSPITAL HAS COLLABORATED WITH THE PARTNERSHIP WITH RESPECT TO AN ASSESSMENT OF HEALTH NEEDS VIA MARYLAND'S STATE HEALTH IMPROVEMENT PROCESS (S.H.I.P.), WHICH WAS ORGANIZED TO PRODUCE A LOCAL HEALTH IMPROVEMENT PLAN (L.H.I.P.). THE PARTNERSHIP ORGANIZATION ENTHUSIASTICALLY AGREED TO SERVE AS THE LOCAL COALITION REQUIRED IN THE S.H.I.P. PROCESS. THIS PROVIDED CARROLL HOSPITAL CENTER YET ANOTHER OPPORTUNITY FOR LINKAGE TO IMPORTANT, VALIDATED INFORMATION ABOUT HEALTH NEEDS IN OUR COMMUNITY AND ONGOING OPPORTUNITIES TO COLLABORATE WITH OUR LOCAL AND STATE HEALTH DEPARTMENT REGARDING IMPLEMENTATION STRATEGIES FOR TARGETED RESULTS.

PURSUANT TO THE S.H.I.P. ASSESSMENT, THIRTY-NINE "HIGH IMPACT OBJECTIVES" WERE IDENTIFIED BY THE STAFF AT MARYLAND'S DEPARTMENT OF HEALTH AND MENTAL HYGIENE. A CARROLL COUNTY SPECIFIC DATA PROFILE SERVED AS THE

Part VI Supplemental Information (Continuation)

BASELINE DOCUMENT. AFTER THOROUGH ANALYSIS, A LOCAL TEAM, WHICH INCLUDED THE HOSPITAL, PRODUCED A LOCAL HEALTH IMPROVEMENT PLAN (L.H.I.P.) ADDRESSING FIVE PRIORITY NEED AREAS. THE S.H.I.P. AND L.H.I.P. PROVIDE ANOTHER IMPORTANT SET OF VERY USEFUL INFORMATION AND IS BEING FULLY INTEGRATED WITHIN THE HOSPITAL'S FIRST IRS COMPLIANT COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND COMMUNITY BENEFIT PLANNING PROCESSES. THE HOSPITAL AND THE PARTNERSHIP HAVE CONDUCTED MULTIPLE PREVIOUS NEEDS ASSESSMENTS, HAVE MADE REAL PROGRESS TOWARDS COMMUNITY ENGAGEMENT IN THESE PROCESSES AND HAVE INTEGRATED ANNUAL MEASUREMENT SYSTEMS INTO THE HEALTH IMPROVEMENT WORK KNOWN AS "HEALTHY CARROLL VITAL SIGNS (HCVS)." THESE MEASURES BUILD ON NATIONAL BENCHMARKS AND IMPROVEMENT TARGETS SUCH AS HP 2020. FUTURE EDITIONS OF HEALTHY CARROLL VITAL SIGNS WILL ALSO INTEGRATE S.H.I.P. 2014 BENCHMARKS AND IMPROVMENT TARGETS.

DURING THE 2012 TAX YEAR, THE HOSPITAL CONDUCTED ITS FIRST COMMUNITY HEALTH NEEDS ASSESSMENT IN COMPLIANCE WITH IRS REQUIREMENTS ("CHNA"). SHORTLY THEREAFTER, THE HOSPITAL BEGAN TO UNDERTAKE CERTAIN INITIATIVES IDENTIFIED IN THE CHNA IMPLEMENTATION STRATEGY TO BEGIN TO ATTEMPT TO MEET IDENTIFIED COMMUNITY HEALTH NEEDS. THE INITIATIVES UNDERTAKEN DURING THE 2012 TAX YEAR TO HELP MEET IDENTIFIED COMMUNITY HEALTH NEEDS ARE FURTHER DESCRIBED IN THE DISCLOSURE TO PART V, SECTION B LINE 6.

PART VI, LINE 3:

CARROLL HOSPITAL CENTER (CHC) HAS A NUMBER OF PROGRAMS TO ASSIST PATIENTS WITH THEIR PAYMENT OBLIGATIONS. FIRST, WE PROVIDE A MEDICAID ENROLLMENT SERVICE TO PATIENTS WHO QUALIFY FOR MEDICAL ASSISTANCE. THIS SERVICE ASSISTS PATIENTS WITH PAPERWORK AND WILL EVEN PROVIDE TRANSPORTATION IF NEEDED. THIS PAST YEAR, CHC ASSISTED 235 PATIENTS IN APPLYING FO THE

Part VI Supplemental Information (Continuation)

STATE'S MEDICAL ASSISTANCE PROGRAM.

FOR PATIENTS WHO DO NOT QUALIFY FOR MEDICAID COVERAGE, CHC HAS AN IN-HOUSE FINANCIAL ASSISTANCE PROGRAM. OUR ELIGIBILITY STANDARDS ARE MORE LENIENT THAN EVEN THOSE PROPOSED BY THE MARYLAND HOSPITAL ASSOCIATION GUIDELINES. WE WRITE OFF 100% OF THE BILL FOR PATIENTS WHOSE INCOME IS BELOW 300% OF THE FEDERAL POVERTY GUIDELINES (FPG) AND WRITE OFF A PORTION OF THE BILL FOR PATIENTS WHOSE INCOME IS BETWEEN 301%-375% OF THE FPG. WHEN PATIENTS EXPRESS THEIR INABILITY TO PAY FOR SERVICES, OUR STAFF WORKS TO FIND THE BEST POSSIBLE OPTION FOR THEM BY DISCUSSING IN DETAIL THEIR SITUATION. THE FAMILY IS INVOLVED IN THOSE CONVERSATIONS TO THE EXTENT THE PATIENT FEELS COMFORTABLE.

THE HOSPITAL ALSO HAS A PROCESS IN PLACE FOR PATIENTS TO HAVE FINANCIAL ASSISTANCE DECISIONS RECONSIDERED AND THAT PROCESS IS CLEARLY OUTLINED IN OUR FINANCIAL ASSISTANCE POLICY AND IN INFORMATION PROVIDED TO OUR PATIENTS. IN ADDITION, FOR PATIENTS WITH INCOME BELOW 500% OF THE FPG AND WHOSE MEDICAL DEBT AT CHC IS IN EXCESS OF 25% OF THEIR HOUSEHOLD INCOME, THE HOSPITAL HAS A MEDICAL HARDSHIP PLAN THAT PROVIDES FOR REDUCED-COST CARE.

IN ADDITION TO THE SIGNAGE AND PRINT COMMUNICATION, CARROLL HOSPITAL ALSO PROVIDES SERVICES AND INFORMATION DURING THE IN-TAKE AND DISCHARGE PROCESS. OUR POLICY IS OFFERED TO ANY PATIENT AT ALL ACCESS POINTS WHO IS EITHER UNINSURED OR UNDER-INSURED. PATIENTS ARE PRE-SCREENED FOR SCHEDULED SERVICES AND DO NOT NEED TO EXPRESS A HARDSHIP; RATHER, WE REACH OUT TO THEM PRIOR TO SERVICE TO DETERMINE IF THEY MAY MEET ELIGIBILITY FOR ANY PROGRAM OFFERED. OUR ADMITTED PATIENTS WHO ARE UNINSURED ARE VISITED BY

Part VI Supplemental Information (Continuation)

FINANCIAL COUNSELORS AT BEDSIDE FOR CONSIDERATION OF ANY AND ALL PROGRAMS OF ASSISTANCE. APPLICATIONS FOR MEDICAID AND FINANCIAL ASSISTANCE ARE STARTED AT THAT POINT.

IN ORDER TO ENSURE THERE ARE NO LANGUAGE BARRIERS, INTERPRETERS ARE USED IN THE APPLICATION PROCESS FOR EVERY PATIENT THAT NEEDS ONE. FAMILY MEMBERS ARE INVOLVED, AS THE PATIENT ALLOWS.

CARROLL HOSPITAL HAS IMPLEMENTED A DISCHARGE PROCESS IN THE EMERGENCY DEPARTMENT TO ASSIST UNINSURED PATIENTS WITH MEDICAL ASSISTANCE APPLICATIONS ONLINE, IF THEIR HEALTH CONDITION ALLOWS. PATIENTS ARE PROVIDED A COPY OF THE FINANCIAL ASSISTANCE APPLICATION ALONG WITH CONTACT INFORMATION AND ENCOURAGED TO COMPLETE IT AT THE TIME OF SERVICE. FOLLOW-UP CALLS ARE MADE BY THE FINANCIAL COUNSELING OFFICE FOR RESOLUTION.

WE ALSO HAVE STAFF MEMBERS WHO ARE CERTIFIED SSI/SSDI OUTREACH, ACCESS, AND RECOVERY(SOAR) SURROGATES, AND THEY SCREEN PATIENTS FOR ELIGIBILITY AND COMPLETE THE APPLICATION PROCESS. THE HOSPITAL ALSO ASSISTS WITH MARYLAND HEALTH INSURANCE PLAN (MHIP).

PART VI, LINE 4:

AS THE ONLY HOSPITAL IN THE COUNTY, CHC'S PRIMARY SERVICE AREA IS THE ENTIRE COUNTY. THE HOSPITAL DOES, HOWEVER, ALSO SERVE PORTIONS OF BALTIMORE, FREDERICK AND MONTGOMERY COUNTIES AS WELL AS AREAS IN SOUTHERN PENNSYLVANIA. THE GENERAL DEMOGRAPHICS FOR OUR PRIMARY COMMUNITY (CARROLL COUNTY) ARE LISTED BELOW:

Part VI Supplemental Information (Continuation)

POPULATION

TOTAL POPULATION 2014: 167,830

POPULATION PERCENT CHANGE 2010 TO 2014: 0.4%

PERSONS UNDER 5 YEARS PERCENT 2014: 4.9%

PERSONS UNDER 18 YEARS PERCENT 2014: 22.5%

PERSONS 65 YEARS AND OVER PERCENT 2014: 15.3%

FEMALE PERSONS, PERCENT 2014: 50.6%

RACE WHITE PERSONS: 92.8%

BLACK PERSONS: 3.6%

PERSONS OF HISPANIC OR LATINO ORIGIN: 3.0%

SOURCE: SOURCE US CENSUS BUREAU: STATE AND COUNTY QUICKFACTS.

FAMILY

TOTAL NUMBER OF HOUSEHOLDS (2007-2011): 59,314

AVERAGE HOUSEHOLD SIZE (2007-2011): 2.75 PERSONS

SOURCE: US CENSUS BUREAU: STATE AND COUNTY QUICK FACTS.

ECONOMICS

MEDIAN HOUSEHOLD INCOME: \$84,790

PERSONS BELOW POVERTY LEVEL, PERCENT: 5.6%

SOURCES: CARROLL COUNTY DEPARTMENT OF ECONOMIC DEVELOPMENT AND US CENSUS BUREAU: STATE AND COUNTY QUICKFACTS.

OTHER SIGNIFICANT DEMOGRAPHIC CHARACTERISTICS

ACCORDING TO AMREICAN COMMUNITY SURVEY THE PERCENTAGE OF UNINSURED PATIENTS IN CARROLL COUNTY IS 6.2%. IN TY 2015, OF THE CARROLL COUNTY RESIDENTS THAT WERE HOSPITALIZED (EITHER AT CHC OR OTHER HOSPITALS), 10.1% WERE ENROLLED IN MEDICAL ASSISTANCE PROGRAMS IN CARROLL COUNTY, WHICH

Part VI Supplemental Information (Continuation)

INCLUDES MCHIP, PAC, AND MEDICAL ASSISTANCE. THE AVERAGE LIFE EXPECTANCY WITH CARROLL COUNTY WAS 79.7.

PART VI, LINE 5:

CARROLL HOSPITAL CENTER, FOUNDED IN 1961, IS THE SOLE HOSPITAL SERVING THE JURISDICTION OF CARROLL COUNTY, MARYLAND WITH A FY 2015 POPULATION ESTIMATED AT 168,000 PERSONS. CARROLL HOSPITAL CENTER IS THE SECOND -LARGEST EMPLOYER IN CARROLL COUNTY WITH OVER 1,750 ASSOCIATES IN FY 2012. CARROLL HOSPITAL CENTER IS ACCREDITED WITH COMMENDATION BY THE JOINT COMMISSION.

OUR GOVERNING BODY IS COMPRISED PREDOMINANTLY OF INDEPENDENT LEADERS REPRESENTATIVE OF OUR COMMUNITY WHO ASSURE THAT ALL FINANCIAL SURPLUSES THE HOSPITAL GENERATES ARE USED EXCLUSIVELY TO FURTHER THE CHARITABLE PURPOSES OF THE ORGANIZATION.

WE ARE A NOT-FOR-PROFIT ORGANIZATION WITH DIVERSE SERVICE LINES INCLUDING COMPREHENSIVE ACUTE CARE SUCH AS MEDICAL, SURGICAL, PERI-NATAL, PEDIATRICS, PSYCHIATRY, MEDICAL AND RADIATION ONCOLOGY, ADULT INTENSIVE CARE AND CARDIOVASCULAR SERVICES, INCLUDING EMERGENCY PERCUTANEOUS INTERVENTIONAL HEART SURGERY. BOTH HOME-BASED AND INPATIENT HOSPICE CARE IS PROVIDED THROUGH OUR AFFILIATED AGENCY, CARROLL HOSPICE INC. DIVERSE DIAGNOSTIC SERVICES ARE PROVIDED AT MULTIPLE LOCATIONS AND INCLUDE BOTH LABORATORY AND RADIOLOGIC CAPABILITIES. WE PARTICIPATE IN MEDICARE AND MEDICAID PROGRAMS.

THERE ARE MORE THAN 400 PHYSICIANS REPRESENTING 38 SPECIALTIES ON OUR MEDICAL STAFF WHOSE MEMBERSHIP IS OPEN TO ALL QUALIFIED AREA PHYSICIANS.

Part VI Supplemental Information (Continuation)

WE OPERATE AN EMERGENCY DEPARTMENT (ED) SERVING ALL PERSONS REGARDLESS OF ABILITY TO PAY.

AN EXTENSIVE NETWORK OF HOSPITAL OPERATED PHYSICIAN PRACTICES ASSURES ADEQUATE AVAILABILITY OF BOTH PRIMARY AND SPECIALTY CARE PHYSICIANS THROUGHOUT THE SERVICE AREA-MEETING THE CARROLL HOSPITAL CENTER STANDARDS OF EXCELLENCE AND INCORPORATING THE SAME VALUES AND PRINCIPLES. BUILDING ON OUR LONG TRADITION OF COLLABORATION WITH OUR LOCAL RESIDENTS, THE HOSPITAL IN JOINT EFFORT WITH THE CARROLL COUNTY HEALTH DEPARTMENT, ESTABLISHED THE PARTNERSHIP FOR A HEALTHIER CARROLL COUNTY, INC. (THE PARTNERSHIP) IN 1999 TO LINK HOSPITAL STRENGTHS, ALONGSIDE THOSE OF OTHER WELL-ESTABLISHED COMMUNITY PARTNERS TO ACHIEVE AN IMPROVED HEALTH STATUS. THE PARTNERSHIP IS A RELATED SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION OF CARROLL HOSPITAL CENTER, WHICH RECEIVES A MAJORITY OF ITS OPERATING FUNDS FROM CONTRIBUTIONS MADE DIRECTLY BY THE HOSPITAL.

THE PARTNERSHIP WAS ESTABLISHED TO:

- * ASSESS UNMET HEALTH NEEDS IN OUR COMMUNITY
- * EXPAND THE CAPACITY FOR HEALTH AND QUALITY OF LIFE IMPROVEMENT IN OUR COMMUNITY
- * SERVE AS OUR COLLABORATIVE VEHICLE FOR INTERACTION WITH THE COMMUNITY
- * DRIVE THE EFFORT TO CREATE A HEALTHIER CARROLL COUNTY COMMUNITY.

THIS STRATEGY HAS ALLOWED CARROLL HOSPITAL CENTER TO REMAIN CONTINUALLY WELL-CONNECTED TO THE COMMUNITY, TO LEVERAGE OUR RESOURCES IN ACTION ALONGSIDE THOSE OF OTHER KEY ORGANIZATIONS AND AGENCIES (PARTICULARLY, THE CARROLL COUNTY HEALTH DEPARTMENT) AND TO ASSURE MEASURABLE RESULTS. MONITORING THE HEALTH STATUS OF THE COMMUNITY IS AN ONGOING AND

Part VI Supplemental Information (Continuation)

INTERACTIVE PROCESS ENGAGED IN BY CARROLL HOSPITAL CENTER AND THE PARTNERSHIP. CARROLL HOSPITAL CENTER AND THE PARTNERSHIP PURSUE IMPROVEMENT IN THE CORE HEALTH IMPROVEMENT AREAS (CHIAS) VIA LEADERSHIP TEAMS COMPRISED OF DIVERSE INDIVIDUALS AND ORGANIZATIONS WHO SHARE EXPERTISE AND INTEREST IN THE CHIA. THOSE LEADERS DEVELOP AND IMPLEMENT ACTION PLANS SPECIFICALLY INTENDED TO ACCOMPLISH TARGETED RESULTS. "HEALTHY CARROLL VITAL SIGNS" ARE THEN AFFIRMED, ARE SPECIFIC TO EACH CHIA LEADERSHIP TEAM AND SERVE AS ONE OF THE PRIMARY TOOLS FOR RESULTS REPORTING. WWW.HEALTHYCARROLL.ORG IS THE PARTNERSHIP'S WEBSITE WHERE CURRENT SECONDARY DATA, NATIONAL BENCHMARKS, IMPROVEMENT TARGETS AND BEST PRACTICE REFERENCES ARE EASILY AVAILABLE, ARE AS CURRENT AS AVAILABLE AND ARE AVAILABLE TO ANYONE AT NO COST.

CARROLL HOSPITAL CENTER HAS LONG RECOGNIZED THAT PROMOTING THE HEALTH OF ITS COMMUNITY IS ONE OF ITS ESSENTIAL RESPONSIBILITIES. EXTENSIVE COMMUNITY OUTREACH AND LEARNING PROGRAMS ARE OFFERED BY THE HOSPITAL WITH AN EMPHASIS ON DISEASE PREVENTION, EARLY INTERVENTION AND WELLNESS.

IN FY 2012 WE EXPANDED ON AN INTEGRATED APPROACH TO POPULATION HEALTH; SEEKING TO ASSURE ACCESS TO EXCELLENT HEALTH CARE AND DISEASE MANAGEMENT ASSISTANCE. OUR INTEGRATED APPROACH RECOGNIZES AND STRIVES TO ELIMINATE BARRIERS SUCH AS TRANSPORTATION CHALLENGES OR LIMITED ABILITIES TO PURCHASE ESSENTIAL PRESCRIPTION PRODUCTS; IT ALSO INCLUDES MORE IN-COMMUNITY CARE COORDINATION AND ASSISTANCE WITH NAVIGATING THE OFTEN COMPLEX WORLD OF HEALTH CARE ASSOCIATED SERVICES.

CHC IS ONE OF THE FOUNDING AND FUNDING PARTNERS IN A UNIQUE AND HIGHLY SUCCESSFUL INTEGRATED PRIMARY CARE CENTER KNOWN AS ACCESS CARROLL. INC. AT

Part VI Supplemental Information (Continuation)

ACCESS CARROLL, INC. THE BARRIERS OF LOW INCOME AND INELIGIBILITY FOR STATE, FEDERAL OR OTHER INSURANCE ASSISTANCE ARE BEING ELIMINATED FOR SIGNIFICANT NUMBERS OF CARROLL COUNTY RESIDENTS WHO ARE RECEIVING THE SAME STELLAR INTEGRATED PRIMARY AND SPECIALTY CARE SERVICES NEEDED TO MANAGE THEIR ACUTE AND/OR CHRONIC DISEASE ISSUES AS THEIR HIGHER INCOME AND INSURED NEIGHBORS. IN ADDITION TO PRIMARY AND SPECIALTY MEDICAL CARE AND CARE MANAGEMENT NAVIGATION ASSISTANCE, THE ACCESS CARROLL PATIENTS RECEIVE DIAGNOSTIC LABORATORY AND RADIOLOGY SERVICES, PRESCRIPTION ASSISTANCE (MORE THAN \$1,000,000 RETAIL VALUE IN FY 2012 FROM PHARMACEUTICAL PRESCRIPTION ASSISTANCE PROGRAMS COORDINATED BY ACCESS CARROLL) AND MORE.

CARROLL HOSPITAL CENTER CONTRIBUTED \$259,245 TO ACCESS CARROLL IN FY15 TO COVER SALARY AND BENEFIT EXPENSES FOR THE EXECUTIVE DIRECTOR, ONE FULL TIME RN CASE MANAGER AND TWO PART-TIME POSITIONS (AIDE AND DEVELOPMENT SPECIALIST). THE HOSPITAL ALSO PROVIDES LABORATORY AND DIAGNOSTIC IMAGING SERVICES TO ACCESS CARROLL, CAPTURED UNDER CHARITY CARE, WHICH TOTALED \$132,657 IN FY15.

THESE HEALTH PROMOTION EFFORTS ARE IN ADDITION TO PROGRAMS AND SERVICES THAT SEEK TO ALSO HELP PEOPLE CHANGE THEIR LIFESTYLES TO MOVE TOWARD A STATE OF OPTIMAL HEALTH IN MIND, BODY AND SPIRIT. CARROLL HOSPITAL CENTER DEMONSTRATES ITS COMMITMENT TO IMPROVING THE HEALTH AND WELLNESS OF THE COMMUNITIES IT SERVES BY PROVIDING SERVICES AND PROGRAMS THAT ADDRESS CRITICAL NEEDS, INCLUDING HEALTH CARE TO VULNERABLE OR UNDERSERVED PEOPLE; PUBLIC HEALTH PROGRAMS; AND HEALTH EDUCATION, SCREENING AND PREVENTION SERVICES. THESE PROGRAMS AND ACTIVITIES INCLUDED HOSPICE SERVICES, PHYSICIAN SUPPORT, CHARITY/UNCOMPENSATED CARE, EDUCATION PROGRAMS, HEALTH SCREENINGS, SUPPORT GROUPS, HEALTH PROFESSIONS EDUCATION AND COMMUNITY

Part VI Supplemental Information (Continuation)

CONTRIBUTIONS.

THE HOSPITAL'S COMMUNITY EDUCATION AND WELLNESS EFFORTS ARE LED BY COMMUNITY EDUCATORS IN THE WOMEN'S PLACE AND THE LEARNING CENTER DEPARTMENTS, IN COORDINATION WITH THE PARTNERSHIP FOR A HEALTHIER CARROLL COUNTY, SO AS TO MAXIMIZE STRATEGIES AND PROGRAMS IN ADDRESSING COMMUNITY HEALTH NEEDS.

CARROLL HOSPITAL CENTER OFFERS THESE PROGRAMS AND SERVICES NOT ONLY TO ADDRESS THE NEEDS OF PEOPLE WITH CHRONIC OR ACUTE MEDICAL ISSUES, BUT ALSO TO ADDRESS PREVENTION AND EDUCATION TO KEEP OUR POPULATION WELL.

