Return of Organization Exempt From Income Tax

Form **990**

Department of the Treasury
Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ 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.*

OMB No. 1545-0047

2014

Open to Public Inspection

A For the 2014 calendar year, or tax year beginning 07/01, 2014, and ending 06/30, 20 15

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
5601 LOCH RAVEN BLVD.

City or town, state or province, country, and ZIP or foreign postal code
BALTIMORE, MD 21239

D Employer identification number
52-0591607

E Telephone number
(410) 772-6721

G Gross receipts $ 325,029,362.

F Name and address of principal officer: JEFFREY MATTON
5601 LOCH RAVEN BLVD BALTIMORE, MD 21239

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.GOODSAM-MD.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶ | **L** Year of formation: 1920 | **M** State of legal domicile: MD

Part I Summary

1 Briefly describe the organization's mission or most significant activities: WE ARE GOOD SAMARITANS, GUIDED BY CATHOLI TRADITION AND TRUSTED TO DELIVER IDEAL HEALTHCARE EXPERIENCES FOR THE PATIENTS WE SERVE.

2 Check this box ▶ ☐ 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	22.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	16.
5	Total number of individuals employed in calendar year 2014 (Part V, line 2a)	5	2,802.
6	Total number of volunteers (estimate if necessary)	6	140.
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	351,687.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	0

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	493,970.	626,931.
9	Program service revenue (Part VIII, line 2g)	309,961,225.	314,065,712.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	4,442,981.	6,555,671.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,487,267.	3,781,048.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	318,385,443.	325,029,362.
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0	0
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	152,920,843.	154,050,181.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	156,017,497.	154,097,048.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	308,938,340.	308,147,229.
19	Revenue less expenses. Subtract line 18 from line 12	9,447,103.	16,882,133.

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		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	189,638,382.	187,336,071.
21	Total liabilities (Part X, line 26)	47,522,422.	58,760,205.
22	Net assets or fund balances. Subtract line 21 from line 20	142,115,960.	128,575,866.

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 — Date: 5/4/16

▶ Joel Bryan VP, Treasurer
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
MARGARET A BRADSHAW	Margaret A. Bradshaw	5/11/16		P00501222

Firm's name ▶ KPMG LLP — Firm's EIN ▶ 13-5565207

Firm's address ▶ 1676 INTERNATIONAL DRIVE MCLEAN, VA 22102 — Phone no. 703-286-8000

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

Form **8868**
(Rev. January 2014)
Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File an Exempt Organization Return

▶ File a separate application for each return.
▶ Information about Form 8868 and its instructions is at *www.irs.gov/form8868.*

OMB No. 1545-1709

- If you are filing for an **Automatic 3-Month Extension, complete only Part I** and check this box . . . . . ▶ [X]
- If you are filing for an **Additional (Not Automatic) 3-Month Extension, complete only Part II** (on page 2 of this form).

Do not complete Part II unless you have already been granted an automatic 3-month extension on a previously filed Form 8868.

Electronic filing *(e-file)*. You can electronically file Form 8868 if you need a 3-month automatic extension of time to file (6 months for a corporation required to file Form 990-T), or an additional (not automatic) 3-month extension of time. You can electronically file Form 8868 to request an extension of time to file any of the forms listed in Part I or Part II with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, which must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit *www.irs.gov/efile* and click on *e-file for Charities & Nonprofits.*

Part I Automatic 3-Month Extension of Time. Only submit original (no copies needed).

A corporation required to file Form 990-T and requesting an automatic 6-month extension - check this box and complete Part I only . . . . . ▶ [ ]

All other corporations (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

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.	Employer identification number (EIN) or
THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.	52-0591607
Number, street, and room or suite no. If a P.O. box, see instructions.	**Social security number (SSN)**
5601 LOCH RAVEN BLVD.	
City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
BALTIMORE, MD 21239	

Enter the Return code for the return that this application is for (file a separate application for each return) 01

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 990-T (corporation)	07
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

- The books are in the care of ▶ JOEL BRYAN, 5565 STERRETT PLACE, 5TH FLROOR COLUMBIA, MD 21044

Telephone No. ▶ 410 772-6721 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.

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 02/15, 20 16, to file the exempt organization return for the organization named above. The extension is for the organization's return for:
▶ [ ] calendar year 20 ____ or
▶ [X] tax year beginning 07/01, 20 14, and ending 06/30, 20 15.

2 If the tax year entered in line 1 is for less than 12 months, check reason: [ ] Initial return [ ] Final return [ ] Change in accounting period

3a	If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	3a	$ 0
b	If this application is for Form 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.	3b	$ 0
c	**Balance due.** Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	3c	$ 0

Caution. If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

- 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).

Type or print / File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.	Enter filer's identifying number, see instructions: Employer identification number (EIN) or
	THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.	52-0591607
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	5601 LOCH RAVEN BLVD.	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
	BALTIMORE, MD 21239	

Enter the Return code for the return that this application is for (file a separate application for each return) 01

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.

- The books are in the care of ▶ JOEL BRYAN, 5565 STERRETT PLACE, 5TH FLOOR, COLUMBIA, MD 21044
  Telephone No. ▶ 410 772-6721 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 05/16, 20 16.

5 For calendar year _____, or other tax year beginning 07/01, 20 14, and ending 06/30, 20 15.

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 INFORMATION NECESSARY TO PREPARE A COMPLETE AND ACCURATE RETURN IS NOT YET AVAILABLE.