PART VI, LINE 6:

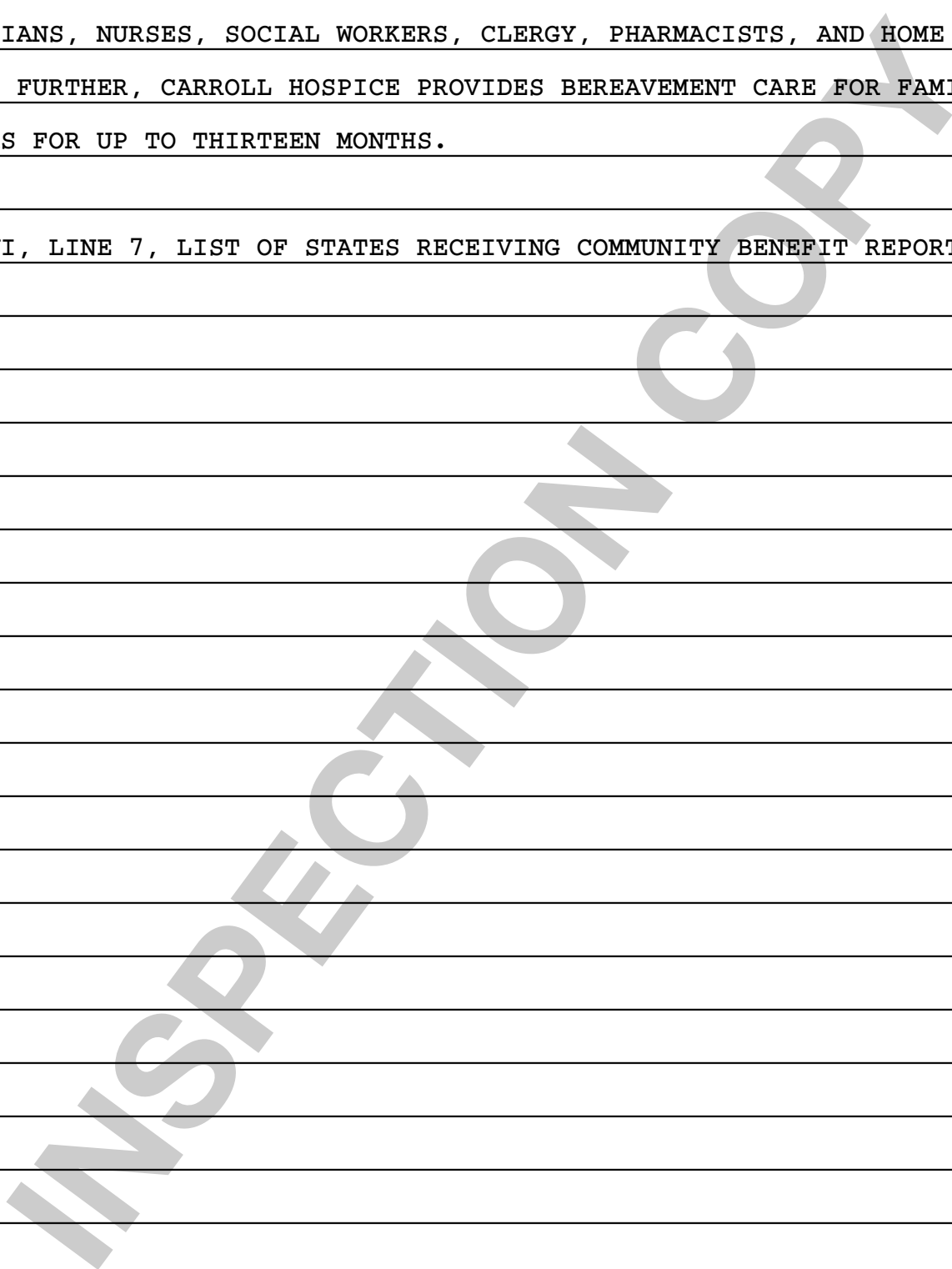
CARROLL HOSPITAL CENTER IS PART OF AN AFFILIATED HEALTH CARE SYSTEM THAT PROVIDES AN ARRAY OF HEALTH CARE SERVICES TO ITS COMMUNITY. THE HOSPITAL, AS A SOLE COMMUNITY PROVIDER, PROVIDES BOTH INPATIENT AND OUTPATIENT CARE, INCLUDING ESSENTIAL HEALTH CARE SERVICES SUCH AS OBSTETRICS, EMERGENCY SERVICES, PEDIATRIC, AND CRITICAL CARE, WHICH WOULD LIKELY OTHERWISE NOT BE PROVIDED WITHIN CARROLL COUNTY DUE TO THEIR UNPROFITABLE NATURE (HIGH COST SERVICES WITH RELATIVELY LOW REIMBURSEMENT). ADDITIONALLY, THE HOSPITAL IS RELATED TO A GROUP PHYSICIAN PRACTICE (CARROLL HEALTH GROUP), WHICH PROVIDES PRIMARY AND SPECIALTY CARE SERVICES TO THE COMMUNITY. THE PROVISION OF THE PHYSICIAN SERVICE HELPS MEET AN IDENTIFIED COMMUNITY HEALTH NEED FOR ADDITIONAL PRIMARY AND SPECIALTY CARE PHYSICIANS IN THE COMMUNITY. CARROLL HOSPICE, AN AFFILIATE OF CARROLL HOSPITAL CENTER, PROVIDES INPATIENT HOSPICE CARE, AS WELL AS RESIDENTIAL HOSPICE AND PALLIATIVE CARE, TO PATIENTS NEARING THE END-OF-LIFE. CARROLL HOSPICE PROVIDES PAIN MANAGEMENT AND SYMPTOM CONTROL AND HELPS COORDINATE HOME AND

Part VI Supplemental Information (Continuation)

INPATIENT SERVICES. IN ORDER TO PROVIDE COMPREHENSIVE AND COMPASSIONATE CARE, CARROLL HOSPICE UTILIZES AN INTERDISCIPLINARY TEAM, INCLUDING PHYSICIANS, NURSES, SOCIAL WORKERS, CLERGY, PHARMACISTS, AND HOME HEALTH AIDES. FURTHER, CARROLL HOSPICE PROVIDES BEREAVEMENT CARE FOR FAMILY MEMBERS FOR UP TO THIRTEEN MONTHS.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

MD



**SCHEDULE I
(Form 990)**

Department of the Treasury
Internal Revenue Service

**Grants and Other Assistance to Organizations,
Governments, and Individuals in the United States**

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 or 22.

▶ Attach to Form 990.

▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2014

Open to Public
Inspection

Name of the organization

CARROLL HOSPITAL CENTER, INC.

Employer identification number

52-1452024

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
PARTNERSHIP FOR HEALTHIER CARROLL COUNTY - 535 OLD WESTMINSTER PIKE, STE 102 - WESTMINSTER, MD 21157-5799	52-2156892	501(C)(3)	173,000.	0.			TO SUPPORT THE OPERATIONS OF PARTNERSHIP.

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table

3 Enter total number of other organizations listed in the line 1 table

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule I (Form 990) (2014)

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" to Form 990, Part IV, line 22.
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance

Part IV **Supplemental Information.** Provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

PART I, LINE 2:

THE GRANT PROVIDED IS TO THE PARTNERSHIP FOR A HEALTHIER CARROLL COUNTY A RELATED ORGANIZATION THAT IS CONTROLLED BY THE ORGANIZATION AND IS A JOINT VENTURE WITH THE CARROLL COUNTY HEALTH DEPARTMENT. THE PARTNERSHIP FOR A HEALTHIER CARROLL COUNTY IS A 501(C)(3) TAX-EXEMPT ORGANIZATION THAT IS DEDICATED TO IMPROVING THE HEALTH AND QUALITY OF LIFE OF INDIVIDUALS LIVING IN CARROLL COUNTY, MARYLAND.

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

2014

Open to Public Inspection

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.

▶ Attach to Form 990.

▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

Department of the Treasury
Internal Revenue Service

Name of the organization

CARROLL HOSPITAL CENTER, INC.

Employer identification number

52-1452024

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|---|---|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input checked="" type="checkbox"/> Tax indemnification and gross-up payments | <input checked="" type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?

3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- | | |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee | <input checked="" type="checkbox"/> Written employment contract |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment?
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
- c** Participate in, or receive payment from, an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

5 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
- b** Any related organization?
- If "Yes" to line 5a or 5b, describe in Part III.

6 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization?
- b** Any related organization?
- If "Yes" to line 6a or 6b, describe in Part III.

7 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III

8 Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III

9 If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
1b	X	
2	X	
4a	X	
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7		X
8		X
9		

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule J (Form 990) 2014

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) LESLIE SIMMONS CHIEF EXECUTIVE OFFICER	(i)	388,820.	102,564.	48,175.	17,500.	13,339.	570,398.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) NEIL MELTZER BOARD MEMBER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	790,719.	419,867.	289,736.	334,475.	24,815.	1,859,612.	0.
(3) KEVIN KELBLY SR VP FINANCE CFO	(i)	308,629.	102,505.	21,008.	28,309.	17,025.	477,476.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) BOB EDMONDSON VICE PRESIDENT	(i)	190,860.	108,498.	12,774.	12,999.	25,291.	350,422.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) CRIS COLEMAN VICE PRESIDENT	(i)	179,456.	34,929.	11,127.	17,221.	22,500.	265,233.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) DAVID LOUDER VICE PRESIDENT	(i)	292,586.	59,054.	19,056.	18,977.	8,519.	398,192.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) JED ROSEN CHIEF MEDICAL INFO OFFICER	(i)	402,474.	82,600.	1,188.	0.	10,146.	496,408.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) JOYCE ROMANS VICE PRESIDENT	(i)	237,563.	0.	13,241.	15,057.	16,466.	282,327.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) M ELLEN FINNERTY MYERS CHIEF DEVELOPMENT OFFICER	(i)	220,002.	50,550.	13,515.	16,490.	2,048.	302,605.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) MARK OLSZYK VICE PRESIDENT	(i)	319,997.	82,214.	33,122.	18,538.	540.	454,411.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) ROBERT WHITE VICE PRESIDENT	(i)	167,524.	33,621.	11,466.	12,302.	12,496.	237,409.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) SHARON GOMEZ-SANDERS VICE PRESIDENT	(i)	151,777.	29,443.	9,713.	9,438.	26,750.	227,121.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) STEPHANIE REID VICE PRESIDENT	(i)	169,803.	33,947.	10,865.	14,813.	1,261.	230,689.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) TRACEY ELLISON VICE PRESIDENT	(i)	187,553.	36,577.	12,055.	14,738.	28,368.	279,291.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) DAVID SALINGER PHYSICIAN	(i)	492,420.	151,000.	27,849.	10,233.	25,001.	706,503.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) FLAVIO KRUTER PHYSICIAN	(i)	617,866.	198,540.	147,913.	16,100.	23,291.	1,003,710.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(17) JANICE NAPIERALSKI AVP	(i)	156,173.	40,165.	7,906.	61,678.	7,465.	273,387.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(18) JOHANNA DIMENTO PHYSICIAN	(i)	337,903.	45,495.	26,149.	12,047.	12,540.	434,134.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(19) RICHARD RAVER EMPLOYEE	(i)	170,686.	0.	90.	884.	23,971.	195,631.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(20) JOHN SERNULKA PRESIDENT/EX-OFFICIO	(i)	145,464.	166,898.	1,485,440.	49,209.	10,176.	1,857,187.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

PART I, LINE 1A:

THE HOSPITAL HAS TAKEN THE POSITION THAT IT WILL INCLUDE IN TAXABLE W-2 WAGES FOR THE PRESIDENT CERTAIN BUSINESS EXPENSES THAT THE IRS MAY QUESTION AS NOT BEING TAX DEDUCTIBLE, SO LONG AS SUCH EXPENSES HAVE A DIRECT CONNECTION TO THE PROMOTION OF THE HOSPITAL'S HEALTH CARE SERVICES. FOR 2014, THESE EXPENSES WERE LESS THAN \$5,400 IN AGGREGATE, FOR THE PRESIDENT. HEALTH OR SOCIAL CLUB DUES OR INITIATION FEES FOR THE PRESIDENT WERE REIMBURSED BY THE HOSPITAL AND INCLUDED ON THE PRESIDENT'S W-2. THE AMOUNT OF THE REIMBURSED FEES WAS CONSIDERED IN THE PROCESS FOR DETERMINING THE PRESIDENT'S COMPENSATION.

PART I, LINES 4A-B:**LINE 4A:**

JOHN SERNULKA RECEIVED \$1,484,817 SEVERANCE PAYMENT IN THE TAX YEAR.

LINE 4B:

JOHN SERNULKA PARTICIPATED IN THE 457(F) DEFERRED COMPENSATION PLANS AND WERE PAID AND/OR CREDITED WITH \$31,709.

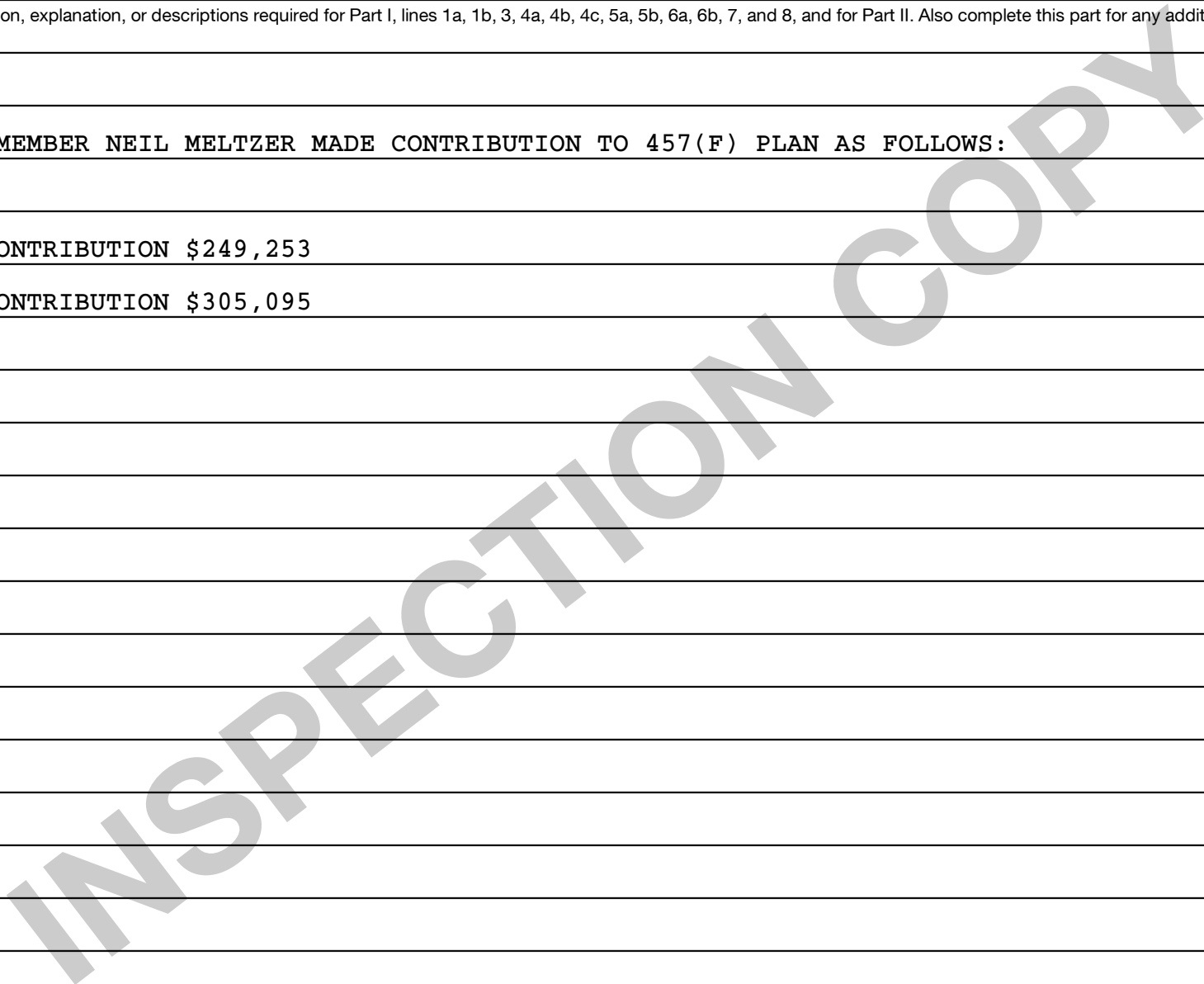
Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

THE BOARD MEMBER NEIL MELTZER MADE CONTRIBUTION TO 457(F) PLAN AS FOLLOWS:

EMPLOYEE CONTRIBUTION \$249,253

EMPLOYER CONTRIBUTION \$305,095



Supplemental Information on Tax-Exempt Bonds

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

▶ **Attach to Form 990.** ▶ **Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.**

Name of the organization

CARROLL HOSPITAL CENTER, INC.

Employer identification number
52-1452024

Part I Bond Issues											
SEE PART VI FOR COLUMNS (A) AND (F) CONTINUATIONS											
(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A MARYLAND HEALTH AND HIGHER EDUCATION FAC AUT	52-0936091	574217B53	12/07/06	36,179,115.	HOSPITAL RENOVATIONS AND E		X		X		X
B MARYLAND HEALTH AND HIGHER EDUCATION FAC AUT	52-0936091	NONE	06/30/10	15,000,000.	HOSPITAL RENOVATIONS AND E		X		X		X
C MARYLAND HEALTH AND HIGHER EDUCATION FAC AUT	52-0936091	574218HJ5	05/31/12	93,596,537.	REFUND 2002 BONDS, FAC ACQ, RENOVA		X		X		X
D											

Part II Proceeds										
	A		B		C		D			
1 Amount of bonds retired			15,000,000.		33,170,000.					
2 Amount of bonds legally defeased										
3 Total proceeds of issue	38,920,902.		15,000,000.		93,596,537.					
4 Gross proceeds in reserve funds	3,225,084.									
5 Capitalized interest from proceeds										
6 Proceeds in refunding escrows										
7 Issuance costs from proceeds	683,750.		255,500.		100,764.					
8 Credit enhancement from proceeds										
9 Working capital expenditures from proceeds										
10 Capital expenditures from proceeds	35,012,068.		14,744,500.		14,899,236.					
11 Other spent proceeds					78,596,537.					
12 Other unspent proceeds										
13 Year of substantial completion	2009		2010		2012					
	Yes	No	Yes	No	Yes	No	Yes	No		
14 Were the bonds issued as part of a current refunding issue?		X		X	X					
15 Were the bonds issued as part of an advance refunding issue?		X		X		X				
16 Has the final allocation of proceeds been made?	X		X		X					
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X					

Part III Private Business Use										
	A		B		C		D			
	Yes	No	Yes	No	Yes	No	Yes	No		
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X				
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X				

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X		X			
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X		X			
c Are there any research agreements that may result in private business use of bond-financed property?		X		X	X			
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?					X			
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government								
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government	1.00	%	1.00	%	1.00	%		%
6 Total of lines 4 and 5	1.00	%	1.00	%	1.00	%		%
7 Does the bond issue meet the private security or payment test?		X		X		X		
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of		%		%		%		%
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X		X			

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X		X		
b Exception to rebate?		X		X		X		
c No rebate due?	X		X		X			
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X	X		X			
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X		
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								

Part IV Arbitrage (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X		X		
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		X			

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X		X		X			

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K (see instructions).

SCHEDULE K, PART I, BOND ISSUES:

(A) ISSUER NAME: MARYLAND HEALTH AND HIGHER EDUCATION FAC AUTHORITY

(F) DESCRIPTION OF PURPOSE: HOSPITAL RENOVATIONS AND EQUIPMENT PURCHASE

(A) ISSUER NAME: MARYLAND HEALTH AND HIGHER EDUCATION FAC AUTHORITY

(F) DESCRIPTION OF PURPOSE: HOSPITAL RENOVATIONS AND EQUIPMENT PURCHASE

(A) ISSUER NAME: MARYLAND HEALTH AND HIGHER EDUCATION FAC AUTHORITY

(F) DESCRIPTION OF PURPOSE: REFUND 2002 BONDS, FAC ACQ, RENOVATION

SCHEDULE K, PART IV, ARBITRAGE, LINE 2C:

(A) ISSUER NAME: MARYLAND HEALTH AND HIGHER EDUCATION FAC AUTHORITY

DATE THE REBATE COMPUTATION WAS PERFORMED: 08/10/2011

(A) ISSUER NAME: MARYLAND HEALTH AND HIGHER EDUCATION FAC AUTHORITY

DATE THE REBATE COMPUTATION WAS PERFORMED: 10/06/2014

(A) ISSUER NAME: MARYLAND HEALTH AND HIGHER EDUCATION FAC AUTHORITY

DATE THE REBATE COMPUTATION WAS PERFORMED: 10/22/2015

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
HEATHER GREEN	DAUGHTER OF AN OFFI	62,616.	EMPLOYEE OF		X
CHELSEA BEAUVAIS	DAUGHTER OF AN OFFI	38,600.	EMPLOYEE OF		X
ROBERT J. BEAUVAIS	SON-IN-LAW OF AN OF	65,336.	EMPLOYEE OF		X
RANDY C GREEN JR	SON-IN-LAW OF AN OF	78,208.	EMPLOYEE OF		X
SOMMER DORSEY	STEP DAUGHTER OF A	30,107.	EMPLOYEE OF		X
JOHN A STEERS MD PA	BUSINESS OWNED BY A	581,740.	INDEPENDENT		X
JOHN A STEERS	BOARD MEMBER	106,015.	RENT OF SUI		X
VASCULAR AND CARDIOTHORACI	BUSINESS OWNED BY A	96,744.	MEDICAL SER		X
JOHN A STEERS MD PA	BUSINESS OWNED BY A	67,740.	ED ON CALL		X
JOYCE VANSANT	SPOUSE OF A BOARD M	25,420.	EMPLOYEE OF		X

Part V Supplemental Information

Provide additional information for responses to questions on Schedule L (see instructions).