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 ▶ Margaret A. Blackshaw Title ▶ PAID PREPARER Date ▶ 2/09/16

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:

ATTACHMENT 1

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 ☒ No

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ Yes ☒ No

If "Yes," describe these changes on Schedule O.

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 $ 228,924,972. including grants of $) (Revenue $ 289,881,720.)

ATTACHMENT 2

4b (Code:) (Expenses $ 31,659,758. including grants of $) (Revenue $ 24,183,992.)

MEDSTAR GOOD SAMARITAN PROVIDED $31.6M IN SUBSIDIZED (MISSION DRIVEN) HEALTH SERVICES IN FISCAL 2015. THESE CRITICAL SERVICES, WHICH ARE DRIVEN BY COMMUNITY NEEDS, OPERATE AT A LOSS. THEY ADDRESS PRIORITIES PRIMARILY THROUGH DISEASE PREVENTION AND IMPROVEMENT OF HEALTH STATUS. SERVICES PROVIDED INCLUDE HOSPITALISTS, PSYCHIATRY, EMERGENCY DEPARTMENT COVERAGE, OUTPATIENT RENAL CARE, AND CERTAIN SUB-ACUTE PROGRAM SUBSIDIES.

4c (Code:) (Expenses $ 7,612,630. including grants of $) (Revenue $)

MEDSTAR GOOD SAMARITAN PROVIDED $7.6M IN HEALTH PROFESSIONS EDUCATION IN FISCAL YEAR 2015. THIS CATEGORY INCLUDES TRAINING IN GRADUATE MEDICAL EDUCATION, AND EDUCATION FOR PHYSICIANS, MEDICAL STUDENTS, NURSES, AND OTHER HEALTH PROFESSIONS.

4d Other program services (Describe in Schedule O.)

(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses ▶ 268,197,360.

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)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		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? *If "Yes," complete Schedule C, Part II*	4		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? *If "Yes," complete Schedule C, Part III*	5		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? *If "Yes," complete Schedule D, Part I*	6		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? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		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? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		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? *If "Yes," complete Schedule D, Part VI*	11a	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? *If "Yes," complete Schedule D, Part VII*	11b		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? *If "Yes," complete Schedule D, Part VIII*	11c		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? *If "Yes," complete Schedule D, Part IX*	11d	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	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)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		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? *If "Yes," complete Schedule F, Parts I and IV*	14b		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? *If "Yes," complete Schedule F, Parts II and IV*	15		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? *If "Yes," complete Schedule F, Parts III and IV*	16		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? *If "Yes," complete Schedule G, Part I* (see instructions)	17		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? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	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? *If "Yes," complete Schedule I, Parts I and II*	21		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? *If "Yes," complete Schedule I, Parts I and III*	22		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? *If "Yes," complete Schedule J*	23	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? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	24a		X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
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?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
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? *If "Yes," complete Schedule L, Part I*	25a		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? *If "Yes," complete Schedule L, Part I*	25b		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? *If "Yes," complete Schedule L, Part II*	26		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? *If "Yes," complete Schedule L, Part III*	27		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? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		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? *If "Yes," complete Schedule L, Part IV.*	28c	X	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I.*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		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? *If "Yes," complete Schedule R, Part I*	33	X	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	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)? *If "Yes," complete Schedule R, Part V, line 2*	35b		X
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		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? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

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 . . . . . ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	0		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return .	2a	2,802		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?	9a			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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 X

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 22		
b	Enter the number of voting members included in line 1a, above, who are independent	1b 16		
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?	2		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? . .	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6	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?	7a	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?	7b	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	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*	9		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?	10a		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? .	11a	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*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	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*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	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	15a	X	
b	Other officers or key employees of the organization	15b	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?	16a		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?	16b		