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: HEATHER GREEN

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

DAUGHTER OF AN OFFICER, LESLIE SIMMONS

(D) DESCRIPTION OF TRANSACTION: EMPLOYEE OF THE HOSPITAL

(A) NAME OF PERSON: CHELSEA BEAUVAIS

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

DAUGHTER OF AN OFFICER, LESLIE SIMMONS

(D) DESCRIPTION OF TRANSACTION: EMPLOYEE OF THE HOSPITAL

(A) NAME OF PERSON: ROBERT J. BEAUVAIS

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SON-IN-LAW OF AN OFFICER, LESLIE SIMMONS

(D) DESCRIPTION OF TRANSACTION: EMPLOYEE OF THE HOSPITAL

(A) NAME OF PERSON: RANDY C GREEN JR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SON-IN-LAW OF AN OFFICER, LESLIE SIMMONS

(D) DESCRIPTION OF TRANSACTION: EMPLOYEE OF THE HOSPITAL

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(A) NAME OF PERSON: SOMMER DORSEY

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

STEP DAUGHTER OF A KEY EMPLOYEE, SHARON GOMEZ-SANDERS

(D) DESCRIPTION OF TRANSACTION: EMPLOYEE OF THE HOSPITAL

(A) NAME OF PERSON: JOHN A STEERS MD PA

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

BUSINESS OWNED BY A BOARD MEMBER JOHN STEERS

(D) DESCRIPTION OF TRANSACTION: INDEPENDENT CONTRACTOR WITH CARROLL HEALTH GROUP

(A) NAME OF PERSON: JOHN A STEERS

(D) DESCRIPTION OF TRANSACTION: RENT OF SUITE

(A) NAME OF INTERESTED PERSON:

VASCULAR AND CARDIOTHORACIC ASSOCIATES OF MARYLAND

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

BUSINESS OWNED BY A BOARD MEMBER DR SOHAILIA ALI

(D) DESCRIPTION OF TRANSACTION: MEDICAL SERVICES

(A) NAME OF PERSON: JOHN A STEERS MD PA

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

BUSINESS OWNED BY A BOARD MEMBER JOHN STEERS

(D) DESCRIPTION OF TRANSACTION: ED ON CALL - HOSPITAL

(A) NAME OF PERSON: JOYCE VANSANT

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

SPOUSE OF A BOARD MEMBER LARRY VAN SANT SR

(D) DESCRIPTION OF TRANSACTION: EMPLOYEE OF THE HOSPITAL/FOUNDATION

(A) NAME OF PERSON: AMANDA VETTER

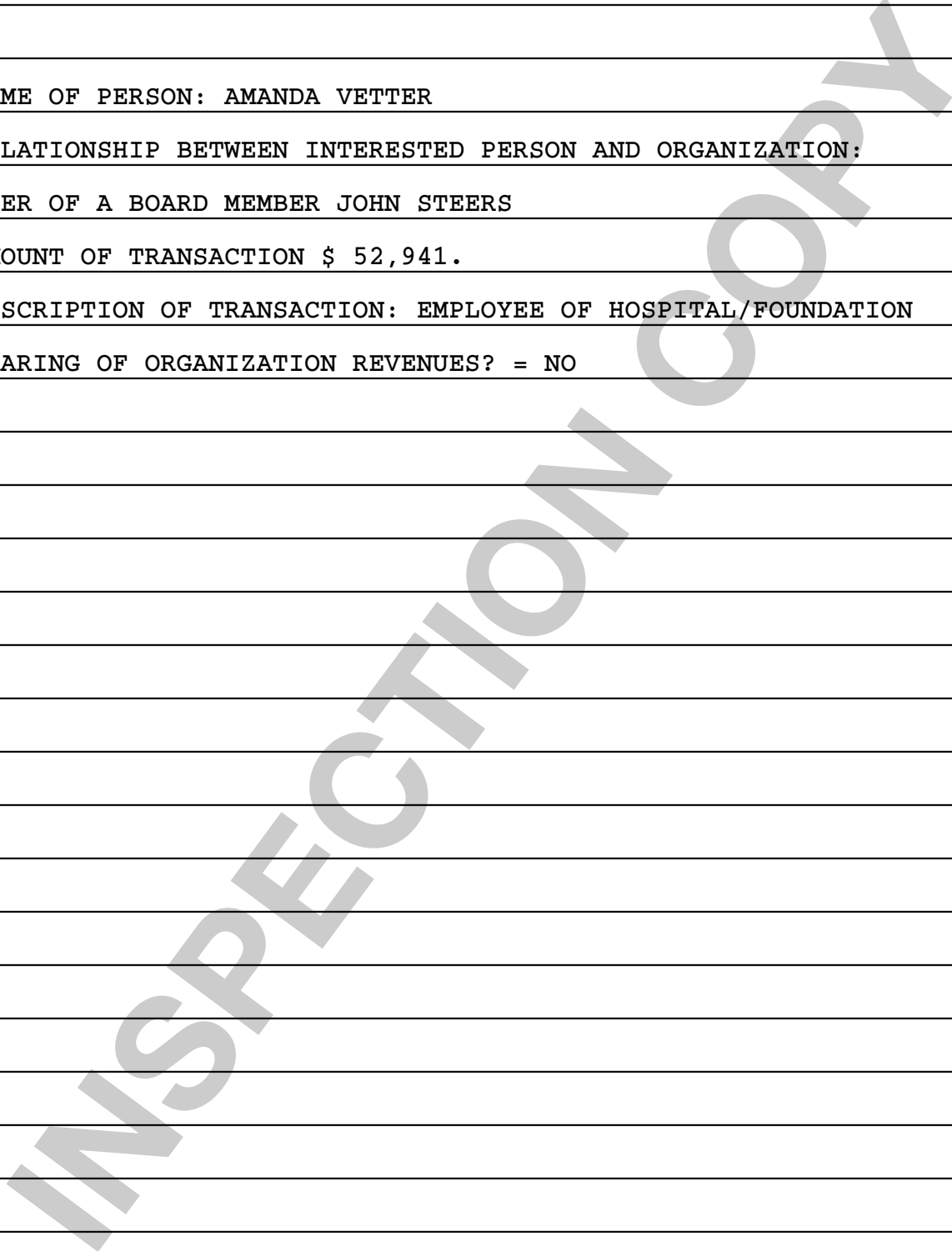
(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

DAUGHTER OF A BOARD MEMBER JOHN STEERS

(C) AMOUNT OF TRANSACTION \$ 52,941.

(D) DESCRIPTION OF TRANSACTION: EMPLOYEE OF HOSPITAL/FOUNDATION

(E) SHARING OF ORGANIZATION REVENUES? = NO



SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2014

Open to Public
Inspection

Name of the organization

CARROLL HOSPITAL CENTER, INC.

Employer identification number

52-1452024

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

GUIDANCE IN MAINTAINING THEIR HEALTH AND WELL-BEING. AT CARROLL
HOSPITAL CENTER, WE OFFER AN UNCOMPROMISING COMMITMENT TO THE HIGHEST
QUALITY HEALTH CARE EXPERIENCE FOR PEOPLE IN ALL STAGES OF LIFE. WE
ARE THE HEART OF HEALTH CARE IN OUR COMMUNITIES.

FORM 990, PART III, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

EXPERIENCE FOR PEOPLE IN ALL STAGES OF LIFE. WE ARE THE HEART OF
HEALTH CARE IN OUR COMMUNITIES.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

VISITS LAST YEAR. THE HOSPITAL PARTICIPATES IN MEDICARE AND MEDICAID
PROGRAMS, HAS A GOVERNING BODY COMPRISED OF INDEPENDENT PERSONS
REPRESENTATIVE OF THE COMMUNITY, ALL FINANCIAL SURPLUSES THE HOSPITAL
GENERATES ARE USED EXCLUSIVELY TO FURTHER THE CHARITABLE PURPOSES OF
THE ORGANIZATION AND ITS MEDICAL STAFF IS OPEN TO ALL QUALIFIED
PHYSICIANS IN THE AREA. AS THE ONLY HOSPITAL IN CARROLL COUNTY, WE
OFFER OUR COMMUNITY A FULL ARRAY OF SERVICES INCLUDING, EMERGENCY
SERVICES, COMPREHENSIVE CANCER CARE, PEDIATRICS, MATERNITY, GERIATRICS,
THE LATEST MINIMALLY INVASIVE SURGICAL PROCEDURES AND ADVANCED TOTAL
AND PARTIAL JOINT REPLACEMENT PROCEDURES. IN THE YEAR ENDING JUNE
2015, CARROLL HOSPITAL CENTER RECORDED 14,813 INPATIENT ADMISSIONS AND
OBSERVATION STAY CASES, 1,079 BIRTHS AND 7,676 SURGICAL PROCEDURES,
ALL CONTRIBUTING TO A TOTAL OF 181,671 PATIENT ENCOUNTERS FOR THE
PERIOD. IN LINE WITH OUR MISSION-"OUR COMMUNITIES EXPECT AND DESERVE

SUPERIOR MEDICAL TREATMENT, COMPASSIONATE CARE, AND EXPERT GUIDANCE IN

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule O (Form 990 or 990-EZ) (2014)

432211
08-27-14

Name of the organization

CARROLL HOSPITAL CENTER, INC.

Employer identification number

52-1452024

MAINTAINING THEIR HEALTH AND WELL-BEING. AT CARROLL HOSPITAL CENTER, WE OFFER AN UNCOMPROMISING COMMITMENT TO THE HIGHEST QUALITY HEALTH CARE EXPERIENCE FOR PEOPLE IN ALL STAGES OF LIFE. WE ARE THE HEART OF HEALTH CARE IN OUR COMMUNITIES." - THE HOSPITAL ALSO PROVIDES PLANNED COMMUNITY BENEFIT ACTIVITIES TO IMPROVE ACCESS TO HEALTH CARE AND IMPROVE THE OVERALL HEALTH OF OUR COMMUNITY. OUR MISSION IS PURSUED IN COLLABORATION WITH OUR RELATED ORGANIZATIONS: CARROLL COUNTY HEALTH SERVICES, CARROLL HOSPICE, THE PARTNERSHIP FOR A HEALTHIER CARROLL COUNTY (OUR COMMUNITY ADVOCACY ARM), AND THE CARROLL HOSPITAL CENTER FOUNDATION (ALSO LISTED IN PART VI). FOR MORE INFORMATION ON THESE SUBSIDIARIES, PLEASE SEE THEIR INDIVIDUAL FORMS 990.

FORM 990, PART VI, SECTION A, LINE 2:

MIRIAM BECK AND JEFF WOTHERS HAVE A MOTHER-N-LAW/SON-N-LAW RELATIONSHIP.

FORM 990, PART VI, SECTION A, LINE 4:

THE ORGANIZATION HAD THE BYLAWS RESTATED AFTER THE MERGER WITH LIFEBRIDGE HEALTH INC.

FORM 990, PART VI, SECTION B, LINE 11:

THE HOSPITAL'S FORM 990 IS REVIEWED IN DETAIL BETWEEN THE PREPARER, AN OUTSIDE ACCOUNTING FIRM, AND THE FINANCE DEPARTMENT OF THE HOSPITAL. A COPY OF THE DRAFT FORM 990 IS PRESENTED TO THE HOSPITAL'S RISK, AUDIT AND COMPLIANCE ("RAC") COMMITTEE, AT WHICH TIME RAC COMMITTEE MEMBERS MAY ASK ANY QUESTIONS OR PROVIDE COMMENTS REGARDING THE DRAFT FORM 990. PRIOR TO FILING THE FORM 990, THE HOSPITAL PROVIDES A COPY OF THE FORM 990 TO EACH MEMBER OF THE BOARD OF DIRECTORS FOR THEIR REVIEW, QUESTIONS, AND COMMENTS, WHICH FEEDBACK IS THEN INCORPORATED INTO THE FILED FORM 990.

Name of the organization CARROLL HOSPITAL CENTER, INC.	Employer identification number 52-1452024
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FORM 990, PART VI, SECTION B, LINE 12C:

THE CONFLICT OF INTEREST POLICY APPLIES TO CARROLL HOSPITAL CENTER AND ITS DIRECT AND INDIRECT SUBSIDIARIES AND PARENT ORGANIZATION. REVIEW OF DISCLOSURE STATEMENTS/REPORT TO THE BOARD. THE CHIEF EXECUTIVE OFFICER OF THE HOSPITAL ORGANIZATION, THE GOVERNANCE COMMITTEE AND THE CORPORATE COMPLIANCE OFFICER SHALL REVIEW THE MATTERS DISCLOSED IN THE DISCLOSURE STATEMENTS AND SHALL SUBMIT TO THE HOSPITAL ORGANIZATION'S BOARD OF DIRECTORS AN ANNUAL SUMMARY OR SPREADSHEET OF THE DISCLOSURES AND HIS OR HER RECOMMENDATION FOR THE RESOLUTION OF ANY CONFLICTS DISCLOSED. IN FORMULATING RECOMMENDATIONS, THE CHIEF EXECUTIVE OFFICER SHALL CONSULT WITH APPROPRIATE OFFICERS OF THE HOSPITAL ORGANIZATION AND COUNSEL AS NECESSARY. THE BOARD OF DIRECTORS OF THE HOSPITAL ORGANIZATION, ACTING IN THE BEST INTERESTS OF THE HOSPITAL ORGANIZATION, SHALL HAVE SOLE DISCRETION TO MAKE ALL FINAL DECISIONS REGARDING CONFLICTS OF INTEREST, OTHER THAN THOSE REGARDING GIFTS TO HOSPITAL ORGANIZATION EMPLOYEES WHICH SHALL BE RESOLVED BY THE APPROPRIATE SUPERVISORY EXECUTIVE.

HOWEVER, NO PERSON SHALL BE INVOLVED IN CONSIDERING THE EXISTENCE OF AN ACTUAL OR POTENTIAL CONFLICT OF INTEREST, IN THE MANAGEMENT AND OVERSIGHT OF A CONFLICT RELATIONSHIP, OR IN THE DETERMINATION OF DISCIPLINE FOR VIOLATIONS OF THIS POLICY, IF THAT PERSON IS A PARTY OR POTENTIAL PARTY TO THAT CONFLICT.

ALL FINAL DECISIONS REGARDING CONFLICTS OF INTEREST SHALL BE REFLECTED IN A REVISED ANNUAL SUMMARY OR SPREADSHEET OF CONFLICT DISCLOSURES WHICH WILL BE SHARED WITH EACH DIRECTOR. THE CHAIR AND VICE-CHAIR OF THE BOARD, AND ALL BOARD COMMITTEE CHAIRS, SHALL HAVE THIS REVISED SUMMARY OR SPREADSHEET

Name of the organization CARROLL HOSPITAL CENTER, INC.	Employer identification number 52-1452024
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AVAILABLE AT THE TIME OF ALL BOARD AND BOARD COMMITTEE MEETINGS IN CASE A MATTER INVOLVING A POTENTIAL CONFLICT ARISES. CONFLICT OF INTEREST RECUSAL PROCEDURE FOR BOARD MEETINGS WHENEVER A HOSPITAL ORGANIZATIONS' BOARD OR BOARD COMMITTEE IS TO CONSIDER A TRANSACTION OR AN ARRANGEMENT WITH ANOTHER ORGANIZATION, ENTITY OR INDIVIDUAL IN WHICH OR WITH WHOM A PERSON COVERED BY THIS POLICY HAS A RELATIONSHIP CREATING AN ACTUAL OR POTENTIAL CONFLICT OF INTEREST, THE FOLLOWING PROCEDURES SHALL BE EMPLOYED:

A. THE INTERESTED PERSON MUST FULLY DISCLOSE THE ACTUAL OR POTENTIAL CONFLICT OF INTEREST TO THE BOARD;

B. THE INTERESTED PERSON SHOULD BE ASKED TO LEAVE THE MEETING DURING DISCUSSION OF THE POTENTIAL CONFLICT AND ANY RELATED VOTES, BUT THE INTERESTED PERSON MAY MAKE A STATEMENT OR ANSWER ANY QUESTIONS ON THE MATTER BEFORE DEPARTING THE MEETING;

C. IF APPROPRIATE, THE BOARD OR BOARD COMMITTEE MAY APPOINT A NON-INTERESTED PERSON OR COMMITTEE TO INVESTIGATE ALTERNATIVES TO THE PROPOSED TRANSACTION OR ARRANGEMENT;

D. TO CONSIDER THE PROPOSED TRANSACTION OR ARRANGEMENT, THE BOARD MUST:

1. FIND, BY A MAJORITY VOTE OF DIRECTORS THEN IN OFFICE, NOT COUNTING THE INTERESTED PERSON, THAT THE PROPOSED TRANSACTION OR ARRANGEMENT IS IN THE HOSPITAL ORGANIZATION'S BEST INTEREST AND FOR THE HOSPITAL ORGANIZATION'S OWN BENEFIT, IT IS FAIR AND REASONABLE, AND THAT, AFTER REASONABLE INVESTIGATION, THE HOSPITAL ORGANIZATION CANNOT OBTAIN A MORE ADVANTAGEOUS TRANSACTION OR ARRANGEMENT USING REASONABLE EFFORTS; AND

Name of the organization CARROLL HOSPITAL CENTER, INC.	Employer identification number 52-1452024
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2. VOTE ON THE TRANSACTION OR ARRANGEMENT, APPROVAL REQUIRING A MAJORITY VOTE OF DIRECTORS THEN IN OFFICE, NOT COUNTING THE INTERESTED PERSON.

E. THE MINUTES SHOULD INCLUDE: (1) THE NAME OF THE PERSON DISCLOSING THE CONFLICT OF INTEREST AND A DESCRIPTION OF THE CONFLICT; (2) THE BOARD'S DETERMINATION OF WHETHER THERE IS A CONFLICT; (3) THE NAMES AND VOTES OF PERSONS PRESENT FOR THE DISCUSSIONS AND VOTES RELATING TO THE TRANSACTION OR ARRANGEMENT; AND (4) THE CONTENT OF THOSE DISCUSSIONS INCLUDING THE BOARD'S DETERMINATION OF WHETHER OR NOT THE TRANSACTION OR ARRANGEMENT IS IN THE HOSPITAL ORGANIZATION'S BEST INTEREST, FAIR AND REASONABLE, AND THE BEST REASONABLY AVAILABLE ALTERNATIVE ONGOING DUTY TO DISCLOSE ONE'S OWN OR OTHERS' CONFLICTS OF INTEREST. AS AN ACTUAL OR POTENTIAL CONFLICT OF INTEREST CAN ARISE AT ANY TIME, ANY ACTUAL OR POTENTIAL CONFLICT MUST BE DISCLOSED PROMPTLY IN WRITING BY USE OF A SUPPLEMENTAL DISCLOSURE STATEMENT, AS SOON AS ITS EXISTENCE IS OR SHOULD BE KNOWN. IF A PERSON IS IN DOUBT ABOUT A SITUATION, THE PERSON SHOULD CONSULT WITH THE CHIEF EXECUTIVE OFFICER, BOARD CHAIRMAN OR THE HOSPITAL ORGANIZATION'S COMPLIANCE OFFICER. PERSONS SHOULD ERR ON THE SIDE OF DISCLOSURE SO THAT A CONFLICT OF INTEREST ASSESSMENT CAN BE MADE. THE POTENTIAL CONFLICT WILL BE REFERRED TO THE GOVERNANCE COMMITTEE FOR REVIEW AND A RESPONSE WILL BE PROVIDED WITHIN 14 DAYS. NONCOMPLIANCE WITH THE POLICY: THE ORGANIZATION'S BOARD OF DIRECTORS RETAINS BROAD POWER AND SOLE DISCRETION UNDER THIS POLICY TO: (1) DETERMINE THE EXISTENCE OF ACTUAL OR POTENTIAL CONFLICTS OF INTEREST; (2) SUBJECT CONFLICT OF INTEREST RELATIONSHIPS TO APPROPRIATE OVERSIGHT, MANAGEMENT, CONDITIONS, RESTRICTIONS AND PROHIBITIONS; AND (3) IMPOSE APPROPRIATE SANCTIONS. A BREACH OF THIS POLICY CAN BECOME GROUNDS FOR DISCIPLINE, UP TO AND INCLUDING REMOVAL FROM OFFICE OR, FOR MANAGEMENT

Name of the organization CARROLL HOSPITAL CENTER, INC.	Employer identification number 52-1452024
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PERSONNEL, TERMINATION OF EMPLOYMENT. IT MAY ALSO RESULT IN CESSATION OF BUSINESS WITH A VENDOR AND IN LIABILITY FOR DAMAGES. GROUNDS FOR DISCIPLINE INCLUDE, BUT ARE NOT LIMITED TO:

- A. WILLFUL FAILURE TO SIGN AND RETURN THE CONFLICT OF INTEREST DISCLOSURE STATEMENT IN ACCORD WITH THIS POLICY;
- B. A MATERIAL MISSTATEMENT OR OMISSION IN THE DISCLOSURE STATEMENT;
- C. WILLFUL FAILURE TO DISCLOSE AN ACTUAL OR POTENTIAL CONFLICT OF INTEREST AT ANY TIME IN ACCORD WITH THE REQUIREMENTS OF THIS POLICY;
- D. WILLFUL PARTICIPATION IN A VOTE OR DECISION INVOLVING A TRANSACTION WHICH RAISES AN UNDISCLOSED CONFLICT OF INTEREST; OR
- E. WILLFUL DISCLOSURE OR USE OF CONFIDENTIAL INFORMATION REGARDING THE AFFAIRS, BUSINESS OR PLANS OF A HOSPITAL ORGANIZATION FOR ANY PURPOSE OTHER THAN IN FURTHERANCE OF THE AFFAIRS AND BEST INTERESTS OF THE HOSPITAL ORGANIZATION.

FORM 990, PART VI, SECTION B, LINE 15:

THE EXECUTIVE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS OF CARROLL HOSPITAL CENTER, WHICH IS COMPRISED OF INDEPENDENT BOARD MEMBERS DETERMINED TO BE FREE OF ANY CONFLICT OF INTEREST, IS CHARGED WITH DETERMINING EXECUTIVE COMPENSATION AND ESTABLISHING PERFORMANCE CRITERIA ACCORDING TO AN APPROVED COMPENSATION PHILOSOPHY. THE COMMITTEE WORKS WITH AN INDEPENDENT EXECUTIVE COMPENSATION CONSULTING AND ADVISORY FIRM THAT PROVIDES MARKET SURVEY DATA CONCERNING COMPENSATION AND BENEFIT LEVELS FOR

Name of the organization CARROLL HOSPITAL CENTER, INC.	Employer identification number 52-1452024
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FUNCTIONALLY COMPARABLE HEALTHCARE EXECUTIVES IN SIMILAR HOSPITALS ACROSS THE REGION AND THE NATION BASED ON SEVERAL FACTORS INCLUDING SIZE, GEOGRAPHY, HOSPITAL TYPE AND COMPLEXITY. THE COMMITTEE REVIEWS AND APPROVES THE COMPENSATION OF THE SENIOR EXECUTIVES AND ENSURES THAT ALL FORMS OF EXECUTIVE COMPENSATION ARE REASONABLE, APPROPRIATE AND CONSISTENT WITH ITS COMPENSATION PHILOSOPHY.

CARROLL HOSPITAL CENTER HAS A WRITTEN POLICY REGARDING THE REVIEW OF PHYSICIAN COMPENSATION TO ENSURE THE PAYMENTS BETWEEN THE HOSPITAL AND THE PHYSICIAN ARE BOTH COMMERCIALY REASONABLE AND NOT GREATER THAN FAIR MARKET VALUE FOR THE SERVICES RENDERED. THE POLICY APPLIES TO CARROLL HOSPITAL CENTER AND EACH OF ITS SUBSIDIARIES/AFFILIATES. PURSUANT TO THE POLICY, CARROLL HOSPITAL CENTER, IN ORDER TO ENSURE THE PAYMENTS TO PHYSICIANS ARE COMMERCIALY REASONABLE AND CONSISTENT WITH FAIR MARKET VALUE, UNDERTAKES A NUMBER OF REVIEW ACTIVITIES, INCLUDING REVIEWING COMPENSATION INFORMATION FROM COMPENSATION SURVEYS AND RELIABLE DATA SUCH AS RECENT EARNINGS AND THIRD PARTY VALUATIONS.

FORM 990, PART VI, SECTION C, LINE 19:

THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.

FORM 990, PART IX, LINE 11G, OTHER FEES:

PHYSICIAN FEES:

PROGRAM SERVICE EXPENSES	13,535,972.
MANAGEMENT AND GENERAL EXPENSES	5,700.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	13,541,672.

Name of the organization CARROLL HOSPITAL CENTER, INC.	Employer identification number 52-1452024
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CONSULTING:

PROGRAM SERVICE EXPENSES	759,258.
MANAGEMENT AND GENERAL EXPENSES	2,544,378.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	3,303,636.

OTHER FEES:

PROGRAM SERVICE EXPENSES	5,484,720.
MANAGEMENT AND GENERAL EXPENSES	3,499,116.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	8,983,836.
TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	25,829,144.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

UNREALIZED LOSS FROM INTEREST RATE HEDGE	-4,614,188.
CONTRIBUTION	-43,900.
INVESTMENT IN CARROLL COUNTY MED SERVICES	-15,925,000.
ASSET IMPAIRMENT	-28,523,000.
EQUITY INVESTMENT IN SUBS	54,774,119.
CHANGE IN MINIMUM PENSION LIABILITY	-3,385,066.
ROUNDING	-2.
TOTAL TO FORM 990, PART XI, LINE 9	2,282,963.

PART VIII, LINE 6

CARROLL HOSPITAL CENTER (CHC) HAS A LEASE WITH AN UNRELATED THIRD PARTY FOR THE USE OF SPACE IN THE FISHER BUILDING. CHC SUBLEASES SPACE IN THE FISHER BUILDING TO SUBTENANTS AT ITS LEASE COST.

Name of the organization

CARROLL HOSPITAL CENTER, INC.

Employer identification number

52-1452024

INSPECTION COPY

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.

▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2014

Open to Public
Inspection

Name of the organization

CARROLL HOSPITAL CENTER, INC.

Employer identification number
52-1452024

Part I Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
CARROLL HOSPITAL CENTER MOB INVEST LLC - 27-1528335, 200 MEMORIAL AVE, WESTMINSTER, MD 21157	INVESTMENTS	MARYLAND	0.	532,985.	CHC
CARROLL REGIONAL CANCER CTR PHYSICIANS - 45-2463175, 200 MEMORIAL AVE, WESTMINSTER, MD 21157	HEALTHCARE	MARYLAND	1,038,432.	740,720.	CHC

Part II Identification of Related Tax-Exempt Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
CARROLL COUNTY HEALTH SERVICES INC - 52-0691413, 200 MEMORIAL AVE, WESTMINSTER, MD 21157	SUPPORT ORGANIZATION	MARYLAND	501(C)(3)	509(A)(3)	N/A		X
CARROLL HOSPITAL CENTER FOUNDATION - 52-1115038, 200 MEMORIAL AVE, WESTMINSTER, MD 21157	FOUNDATION	MARYLAND	501(C)(3)	509(A)(3)	CHC	X	
CARROLL HOSPICE, INC - 52-1565870 200 MEMORIAL AVE WESTMINSTER, MD 21157	HOSPICE	MARYLAND	501(C)(3)	170(B)(1A)	CHC	X	
PARTNERSHIP FOR A HEALTHIER CARROLL CTY - 52-2156892, 200 MEMORIAL AVE, WESTMINSTER, MD 21157	HEALTH SERVICES	MARYLAND	501(C)(3)	170B1(A)VI	N/A	X	

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule R (Form 990) 2014

Part II Continuation of Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC. - 52-0607913, 2434 WEST BELVEDERE AVE, BALTIMORE, MD 21215	GERIATRIC HOSPITAL DEDICATED TO PROVIDING SERVICE TO THE AGED	MARYLAND	501(C)(3)	LINE 3	LIFEBRIDGE HEALTH, INC		X
SINAI HOSPITAL OF BALTIMORE, INC. - 52-0486540, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215	PROVIDE MEDICAL CARE, EDUCATE STUDENTS, & PERFORM MEDICAL RESEARCH	MARYLAND	501(C)(3)	LINE 3	LIFEBRIDGE HEALTH, INC		X
COURTLAND GARDENS NURSING AND REHABILITATION - 52-0607907, 2434 WEST BELVEDERE AVE, BALTIMORE, MD 21215	SKILLED NURSING CARE FOR THE ELDERLY AND DISABLED	MARYLAND	501(C)(3)	LINE 9	LEVINDALE		X
NORTHWEST HOSPITAL CENTER, INC. - 52-1372665 5401 OLD COURT ROAD RANDALLSTOWN, MD 21133	A HOSPITAL ASPIRING TO IMPROVE THE WELLBEING OF THE COMMUNITY IT SERVES	MARYLAND	501(C)(3)	LINE 3	LIFEBRIDGE HEALTH, INC		X
CHILDREN'S HOSPITAL OF BALTIMORE CITY - 52-0591592, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215	CHARITY SUPPORT FOR SINAI HOSPITAL OF BALTIMORE, INC.	MARYLAND	501(C)(3)	LINE 11B, II	LIFEBRIDGE HEALTH, INC		X
THE BALTIMORE JEWISH HEALTH FOUNDATION, INC. - 52-2111541, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215	CHARITY SUPPORT FOR SINAI HOSPITAL OF BALTIMORE, INC.	MARYLAND	501(C)(3)	LINE 11B, II	LIFEBRIDGE HEALTH, INC		X
CHILDREN'S HOSPITAL AT SINAI FOUNDATION - 52-2167587, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215	CHARITY SUPPORT FOR SINAI HOSPITAL OF BALTIMORE, INC.	MARYLAND	501(C)(3)	LINE 11B, II	LIFEBRIDGE HEALTH, INC		X
THE BALTIMORE JEWISH ELDERCARE FOUNDATION - 52-2337669, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215	CHARITY SUPPORT FOR LEVINDALE HEBREW GERIATRIC CENTER HOSPITAL	MARYLAND	501(C)(3)	LINE 11B, II	LIFEBRIDGE HEALTH, INC		X
LIFEBRIDGE HEALTH INC. - 52-1402373 2401 WEST BELVEDERE AVE BALTIMORE, MD 21215	HEALTH SERVICES	MARYLAND	501(C)(3)	LINE 11A, I	N/A		X

Part III Identification of Related Organizations Taxable as a Partnership Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
CARROLL COUNTY RADIOLOGY LLC - 52-2190849, 7253 AMBASSADOR RD, BALTIMORE, MD 21244	RADIOLOGY	MD	CHC		2,273,939.	10,749,899.	X		N/A	X		60.00%
CARROLL CARE PHARMACIES LLC - 20-1141106, 95 CARROLL ST STE 104, WESTMINSTER, MD 21157	PHARMACY	MD	CCMS				X		N/A	X		
CARROLL OCCUPATIONAL HEALTH LLC - 20-2769332, 7001 CORPORATE CENTER CT, WESTMINSTER, MD 21157	OCCUPATIONAL	MD	CCMS				X		N/A	X		
CARDIOVASCULAR ASSOCIATES OF MARYLAND, LLC - 46-2935110, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD					X		N/A	X		

Part IV Identification of Related Organizations Taxable as a Corporation or Trust Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
CARROLL COUNTY MED SERVICES INC - 52-1891102 200 MEMORIAL AVE WESTMINSTER, MD 21157	MEDICAL SERVICES	MD	CCHS	C CORP				X	
CEN-MAR ASSURANCE CO - 98-6011607 PO BOX 1085 GRAND CAYMAN, CAYMAN ISLANDS KY1-1102	INSURANCE	CAYMAN ISLANDS	CHC	C CORP	2,209,586.	18,453,758.	100.00%	X	
CARROLL HEALTH GROUP, LLC - 27-1956453 200 MEMORIAL AVE WESTMINSTER, MD 21157	HEALTH CARE	MD	CCMS	C CORP				X	
CARROLL URGENT CARE LLC - 46-5739154 200 MEMORIAL AVE WESTMINSTER, MD 21157	REAL ESTATE	MD	CCMS	C CORP				X	
CARROLL PHO LLC - 46-0613864 200 MEMORIAL AVE WESTMINSTER, MD 21157	HEALTH CARE	MD	CCMS	C CORP					X

Part III Continuation of Identification of Related Organizations Taxable as a Partnership

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportion- ate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
HOMECARE MARYLAND, LLC - 26-1378175, 8028 RITCHIE HIGHWAY, SUITE 210B, PASADENA, MD 21122	MEDICAL SERVICES	MD						X		N/A		X
LIFEBRIDGE CARDIOLOGY OF PARKVILLE, LLC - 46-3742313, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD						X		N/A		X
LIFEBRIDGE COMMUNITY GASTROENTEROLOGY, LLC - 46-2863298, 2401 WEST BELVEDERE AVE, BALTIMORE, MD	MEDICAL SERVICES	MD						X		N/A		X
LIFEBRIDGE COMMUNITY PEDIATRICS, LLC - 46-2842468, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD						X		N/A		X
LIFEBRIDGE COMMUNITY PULMONOLOGY, LLC - 46-1401312, 2401 WEST BELVEDERE AVE, BALTIMORE, MD	MEDICAL SERVICES	MD						X		N/A		X
LIFEBRIDGE GYNECOLOGY OF PIKESVILLE, LLC - 46-2949092, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD						X		N/A		X
LIFEBRIDGE MEDICAL ASSOCIATES, LLC - 46-2941505, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD						X		N/A		X
LIFEBRIDGE ORTHOPEDIC SPECIALISTS, LLC - 45-0719598, 2401 WEST BELVEDERE AVE, BALTIMORE, MD	MEDICAL SERVICES	MD						X		N/A		X
LIFEBRIDGE PRIMARY CARE OF ELDERSBURG, LLC - 38-3897702, 2401 WEST BELVEDERE AVE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD						X		N/A		X

Part IV Continuation of Identification of Related Organizations Taxable as a Corporation or Trust

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
CARROLL ACO LLC - 46-5641917 200 MEMORIAL AVE WESTMINSTER, MD 21157	HEALTH CARE	MD	CCMS	C CORP					X
LIFEBRIDGE INVESTMENTS, INC. - 52-1483166 2401 WEST BELVEDERE AVE. BALTIMORE, MD 21215	INVESTMENT	MD	LIFEBRIDGE HEALTH, INC.	C CORP				X	
HEALTHSTAR MEDICAL SERVICES, INC. - 52-1829098, 2401 WEST BELVEDERE AVE., BALTIMORE, MD 21215	HEALTH CARE	MD	LIFEBRIDGE HEALTH, INC.	C CORP				X	
PRACTICE DYNAMICS, INC. - 52-1960319 124 BUSINESS CENTER DRIVE REISTERSTOWN, MD 21136	MANAGEMENT	MD	LIFEBRIDGE HEALTH, INC.	C CORP				X	
SURGICAL ONCOLOGY ASSOCIATES, INC. - 52-1804659, 2401 WEST BELVEDERE AVE., BALTIMORE, MD 21215	HEALTH CARE	MD	LIFEBRIDGE HEALTH, INC.	C CORP				X	
LIFEBRIDGE INSURANCE COMPANY, LTD. - 98-0415396, PO BOX 1109, GRAND CAYMAN, GRAND CAYMAN, CAYMAN ISLANDS	INSURANCE	CAYMAN ISLANDS	LIFEBRIDGE HEALTH, INC.	C CORP				X	
LIFEBRIDGE COMMUNITY PHYSICIANS, INC. - 80-0719005, 2401 WEST BELVEDERE AVE., BALTIMORE, MD 21215	HEALTH CARE	MD	LIFEBRIDGE INVESTMENTS	C CORP				X	

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

	Yes	No
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to related organization(s)	X	
c Gift, grant, or capital contribution from related organization(s)	X	
d Loans or loan guarantees to or for related organization(s)		X
e Loans or loan guarantees by related organization(s)		X
f Dividends from related organization(s)		X
g Sale of assets to related organization(s)		X
h Purchase of assets from related organization(s)		X
i Exchange of assets with related organization(s)		X
j Lease of facilities, equipment, or other assets to related organization(s)		X
k Lease of facilities, equipment, or other assets from related organization(s)		X
l Performance of services or membership or fundraising solicitations for related organization(s)	X	
m Performance of services or membership or fundraising solicitations by related organization(s)	X	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
o Sharing of paid employees with related organization(s)	X	
p Reimbursement paid to related organization(s) for expenses		X
q Reimbursement paid by related organization(s) for expenses	X	
r Other transfer of cash or property to related organization(s)	X	
s Other transfer of cash or property from related organization(s)		X

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) CARROLL HOSPITAL FOUNDATION	C	3,303,940.	CASH
(2) CARROLL HOSPICE	Q	3,800,000.	FMV
(3) CARROLL HOSPICE	L	75,000.	FMV
(4) CEN-MAR ASSURANCE CO	R	2,370,297.	CASH
(5) PARTNERSHIP FOR A HEALTHIER CARROLL COUNTY	B	173,000.	CASH
(6)			

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R (see instructions).

PART III, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS PARTNERSHIP:

NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:

LIFEBRIDGE COMMUNITY GASTROENTEROLOGY, LLC

EIN: 46-2863298

2401 WEST BELVEDERE AVE

BALTIMORE, MD 21215

NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:

LIFEBRIDGE COMMUNITY PULMONOLOGY, LLC

EIN: 46-1401312

2401 WEST BELVEDERE AVE

BALTIMORE, MD 21215

NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:

LIFEBRIDGE ORTHOPEDIC SPECIALISTS, LLC

EIN: 45-0719598

2401 WEST BELVEDERE AVE

BALTIMORE, MD 21215

NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:

LIFEBRIDGE PRIMARY CARE OF NORTH CARROLL, LLC

EIN: 80-0883321

2401 WEST BELVEDERE AVE

BALTIMORE, MD 21215

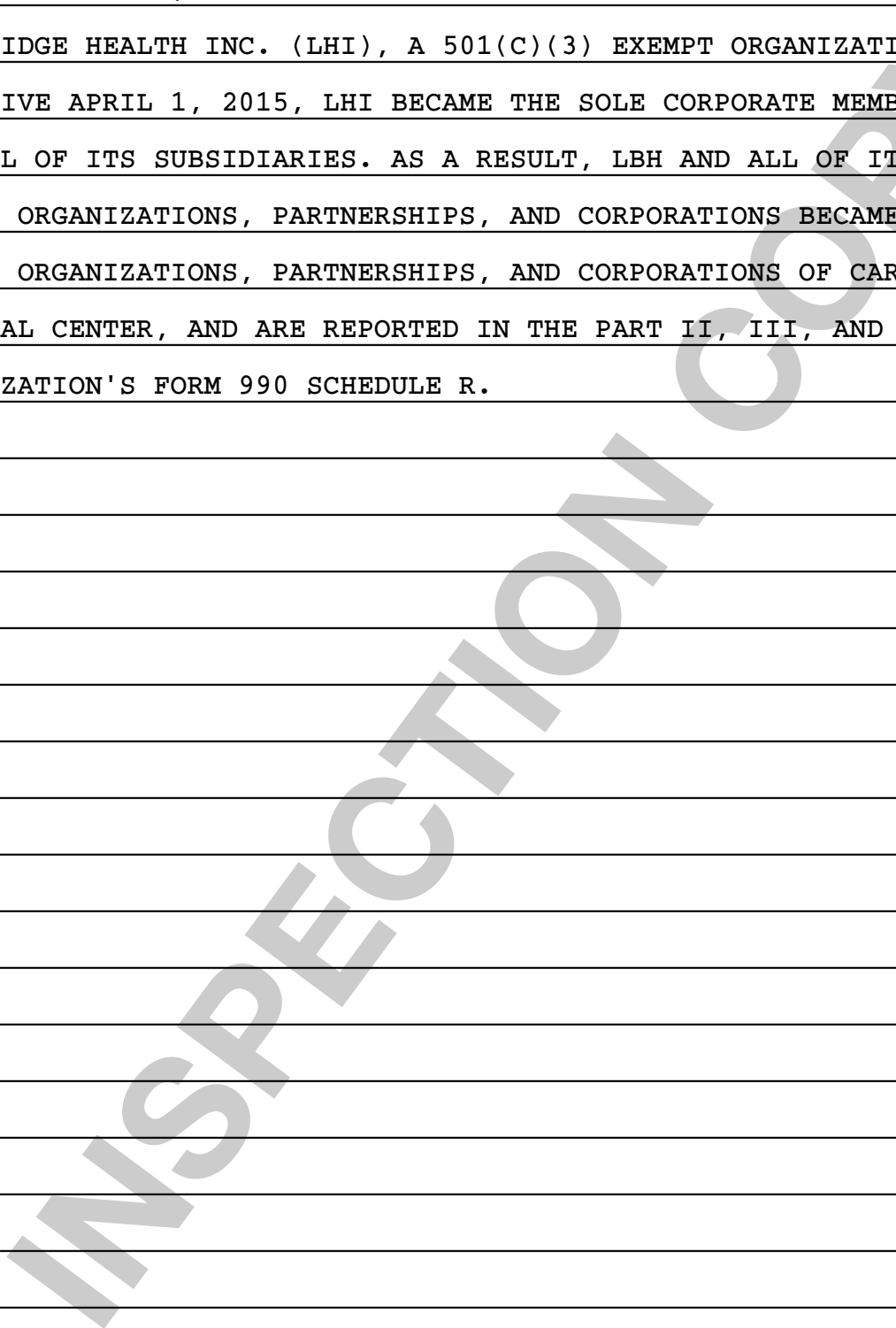
SCHEDULE R PART II, III, & IV

ON MARCH 27, 2015 CARROLL COUNTY HEALTH SERVICES CORPORATION (CCHS),

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R (see instructions).

THE ULTIMATE PARENT OF CARROLL HOSPITAL CENTER INC. AND THE OTHER
 CARROLL ENTITIES, VOTED TO APPROVE AN AFFILIATION AGREEMENT WITH
 LIFEBRIDGE HEALTH INC. (LHI), A 501(C)(3) EXEMPT ORGANIZATION.
 EFFECTIVE APRIL 1, 2015, LHI BECAME THE SOLE CORPORATE MEMBER OF CCHS
 AND ALL OF ITS SUBSIDIARIES. AS A RESULT, LBH AND ALL OF ITS RELATED
 EXEMPT ORGANIZATIONS, PARTNERSHIPS, AND CORPORATIONS BECAME RELATED
 EXEMPT ORGANIZATIONS, PARTNERSHIPS, AND CORPORATIONS OF CARROLL
 HOSPITAL CENTER, AND ARE REPORTED IN THE PART II, III, AND IV OF THE
 ORGANIZATION'S FORM 990 SCHEDULE R.



TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

June 30, 2015

Prepared for	Carroll Hospital Center, Inc. 200 Memorial Avenue Westminster, MD 21157
Prepared by	Dixon Hughes Goodman LLP 1410 Spring Hill Road, 5th Floor Tysons, VA 22102
Amount due or refund	No amount is due.
Make check payable to	No amount is due.
Mail tax return and check (if applicable) to	Department of the Treasury Internal Revenue Service Center Ogden, UT 84201-0027
Return must be mailed on or before	May 16, 2016
Special Instructions	<p>The return should be signed and dated.</p> <p>We recommend that you file your return using certified mail with a postmarked receipt for proof of timely filing. You should write the certified mail receipt number on the return in the margin near your signature prior to filing. You should also retain the certified mail receipt with your copy of the return.</p>

Exempt Organization Business Income Tax Return (and proxy tax under section 6033(e))

For calendar year 2014 or other tax year beginning JUL 1, 2014, and ending JUN 30, 2015

2014

Department of the Treasury
Internal Revenue Service

▶ Information about Form 990-T and its instructions is available at www.irs.gov/form990t.
▶ Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).

Open to Public Inspection for
501(c)(3) Organizations Only

A <input type="checkbox"/> Check box if address changed B Exempt under section <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 408(e) <input type="checkbox"/> 220(e) <input type="checkbox"/> 408A <input type="checkbox"/> 530(a) <input type="checkbox"/> 529(a)	Print or Type	Name of organization (<input type="checkbox"/> Check box if name changed and see instructions.) CARROLL HOSPITAL CENTER, INC. Number, street, and room or suite no. If a P.O. box, see instructions. 200 MEMORIAL AVENUE City or town, state or province, country, and ZIP or foreign postal code WESTMINSTER, MD 21157	D Employer identification number (Employees' trust, see instructions.) 52-1452024 E Unrelated business activity codes (See instructions.) 525990 621500
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C Book value of all assets at end of year 352,894,518.	F Group exemption number (See instructions.)	G Check organization type ▶ <input checked="" type="checkbox"/> 501(c) corporation <input type="checkbox"/> 501(c) trust <input type="checkbox"/> 401(a) trust <input type="checkbox"/> Other trust
--	---	--

H Describe the organization's primary unrelated business activity. ▶ **OTHER FINANCIAL ACTIVITY LAB**

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ Yes No
If "Yes," enter the name and identifying number of the parent corporation. ▶

J The books are in care of ▶ **DAVID MCCORMICK** Telephone number ▶ **410-871-6859**

Part I Unrelated Trade or Business Income	(A) Income	(B) Expenses	(C) Net
1a Gross receipts or sales <u>3,958,118.</u>			
b Less returns and allowances <u>1,306,179.</u> c Balance ▶	1c <u>2,651,939.</u>		
2 Cost of goods sold (Schedule A, line 7)	2		
3 Gross profit. Subtract line 2 from line 1c	3 <u>2,651,939.</u>		<u>2,651,939.</u>
4a Capital gain net income (attach Schedule D)	4a		
b Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b		
c Capital loss deduction for trusts	4c		
5 Income (loss) from partnerships and S corporations (attach statement)	5 <u>-118,956.</u>	STMT 1	<u>-118,956.</u>
6 Rent income (Schedule C)	6 <u>22,875.</u>		<u>22,875.</u>
7 Unrelated debt-financed income (Schedule E)	7		
8 Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8		
9 Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9		
10 Exploited exempt activity income (Schedule I)	10		
11 Advertising income (Schedule J)	11		
12 Other income (See instructions; attach schedule) STATEMENT 2	12 <u>90,000.</u>		<u>90,000.</u>
13 Total. Combine lines 3 through 12	13 <u>2,645,858.</u>		<u>2,645,858.</u>

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.)
(Except for contributions, deductions must be directly connected with the unrelated business income.)

14 Compensation of officers, directors, and trustees (Schedule K)	14		
15 Salaries and wages	15		<u>1,098,961.</u>
16 Repairs and maintenance	16		
17 Bad debts	17		
18 Interest (attach schedule)	18		
19 Taxes and licenses	19		<u>3,223.</u>
20 Charitable contributions (See instructions for limitation rules)	20		
21 Depreciation (attach Form 4562)	21	<u>325,281.</u>	
22 Less depreciation claimed on Schedule A and elsewhere on return	22a		<u>325,281.</u>
23 Depletion	23		
24 Contributions to deferred compensation plans	24		
25 Employee benefit programs	25		<u>212,076.</u>
26 Excess exempt expenses (Schedule I)	26		
27 Excess readership costs (Schedule J)	27		
28 Other deductions (attach schedule)	28	SEE STATEMENT 3	<u>1,239,166.</u>
29 Total deductions. Add lines 14 through 28	29		<u>2,878,707.</u>
30 Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13	30		<u>-232,849.</u>
31 Net operating loss deduction (limited to the amount on line 30)	31	SEE STATEMENT 4	
32 Unrelated business taxable income before specific deduction. Subtract line 31 from line 30	32		<u>-232,849.</u>
33 Specific deduction (Generally \$1,000, but see line 33 instructions for exceptions)	33		<u>1,000.</u>
34 Unrelated business taxable income. Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32	34		<u>-232,849.</u>

Part III Tax Computation

35 Organizations Taxable as Corporations. See instructions for tax computation. Controlled group members (sections 1561 and 1563) check here <input type="checkbox"/> See instructions and:			
a Enter your share of the \$50,000, \$25,000, and \$9,925,000 taxable income brackets (in that order):	(1) \$ _____ (2) \$ _____ (3) \$ _____		
b Enter organization's share of: (1) Additional 5% tax (not more than \$11,750)	\$ _____		
(2) Additional 3% tax (not more than \$100,000)	\$ _____		
c Income tax on the amount on line 34		35c	0.
36 Trusts Taxable at Trust Rates. See instructions for tax computation. Income tax on the amount on line 34 from:			
<input type="checkbox"/> Tax rate schedule or <input type="checkbox"/> Schedule D (Form 1041)		36	
37 Proxy tax. See instructions		37	
38 Alternative minimum tax		38	
39 Total. Add lines 37 and 38 to line 35c or 36, whichever applies		39	0.