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ MD,

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: ▶

JOEL BRYAN 5565 STERRETT PLACE, 5TH FLROOR COLUMBIA, MD 21044 410-772-6721

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 X

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 dotted 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) DANIEL P. CAHILL	1.00									
BOARD CHAIR	0	X						0	0	0
(2) MOIRA P. LARSEN, MD	1.00									
BOARD MEMBER	0	X						49,481.	0	59.
(3) JEFFREY A. MATTON	40.00									
PRESIDENT/BOARD MEMBER	0	X		X				841,202.	0	34,381.
(4) KENNETH A. SAMET	1.00									
BOARD MEMBER	39.00	X						0	4,325,505.	64,424.
(5) BERNARD H. RAVITZ, MD	1.00									
BOARD MEMBER	0	X						0	0	0
(6) HOWARD S. FREELAND, M.D.	1.00									
BOARD MEMBER	0	X						0	0	0
(7) LUIS GIMENEZ MD	1.00									
BOARD MEMBER	0	X						0	0	0
(8) DAVIS M HAHN MD	1.00									
BOARD MEMBER (UNTIL 10/2014)	0	X						0	0	0
(9) JEREMY P WEINER MD	1.00									
BOARD MEMBER (UNTIL 10/2014)	0	X						0	0	0
(10) CHARLES L BAUERMANN	1.00									
BOARD MEMBER	0	X						0	0	0
(11) KAY G BEE	1.00									
BOARD MEMBER	0	X						0	0	0
(12) JEFFREY R DONNELLY	1.00									
BOARD MEMBER	0	X						0	0	0
(13) SONYA H GRAY	1.00									
BOARD MEMBER	0	X						0	0	0
(14) REV DENIS J MADDEN	1.00									
BOARD MEMBER	0	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 dotted 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			
15) DR ALLAN NOONAN	1.00									
CHAIR	0	X						0	0	0
16) T EDGIE RUSSELL	1.00									
BOARD MEMBER	0	X						0	0	0
17) REV PM SMITH	1.00									
BOARD MEMBER	0	X						0	0	0
18) JOHN C SMYTH	1.00									
VICE CHAIR	0	X						0	0	0
19) KATHLEEN J WHITING	1.00									
BOARD MEMBER	0	X						0	0	0
20) DAVID WEISMAN	40.00									
BOARD MEMBER	0	X						186,216.	0	22,845.
21) THOMAS L. OWSLEY	1.00									
BOARD MEMBER	0	X						0	0	0
22) CAROL J. PACIONE	1.00									
BOARD MEMBER (UNTIL 9/2014)	0	X						0	0	0
23) MONS. ADAM J. PARKER	1.00									
BOARD MEMBER	0	X						0	0	0
24) ELIAS SHAYA , M.D.	40.00									
BOARD MEMBER	0	X						355,555.	0	9,024.
25) MICHAEL JACOBS, M.D.	40.00									
BOARD MEMBER	0	X						803,017.	0	19,399.
1b Sub-total ▶								890,683.	4,325,505.	98,864.
c Total from continuation sheets to Part VII, Section A ▶								5,560,839.	0	232,754.
d Total (add lines 1b and 1c) ▶								6,451,522.	4,325,505.	331,618.

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 ▶ 263

		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*	3 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*	4 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*	5	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
ATTACHMENT 3		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 42

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 dotted 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			
26) THOMAS SENKER	40.00									
SECRETARY	0			X				251,864.	0	21,989.
27) DEANA STOUT	40.00									
TREASURER	0			X				366,227.	0	40,149.
28) SHIRLEY ROTH	40.00									
CHIEF NURSING OFFICER	0				X			234,971.	0	18,202.
29) MARTIN BINSTOCK	40.00									
VP MEDICAL AFFAIRS	0					X		531,285.	0	32,873.
30) ROBERT PEROUTKA, M.D.	40.00									
PHYSICIAN	0					X		652,624.	0	6,808.
31) DALE BUCHBINDER, M.D.	40.00									
VICE PRESIDENT	0					X		640,068.	0	19,275.
32) MESFIN LEMMA, M.D.	40.00									
PHYSICIAN	0					X		587,504.	0	969.
33) DAVID COLL, M.D.	40.00									
CHIEF	0					X		513,641.	0	22,233.
34) JENNIFER WILKERSON	40.00									
FORMER OFFICER	0						X	226,557.	0	18,988.
35) LAWRENCE BECK	0									
FORMER OFFICER	0						X	211,310.	0	0
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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 ▶ 263

		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*	3	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*	4	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*	5		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

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

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	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d				
	e Government grants (contributions)	1e	4,000.			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	622,931.			
	g Noncash contributions included in lines 1a-1f: $					
	h Total. Add lines 1a-1f ▶		626,931.			
Program Service Revenue		Business Code				
	2a NET PATIENT SERVICE REVENUE	621400	304,926,068.	304,926,068.		
	b PHARMACY INCOME	900099	6,961,903.	6,961,903.		
	c MEANINGFUL USE INCOME	900099	2,177,741.	2,177,741.		
	d					
	e					
	f All other program service revenue					
	g Total. Add lines 2a-2f ▶		314,065,712.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶		1,225,117.			1,225,117.
	4 Income from investment of tax-exempt bond proceeds ▶		0			
	5 Royalties ▶		0			
		(i) Real	(ii) Personal			
	6a Gross rents	394,964.				
	b Less: rental expenses					
	c Rental income or (loss)	394,964.				
	d Net rental income or (loss) ▶		394,964.			394,964.
	7a Gross amount from sales of assets other than inventory	(i) Securities 5,272,309.	(ii) Other 58,245.			
	b Less: cost or other basis and sales expenses					
	c Gain or (loss)	5,272,309.	58,245.			
	d Net gain or (loss) ▶		5,330,554.			5,330,554.
	8a 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 ▶		0			
	9a Gross income from gaming activities. See Part IV, line 19 a					
	b Less: direct expenses b					
	c Net income or (loss) from gaming activities ▶		0			
	10a 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 ▶		0			
	Miscellaneous Revenue	Business Code				
	11a REBATE INCOME	900099	1,126,152.			1,126,152.
	b CHILD DAY CARE	900099	489,343.			489,343.
	c MEALS ON WHEELS	900099	84,762.			84,762.
	d All other revenue	900099	1,685,827.		351,687.	1,334,140.
	e Total. Add lines 11a-11d ▶		3,386,084.			
	12 Total revenue. See instructions ▶		325,029,362.	314,065,712.	351,687.	9,985,032.