Part IV Tax and Payments

40a Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	40a		
b Other credits (see instructions)	40b		
c General business credit. Attach Form 3800	40c		
d Credit for prior year minimum tax (attach Form 8801 or 8827)	40d		
e Total credits. Add lines 40a through 40d		40e	
41 Subtract line 40e from line 39		41	0.
42 Other taxes. Check if from: <input type="checkbox"/> Form 4255 <input type="checkbox"/> Form 8611 <input type="checkbox"/> Form 8697 <input type="checkbox"/> Form 8866 <input type="checkbox"/> Other (attach schedule)		42	
43 Total tax. Add lines 41 and 42		43	0.
44a Payments: A 2013 overpayment credited to 2014	44a		
b 2014 estimated tax payments	44b		
c Tax deposited with Form 8868	44c		
d Foreign organizations: Tax paid or withheld at source (see instructions)	44d		
e Backup withholding (see instructions)	44e		
f Credit for small employer health insurance premiums (Attach Form 8941)	44f		
g Other credits and payments: <input type="checkbox"/> Form 2439 <input type="checkbox"/> Form 4136 <input type="checkbox"/> Other	44g		
45 Total payments. Add lines 44a through 44g		45	
46 Estimated tax penalty (see instructions). Check if Form 2220 is attached <input type="checkbox"/>		46	
47 Tax due. If line 45 is less than the total of lines 43 and 46, enter amount owed		47	0.
48 Overpayment. If line 45 is larger than the total of lines 43 and 46, enter amount overpaid		48	0.
49 Enter the amount of line 48 you want: Credited to 2015 estimated tax <input type="checkbox"/> Refunded <input type="checkbox"/>		49	

Part V Statements Regarding Certain Activities and Other Information (see instructions)

1 At any time during the 2014 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file Form FinCEN Form 114, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here CAYMAN ISLANDS	Yes	No
2 During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If YES, see instructions for other forms the organization may have to file.		X
3 Enter the amount of tax-exempt interest received or accrued during the tax year \$		

Schedule A - Cost of Goods Sold. Enter method of inventory valuation **N/A**

1 Inventory at beginning of year	1		6 Inventory at end of year	6	
2 Purchases	2		7 Cost of goods sold. Subtract line 6 from line 5. Enter here and in Part I, line 2	7	
3 Cost of labor	3		8 Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
4a Additional section 263A costs (att. schedule)	4a				
b Other costs (attach schedule)	4b				
5 Total. Add lines 1 through 4b	5				

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Sign Here	Signature of officer _____	Date _____	CFO Title _____	May the IRS discuss this return with the preparer shown below (see instructions)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Paid Preparer Use Only	Print/Type preparer's name TAMARA VINEYARD		
	Firm's name DIXON HUGHES GOODMAN LLP	Firm's EIN 56-0747981	Check <input type="checkbox"/> if self-employed	PTIN P01775208
	Firm's address 1410 SPRING HILL ROAD, 5TH FLOOR	Phone no. 703-970-0400		
	TYSONS, VA 22102			

Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property) (see instructions)

1. Description of property

(1) SUBWAY			
(2)			
(3)			
(4)			
2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)	
(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)		
(1)	22,875.		
(2)			
(3)			
(4)			
Total	0.	Total	22,875.
(c) Total income. Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶		(b) Total deductions. Enter here and on page 1, Part I, line 6, column (B) ▶	
		0.	

Schedule E - Unrelated Debt-Financed Income (see instructions)

1. Description of debt-financed property		2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property	
			(a) Straight line depreciation (attach schedule)	(b) Other deductions (attach schedule)
(1)				
(2)				
(3)				
(4)				
4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5. Average adjusted basis of or allocable to debt-financed property (attach schedule)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)		%		
(2)		%		
(3)		%		
(4)		%		
Totals ▶			0.	0.
Total dividends-received deductions included in column 8 ▶			0.	

Schedule F - Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions)

1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations			
		3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)					
(2)					
(3)					
(4)					

Nonexempt Controlled Organizations

7. Taxable income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)				
(2)				
(3)				
(4)				
Totals ▶			0.	0.

Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization

(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
Totals		0.		0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income

(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals		0.	0.			0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5))		0.	0.			0.

Part II Income From Periodicals Reported on a Separate Basis (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I		0.	0.			0.
Totals, Part II (lines 1-5)		0.	0.			0.

Schedule K - Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14			0.

FORM 990-T INCOME (LOSS) FROM PARTNERSHIPS AND S CORPORATIONS STATEMENT 1

DESCRIPTION	AMOUNT
K-1 PREMIER PURCHASING	6,883.
K-1 CHESAPEAKE INVESTMENTS III	-115,309.
K-1 SEAMARK CAPITAL	-27,176.
K-1 GREENSPRING	16,646.
TOTAL TO FORM 990-T, PAGE 1, LINE 5	-118,956.

FORM 990-T OTHER INCOME STATEMENT 2

DESCRIPTION	AMOUNT
CC MED SERVICES MANAGMENT INCOME	90,000.
TOTAL TO FORM 990-T, PAGE 1, LINE 12	90,000.

FORM 990-T OTHER DEDUCTIONS STATEMENT 3

DESCRIPTION	AMOUNT
PROFESSIONAL FEES	53,218.
SUPPLIES	621,071.
PURCHASED SERVICES	147,901.
SUPPORT EXPENSES	416,976.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	1,239,166.

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 4

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
06/30/06	171,269.	171,269.	0.	0.
06/30/07	151,971.	137,102.	14,869.	14,869.
06/30/08	151,028.	0.	151,028.	151,028.
06/30/09	113,260.	0.	113,260.	113,260.
06/30/10	32,318.	0.	32,318.	32,318.
NOL CARRYOVER AVAILABLE THIS YEAR			311,475.	311,475.

Information Return of U.S. Persons With Respect To Certain Foreign Corporations

(Rev. December 2012)
Department of the Treasury
Internal Revenue Service

► For more information about Form 5471, see www.irs.gov/form5471.
Information furnished for the foreign corporation's annual accounting period (tax year required by section 898) (see instructions) beginning **JUL 1**, 2014, and ending **JUN 30**, 2015

Attachment
Sequence No. **121**

Name of person filing this return CARROLL HOSPITAL CENTER, INC. <small>Number, street, and room or suite no. (or P.O. box number if mail is not delivered to street address)</small> 200 MEMORIAL AVENUE City or town, state, and ZIP code WESTMINSTER, MD 21157	A Identifying number 52-1452024 B Category of filer (See instructions. Check applicable box(es): 1 (repealed) 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input checked="" type="checkbox"/> 5 <input checked="" type="checkbox"/> C Enter the total percentage of the foreign corporation's voting stock you owned at the end of its annual accounting period 100.00 %
Filer's tax year beginning JUL 1 , 2014, and ending JUN 30 , 2015	

D Person(s) on whose behalf this information return is filed:

(1) Name	(2) Address	(3) Identifying number	(4) Check applicable box(es)		
			Shareholder	Officer	Director

Important: Fill in all applicable lines and schedules. All information **must** be in English. All amounts **must** be stated in U.S. dollars unless otherwise indicated.

1a Name and address of foreign corporation CEN-MAR ASSURANCE COMPANY P.O. BOX 1051 GRAND CAYMAN KY1-1102 CAYMAN ISLANDS				b(1) Employer identification number, if any 98-0611607
b(2) Reference ID number (see instructions) _____				
c Country under whose laws incorporated CAYMAN ISLANDS				
d Date of incorporation	e Principal place of business	f Principal business activity code number	g Principal business activity	h Functional currency
06/20/07	CAYMAN ISLANDS	525100	OTHER INSURANCE FUND	UNITED STATES, DOLLAR

2 Provide the following information for the foreign corporation's accounting period stated above.

a Name, address, and identifying number of branch office or agent (if any) in the United States N/A	b If a U.S. income tax return was filed, enter: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">(i) Taxable income or (loss)</td> <td style="width:50%;">(ii) U.S. income tax paid (after all credits)</td> </tr> <tr> <td> </td> <td> </td> </tr> </table>		(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)		
(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)					
c Name and address of foreign corporation's statutory or resident agent in country of incorporation MARSH MANAGEMENT SERVICES (CAYMAN) P.O. BOX 1051 GRAND CAYMAN KY1-1102 CAYMAN ISLANDS	d Name and address (including corporate department, if applicable) of person (or persons) with custody of the books and records of the foreign corporation, and the location of such books and records, if different SAME AS 2C					

Schedule A Stock of the Foreign Corporation		
(a) Description of each class of stock	(b) Number of shares issued and outstanding	
	(i) Beginning of annual accounting period	(ii) End of annual accounting period
COMMON	50,000	50,000

Schedule E Income, War Profits, and Excess Profits Taxes Paid or Accrued

	(a) Name of country or U.S. possession	Amount of tax		
		(b) In foreign currency	(c) Conversion rate	(d) In U.S. dollars
1	U.S.			
2				
3				
4				
5				
6				
7				
8	Total			

Schedule F Balance Sheet

Important: Report all amounts in U.S. dollars prepared and translated in accordance with U.S. GAAP. See instructions for an exception for DASTM corporations.

Assets		(a) Beginning of annual accounting period	(b) End of annual accounting period
1	Cash	2,374,339.	3,109,520.
2a	Trade notes and accounts receivable		
b	Less allowance for bad debts	()	()
3	Inventories		
4	Other current assets (attach statement) SEE STATEMENT 6	6,513,720.	7,195,319.
5	Loans to shareholders and other related persons		
6	Investment in subsidiaries (attach statement)		
7	Other investments (attach statement) SEE STATEMENT 7	7,135,311.	8,148,919.
8a	Buildings and other depreciable assets		
b	Less accumulated depreciation	()	()
9a	Depletable assets		
b	Less accumulated depletion	()	()
10	Land (net of any amortization)		
11	Intangible assets:		
a	Goodwill		
b	Organization costs		
c	Patents, trademarks, and other intangible assets		
d	Less accumulated amortization for lines 11a, b, and c	()	()
12	Other assets (attach statement)		
13	Total assets	16,023,370.	18,453,758.
Liabilities and Shareholders' Equity			
14	Accounts payable	87,873.	70,786.
15	Other current liabilities (attach statement) SEE STATEMENT 8	1,093.	9,783.
16	Loans from shareholders and other related persons		
17	Other liabilities (attach statement) SEE STATEMENT 9	11,811,389.	12,040,588.
18	Capital stock:		
a	Preferred stock		
b	Common stock	50,000.	50,000.
19	Paid-in or capital surplus (attach reconciliation)	350,000.	350,000.
20	Retained earnings	3,723,015.	5,932,601.
21	Less cost of treasury stock	()	()
22	Total liabilities and shareholders' equity	16,023,370.	18,453,758.

Schedule G Other Information

	Yes	No
1 During the tax year, did the foreign corporation own at least a 10% interest, directly or indirectly, in any foreign partnership?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If "Yes," see the instructions for required statement.		
2 During the tax year, did the foreign corporation own an interest in any trust?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3 During the tax year, did the foreign corporation own any foreign entities that were disregarded as entities separate from their owners under Regulations sections 301.7701-2 and 301.7701-3?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If "Yes," you are generally required to attach Form 8858 for each entity (see instructions).		
4 During the tax year, was the foreign corporation a participant in any cost sharing arrangement?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5 During the course of the tax year, did the foreign corporation become a participant in any cost sharing arrangement?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6 During the tax year, did the foreign corporation participate in any reportable transaction as defined in Regulations section 1.6011-4?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If "Yes," attach Form(s) 8886 if required by Regulations section 1.6011-4(c)(3)(i)(G).		
7 During the tax year, did the foreign corporation pay or accrue any foreign tax that was disqualified for credit under section 901(m)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8 During the tax year, did the foreign corporation pay or accrue foreign taxes to which section 909 applies, or treat foreign taxes that were previously suspended under section 909 as no longer suspended?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Schedule H Current Earnings and Profits

Important: Enter the amounts on lines 1 through 5c in *functional* currency.

1 Current year net income or (loss) per foreign books of account	1	2,209,586.
2 Net adjustments made to line 1 to determine current earnings and profits according to U.S. financial and tax accounting standards (see instructions):		
a Capital gains or losses	Net Additions	Net Subtractions
b Depreciation and amortization		46,295.
c Depletion		
d Investment or incentive allowance		
e Charges to statutory reserves		
f Inventory adjustments		
g Taxes		
h Other (attach statement) STATEMENT 10		2,574,429.
3 Total net additions		
4 Total net subtractions		2,620,724.
5a Current earnings and profits (line 1 plus line 3 minus line 4)	5a	-411,138.
b DASTM gain or (loss) for foreign corporations that use DASTM	5b	
c Combine lines 5a and 5b	5c	-411,138.
d Current earnings and profits in U.S. dollars (line 5c translated at the appropriate exchange rate as defined in section 989(b) and the related regulations)	5d	-411,138.
Enter exchange rate used for line 5d ▶ 1.000000		

Schedule I Summary of Shareholder's Income From Foreign Corporation

If item D on page 1 is completed, a separate Schedule I must be filed for each Category 4 or 5 filer for whom reporting is furnished on this Form 5471. This schedule I is being completed for:

Name of U.S. shareholder ▶ CARROLL HOSPITAL CENTER	Identifying number ▶ 52-1452024	
1 Subpart F income (line 38b, Worksheet A in the instructions)	1	
2 Earnings invested in U.S. property (line 17, Worksheet B in the instructions)	2	
3 Previously excluded subpart F income withdrawn from qualified investments (line 6b, Worksheet C in the instructions)	3	
4 Previously excluded export trade income withdrawn from investment in export trade assets (line 7b, Worksheet D in the instructions)	4	
5 Factoring income	5	
6 Total of lines 1 through 5. Enter here and on your income tax return	6	
7 Dividends received (translated at spot rate on payment date under section 989(b)(1))	7	
8 Exchange gain or (loss) on a distribution of previously taxed income	8	

• Was any income of the foreign corporation blocked?	Yes	No
• Did any such income become unblocked during the tax year (see section 964(b))?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If the answer to either question is "Yes," attach an explanation.

FORM 5471 OTHER DEDUCTIONS STATEMENT 5

DESCRIPTION	FUNCTIONAL CURRENCY	EXCHANGE RATE	U.S. DOLLAR
UNDERWRITING EXPENSES			12,343.
ACTUARIAL FEES			46,630.
MANAGEMENT FEES			43,928.
AUDIT FEES			28,080.
INVESTMENT MANAGEMENT FEES			39,766.
LEGAL & PROFESSIONAL FEES			29,234.
MEETING EXPENSES			25,207.
GOVERNMENT FEES			14,024.
MISCELLANEOUS EXPENSES			5,744.
TOTAL TO 5471, SCHEDULE C, LINE 16			244,956.

FORM 5471 OTHER CURRENT ASSETS STATEMENT 6

DESCRIPTION	BEG. OF ANNUAL ACCOUNTING PERIOD	END OF ANNUAL ACCOUNTING PERIOD
FUNDS WITHHELD	1,000.	1,000.
PREPAID EXPENSES	6,410.	6,410.
OUTSTANDING CLAIMS RECOVERABLE	6,405,033.	7,168,666.
ACCRUED INTEREST	19,337.	17,558.
INSURANCE PREMIUMS RECEIVABLE	80,135.	
ACCOUNTS RECEIVABLE	1,805.	1,685.
TOTAL TO 5471, PAGE 3, SCHEDULE F, LINE 4	6,513,720.	7,195,319.

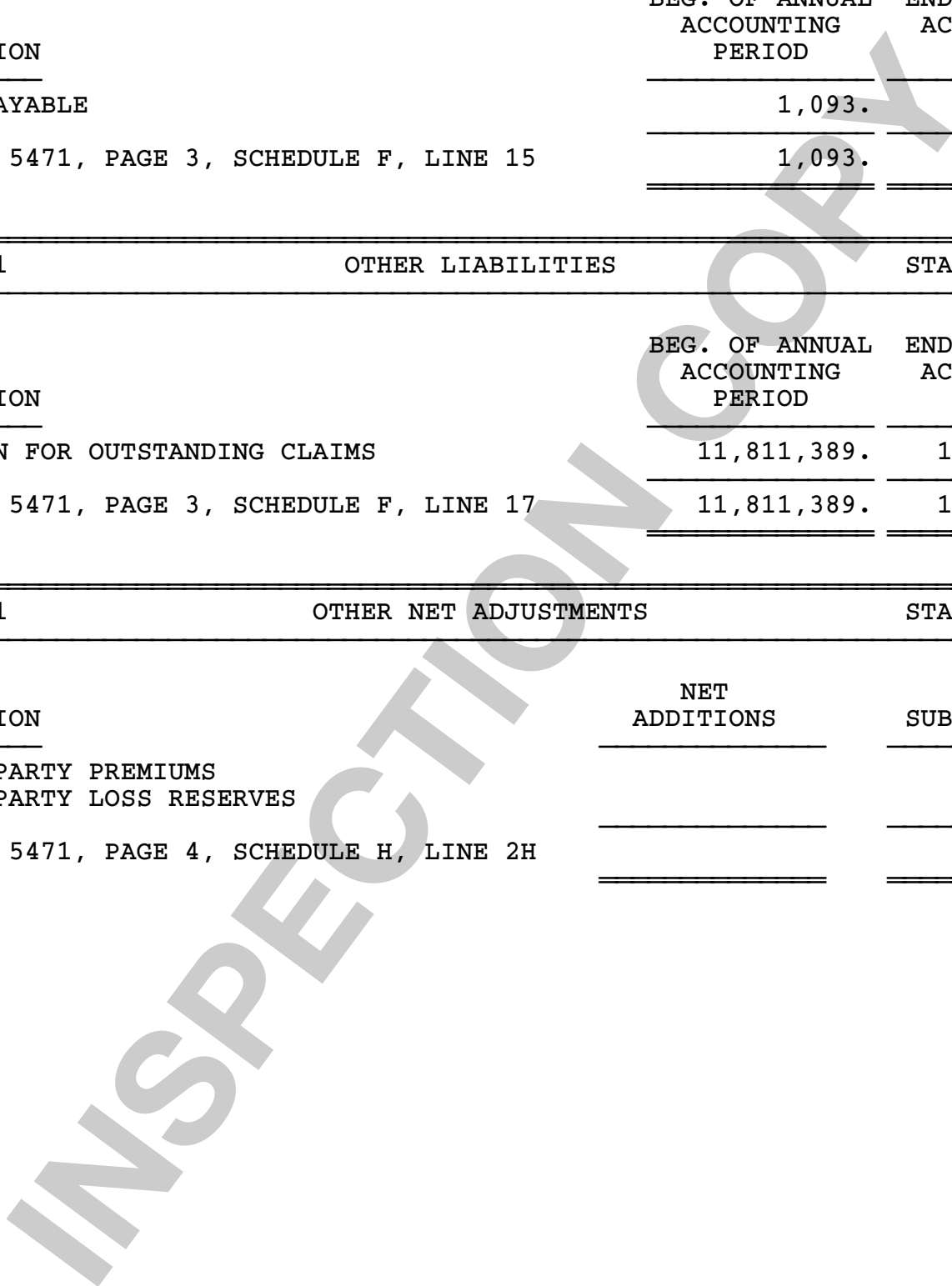
FORM 5471 OTHER INVESTMENTS STATEMENT 7

DESCRIPTION	BEG. OF ANNUAL ACCOUNTING PERIOD	END OF ANNUAL ACCOUNTING PERIOD
MATTHEWS ASIA FUNDS SICAV	262,195.	378,867.
U.S. TREASURY BONDS	1,153,470.	1,430,652.
MORTGAGE BACKED SECURITIES	3,590,481.	3,506,721.
CORPORATE DEBT SECURITIES	982,126.	1,014,890.
FRANKLIN U.S. OPPORTUNITY FUND	555,795.	624,820.
BBH LUXEMBOURG CORE SELECT	186,327.	337,134.
PIMCO FUNDS GBL INVESTOR SER PLC	404,917.	855,835.
TOTAL TO 5471, PAGE 3, SCHEDULE F, LINE 7	7,135,311.	8,148,919.

FORM 5471	OTHER CURRENT LIABILITIES	STATEMENT	8
DESCRIPTION	BEG. OF ANNUAL ACCOUNTING PERIOD	END OF ANNUAL ACCOUNTING PERIOD	
CLAIMS PAYABLE	1,093.	9,783.	
TOTAL TO 5471, PAGE 3, SCHEDULE F, LINE 15	1,093.	9,783.	

FORM 5471	OTHER LIABILITIES	STATEMENT	9
DESCRIPTION	BEG. OF ANNUAL ACCOUNTING PERIOD	END OF ANNUAL ACCOUNTING PERIOD	
PROVISION FOR OUTSTANDING CLAIMS	11,811,389.	12,040,588.	
TOTAL TO 5471, PAGE 3, SCHEDULE F, LINE 17	11,811,389.	12,040,588.	

FORM 5471	OTHER NET ADJUSTMENTS	STATEMENT	10
DESCRIPTION	NET ADDITIONS	NET SUBTRACTIONS	
RELATED PARTY PREMIUMS		2,290,072.	
RELATED PARTY LOSS RESERVES		284,357.	
TOTAL TO 5471, PAGE 4, SCHEDULE H, LINE 2H		2,574,429.	



**SCHEDULE J
(Form 5471)**

(Rev. December 2012)
Department of the Treasury
Internal Revenue Service

**Accumulated Earnings and Profits (E&P)
of Controlled Foreign Corporation**

► Information about Schedule J (Form 5471) and its instructions is at www.irs.gov/form5471.
► Attach to Form 5471.

OMB No. 1545-0704

Name of person filing Form 5471

Identifying number

CARROLL HOSPITAL CENTER, INC.

52-1452024

Name of foreign corporation

EIN (if any)

Reference ID number

CEN-MAR ASSURANCE COMPANY

98-0611607

Important: Enter amounts in functional currency.	(a) Post-1986 Undistributed Earnings (post-86 section 959(c)(3) balance)	(b) Pre-1987 E&P Not Previously Taxed (pre-87 section 959(c)(3) balance)	(c) Previously Taxed E&P (sections 959(c)(1) and (2) balances)			(d) Total Section 964(a) E&P (combine columns (a), (b), and (c))
			(i) Earnings Invested in U.S. Property	(ii) Earnings Invested in Excess Passive Assets	(iii) Subpart F Income	
1 Balance at beginning of year	- 2,222,156.					- 2,222,156.
2a Current year E&P						
b Current year deficit in E&P	411,138.					
3 Total current and accumulated E&P not previously taxed (line 1 plus line 2a or line 1 minus line 2b)	- 2,633,294.					
4 Amounts included under section 951(a) or reclassified under section 959(c) in current year						
5a Actual distributions or reclassifications of previously taxed E&P						
b Actual distributions of nonpreviously taxed E&P						
6a Balance of previously taxed E&P at end of year (line 1 plus line 4, minus line 5a)						
b Balance of E&P not previously taxed at end of year (line 3 minus line 4, minus line 5b)	- 2,633,294.					
7 Balance at end of year. (Enter amount from line 6a or line 6b, whichever is applicable.)	- 2,633,294.					- 2,633,294.

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 5471.

Schedule J (Form 5471) (Rev. 12-2012)

**SCHEDULE M
(Form 5471)**

(Rev. December 2012)

Department of the Treasury
Internal Revenue Service

**Transactions Between Controlled Foreign Corporation
and Shareholders or Other Related Persons**

OMB No. 1545-0704

▶ Information about Schedule M (Form 5471) and its instructions is at www.irs.gov/form5471.

▶ Attach to Form 5471.

Name of person filing Form 5471 CARROLL HOSPITAL CENTER, INC.		Identifying number 52-1452024
Name of foreign corporation CEN-MAR ASSURANCE COMPANY	EIN (if any) 98-0611607	Reference ID number

Important: Complete a *separate* Schedule M for each controlled foreign corporation. Enter the totals for each type of transaction that occurred during the annual accounting period between the foreign corporation and the persons listed in columns (b) through (f). All amounts must be stated in U.S. dollars translated from functional currency at the average exchange rate for the foreign corporation's tax year. See instructions.

Enter the relevant functional currency and the exchange rate used throughout this schedule ▶ **UNITED STATES, DOLLAR** **1.000000**

(a) Transactions of foreign corporation	(b) U.S. person filing this return	(c) Any domestic corporation or partnership controlled by U.S. person filing this return	(d) Any other foreign corporation or partnership controlled by U.S. person filing this return	(e) 10% or more U.S. shareholder of controlled foreign corporation (other than the U.S. person filing this return)	(f) 10% or more U.S. shareholder of any corporation controlling the foreign corporation
1 Sales of stock in trade (inventory) ...					
2 Sales of tangible property other than stock in trade					
3 Sales of property rights (patents, trademarks, etc.)					
4 Platform contribution transaction payments received					
5 Cost sharing transaction payments received					
6 Compensation received for technical, managerial, engineering, construction, or like services					
7 Commissions received					
8 Rents, royalties, and license fees received					
9 Dividends received (exclude deemed distributions under subpart F and distributions of previously taxed income)					
10 Interest received					
11 Premiums received for insurance or reinsurance	686,371.				
12 Add lines 1 through 11	686,371.				
13 Purchases of stock in trade (inventory)					
14 Purchases of tangible property other than stock in trade					
15 Purchases of property rights (patents, trademarks, etc.)					
16 Platform contribution transaction payments paid					
17 Cost sharing transaction payments paid					
18 Compensation paid for technical, managerial, engineering, construction, or like services					
19 Commissions paid					
20 Rents, royalties, and license fees paid					
21 Dividends paid					
22 Interest paid					
23 Premiums paid for insurance or reinsurance					
24 Add lines 13 through 23					
25 Amounts borrowed (enter the maximum loan balance during the year) - see instr.					
26 Amounts loaned (enter the maximum loan balance during the year) - see instr.					

**Return by a U.S. Transferor of Property
 to a Foreign Corporation**

OMB No. 1545-0026

▶ Information about Form 926 and its separate instructions is at www.irs.gov/form926.
 ▶ Attach to your income tax return for the year of the transfer or distribution.

Attachment
 Sequence No. **128**

Part I U.S. Transferor Information (see instructions)

Name of transferor
CARROLL HOSPITAL CENTER, INC.

Identifying number (see instructions)
52-1452024

- 1** If the transferor was a corporation, complete questions 1a through 1d.
- a** If the transfer was a section 361(a) or (b) transfer, was the transferor controlled (under section 368(c)) by 5 or fewer domestic corporations? Yes No
- b** Did the transferor remain in existence after the transfer? Yes No
- If not, list the controlling shareholder(s) and their identifying number(s):

Controlling shareholder	Identifying number

- c** If the transferor was a member of an affiliated group filing a consolidated return, was it the parent corporation? Yes No
- If not, list the name and employer identification number (EIN) of the parent corporation:

Name of parent corporation	EIN of parent corporation

- d** Have basis adjustments under section 367(a)(5) been made? Yes No

- 2** If the transferor was a partner in a partnership that was the actual transferor (but is not treated as such under section 367), complete questions 2a through 2d.

- a** List the name and EIN of the transferor's partnership:

Name of partnership	EIN of partnership

- b** Did the partner pick up its pro rata share of gain on the transfer of partnership assets? Yes No
- c** Is the partner disposing of its **entire** interest in the partnership? Yes No
- d** Is the partner disposing of an interest in a limited partnership that is regularly traded on an established securities market? Yes No

Part II Transferee Foreign Corporation Information (see instructions)

3 Name of transferee (foreign corporation)
CEN- MAR ASSURANCE COMPANY

4a Identifying number, if any
98-0611607

5 Address (including country)
**P.O. BOX 1051
 GRAND CAYMAN, KY1-1102 CAYMAN ISLANDS**

4b Reference ID number

6 Country code of country of incorporation or organization
CJ

7 Foreign law characterization (see instructions)
CORPORATION

- 8** Is the transferee foreign corporation a controlled foreign corporation? Yes No

Part III Information Regarding Transfer of Property (see instructions)

Type of property	(a) Date of transfer	(b) Description of property	(c) Fair market value on date of transfer	(d) Cost or other basis	(e) Gain recognized on transfer
Cash			2,370,297.		
Stock and securities					
Installment obligations, account receivables or similar property					
Foreign currency or other property denominated in foreign currency					
Inventory					
Assets subject to depreciation recapture (see Temp. Regs. sec. 1.367(a)-4T(b))					
Tangible property used in trade or business not listed under another category					
Intangible property					
Property to be leased (as described in final and temp. Regs. sec. 1.367(a)-4(c))					
Property to be sold (as described in Temp. Regs. sec. 1.367(a)-4T(d))					
Transfers of oil and gas working interests (as described in Temp. Regs. sec. 1.367(a)-4T(e))					
Other property					

Supplemental Information Required To Be Reported (see instructions):

Part IV Additional Information Regarding Transfer of Property (see instructions)

9 Enter the transferor's interest in the foreign transferee corporation before and after the transfer:

(a) Before 100.0000 % (b) After 100.0000 %

10 Type of nonrecognition transaction (see instructions) ▶ IRC SEC 351

11 Indicate whether any transfer reported in Part III is subject to any of the following:

- a Gain recognition under section 904(f)(3) Yes No
- b Gain recognition under section 904(f)(5)(F) Yes No
- c Recapture under section 1503(d) Yes No
- d Exchange gain under section 987 Yes No

12 Did this transfer result from a change in the classification of the transferee to that of a foreign corporation? Yes No

13 Indicate whether the transferor was required to recognize income under final and Temporary Regulations sections 1.367(a)-4 through 1.367(a)-6 for any of the following:

- a Tainted property Yes No
- b Depreciation recapture Yes No
- c Branch loss recapture Yes No
- d Any other income recognition provision contained in the above-referenced regulations Yes No

14 Did the transferor transfer assets which qualify for the trade or business exception under section 367(a)(3)? Yes No

15 a Did the transferor transfer foreign goodwill or going concern value as defined in Temporary Regulations section 1.367(a)-1T(d)(5)(iii)? Yes No

b If the answer to line 15a is "Yes," enter the amount of foreign goodwill or going concern value transferred ▶ \$ _____

16 Was cash the only property transferred? Yes No

17 a Was intangible property (within the meaning of section 936(h)(3)(B)) transferred as a result of the transaction? Yes No

b If "Yes," describe the nature of the rights to the intangible property that was transferred as a result of the transaction:

• If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** and check this box **X**

Note. Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.

• If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** (on page 1).

Part II Additional (Not Automatic) 3-Month Extension of Time. Only file the original (no copies needed).

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions. CARROLL HOSPITAL CENTER, INC.	Employer identification number (EIN) or 52-1452024
	Number, street, and room or suite no. If a P.O. box, see instructions. 200 MEMORIAL AVENUE	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. WESTMINSTER, MD 21157	

Enter the Return code for the return that this application is for (file a separate application for each return)

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.

DAVID MCCORMICK

• The books are in the care of **200 MEMORIAL AVE - WESTMINSTER, MD 21157**
Telephone No. **410-871-6859** Fax No.

• If the organization does not have an office or place of business in the United States, check this box

• If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until **MAY 15, 2016**.

5 For calendar year _____, or other tax year beginning **JUL 1, 2014**, and ending **JUN 30, 2015**.

6 If the tax year entered in line 5 is for less than 12 months, check reason: Initial return Final return
 Change in accounting period

7 State in detail why you need the extension
NEED ADDITIONAL INFORMATION TO COMPLETE THE RETURN

8a If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	8a	\$	0.
b If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	8b	\$	0.
c Balance due. Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	8c	\$	0.

Signature and Verification must be completed for Part II only.

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form.

Signature Title Date

TAX RETURN FILING INSTRUCTIONS

CALIFORNIA FORM 199

FOR THE YEAR ENDING

June 30, 2015

Prepared for	Carroll Hospital Center, Inc. 200 Memorial Avenue Westminster, MD 21157
Prepared by	Dixon Hughes Goodman LLP 1410 Spring Hill Road, 5th Floor Tysons, VA 22102
Amount due or refund	No payment required
Make check payable to	Not applicable
Mail tax return and check (if applicable) to	Franchise Tax Board P.O. Box 942857 Sacramento, CA 94257-0500
Return must be mailed on or before	May 16, 2016
Special Instructions	<p>The return should be signed and dated by an authorized individual.</p> <p>We recommend that you file your return using certified mail with a postmarked receipt for proof of timely filing. You should write the certified mail receipt number on the return in the margin near your signature prior to filing. You should also retain the certified mail receipt with your copy of the return.</p>

2014

California Exempt Organization Annual Information Return

199

Calendar Year 2014 or fiscal year beginning (mm/dd/yyyy) **07/01/2014**, and ending (mm/dd/yyyy) **06/30/2015**

Corporation/Organization Name CARROLL HOSPITAL CENTER, INC.		California corporation number	
Additional Information. See instructions.		FEIN 52-1452024	
Street address (suite or room) 200 MEMORIAL AVENUE		PMB no.	
City WESTMINSTER		State MD	ZIP code 21157
Foreign country name		Foreign province/state/country	
		Foreign postal code	

<p>A First Return <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>B Amended Return <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>C IRC Section 4947(a)(1) trust <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>D Final Information Return? <input type="checkbox"/> Dissolved <input type="checkbox"/> Surrendered (Withdrawn) <input type="checkbox"/> Merged/Reorganized Enter date: (mm/dd/yyyy)</p> <p>E Check accounting method: (1) <input type="checkbox"/> Cash (2) <input checked="" type="checkbox"/> Accrual (3) <input type="checkbox"/> Other</p> <p>F Federal return filed? (1) <input checked="" type="checkbox"/> 990T (2) <input type="checkbox"/> 990-PF (3) <input checked="" type="checkbox"/> Sch H (990)</p> <p>G Is this a group filing? See instructions. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>H Is this organization in a group exemption? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," what is the parent's name?</p> <p>I Did the organization have any changes to its guidelines not reported to the FTB? See instructions. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>J If exempt under R&TC Section 23701d, has the organization engaged in political activities? See instructions. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>K Is the organization exempt under R&TC Section 23701g? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," enter the gross receipts from nonmember sources \$ _____</p> <p>L If organization is exempt under R&TC Section 23701d and meets the filing fee exception, check box. No filing fee is required. <input type="checkbox"/></p> <p>M Is the organization a Limited Liability Company? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>N Did the organization file Form 100 or Form 109 to report taxable income? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>O Is the organization under audit by the IRS or has the IRS audited in a prior year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>P Is an IRS Form 1023/1024 pending? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date filed with IRS _____</p>
---	---

Part I Complete Part I unless not required to file this form. See General Instructions B and C.

Receipts and Revenues	1	Gross sales or receipts from other sources. From Side 2, Part II, line 8	1	229,027,234.00
	2	Gross dues and assessments from members and affiliates	2	00
	3	Gross contributions, gifts, grants, and similar amounts received STMT 1	3	3,347,840.00
	4	Total gross receipts for filing requirement test. Add line 1 through line 3. This line must be completed. If the result is less than \$50,000, see General Instruction B	4	232,375,074.00
	5	Cost of goods sold	5	00
	6	Cost or other basis, and sales expenses of assets sold	6	14,847.00
	7	Total costs. Add line 5 and line 6	7	14,847.00
	8	Total gross income. Subtract line 7 from line 4	8	232,360,227.00
Expenses	9	Total expenses and disbursements. From Side 2, Part II, line 18	9	221,145,222.00
	10	Excess of receipts over expenses and disbursements. Subtract line 9 from line 8	10	11,215,005.00
Filing Fee	11	Filing fee \$10 or \$25. See General Instruction F	11	10.00
	12	Total payments AMT PAID WITH FM 3539:	12	10.00
	13	Penalties and Interest. See General Instruction J	13	00
	14	Use tax. See General Instruction K	14	00
	15	Balance due. Add line 11, line 13, and line 14. Then subtract line 12 from the result	15	00

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Sign Here	Signature of officer	Title CFO	Date	• Telephone
Paid Preparer's Use Only	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	• PTIN P01775208
	Firm's name (or yours, if self-employed) and address DIXON HUGHES GOODMAN LLP 1410 SPRING HILL ROAD, 5TH FLOOR TYSONS, VA 22102			• FEIN 56-0747981
	May the FTB discuss this return with the preparer shown above? See instructions <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			• Telephone 703-970-0400

Part II Organizations with gross receipts of more than \$50,000 and private foundations regardless of amount of gross receipts - complete Part II or furnish substitute information.

Receipts from Other Sources	1	Gross sales or receipts from all business activities. See instructions	•	1	00	
	2	Interest	•	2	00	
	3	Dividends	•	3	486,608.00	
	4	Gross rents	•	4	473,100.00	
	5	Gross royalties	•	5	00	
	6	Gross amount received from sale of assets (See Instructions) STATEMENT 2	•	6	0.00	
	7	Other income SEE STATEMENT 3	•	7	228,067,526.00	
	8	Total gross sales or receipts from other sources. Add line 1 through line 7. Enter here and on Side 1, Part I, line 1	•	8	229,027,234.00	
	9	Contributions, gifts, grants, and similar amounts paid	•	9	173,000.00	
	10	Disbursements to or for members	•	10	00	
	11	Compensation of officers, directors, and trustees SEE STATEMENT 4	•	11	6,216,968.00	
	12	Other salaries and wages	•	12	83,948,115.00	
	Expenses and Disbursements	13	Interest	•	13	5,894,245.00
		14	Taxes	•	14	7,239,936.00
		15	Rents	•	15	4,098,068.00
		16	Depreciation and depletion (See instructions)	•	16	15,186,189.00
		17	Other Expenses and Disbursements SEE STATEMENT 5	•	17	98,388,701.00
		18	Total expenses and disbursements. Add line 9 through line 17. Enter here and on Side 1, Part I, line 9	•	18	221,145,222.00

Schedule L Balance Sheets	Beginning of taxable year		End of taxable year	
	(a)	(b)	(c)	(d)
Assets				
1 Cash		22,324,408.		• 11,468,757.
2 Net accounts receivable		23,389,282.		• 19,510,699.
3 Net notes receivable				•
4 Inventories		3,041,830.		• 3,018,003.
5 Federal and state government obligations				•
6 Investments in other bonds				•
7 Investments in stock				•
8 Mortgage loans				•
9 Other investments STMT 6		130,112,144.		• 171,818,670.
10 a Depreciable assets	313,530,630.		294,956,545.	
b Less accumulated depreciation	(164,338,712.)	149,191,918.	(178,479,720.)	116,476,825.
11 Land		1,983,973.		• 1,983,973.
12 Other assets STMT 7		39,708,413.		• 28,617,591.
13 Total assets		369,751,968.		352,894,518.
Liabilities and net worth				
14 Accounts payable		28,868,635.		• 23,278,070.
15 Contributions, gifts, or grants payable				•
16 Bonds and notes payable STMT 8		139,094,739.		• 96,060,517.
17 Mortgages payable				•
18 Other liabilities STMT 9		52,591,768.		70,137,903.
19 Capital stock or principal fund				•
20 Paid-in or capital surplus. Attach reconciliation				•
21 Retained earnings or income fund		149,196,826.		• 163,418,028.
22 Total liabilities and net worth		369,751,968.		352,894,518.

Schedule M-1 Reconciliation of income per books with income per return			
Do not complete this schedule if the amount on Schedule L, line 13, column (d), is less than \$50,000.			
1 Net income per books	• 11,215,005.	7 Income recorded on books this year not included in this return.	•
2 Federal income tax	•	8 Deductions in this return not charged against book income this year	•
3 Excess of capital losses over capital gains	•	9 Total. Add line 7 and line 8	
4 Income not recorded on books this year	•	10 Net income per return.	
5 Expenses recorded on books this year not deducted in this return	•	Subtract line 9 from line 6	11,215,005.
6 Total. Add line 1 through line 5	11,215,005.		

FORM 199

CASH CONTRIBUTIONS
INCLUDED ON PART I, LINE 3

STATEMENT 1

CONTRIBUTOR'S NAME	CONTRIBUTOR'S ADDRESS	DATE OF GIFT	AMOUNT
CARROLL HOSPITAL CENTER FOUNDATION	200 MEMORIAL AVE. WESTMINSTER, MD 21157		3,303,940.
MHA	6820 DEER PATH RD ELKRIDGE, MD 21075-6234		43,900.
TOTAL INCLUDED ON LINE 3			<u>3,347,840.</u>

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FORM 199 GROSS AMOUNT FROM SALE OF ASSETS STATEMENT 2

DESCRIPTION	DATE ACQUIRED	DATE SOLD	METHOD ACQUIRED	
			PURCHASED	
	COST OR OTHER BASIS	DEPREC.	EXPENSE OF SALE	GROSS SALES PRICE
	14,847.	0.	0.	0.
TOTAL TO FORM 199, PAGE 2, LN 6	14,847.	0.	0.	0.

FORM 199 OTHER INCOME STATEMENT 3

DESCRIPTION	AMOUNT
CARROLL COUNTY MED SERVICES MGMT FEE	90,000.
OTHER REVENUE	12,533.
NET PATIENT SERVICE REVENUE	223,685,430.
CAFETERIA/VENDING	880,618.
NONPATIENT LAB	2,651,939.
OTHER OPERATING REVENUE	747,006.
TOTAL TO FORM 199, PART II, LINE 7	228,067,526.

 FORM 199 COMPENSATION OF OFFICERS, DIRECTORS AND TRUSTEES STATEMENT 4

NAME AND ADDRESS	TITLE AND AVERAGE HRS WORKED/WK	COMPENSATION
CHARLES O FISHER JR 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
DR. SOHAILIA ALI 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
ETHAN SEIDEL PHD 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
GERALD LEE STURGILL 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	EX-OFFICIO 1.00	0.
HELEN W WHITEHEAD 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	CHAIR 1.00	0.
JASON BLAVATT, ESQUIRE 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
JEFFREY A WOTHERS 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
JOHN STEERS MD 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
KIMBERLY JOHNSTON, MD 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
LARRY VAN SANT SR 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
LESLIE SIMMONS 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	CHIEF EXECUTIVE OFFICER 37.00	0.

MARCUS PRIMM 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
MARTIN HILL 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
MIRIAM BECK 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	SECRETARY 2.00	0.
NEIL MELTZER 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
THOMAS WELLIVER 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
W DENNIS THOMAS 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BOARD MEMBER 1.00	0.
KEVIN KELBLY 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	SR VP FINANCE CFO 35.00	0.
BOB EDMONDSON 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	VICE PRESIDENT 40.00	0.
CRIS COLEMAN 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	VICE PRESIDENT 40.00	0.
DAVID LOUDER 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	VICE PRESIDENT 39.00	0.
JED ROSEN 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	CHIEF MEDICAL INFO OFFICER 40.00	0.
JOYCE ROMANS 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	VICE PRESIDENT 40.00	0.
M ELLEN FINNERTY MYERS 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	CHIEF DEVELOPMENT OFFICER 20.00	0.

MARK OLSZYK 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	VICE PRESIDENT 40.00	0.
ROBERT WHITE 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	VICE PRESIDENT 40.00	0.
SHARON GOMEZ-SANDERS 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	VICE PRESIDENT 39.00	0.
STEPHANIE REID 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	VICE PRESIDENT 39.00	0.
TRACEY ELLISON 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	VICE PRESIDENT 40.00	0.
DAVID SALINGER 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	PHYSICIAN 39.00	0.
FLAVIO KRUTER 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	PHYSICIAN 39.00	0.
JANICE NAPIERALSKI 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	AVP 40.00	0.
JOHANNA DIMENTO 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	PHYSICIAN 40.00	0.
RICHARD RAVER 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	EMPLOYEE 40.00	0.
JOHN SERNULKA 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	PRESIDENT/EX-OFFICIO 0.00	0.
TOTAL TO FORM 199, PART II, LINE 11		0.

FORM 199	OTHER EXPENSES	STATEMENT	5
DESCRIPTION		AMOUNT	
MEDICAL SUPPLIES		35,453,495.	
CONTRACTED SERVICES		11,134,640.	
DUES BOOKS AND SUBSCRIP		2,215,529.	
OTHER PURCHASED SERVICE		1,905,343.	
OFFICE RENT		0.	
PENSION PLAN CONTRIBUTIONS		2,363,220.	
OTHER EMPLOYEE BENEFITS		7,729,503.	
LEGAL FEES		13,659.	
ACCOUNTING FEES		245,988.	
INVESTMENT MANAGEMENT FEES		481,896.	
OTHER PROFESSIONAL FEES		25,829,144.	
ADVERTISING AND PROMOTION		782,324.	
OFFICE EXPENSES		2,102,328.	
INFORMATION TECHNOLOGY		94,692.	
TRAVEL		506,594.	
CONFERENCES AND CONVENTIONS		91,074.	
INSURANCE		2,491,078.	
ALL OTHER EXPENSES		4,948,194.	
TOTAL TO FORM 199, PART II, LINE 17		98,388,701.	

FORM 199	OTHER INVESTMENTS	STATEMENT	6
DESCRIPTION	BEG. OF YEAR	END OF YEAR	
INVESTMENTS IN FOUNDATION	22,828,444.	71,455,110.	
INVESTMENT IN PREMIER	294,374.	195,176.	
INVESTMENT IN MT AIRY HEALTH SERVICE	46,522.	288.	
INVESTMENT IN COLONIAL	27,924.	7,362.	
INVESTMENT IN CMOA	1,020,632.	523,192.	
INVESTMENT IN HOSPICE	8,554,364.	10,218,291.	
INVESTMENT IN CARROLL COUNTY RADIOLOGY	5,806,312.	5,802,522.	
INVESTMENT IN CEN MAR	4,123,015.	6,332,601.	
SHORT TERM INVESTMENT	14,799,973.	6,907,545.	
LONG-TERM INVESTMENTS	18,427,641.	17,922,674.	
L-T INVESTMENTS IN EXEC OPTION PLAN	387,321.	33,976.	
OTHER PUBLICLY TRADED SECURITIES	53,795,622.	52,419,933.	
TOTAL TO FORM 199, SCHEDULE L, LINE 9	130,112,144.	171,818,670.	

FORM 199	OTHER ASSETS	STATEMENT	7
DESCRIPTION	BEG. OF YEAR	END OF YEAR	
PREPAID EXPENSES AND DEFERRED CHARGES	5,660,075.	6,017,164.	
INTANGIBLE ASSETS	3,050,000.	12,600,000.	
DUE FROM AFFILIATES	12,357,655.	0.	
UNAMORTIZED BOND ISSUANCE COST	1,887,274.	1,812,809.	
OTHER RECEIVABLES	530,669.	1,321,016.	
FUNDS HELD BY TRUSTEE	16,222,740.	6,866,602.	
TOTAL TO FORM 199, SCHEDULE L, LINE 12	39,708,413.	28,617,591.	