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	0			
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	3,245,255.	2,955,998.	289,257.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	122,938,136.	111,954,455.	10,983,681.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	2,231,989.	2,031,110.	200,879.	
9 Other employee benefits	16,853,445.	15,421,335.	1,432,110.	
10 Payroll taxes	8,781,356.	8,038,759.	742,597.	
11 Fees for services (non-employees):				
a Management	29,080,964.	18,760,640.	10,320,324.	
b Legal	1,280.		1,280.	
c Accounting	0			
d Lobbying	0			
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	0			
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.) ATCH 4	37,145,459.	33,797,019.	3,348,440.	
12 Advertising and promotion	584,376.	20,484.	563,892.	
13 Office expenses	2,010,474.	1,454,892.	555,582.	
14 Information technology	0			
15 Royalties	0			
16 Occupancy	1,659,497.	925,423.	734,074.	
17 Travel	322,158.	303,651.	18,507.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	30,898.	22,279.	8,619.	
20 Interest	2,504,406.		2,504,406.	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	14,037,471.	7,956,069.	6,081,402.	
23 Insurance	4,170,449.	4,128,731.	41,718.	
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 MED /SURG SUPPLIES	37,917,599.	37,891,462.	26,137.	
b IMPLANTS/PROSTHESES	5,919,904.	5,919,904.		
c UTILITIES	4,740,545.	4,463,097.	277,448.	
d ALL OTHER EXPENSES	4,536,824.	3,350,188.	1,186,636.	
e All other expenses	9,434,744.	8,801,864.	632,880.	
25 **Total functional expenses.** Add lines 1 through 24e	308,147,229.	268,197,360.	39,949,869.	
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 ▶ ☐ if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	3,998.	1	4,364.
	2	Savings and temporary cash investments	0	2	0
	3	Pledges and grants receivable, net	0	3	0
	4	Accounts receivable, net	42,364,355.	4	46,362,907.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	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 instructions). Complete Part II of Schedule L	0	6	0
	7	Notes and loans receivable, net	0	7	0
	8	Inventories for sale or use	2,755,453.	8	3,018,925.
	9	Prepaid expenses and deferred charges	1,244,286.	9	1,447,209.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 234,134,595.			
	b	Less: accumulated depreciation — 10b: 162,251,418.	77,009,730.	10c	71,883,177.
	11	Investments - publicly traded securities	0	11	0
	12	Investments - other securities. See Part IV, line 11	480,332.	12	994,427.
	13	Investments - program-related. See Part IV, line 11	0	13	0
	14	Intangible assets	0	14	0
	15	Other assets. See Part IV, line 11	65,780,228.	15	63,625,062.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	189,638,382.	16	187,336,071.
Liabilities	17	Accounts payable and accrued expenses	25,416,341.	17	22,054,267.
	18	Grants payable	0	18	0
	19	Deferred revenue	115,467.	19	576,596.
	20	Tax-exempt bond liabilities	0	20	0
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	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	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties	0	23	0
	24	Unsecured notes and loans payable to unrelated third parties	0	24	0
	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	21,990,614.	25	36,129,342.
	26	**Total liabilities.** Add lines 17 through 25	47,522,422.	26	58,760,205.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	76,740,419.	27	64,605,428.
	28	Temporarily restricted net assets	65,375,541.	28	63,970,438.
	29	Permanently restricted net assets	0	29	0
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ 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	142,115,960.	33	128,575,866.
	34	Total liabilities and net assets/fund balances	189,638,382.	34	187,336,071.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	325,029,362.
2	Total expenses (must equal Part IX, column (A), line 25)	2	308,147,229.
3	Revenue less expenses. Subtract line 2 from line 1	3	16,882,133.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	142,115,960.
5	Net unrealized gains (losses) on investments	5	-5,738,104.
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-24,684,123.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	128,575,866.

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ 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? 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: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis	2a		X
b	Were the organization's financial statements audited by an independent accountant? 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: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis	2b	X	
c	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? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	X	
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?	3a		X
b	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.	3b		

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	Employer identification number
THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.	52-0591607

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? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
(A)						
(B)						
(C)						
(D)						
(E)						
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** . . . . . ▶ ☐

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 . . . . . ▶ ☐

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 . . . . . ▶ ☐

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 . . . . . ▶ ☐

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 . . . . . ▶ ☐

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 . . . . . ▶ ☐

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? *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.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If "Yes," explain in **Part VI** how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
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)? *If "Yes," describe in **Part VI** when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in **Part VI** what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *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.*	4b		
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)? *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.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *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).*	5a		
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?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
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? *If "Yes," provide detail in **Part VI.***	6		
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? *If "Yes," complete Part I of Schedule L (Form 990).*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990).*	8		
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))? *If "Yes," provide detail in **Part VI.***	9a		
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? *If "Yes," provide detail in **Part VI.***	9b		
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? *If "Yes," provide detail in **Part VI.***	9c		
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)? *If "Yes," answer (b) below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)*	10b		

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?	11a		
b	A family member of a person described in (a) above?	11b		
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.***	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.*	1		
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.*	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. All 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?	1		
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).*	2		
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.*	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 ☐ The organization satisfied the Activities Test. *Complete* **line 2** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* ***line 3*** *below.*

c ☐ The organization supported a governmental entity. *Describe in Part VI how you supported a government entity (see instructions).*

			Yes	No
2	Activities Test. ***Answer (a) and (b) below.***			
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.*	2a		
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.*	2b		
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.***	3a		
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.*	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 ☐ 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			

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

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
THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number
52-0591607

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	[X] 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

[X] 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 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).