FORM 199	BONDS AND NOTES PAYABLE	STATEMENT	8
DESCRIPTION	BEG. OF YEAR	END OF YEAR	
TAX-EXEMPT BONDS LIABILITIES	139,094,739.	96,060,517.	
TOTAL TO FORM 199, SCHEDULE L, LINE 16	139,094,739.	96,060,517.	

FORM 199	OTHER LIABILITIES	STATEMENT	9
DESCRIPTION	BEG. OF YEAR	END OF YEAR	
ADVANCES FROM THIRD PARTY	6,504,681.	6,731,774.	
ACCRUED PENSION	7,808,261.	7,742,535.	
CAPITAL LEASE	992,021.	743,156.	
MOB DEBT	17,192,397.	17,192,397.	
DEFERRED COMPENSATION	387,321.	33,976.	
DUE TO CENMAR	10,128,937.	10,128,937.	
MERRILL LYNCH SWAP RATE LIABILITY	9,274,863.	0.	
DUE TO AFFILIATES	0.	27,353,465.	
DEFERRED REVENUE	303,287.	211,663.	
TOTAL TO FORM 199, SCHEDULE L, LINE 18	52,591,768.	70,137,903.	

FORM 199 FUND BALANCES STATEMENT 10

DESCRIPTION	BEG. OF YEAR	END OF YEAR
UNRESTRICTED ASSETS	137,821,978.	103,620,476.
TEMPORARILY RESTRICTED ASSETS	10,202,084.	58,624,788.
PERMANENTLY RESTRICTED ASSETS	1,172,764.	1,172,764.
TOTAL TO FORM 199, SCHEDULE L, LINE 21	149,196,826.	163,418,028.

INSPECTION COPY

TAX RETURN FILING INSTRUCTIONS

CALIFORNIA FORM 109

FOR THE YEAR ENDING

June 30, 2015

Prepared for	Carroll Hospital Center, Inc. 200 Memorial Avenue Westminster, MD 21157
Prepared by	Dixon Hughes Goodman LLP 1410 Spring Hill Road, 5th Floor Tysons, VA 22102
Amount due or refund	No payment required
Make check payable to	Not applicable
Mail tax return and check (if applicable) to	Franchise Tax Board P.O. Box 942857 Sacramento, CA 94257-0500
Return must be mailed on or before	May 16, 2016
Special Instructions	<p>The return should be signed and dated by an authorized individual.</p> <p>We recommend that you file your return using certified mail with a postmarked receipt for proof of timely filing. You should write the certified mail receipt number on the return in the margin near your signature prior to filing. You should also retain the certified mail receipt with your copy of the return.</p>

2014

California Exempt Organization Business Income Tax Return

109

Calendar Year 2014 or fiscal year beginning (mm/dd/yyyy) 07/01/2014, and ending (mm/dd/yyyy) 06/30/2015

Corporation/Organization name CARROLL HOSPITAL CENTER, INC. California corporation number

Additional information. See instructions. FEIN 52-1452024

Street address (suite/room no.) 200 MEMORIAL AVENUE PMB no.

City (If the corporation has a foreign address, see instructions.) WESTMINSTER State MD ZIP code 21157

Foreign country name Foreign province/state/county Foreign postal code

- A First Return Filed? B Is this an education IRA... C Is the organization under audit... D Final Return? E Amended Return F Accounting Method Used G Nature of trade or business H Is the organization a non-exempt charitable trust... I Is this organization claiming any former... J Is this organization a qualified pension... K Unrelated Business Activity (UBA) Code L Is this a Hospital?

Table with 4 main sections: Taxable Corporation, Taxable Trust, Total Tax, and Refund (Direct Deposit of Refund) or Amount Due. Rows 1-27 with descriptions and numerical values.

Unrelated Business Taxable Income

Part I Unrelated Trade or Business Income

1	a	Gross receipts or gross sales	3,958,118.	b	Less returns and allowances	1,306,179.	c	Balance	1c	2,651,939.00
2		Cost of goods sold and/or operations (Schedule A, line 7)							2	00
3		Gross profit. Subtract line 2 from line 1c							3	2,651,939.00
4	a	Capital gain net income. See Specific Line Instructions - Trusts attach Schedule D (541)							4a	00
	b	Net gain (loss) from Part II, Schedule D-1							4b	00
	c	Capital loss deduction for trusts							4c	00
5		Income (or loss) from partnerships, limited liability companies, or S corporations. See specific line instructions. Attach Schedule K-1 (565, 568, or 100S) or similar schedule	SEE STATEMENT 12						5	-118,956.00
6		Rental income (Schedule C)							6	22,875.00
7		Unrelated debt-financed income (Schedule D)							7	00
8		Investment income of an R&TC Section 23701g, 23701i, or 23701n organization (Schedule E)							8	00
9		Interest, Annuities, Royalties and Rents from controlled organizations (Schedule F)							9	00
10		Exploited exempt activity income (Schedule G)							10	00
11		Advertising income (Schedule H, Part III, Column A)							11	00
12		Other income. Attach schedule	SEE STATEMENT 13						12	90,000.00
13		Total unrelated trade or business income. Add line 3 through line 12							13	2,645,858.00

Part II Deductions Not Taken Elsewhere (Except for contributions, deductions must be directly connected with the unrelated business income.)

14		Compensation of officers, directors, and trustees from Schedule I							14	00
15		Salaries and wages							15	1,098,961.00
16		Repairs							16	00
17		Bad debts							17	00
18		Interest							18	00
19		Taxes							19	00
20		Contributions							20	00
21	a	Depreciation (Corporations and Associations - Schedule J) (Trusts - form FTB 3885F)	21a	325,281.00						
	b	Less: depreciation claimed on Schedule A	21b	00					21	325,281.00
22		Depletion							22	00
23	a	Contributions to deferred compensation plans							23a	00
	b	Employee benefit programs							23b	212,076.00
24		Other deductions	SEE STATEMENT 14						24	1,239,166.00
25		Total deductions. Add line 14 through line 24							25	2,875,484.00
26		Unrelated business taxable income before allowable excess advertising costs. Subtract line 25 from line 13							26	-229,626.00
27		Excess advertising costs (Schedule H, Part III, Column B)							27	00
28		Unrelated business taxable income before specific deduction. Subtract line 27 from line 26							28	-229,626.00
29		Specific deduction							29	1,000.00
30		Unrelated business taxable income. Subtract line 29 from line 28. If line 28 is a loss, enter line 28							30	-229,626.00

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Sign Here	Signature of officer	Title CFO	Date	Telephone
	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN P01775208
Paid Preparer's Use Only	Firm's name (or yours, if self-employed) and address	DIXON HUGHES GOODMAN LLP 1410 SPRING HILL ROAD, 5TH FLOOR TYSONS, VA 22102		FEIN 56-0747981 Telephone 703-970-0400
	May the FTB discuss this return with the preparer shown above? See instructions			

Schedule A Cost of Goods Sold and/or Operations.

Method of inventory valuation (specify)

N/A

Table with 7 rows for Schedule A: 1 Inventory at beginning of year, 2 Purchases, 3 Cost of labor, 4a Additional IRC Section 263A costs, 4b Other costs, 5 Total, 6 Inventory at end of year, 7 Cost of goods sold and/or operations. Includes a checkbox for IRC Section 263A rules.

Schedule B Tax Credits. Do not claim the New Employment Credit on Schedule B.

Table for Schedule B with 4 rows: 1 Enter credit name, 2 Enter credit name, 3 Enter credit name, 4 Total. Add line 1 through line 3.

Schedule K Add-On Taxes or Recapture of Tax.

Table for Schedule K with 5 rows: 1 Interest computation under the look-back method, 2 Interest on tax attributable to installment, 3 IRC Section 197(f)(9)(B)(ii) election, 4 Credit recapture, 5 Total.

Schedule R Apportionment Formula Worksheet. Use only for unrelated trade or business amounts.

Part A. Standard Method - Single-Sales Factor Formula. Complete this part only if the corporation uses the single-sales factor formula.

Table for Part A with 2 rows: 1 Total Sales, 2 Apportionment percentage. Includes columns for total sales, sales within California, and percent within California.

Part B. Three Factor Formula. Complete this part only if the corporation uses the three-factor formula.

Table for Part B with 5 rows: 1 Property factor, 2 Payroll factor, 3 Sales factor, 4 Total percentage, 5 Average apportionment percentage.

Schedule C Rental Income from Real Property and Personal Property Leased with Real Property

For rental income from debt-financed property, use Schedule D, R&TC Section 23701g, Section 23701i, and Section 23701n organizations. See instructions for exceptions.

Table for Schedule C with 4 main sections: 1 Description of property, 2 Rent received or accrued, 3 Percentage of rent attributable to personal property, 4/5 Deductions and income calculations.

Schedule D Unrelated Debt-Financed Income

1 Description of debt-financed property		2 Gross income from or allocable to debt-financed property	3 Deductions directly connected with or allocable to debt-financed property		9 Net income (or loss) includible, column 7 less column 8
			(a) Straight-line depreciation	(b) Other deductions	
4 Amount of average acquisition indebtedness on or allocable to debt-financed property	5 Average adjusted basis of or allocable to debt-financed property	6 Debt basis percentage, column 4 ÷ column 5	7 Gross income reportable, column 2 x column 6	8 Allocable deductions, total of columns 3(a) and 3(b) x column 6	
		%			
		%			
		%			

Total. Enter here and on Side 2, Part I, line 7

Schedule E Investment Income of an R&TC Section 23701g, Section 23701i, or Section 23701n Organization

1 Description	2 Amount	3 Deductions directly connected	4 Net investment income, column 2 less column 3	5 Set-asides	6 Balance of investment income, column 4 less column 5

Total. Enter here and on Side 2, Part I, line 8

Enter gross income from members (dues, fees, charges, or similar amounts)

Schedule F Interest, Annuities, Royalties and Rents from Controlled Organizations

Exempt Controlled Organizations					
1 Name of controlled organizations	2 Employer Identification Number	3 Net unrelated income (loss)	4 Total of specified payments made	5 Part of column (4) that is included in the controlling organization's gross income	6 Deductions directly connected with income in column (5)
1					
2					
3					

Nonexempt Controlled Organizations

7 Taxable Income	8 Net unrelated income (loss)	9 Total of specified payments made	10 Part of column (9) that is included in the controlling organization's gross income	11 Deductions directly connected with income in column (10)
1				
2				
3				

4 Add columns 5 and 10

5 Add columns 6 and 11

6 Subtract line 5 from line 4. Enter here and on Side 2, Part 1, line 9

Schedule G Exploited Exempt Activity Income, other than Advertising Income

1 Description of exploited activity (attach schedule if more than one unrelated activity is exploiting the same exempt activity)	2 Gross unrelated business income from trade or business	3 Expenses directly connected with production of unrelated business income	4 Net income from unrelated trade or business, column 2 less column 3	5 Gross income from activity that is not unrelated business income	6 Expenses attributable to column 5	7 Excess exempt expense, column 6 less column 5 but not more than column 4	8 Net income includible, column 4 less column 7 but not less than zero

Total. Enter here and on Side 2, Part I, line 10

Schedule H Advertising Income and Excess Advertising Costs

Part I Income from Periodicals Reported on a Consolidated Basis

Table with 7 columns: 1 Name of periodical, 2 Gross advertising income, 3 Direct advertising costs, 4 Advertising income or excess advertising costs, 5 Circulation income, 6 Readership costs, 7 If column 5 is greater than column 6, enter the income shown in column 4, in Part III, column A(b).

Part II Income from Periodicals Reported on a Separate Basis

Table with 7 columns for separate basis reporting, identical structure to Part I.

Part III Column A - Net Advertising Income

Part III Column B - Excess Advertising Costs

Table with 4 columns: (a) Enter "consolidated periodical" and/or names of non-consolidated periodicals, (b) Enter total amount from Part I, column 4 or 7, and amounts listed in Part II, cols. 4 and 7.

Enter total here and on Side 2, Part I, line 11

Enter total here and on Side 2, Part II, line 27

Schedule I Compensation of Officers, Directors, and Trustees

Table with 6 columns: 1 Name of Officer, 2 SSN or ITIN, 3 Title, 4 Percent of time devoted to business, 5 Compensation attributable to unrelated business, 6 Expense account allowances.

Total. Enter here and on Side 2, Part II, line 14

Schedule J Depreciation (Corporations and Associations only. Trusts use form FTB 3885F.)

Table with 7 columns: 1 Group and guideline class or description of property, 2 Date acquired (mm/dd/yyyy), 3 Cost or other basis, 4 Depreciation allowed or allowable in prior years, 5 Method of computing depreciation, 6 Life or rate, 7 Depreciation for this year.

FORM 109 NATURE OF TRADE OR BUSINESS STATEMENT 11

OTHER FINANCIAL ACTIVITY LAB

TO FORM 109, PAGE 1

FORM 109 INCOME OR (LOSS) FROM PARTNERSHIPS, LIMITED LIABILITY COMPANIES OR S CORPORATIONS STATEMENT 12

DESCRIPTION	AMOUNT
K-1 PREMIER PURCHASING	6,883.
K-1 CHESAPEAKE INVESTMENTS III	-115,309.
K-1 SEAMARK CAPITAL	-27,176.
K-1 GREENSPRING	16,646.
TOTAL TO FORM 109, PAGE 2, LINE 5	-118,956.

FORM 109 OTHER INCOME STATEMENT 13

DESCRIPTION	AMOUNT
CC MED SERVICES MANAGMENT INCOME	90,000.
TOTAL TO FORM 109, PAGE 2, LINE 12	90,000.

FORM 109 OTHER DEDUCTIONS STATEMENT 14

DESCRIPTION	AMOUNT
PROFESSIONAL FEES	53,218.
SUPPLIES	621,071.
PURCHASED SERVICES	147,901.
SUPPORT EXPENSES	416,976.
TOTAL TO FORM 109, PAGE 2, LINE 24	1,239,166.

TAX RETURN FILING INSTRUCTIONS

GEORGIA FORM 600-T

FOR THE YEAR ENDING

June 30, 2015

Prepared for	Carroll Hospital Center, Inc. 200 Memorial Avenue Westminster, MD 21157
Prepared by	Dixon Hughes Goodman LLP 1410 Spring Hill Road, 5th Floor Tysons, VA 22102
Amount due or refund	Refund of \$3,213
Make check payable to	Not applicable
Mail tax return and check (if applicable) to	Georgia Department of Revenue P.O. Box 740397 Atlanta, GA 30374-0397
Return must be mailed on or before	May 16, 2016
Special Instructions	<p>The return should be signed and dated by an authorized individual.</p> <p>We recommend that you file your return using certified mail with a postmarked receipt for proof of timely filing. You should write the certified mail receipt number on the return in the margin near your signature prior to filing. You should also retain the certified mail receipt with your copy of the return.</p>



MAIL TO: Georgia Department of Revenue Processing Center PO Box 740320 Atlanta, GA 30374-0320

Georgia Department of Revenue APPLICATION FOR EXTENSION OF TIME FOR FILING STATE INCOME TAX RETURNS

IMPORTANT! ACCEPTANCE OF FEDERAL EXTENSIONS

A FEDERAL EXTENSION WILL BE ACCEPTED AS A GEORGIA EXTENSION IF: (1) THE RETURN IS RECEIVED WITHIN THE TIME AS EXTENDED BY THE INTERNAL REVENUE SERVICE, AND (2) A COPY OF THE FEDERAL EXTENSION(S) IS ATTACHED TO THE RETURN WHEN FILED. NOTE: THERE IS NO EXTENSION FOR PAYMENT OF TAX. INCOME TAX OR CORPORATE NET WORTH TAX MUST BE PAID BY THE PRESCRIBED DUE DATE TO AVOID THE ASSESSMENT OF LATE PAYMENT PENALTIES AND INTEREST.

THIS IS NOT A PAYMENT FORM! REMIT PAYMENT ON FORM IT-560 OR IT-560C.

COMPLETE THIS FORM IN TRIPPLICATE. MAIL THE ORIGINAL PRIOR TO THE RETURN DUE DATE AND KEEP 2 COPIES. ATTACH ONE COPY TO RETURN WHEN FILED AND RETAIN ONE COPY FOR YOUR RECORDS. WE WILL NOTIFY YOU ONLY IF YOUR EXTENSION REQUEST IS DENIED.

SECTION 1: NAME, ADDRESS, CITY, STATE, ZIP CODE, SOCIAL SECURITY NO. OR FEIN. Includes fields for CARROLL HOSPITAL CENTER, INC. and 200 MEMORIAL AVENUE, WESTMINSTER, MD, 21157.

SECTION 2: APPLICATION IS HEREBY MADE FOR AN EXTENSION OF TIME FOR THE FOLLOWING STATE TAX RETURN. Includes checkboxes for return types and fields for period ending (06/30/15) and extension requested to (05/16/16).

SECTION 3: REASON FOR EXTENSION: NEED ADDITIONAL INFORMATION TO COMPLETE THE RETURN. Includes a large blank area for providing details.

I AFFIRM THAT THE ABOVE INFORMATION IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE AND ACCURATE. THIS AFFIRMATION IS MADE UNDER THE PENALTIES PRESCRIBED BY LAW.

DATE SIGNATURE OF TAXPAYER OR AUTHORIZED AGENT IF SIGNED BY AGENT, AGENT'S FIRM OR TRADE NAME

**APPLICATION FOR EXTENSION OF TIME
FOR FILING STATE INCOME TAX RETURNS****INSTRUCTIONS**

- 1) Extensions of time for filing returns may be granted in cases of sickness, absence, or other disability or whenever reasonable cause exists.
- 2) This form must be completed in triplicate. Mail the original form prior to the return due date to:
Georgia Department of Revenue, Processing Center, P.O. Box 740320, Atlanta, GA 30374-0320.
- 3) **One copy of the extension must be attached to the completed return when filed.** Retain the other copy for your records.
- 4) Separate applications for extension must be submitted for husband and wife if separate returns are filed.
- 5) An extension request will not be accepted by telephone. Lists are not acceptable. Application must be made on this form, unless a copy of an approved federal extension is attached to your Georgia return when filed. If applicable, explain why it was not necessary to request a federal filing extension.
- 6) Additional time to file, within the six month limit, will require the submission of a new form along with a copy of the first extension request. **For tax years beginning on or after January 1, 2010, a partnership and fiduciary will only be granted an extension up to 5 months.**
- 7) Corporations filing consolidated returns must file a separate application for extension for filing Net Worth Tax for each subsidiary. Corporations not filing consolidated returns may request an extension for filing income tax and net worth tax returns on one form.
- 8) Interest will be assessed at a rate of 1% per month from the due date prescribed by law for filing the return until the date of payment. Interest accrues regardless of an approved extension request.
- 9) Late filing penalty on returns filed after the due date prescribed by law will be assessed at a rate of 5% per month computed on the tax not paid by the original due date.
- 10) Late payment penalty will be assessed at a rate of 1/2 of 1% per month if tax due on the return is not paid by the date prescribed by law. Late payment penalty accrues regardless of an approved extension request. Individuals and fiduciaries should remit payment due on Form IT-560. Corporations should remit payment on Form IT-560C. Composite tax should be remitted on Form IT-560C.

NOTE: Remitting payment with Form IT-560 or IT-560C will not extend the due date for filing your return. For filing a Net Worth Tax Return after the date prescribed by law, there shall be assessed a penalty amounting to 10% of the tax shown to be due. For failure to pay tax within the time prescribed by law, there shall be due an additional penalty amounting to 10% of the tax shown to be due.

IMPORTANT

THIS FORM IS TO BE USED BY **CORPORATE TAXPAYERS** FOR PAYMENT OF INCOME TAX AND/OR NET WORTH TAX WHEN AN EXTENSION HAS BEEN REQUESTED OR IS ENFORCED.

Instructions for Form IT 560C

When a taxpayer receives an automatic extension of time in which to file a Federal return, Georgia will honor that extension. No penalty for late filing will be assessed if the Georgia return is filed by the extended due date of the Federal return. The extension is for filing the return and does not extend the time for paying the tax. The tax must be paid by the statutory due date. An extension of time for filing does not relieve the taxpayer of liability for interest or penalty for late payment of tax.

1. This form is to be used to submit any payment of tax when an extension is requested or enforced.
2. The amount paid with this form should be claimed on the completed return as credits and payments.
3. This form must be submitted with remittance to pay the tax that will be due as reflected on the final return. If the tax is not paid by the original due date of the return, a penalty of 1/2 of 1% per month of the tax due will be assessed as a late payment penalty. The addition of this penalty does not relieve the taxpayer of liability for interest due on the unpaid balance of tax.
4. The amount paid is to be credited as a payment on the liability that may be due as indicated on the completed return. Georgia Public Revenue Code Section 48-2-31 stipulates that taxes shall be paid in lawful money of the United States, free of any expense to the State of Georgia.

For faster and more accurate posting to your account, use a payment voucher with a valid scanline from Georgia Department of Revenue's website <http://dor.ga.gov> or one produced by an approved software company listed at <http://dor.ga.gov>

If you have any questions call: 1-877-423-6711

Make check payable to: Georgia Department of Revenue (Include FEI Number on check)

Mail the completed IT 560C with remittance to:

Processing Center
Georgia Department of Revenue
PO Box 740239
Atlanta, GA 30374-0239

PLEASE DO NOT mail this entire page. Please cut along dotted line and mail only voucher and payment.

PLEASE DO NOT STAPLE. PLEASE REMOVE ALL CHECK STUBS.

445501
01-28-15

----- Cut along dotted line -----

IT 560 C (Rev. 12/14)

FOR CORPORATION AND COMPOSITE ONLY
Payment of Income Tax
Income/Net Worth Payment Voucher
Telephone No. 1-877-423-6711
2014



1501205013

MAIL TO:

Processing Center
Georgia Department of Revenue
PO Box 740239
Atlanta, Georgia 30374-0239

<input type="checkbox"/> Composite Tax	<input checked="" type="checkbox"/> Corporate Income Tax	<input type="checkbox"/> Net Worth Tax	<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change
FEI Number 52-1452024	Income Tax Year 2014	Beginning Date 07-01-2014	Ending Date 06-30-2015	Vendor Code 050
Name (Type or print plainly the exact Corporation Name) CARROLL HOSPITAL CENTER, INC.			Signature of Officer or Agent	Title Date
Business Address 200 MEMORIAL AVENUE		City WESTMINSTER	State MD	ZIP Code 21157

PLEASE DO NOT STAPLE. REMOVE ALL CHECK STUBS.