Name of organization THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC. | Employer identification number 52-0591607

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		$ 375,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 150,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 20,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
5		$ 8,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
6		$ 7,290.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC. | Employer identification number 52-0591607

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
7		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number 52-0591607

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
		$	

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

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

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

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

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

Name of organization THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number 52-0591607

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 information once. See instructions.) ▶ $ ____________
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 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

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

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? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No

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)? ☐ Yes ☐ No

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					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

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

a Board designated or quasi-endowment ▶ _____ %
b Permanent endowment ▶ _____ %
c Temporarily restricted endowment ▶ _____ %

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:

		Yes	No
(i) unrelated organizations	3a(i)		
(ii) related organizations	3a(ii)		
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b		

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				
b Buildings		69,123,892.	41,624,111.	27,499,781.
c Leasehold improvements		941,064.	451,871.	489,193.
d Equipment		160,327,219.	117,618,671.	42,708,548.
e Other		3,742,420.	2,556,765.	1,185,655.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				71,883,177.

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)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶		

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)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 13.)* ▶		

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) CATHOLIC HEALTH CARE FUND	62,976,013.
(2) OPTION IT ASSET	649,024.
(3) OTHER ASSETS	25.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	63,625,062.

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 3RD PARTY PAYORS	7,139,056.
(3) ASBESTOS ABATEMENT LIABILITY	2,820,676.
(4) STOCK OPTION PLAN	577,913.
(5) WORKERS COMP	2,853,551.
(6) CREDIT BALANCE PATIENT A/R	1,250,935.
(7) OTHER LIABILITIES	18,779,684.
(8) INTERCOMPANY PAYABLES	2,707,527.
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	36,129,342.

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 [X]

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.

SEE PAGE 5

Part XIII Supplemental Information *(continued)*

FIN 48 FOOTNOTE

PART X, LINE 2

INCOME TAXES ARE ACCOUNTED FOR UNDER THE ASSET AND LIABILITY METHOD. DEFERRED TAX ASSETS AND LIABILITIES ARE RECOGNIZED FOR THE FUTURE TAX CONSEQUENCES ATTRIBUTABLE TO DIFFERENCES BETWEEN THE FINANCIAL STATEMENT CARRYING AMOUNTS OF EXISTING ASSETS AND LIABILITIES AND THEIR RESPECTIVE TAX BASES AND OPERATING LOSS AND TAX CREDIT CARRYFORWARDS. DEFERRED TAX ASSETS AND LIABILITIES ARE MEASURED USING ENACTED TAX RATES EXPECTED TO APPLY TO TAXABLE INCOME IN THE YEARS IN WHICH THOSE TEMPORARY DIFFERENCES ARE EXPECTED TO BE RECOVERED OR SETTLED. THE EFFECT ON DEFERRED TAX ASSETS AND LIABILITIES OF A CHANGE IN TAX RATES IS RECOGNIZED IN THE PERIOD THAT INCLUDES THE ENACTMENT DATE. ANY CHANGES TO THE VALUATION ALLOWANCE ON THE DEFERRED TAX ASSET ARE REFLECTED IN THE YEAR OF CHANGE. THE CORPORATION ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH THE FASB ACCOUNTING STANDARDS CODIFICATION (ASC) TOPIC 740, INCOME TAXES. THERE WAS NO LIABILITY RECORDED FOR UNCERTAIN TAX POSITIONS AS OF JUNE 30, 2015.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ 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.*

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization
THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number
52-0591607

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. [X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities [ ] 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: [ ] 100% [ ] 150% [X] 200% [ ] Other _____ %	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: [ ] 200% [ ] 250% [ ] 300% [ ] 350% [X] 400% [ ] Other _____%	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?		X
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

Financial Assistance and Means-Tested Government Programs	(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
a Financial Assistance at cost (from Worksheet 1)			2,897,951.		2,897,951.	.94
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			2,897,951.		2,897,951.	.94
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			1,201,515.	39,840.	1,161,675.	.38
f Health professions education (from Worksheet 5)			7,612,630.		7,612,630.	2.47
g Subsidized health services (from Worksheet 6)			31,659,758.	24,183,992.	7,475,766.	2.42
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			34,963.	3,000.	31,963.	.01
j **Total.** Other Benefits			40,508,866.	24,226,832.	16,282,034.	5.28
k **Total.** Add lines 7d and 7j			43,406,817.	24,226,832.	19,179,985.	6.22

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			829,643.	498,778.	330,865.	.11
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy			29,317.		29,317.	.01
8 Workforce development			2,409.		2,409.	
9 Other						
10 Total			861,369.	498,778.	362,591.	.12

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?	1	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	2 10,265,334.		
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.	3		
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		
6	Enter Medicare allowable costs of care relating to payments on line 5	6		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7		
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: ☐ Cost accounting system ☒ Cost to charge ratio ☐ 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					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest - see instructions)

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)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 MAIN HOSPITAL BUILDING 5601 LOCH RAVEN BLVD BALTIMORE MD 21239	X	X		X			X			
2										
3										
4										
5										
6										
7										
8										
9										
10										

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 MAIN HOSPITAL BUILDING

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

	Community Health Needs Assessment		Yes	No
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?	1		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	2		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	3	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 14			
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	5	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	6a		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	6b		X
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): WWW.MEDSTARGOODSAM.ORG			
b	[ ] Other website (list url):			
c	[X] Made a paper copy available for public inspection without charge at the hospital facility			
d	[ ] 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	8	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 2014			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): WWW.MEDSTARGOODSAM.ORG			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		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)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
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 MAIN HOSPITAL BUILDING

			Yes	No
		Did the hospital facility have in place during the tax year a written financial assistance policy that:		
13		Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
	a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 400 %		
	b	[X] Income level other than FPG (describe in Section C)		
	c	[X] Asset level		
	d	[X] Medical indigency		
	e	[X] Insurance status		
	f	[X] Underinsurance status		
	g	[ ] Residency		
	h	[ ] Other (describe in Section C)		
14		Explained the basis for calculating amounts charged to patients?	X	
15		Explained the method for applying for financial assistance?	X	
		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):		
	a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application		
	b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
	c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
	d	[X] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
	e	[ ] Other (describe in Section C)		
16		Included measures to publicize the policy within the community served by the hospital facility?	X	
		If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
	a	[X] The FAP was widely available on a website (list url): WWW.MEDSTARGOODSAM.ORG		
	b	[X] The FAP application form was widely available on a website (list url): WWW.MEDSTARGOODSAM.ORG		
	c	[X] A plain language summary of the FAP was widely available on a website (list url): WWW.MEDSTARGOODSAM.ORG		
	d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
	e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
	f	[X] A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
	g	[X] Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
	h	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP		
	i	[ ] Other (describe in Section C)		
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?	17 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	[ ] Reporting to credit agency(ies)		
	b	[ ] Selling an individual's debt to another party		
	c	[ ] Actions that require a legal or judicial process		
	d	[ ] Other similar actions (describe in Section C)		
	e	[X] 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 MAIN HOSPITAL BUILDING

			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?	19		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Actions that require a legal or judicial process			
d	☐ 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 ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☐ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☐ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Section C)
- f ☐ 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	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ 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	☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b	☒ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c	☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d	☐ 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? If "Yes," explain in Section C.	23		X
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? If "Yes," explain in Section C.	24		X

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.

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? 6

	Name and address	Type of Facility (describe)
1	TRANSITIONAL CARE AT GOOD SAMARITAN 5601 LOCH RAVEN BLVD BALTIMORE MD 21239	COMPREHENSIVE CARE FACILITY
2	FUTURECARE COLDSPRING 4700 HARFORD RD. BALTIMORE MD 21224	RENAL DIALYSIS FACILITY
3	FUTURECARE NORTHPOINT 1046 NORTHPOINT RD. BALTIMORE MD 21239	RENAL DIALYSIS FACILITY
4	MANORCARE 6600 RIDGE RD. BALTIMORE MD 21239	RENAL DIALYSIS FACILITY
5	LORIEN FRANKFORD 5009 FRANKFORD AVE. BALTIMORE MD 21206	RENAL DIALYSIS FACILITY
6	GOOD SAMARITAN HOSPITAL AT CROMWELL 8710 EMGE RD. BALTIMORE MD 21234	RENAL DIALYSIS FACILITY
7		
8		
9		
10		

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.

CHARITY CARE AT COST

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 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 PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

UNREIMBURSED MEDICAID

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 SAME HOSPITAL. MARYLAND'S

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.

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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.

UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED 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 OF ITS SHARE OF THE 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.

BAD DEBT

PART III, LINE 4

MEDSTAR HEALTH AND ITS AFFILIATED ORGANIZATIONS REPORT BAD DEBT EXPENSE IN ACCORDANCE WITH ASU 2011-07, WHICH REQUIRES CERTAIN HEALTHCARE ENTITIES TO CHANGE THE PRESENTATION OF THEIR STATEMENT OF OPERATIONS BY RECLASSIFYING THE PROVISION FOR BAD DEBTS ASSOCIATED WITH PATIENT SERVICE REVENUE FROM AN OPERATING EXPENSE TO A DEDUCTION FROM PATIENT SERVICE REVENUE (NET OF CONTRACTUAL ALLOWANCES AND DISCOUNTS). HOWEVER, MEDSTAR AND ITS AFFILIATED ENTITIES DO NOT MAKE A DETERMINATION AS TO WHETHER

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.

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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.

SELF PAY AMOUNTS ARE COLLECTIBLE IN DETERMINING REVENUE RECOGNITION.

RESERVE MODELS, WHICH HAVE BEEN DEVELOPED BASED ON HISTORICAL COLLECTION

RESULTS AND WHICH ARE ADJUSTED PERIODICALLY BASED ON ACTUAL COLLECTIONS

EXPERIENCE, ARE USED TO ESTIMATE UNCOLLECTIBLE AMOUNTS ACROSS ALL PAYORS

INCLUDING SELF PAY. BAD DEBT DETERMINATIONS ARE MADE ONLY AFTER

SUFFICIENT EVIDENCE IS OBTAINED TO SUPPORT THAT AN AMOUNT IS NOT

COLLECTIBLE.

MEDICARE

PART III, LINE 8

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 PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO

BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. AS SUCH,

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.

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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.

THE NET EFFECT FOR MEDICARE EXPENSES AND REVENUES IN MARYLAND IS ZERO.