Amount Paid \$ 3213.00

0125214520240070630152122200000000005000003213002



Amended Amended due to IRS Audit Address Change UET Annualization Exception attached

Exempt Organization Unrelated Business Income Tax Return (Under Georgia Code Section 48-7-25)					2014
For the taxable year beginning					07/01/2014 and ending 06/30/2015
Name of Organization		Name of Fiduciary		Federal Employer ID No. (in case of employees' trust described in section 401 (a) and exempt under section 501 (a), insert the trust's identification number.)	
CARROLL HOSPITAL CENTER,				52-1452024	
Number and Street		Number and Street		NAICS Code	Date of current exemption letter.
200 MEMORIAL AVENUE				525990	501 (E)
City or Town		City or Town			
WESTMINSTER					
State	ZIP Code	State	ZIP Code		
MD	21157				
SCHEDULE 1					
1. Unrelated business taxable income from Federal Form 990-T (attach copy)	▶	1.			-232,849.
2. Additions SEE STATEMENT 1	▶	2.			232,849.
3. Total (add line 1 and line 2)	▶	3.			
4. Subtractions	▶	4.			
5. Georgia unrelated business taxable income (line 3 less line 4)	▶	5.			0.
COMPUTATION OF GEORGIA UNRELATED BUSINESS INCOME TAX					
SCHEDULE 2					
1. Line 5, above, multiplied by 6%	▶	1.			
2. Less: Credits and Payments	▶	2.			3,213.
3. Withholding Credits (G2-A, G2-LP and/or G2-RP)	▶	3.			
4. Balance of tax due OR overpayment	▶	4.			-3,213.
5. Interest due (see instructions)	▶	5.			
6. Underestimated tax penalty	▶	6.			
7. Other penalties due (see instructions)	▶	7.			
8. Balance of tax, interest and penalties due with return	▶	8.			-3,213.
9. If line 4 is an overpayment, amount to be credited on _____					
Estimated Tax ▶					3,213.
Refunded ▶					

A COPY OF THE FEDERAL 990 T AND SUPPORTING SCHEDULES (AND ANY EXTENSION) MUST BE ATTACHED TO THIS RETURN.
 DECLARATION: I/We declare, under penalty of perjury that I/we have examined this return (including accompanying schedules and statements) and to the best of my/our knowledge and belief it is true, correct and complete. If prepared by a person other than a taxpayer, his/her declaration is based on all information of which he/she has any knowledge.

KEVIN KELBLY
 Signature of Officer
 CFO
 Title _____ Date _____

Signature of Individual or Firm Preparing Return
P01775208
 Employee ID or Social Security Number

445981
 09-15-14

GA 600-T ADDITIONS TO TAXABLE INCOME STATEMENT 1

DESCRIPTION	AMOUNT
TOTAL TO FORM 600-T, LINE 2	232,849.

INSPECTION COPY

TAX RETURN FILING INSTRUCTIONS

INDIANA FORM IT-20NP

FOR THE YEAR ENDING

June 30, 2015

Prepared for	Carroll Hospital Center, Inc. 200 Memorial Avenue Westminster, MD 21157
Prepared by	Dixon Hughes Goodman LLP 1410 Spring Hill Road, 5th Floor Tysons, VA 22102
Amount due or refund	No payment required
Make check payable to	Not applicable
Mail tax return and check (if applicable) to	Indiana Department of Revenue P.O. Box 7228 Indianapolis, IN 46207-7228
Return must be mailed on or before	May 16, 2016
Special Instructions	<p>The return should be signed and dated by an authorized individual.</p> <p>We recommend that you file your return using certified mail with a postmarked receipt for proof of timely filing. You should write the certified mail receipt number on the return in the margin near your signature prior to filing. You should also retain the certified mail receipt with your copy of the return.</p>

Indiana Nonprofit Organization Unrelated Business Income Tax Return

2014

Calendar Year Ending December 31, 2014 or

Fiscal Year Beginning 07 01 2014 and Ending 06 30 2015

Check box if amended.

Check box if name changed.

Name of Organization CARROLL HOSPITAL CENTER INC			Federal Identification Number (FID) 52 1452024
Number and Street 200 MEMORIAL AVENUE		Indiana County or O.O.S.	Principal Business Activity Code 525990
City WESTMINSTER, MD	State MD	ZIP Code 21157	Telephone Number 410 871 6859
K Check all boxes that apply: <input type="checkbox"/> Initial Return <input type="checkbox"/> Final Return <input type="checkbox"/> In Bankruptcy <input type="checkbox"/> Schedule M L Do you have on file a valid extension of time to file your return (federal Form 7004 or an electronic extension of time)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Due Date: 15th day of the fifth month following close of the tax year.			

Adjusted Gross Income Tax Calculation on Unrelated Business Income

Round all entries

1. Unrelated business taxable income (before NOL) deduction and specific deduction from federal return Form 990T (enclose Form 990T); use minus sign for negative amounts	1	-232849.00
2. Specific deduction (generally \$1,000; see instructions)	2	1000.00
3. Interest on U.S. government obligations on the federal return less related expenses	3	.00
4. Deduction for qualified patents income	4	.00
5. Enter total from lines 2 through 4	5	1000.00
6. Subtotal for unrelated business income (subtract line 5 from line 1)	6	-233849.00
7. Indiana modifications. See instructions. (Use a minus sign to denote negative amounts.)	7	.00
8. Unrelated business income, as adjusted (add lines 6 and 7). (If not apportioning, enter same amount on line 10.)	8	-233849.00
9. Enter Indiana apportionment percentage, if applicable, from line 9 of IT-20 Schedule E apportionment (enclose schedule)	9	.61 %
10. Unrelated business apportioned to Indiana (multiply line 8 by line 9; otherwise, enter line 8 amount)	10	-1426.00
11. Enter Indiana NOL deduction without specific deduction (enclose Schedule IT-20NOL; see instructions)	11	.00
12. Taxable Indiana unrelated business income (subtract line 11 from line 10)	12	-1426.00
13. Taxable income from other forms (Form 1120-POL)	13	.00
14. Subtotal (add lines 12 and 13)	14	-1426.00
15. Indiana tax on unrelated business income (multiply line 14 by tax rate). See instructions for line 15	15	0.00
16. Sales/use tax on purchases subject to use tax from Sales/Use Tax Worksheet	16	.00
17. Total tax due (add lines 15 and 16) Total Tax	17	0.00
Credit for Estimated Tax and Other Payments		
18. Quarterly estimated tax paid: Qrt. 1 _____ Qrt. 2 _____ Qrt. 3 _____ Qrt. 4 _____ Enter total	18	.00
19. Amount paid with extension	19	.00
20. Amount of overpayment credit (from tax year ending _____)	20	.00
21. EDGE credit. Enter the total EDGE credit amount claimed (line 19 on Schedule IN-EDGE)	21	.00
22. EDGE-R credit. Enter the total EDGE-R credit amount claimed (line 19 on Schedule IN-EDGE-R)	22	.00
23. Enter the amount of other credit _____ Code No. 23a _____	23b	.00
24. Certified credits. Enter the total of certified credits claimed from Schedule IN-OCC and enclose this schedule with your return	24	.00
25. Total credits (add lines 18-24) Total Credits	25	.00
26. Balance of tax due (line 17 minus 25; if line 25 is greater than line 17, proceed to lines 27, 28, and 31)	26	0.00
27. Penalty for the underpayment of income tax. enclose Schedule IT-2220 <input type="checkbox"/> Check box if using annualization method	27	.00
28. Interest: If payment is made after the original due date, compute interest	28	.00
29. Penalty: If paid late, enter 10% of line 26; see instructions. If line 17 is zero, enter \$10 per day filed past due date	29	.00
30. Total payment due (add lines 26-29). (Payment must be made in U.S. funds) PAY THIS AMOUNT	30	.00
31. Total overpayment (line 25 minus lines 17 and 27-29)	31	.00
32. Amount of line 31 to be refunded	32	.00
33. Amount of line 31 to be applied to the following year's estimated tax account	33	.00



Indiana Department of Revenue
Indiana Nonprofit Organization Unrelated Business Income

Additional Explanation or Adjustment		
State Form 49189 (R11 / 8-12)		
Line (a)	Explanation (b)	Amount (c)
		.00
		.00
		.00

Certification of Signatures and Authorization Section
 Under penalties of perjury, I declare I have examined this return, including all accompanying schedules and statements, and to the best of my knowledge and belief it is true, correct, and complete.

I authorize the Department to discuss my return with my personal representative (see instructions) Yes No

Paid Preparer's Email Address | EE | _____

DAVID MCCORMICK
 Personal Representative's Name (Print or Type)

DIXON HUGHES GOODMAN LLP
 Paid Preparer: Firm's Name (or yours if self-employed)

Personal Representative's Email Address _____

PTIN
P01775208

Signature of Corporate Officer
KEVIN KELBLY
 Print or Type Name of Corporate Officer

Date
CFO
 Title

703 970 0400
 Telephone Number

1410 SPRING HILL ROAD, 5TH FLOOR
 Address
TYSONS

Signature of Paid Preparer
TAMARA VINEYARD
 Print or Type Name of Paid Preparer

Date _____

City
VA **22102**
 State ZIP Code +4

Sales/Use Tax Worksheet		
List all purchases made during 2014 from out-of-state companies.		
Column A Description of personal property purchased from out-of-state retailer	Column B Date of Purchase(s)	Column C Purchase Price
Magazine subscriptions:		.00
Mail order purchases:		.00
Internet purchases:		.00
Other purchases:		.00
1. Total purchase price of property subject to the sales/use tax	1C	.00
2. Sales/use tax: Multiply line 1 by .07 (7%)	2C	.00
3. Sales tax previously paid on the above items (up to 7% per item)	3C	.00
4. Total amount due: Subtract line 3 from line 2. Carry to Form IT-20NP, line 16. If the amount is negative, enter zero and put no entry on line 16 of the IT-20NP	4C	.00

Please mail your forms to:
 Indiana Department of Revenue
 PO Box 7228
 Indianapolis, IN 46207-7228



Indiana Department of Revenue
Apportionment of Income for Indiana
07 01 2014 and Ending 06 30 2015

For Tax Year Beginning

Federal Identification Number

CARROLL HOSPITAL CENTER, INC.

52 1452024

Each filing entity having income from sources both within and outside Indiana must complete an apportionment schedule except financial institutions and certain insurance companies that use a single receipts factor. Interstate transportation entities must use Schedule E-7. Combined unitary filers must use the apportioning method (relative formula percentage) as outlined in Information Bulletin #12 and Tax Policy Directive #6. Omit cents; percents should be rounded two decimal places; read apportionment instructions.

Part I - Indiana Apportionment of Adjusted Gross Income

Sales/Receipts (less returns and allowances)

Include all non-exempt apportioned gross business income. Do not use non-unitary partnership income of previously apportioned income that must be separately reported as allocated income.

	Column A Total Within Indiana	Column B Total Within and Outside Indiana	Column C Indiana Percentage
Sales delivered or shipped to Indiana:			
1. Shipped from within Indiana _____	.00		
2. Shipped from outside Indiana _____	.00		
Sales shipped from Indiana to:			
3. The United States government _____	.00		
4. Purchasers in a state where the taxpayer is not subject to income tax (under P.L. 86-272)	.00		
Other:			
5. Interest & other receipts from extending credit attributed to Indiana _____	16046.00		
6. Other gross business receipts not previously apportioned _____	0.00		
7. Direct premiums and annuities received for insurance upon property or risks in Indiana _____	.00		
8. Total Receipts: Add column A receipts lines on 1A through 7A and enter in line 8A. Enter all receipts on line 8B _____	8A 16046.00	8B 2645858.00	

Apportionment of income for Indiana:

9. **Apportionment Percentage:** Divide line 8A by line 8B (insert as percent, not decimal) _____ **9 .61 %**

Part II - Business/Other Income Questionnaire

1. List all business locations where the taxpayer has operations or partnership interests and indicate type of activities. This section must be completed - attach additional sheets if necessary.

(a) Location City and State	(b) Nature of Business Activity at Location	(c) Accepts Orders?		(d) Registered to Do Business?		(e) Files Returns in State?		Property in State	
		Yes	No	Yes	No	Yes	No	(f) Leased? Yes No	(g) Owned? Yes No

2. Briefly describe the nature of Indiana business activities, including the exact title and principal business activity of any partnership in which the taxpayer has an interest:

3. Indicate any partnership in which you have a unitary or general partnership relationship:

4. Briefly describe the nature of activities of sales personnel operating and soliciting business in Indiana:

5. Do Indiana receipts for line 3A include all sales shipped from Indiana to (1) the U.S. government; or (2) locations where this taxpayer's only activity in the state of the purchaser consists of the mere solicitation of orders? **Y N** If no, please explain:

6. List the source of any directly allocated income from partnerships, estates, and trusts not in the taxpayer's apportioned tax base:



TAX RETURN FILING INSTRUCTIONS

MINNESOTA FORM M4NP

FOR THE YEAR ENDING

June 30, 2015

Prepared for	Carroll Hospital Center, Inc. 200 Memorial Avenue Westminster, MD 21157
Prepared by	Dixon Hughes Goodman LLP 1410 Spring Hill Road, 5th Floor Tysons, VA 22102
Amount due or refund	Balance due of \$638
Make check payable to	Minnesota Revenue
Mail tax return and check (if applicable) to	Minnesota Revenue Mail Station 1257 St. Paul, MN 55146-1257
Return must be mailed on or before	May 16, 2016
Special Instructions	<p>The return should be signed and dated by an authorized individual.</p> <p>Include the organization's employer identification number and "2014 Form M4NP" on the remittance.</p> <p>We recommend that you file your return using certified mail with a postmarked receipt for proof of timely filing. You should write the certified mail receipt number on the return in the margin near your signature prior to filing. You should also retain the certified mail receipt with your copy of the return.</p>

Unrelated Business Income Tax (UBIT) Return 2014

For tax-exempt organizations, cooperatives, homeowners associations and political organizations with unrelated business income.

Tax year beginning 07012014, 2014, and ending 06302015 (required)

Please Print or Type	Name of Organization CARROLL HOSPITAL CENTER, INC.		FEIN 521452024	Minnesota Tax ID (required)	
	Current Address 200 MEMORIAL AVENUE		<input type="checkbox"/> Check if New Address This Organization Files Federal Form (check one) <input checked="" type="checkbox"/> 990-T <input type="checkbox"/> 1120-C <input type="checkbox"/> 1120-H <input type="checkbox"/> 1120-POL		
	City WESTMINSTER	County	State MD	ZIP Code 21157	Exempt Under IRS Section (check one) <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 528 <input type="checkbox"/> Other:
	Check All That Apply: <input type="checkbox"/> Amended Return <input type="checkbox"/> Filing Under an Extension <input type="checkbox"/> Final Return (see inst., pg. 3)		Enter your NAICS Codes (see instructions, pg. 3) 525990 / 621500		
	Are you filing a combined income return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Was 100% of the business conducted in Minnesota for this tax year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (complete and attach Schedule M4NPA)		

Determining Tax	1	Federal taxable income before net operating loss and specific deduction (from federal Form 990-T, line 30; 1120-C, line 25a; 1120-H, line 17; or 1120-POL, line 17c)	1	<u>-232849</u>
	2	Total subtractions from federal taxable income (from M4NPI, line 1)	2	<u> </u>
	3	Federal taxable income or (loss) after subtractions (see instructions)	3	<u>-232849</u>
	If you conducted business both within and outside Minnesota, complete M4NPA (see instructions, pg. 6). If 100% of your activities were conducted in Minnesota, do not complete M4NPA. Enter line 3 on line 4.			
	4	Minnesota taxable net income or (loss) (from M4NPA, line 15, or if 100% of your activities were conducted in Minnesota, enter amount from line 3 above)	4	<u>6360</u>
	5	Minnesota net operating loss deduction (from NOL)	5	<u>0</u>
	6	Subtract line 5 from line 4 (if zero or less, enter zero)	6	<u>6360</u>
	7	Total deductions from taxable net income (from M4NPI, line 2)	7	<u> </u>
	8	Taxable income (subtract line 7 from line 6; if zero or less, enter zero)	8	<u>6360</u>
	9	Regular tax (multiply line 8 by 9.8% [0.098]; if zero or less, enter zero)	9	<u>623</u>
Credits and Payments	10	Proxy tax (see instructions, pg. 3)	10	<u> </u>
	11	Tax before credits (add lines 9 and 10)	11	<u>623</u>
	12	Total credits against tax (from M4NPI, line 3)	12	<u> </u>
	13	Minnesota tax liability (subtract line 12 from line 11; if zero or less, enter zero)	13	<u>623</u>
	14	Minnesota Nongame Wildlife Fund donation (see instructions, pg. 3)	14	<u> </u>
	15	Add lines 13 and 14	15	<u>623</u>
	16	Total refundable credits (from M4NPI, line 4)	16	<u> </u>
	17	Amount credited from your 2013 Form M4NP, line 30	17	<u> </u>
	18	2014 estimated tax payments	18	<u> </u>
	19	2014 extension payment	19	<u> </u>
	20	Total refundable credits and payments (add lines 16, 17, 18 and 19)	20	<u> </u>
	21	Subtract line 20 from line 15	21	<u>623</u>
	22	Penalty (determine from worksheet in the instructions, pg. 4)	22	<u> </u>
	23	Interest (determine from worksheet in the instructions, pg. 4)	23	<u> </u>
	24	Additional charge for underpayment of estimated tax (from M15NP, line 17)	24	<u>15</u>
25	Tax, Nongame Wildlife Fund donation, penalty, interest and additional charge for underpayment of estimated tax (add lines 15, 22, 23 and 24)	25	<u>638</u>	

Unrelated Business Income Tax (UBIT) Return 2014 (continued)

Name of Organization CARROLL HOSPITAL CENTER, INC.	FEIN 521452024	Minnesota Tax ID
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Amount Due or Overpaid	26 Amount from line 25 on the front of this form	26	<u>638</u>
	27 Amount from line 20 on the front of this form	27	<u> </u>
	28 AMOUNT DUE. If line 26 is more than or equal to line 27, subtract line 27 from 26	28	<u>638</u>
	Payment method: <input type="checkbox"/> Electronic (see inst., pg. 2) <input checked="" type="checkbox"/> Check (see inst., pg2) <input type="checkbox"/> Amended return payment by check (see inst., pg. 2)		
	29 OVERPAYMENT. If line 27 is more than line 26, subtract line 26 from line 27	29	<u> </u>
	30 Amount of line 29 to be credited to your 2015 estimated tax.....	30	<u> </u>
31 Refund (subtract line 30 from line 29)	31	<u> </u>	

To have your refund direct deposited, enter your banking information below.

Account type:	Routing number	Account number (use an account not associated with any foreign banks)
<input type="checkbox"/> Checking <input type="checkbox"/> Savings	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>

I declare that this return is correct and complete to the best of my knowledge and belief.

Sign Here	Authorized Signature	Title	Date	Daytime Phone	<input checked="" type="checkbox"/> I authorize the Minnesota Department of Revenue to discuss this tax return with the paid preparer listed here.
		CFO			
	Paid Preparer's Signature	PTIN	Date	Daytime Phone	
		P01775208		703-970-0400	
Email Address for Correspondence, if Desired				This email address belongs to (check one):	
				<input type="checkbox"/> Employee <input type="checkbox"/> Paid Preparer	

Attach a complete copy of your federal Form 990-T, 1120-C, 1120-H or 1120-POL and all supporting schedules.
 Mail to: Minnesota Revenue, Mail Station 1257, St. Paul, MN 55146-1257

Apportionment Calculation - Schedule A 2014

For tax-exempt organizations, cooperatives, homeowners associations and political organizations with unrelated business income.

If you conducted business both within and outside Minnesota during the year, complete Schedule M4NPA to determine your Minnesota source income. Do not complete this schedule if you conducted all your business in Minnesota during the tax year. See instructions beginning on page 7.

Name of Organization CARROLL HOSPITAL CENTER, INC.	FEIN 521452024	Minnesota Tax ID
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You must round amounts to nearest whole dollar.

		A Minnesota	B Total
Apportionment Income	1 Federal taxable income or (loss) (from M4NP, line 3) 1 ■	-232849	
	2 Total nonapportionable income 2 ■		
	3 Total apportionable income (subtract line 2 from line 1) ... 3 ■	-232849	
Sales Ratio/Apportionment	4 Average inventory 4 ■		
	5 Average tangible property and land owned/used (at original cost) 5 ■	0	296940518
	6 Capitalized rents (gross rents x 8) 6 ■		
	7 Total property (add lines 4, 5 and 6) 7 ■	0	296940518
	8 Payroll/officer's compensation 8 ■	0	90075083
	9 Sales or receipts 9 ■		
	10 Sales of non-filing entities (see instructions pg. 8) 10 ■		
11 Total sales or receipts (add lines 9 and 10) (Financial institutions: see inst., pg. 8) 11 ■			
Minnesota Taxable Income	12 Minnesota apportionment factor (divide line 11A amount by line 11B; carry to six decimal places) 12 ■		
	13 Net income apportioned to Minnesota (multiply line 3 by line 12) 13 ■		
	14 Minnesota nonapportionable income 14 ■	6360	
	15 Minnesota taxable net income or (loss) (add lines 13 and 14) Enter on Form M4NP, line 4 15 ■	6360	

Additional Charge for Underpayment of Estimated Tax 2014

For tax-exempt organizations, cooperatives, homeowners associations and political organizations with unrelated business income.

Complete this schedule if your total tax is more than \$500 or you did not pay the correct amount of estimated tax by the due dates.

Name of Organization CARROLL HOSPITAL CENTER, INC.	FEIN 521452024	Minnesota Tax ID
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Installment Method

Check installment method used on this schedule (must check one box):

- Standard Installment Method Adjusted Seasonal Installment Method Annualized Income Installment Method

You must round amounts to nearest whole dollar.

Required Annual Payment

- 1 Enter your 2014 total tax liability (from 2014 M4NP, line 13 minus line 16) 1 623
If \$500 or less, do not complete this form. You owe no additional charge.
- 2 Enter your 2013 regular tax (from 2013 Form M4NP, line 13 minus line 16) 2 _____
- 3 Required annual payment. Enter the amount from line 1 or line 2, whichever is less 3 623
Exceptions: If you did not file a 2013 return or filed a return for less than a full 12-month period in the preceding tax year, or you did not have a 2013 tax liability, you must enter the amount from line 1.

Underpayment / Overpayment

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
4 Enter the due dates 4	<u>09/15/14</u>	<u>12/15/14</u>	<u>03/16/15</u>	<u>06/15/15</u>
5 Required installments (see instructions) 5	<u>156</u>	<u>156</u>	<u>156</u>	<u>156</u>
6 Amount paid each period (see instructions) 6	_____	_____	_____	_____
Complete lines 7-13 for one column before completing the next column. For the first column only, enter the amount from line 6 on line 10.				
7 Enter the amount from line 13 of the previous column 7	_____	_____	_____	_____
8 Add lines 6 and 7 8	_____	_____	_____	_____
9 Add lines 11 and 12 of the previous column 9	_____	<u>156</u>	<u>312</u>	<u>468</u>
10 Subtract line 9 from line 8. If less than zero, enter zero 10	_____	<u>0</u>	<u>0</u>	<u>0</u>
11 Remaining underpayment from previous period. If line 10 is zero, subtract line 8 from line 9. Otherwise, enter zero 11	_____	<u>156</u>	<u>312</u>	<u>468</u>
12 UNDERPAYMENT. If line 10 is less than or equal to line 5, subtract line 10 from line 5, enter the result and go to line 6 of the next column. Otherwise, go to line 13 12	<u>156</u>	<u>156</u>	<u>156</u>	<u>156</u>
13 OVERPAYMENT. If line 5 is less than line 10, subtract line 5 from line 10 and enter the result. Go to line 6 of the next column 13	_____	_____	_____	_____

Additional Charge

- 14 Date underpayment is paid or regular due date of 2014 return, whichever is earlier 14 _____
- 15 Number of days from the due date on line 4 to the date on line 14 15 _____
- 16 Additional charge (line 15 ÷ 365 x .03 x line 12) 16 _____
- 17 **TOTAL.** Add amounts on line 16. Enter this amount on M4NP, line 24 17 15

Attach this schedule to Form M4NP.