CHNA INPUT

PART V, SECTION B, LINE 5

HOSPITAL LEAD

ROLE DESCRIPTION

THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) HOSPITAL LEAD SERVES AS THE COORDINATOR OF ALL ASPECTS OF THE COMMUNITY HEALTH ASSESSMENT PROCESS. HE/SHE HELPS ESTABLISH AND COORDINATE THE ACTIVITIES OF THE ADVISORY TASK FORCE. THE LEAD ALSO HELPS PRODUCE THE HOSPITAL'S COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY. HE/SHE WORKS COLLABORATIVELY WITH REPRESENTATIVES FROM THE CORPORATE COMMUNITY HEALTH DEPARTMENT ON ALL SCHEDULE HS. THE LEAD ALSO WORKS CLOSELY WITH THE WRITER. HE/SHE REVIEWS ALL NARRATIVES PRIOR TO PUBLICATION.

NAME OF HOSPITAL LEAD: DEBORAH BENA, MITCH HERBERT

Part VI Supplemental Information

Provide the following information.

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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.

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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.

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EXECUTIVE SPONSOR

ROLE DESCRIPTION

THE EXECUTIVE SPONSOR SERVES AS THE CONDUIT BETWEEN THE ADVISORY TASK FORCE AND THE SENIOR MANAGEMENT TEAM. THE SPONSOR IS AN ACTIVE PARTICIPANT OF THE ADVISORY TASK FORCE AND HE/SHE COMMUNICATES THE HOSPITAL'S CLINICAL STRENGTHS AND PROGRAM PRIORITIES TO DIVERSE AUDIENCES.

NAME OF EXECUTIVE SPONSOR: BRADLEY CHAMBERS

ADVISORY TASK FORCE

ROLE DESCRIPTION

THE ADVISORY TASK FORCE (ATF) REVIEWS PRIMARY/SECONDARY DATA AND LOCAL/STATE/FEDERAL COMMUNITY HEALTH GOALS. BASED ON FINDINGS, THE ATF PROVIDES INPUT INTO THE HOSPITAL'S THREE-YEAR IMPLEMENTATION STRATEGY.

Part VI Supplemental Information

Provide the following information.

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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.

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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.

AS AMBASSADORS FOR THE CHNA PROCESS, THE ATF MEMBERS SUPPORT EFFORTS TO OPTIMIZE COMMUNITY PARTICIPATION.

NOTE:

THE ATF SHOULD BE A COMBINATION OF COMMUNITY REPRESENTATIVES AND STAFF. COMMUNITY REPRESENTATIVES SHOULD MAKEUP AT LEAST 50% OF TOTAL PARTICIPANTS.

NAME:	TITLE:	AFFILIATION WITH HOSPITAL (I.E., BOARD MEMBER, VOLUNTEER, COMMUNITY ADVOCATE, STAFF)	HOSPITAL EMPLOYEE (YES/NO)
MITCHELL HERBERT	REGIONAL DIRECTOR,	STAFF	YES

Part VI Supplemental Information

Provide the following information.

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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.

	STRATEGIC AND BUSINESS PLANNING		
DEBORAH BENA	HEALTH MINISTRIES COORDINATOR	STAFF	YES
JEFFREY MATTON	PRESIDENT	STAFF	YES
ALLAN NOONAN	BOARD CHAIR	BOARD MEMBER	NO/ BOARD
SONYA GRAY	BOARD MEMBER	BOARD MEMBER	NO/ BOARD
CAROL PACIONE	PASTORAL LIFE DIRECTOR, ST. PIUS CHURCH	COMMUNITY ADVOCATE	NO
DAVID WEISMAN, MD	PHYSICIAN	STAFF	YES
MICHELLE ZIKUSOKA, MD	PHYSICIAN	STAFF	YES
ANDREW DZIUBAN	DIRECTOR OF PHILANTHROPY	STAFF	YES
BERNADETTE KROL, RN	REGISTERED NURSE	STAFF	YES
MOIRA LARSEN, MD	PHYSICIAN	STAFF	YES
RACHEL V. NEILL	RESIDENT, GOVANS ECUMENICAL DEVELOPMENT	COMMUNITY ADVOCATE	NO

Part VI Supplemental Information

Provide the following information.

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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.

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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.

	CORPORATION (GEDCO) - CARES PROGRAM		
LORETHA MYERS	RESIDENT, LOCH RAVEN IMPROVEMENT ASSOCIATION, NORTHEAST COMMUNITY ASSOCIATION	COMMUNITY ADVOCATE	NO
PATRICIA STABILE	PROGRAM DIRECTOR, HARBEL PREVENTION AND RECOVERY CENTER	COMMUNITY ADVOCATE	NO
RANDOLPH ROWEL, PHD	CHAIR AND ASSOCIATE PROFESSOR, DEPARTMENT OF BEHAVIOURAL HEALTH SCIENCES, MORGAN STATE UNIVERSITY	COMMUNITY ADVOCATE	NO

IMPLEMENTATION STRATEGY

PART V, SECTION B, LINE 8

THE IMPLEMENTATION STRATEGIES SERVE AS A ROADMAP FOR HOW COMMUNITY

Part VI Supplemental Information

Provide the following information.

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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.

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BENEFIT RESOURCES WILL BE ALLOCATED AND DEPLOYED. MEDSTAR'S HOSPITALS

WILL BE ABLE TO MEASURE OUR CONTRIBUTION TO IMPROVING THE HEALTH OF

UNDERSERVED AND VULNERABLE POPULATIONS IN THE REGIONS WE SERVE.

THREE-YEAR IMPLEMENTATION STRATEGIES WITH MEASURABLE OBJECTIVES WERE

DEVELOPED FOR EACH HOSPITAL'S COMMUNITY BENEFIT SERVICE AREA - A SPECIFIC

COMMUNITY OR TARGET POPULATION OF FOCUS. PRIORITIES WERE BASED ON

COMMUNITY NEED AS DETERMINED BY QUANTITATIVE DATA AND COMMUNITY INPUT, AS

WELL AS ON HOSPITAL EXPERTISE, RESOURCES, STRENGTHS OF EXISTING

PROGRAMMING AND PARTNERSHIPS, AND ALIGNMENT WITH NATIONAL, STATE, AND

LOCAL HEALTH GOALS. THE MEDSTAR HEALTH CORPORATE COMMUNITY HEALTH

DEPARTMENT WILL PROVIDE SYSTEM-WIDE COORDINATION AND OVERSIGHT OF

COMMUNITY BENEFIT PROGRAMMING.

NEEDS ASSESSMENT

PART VI, LINE 2

IN FY15, MEDSTAR GOOD SAMARITAN HOSPITAL CONDUCTED A COMMUNITY HEALTH

NEEDS ASSESSMENT (CHNA) IN ACCORDANCE WITH THE GUIDELINES ESTABLISHED BY

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE INTERNAL REVENUE

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.

SERVICE.

THE HOSPITAL'S CHNA WAS LED BY 15 ADVISORY TASK FORCE (ATF) MEMBERS, WHICH WAS COMPRISED OF A DIVERSE GROUP OF INDIVIDUALS, INCLUDING GRASSROOTS ACTIVISTS, COMMUNITY RESIDENTS, FAITH-BASED LEADERS, HOSPITAL REPRESENTATIVES, PUBLIC HEALTH LEADERS, AND OTHER STAKEHOLDER ORGANIZATIONS, SUCH AS REPRESENTATIVES FROM LOCAL HEALTH DEPARTMENTS. THE ATF REVIEWED QUANTITATIVE AND QUALITATIVE COMMUNITY HEALTH DATA, AS WELL AS LOCAL, REGIONAL AND NATIONAL HEALTH GOALS.

BASED ON THEIR FINDINGS, THE ATF DESIGNED A SURVEY TO IDENTIFY TRENDS IN HOW PARTICIPANTS PERCEIVED THE SEVERITY OF KEY HEALTH ISSUES IN THE FOLLOWING CATEGORIES: WELLNESS AND PREVENTION, ACCESS TO CARE, QUALITY OF LIFE, AND ENVIRONMENT. COMMUNITY MEMBERS RESPONDED TO THE SURVEY BY ATTENDING A COMMUNITY INPUT SESSION OR COMPLETING IT ONLINE OR VIA HARDCOPY.

BASED ON THE ATF'S RECOMMENDATION, THE HOSPITAL IDENTIFIED GOVANS AS ITS

Part VI Supplemental Information

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COMMUNITY BENEFIT SERVICE AREA (CBSA) - GEOGRAPHY WITH A HIGH DENSITY OF LOW-INCOME OR VULNERABLE RESIDENTS WITHIN CLOSE PROXIMITY OF THE HOSPITAL. HEALTH PRIORITIES FOR THE CBSA INCLUDE CHRONIC DISEASE (HEART DISEASE/STROKE, DIABETES, AND OBESITY).

THE HOSPITAL'S FY15 CHNA AND THREE-YEAR IMPLEMENTATION STRATEGIES WERE ENDORSED BY MEDSTAR GOOD SAMARITAN'S BOARD OF DIRECTORS AND APPROVED BY THE MEDSTAR HEALTH BOARD OF DIRECTORS. THE DOCUMENT WAS PUBLISHED ON THE HOSPITAL'S WEBSITE ON JUNE 30, 2015.

AS A PROUD MEMBER OF MEDSTAR HEALTH, REPRESENTATIVES FROM MEDSTAR GOOD SAMARITAN ROUTINELY PARTICIPATE IN THE MEDSTAR HEALTH COMMUNITY BENEFIT WORKGROUP. THE WORKGROUP IS COMPRISED OF COMMUNITY HEALTH PROFESSIONALS WHO REPRESENT ALL TEN MEDSTAR HOSPITALS. THE TEAM ANALYZES LOCAL AND REGIONAL COMMUNITY HEALTH DATA, ESTABLISHES SYSTEM-WIDE COMMUNITY HEALTH PROGRAMMING PERFORMANCE AND EVALUATION MEASURES AND SHARES BEST PRACTICES.

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.

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PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

AS ONE OF THE REGION'S LEADING NOT-FOR-PROFIT HEALTHCARE SYSTEMS, MEDSTAR HEALTH IS COMMITTED TO ENSURING THAT UNINSURED PATIENTS WITHIN THE COMMUNITIES WE SERVE WHO LACK FINANCIAL RESOURCES HAVE ACCESS TO NECESSARY HOSPITAL SERVICES.1 MEDSTAR HEALTH AND ITS HEALTHCARE FACILITIES WILL:

* TREAT ALL PATIENTS EQUITABLY, WITH DIGNITY, WITH RESPECT AND WITH COMPASSION.
* SERVE THE EMERGENCY HEALTH CARE NEEDS OF EVERYONE WHO PRESENTS AT OUR FACILITIES REGARDLESS OF A PATIENT'S ABILITY TO PAY FOR CARE.
* ASSIST THOSE PATIENTS WHO ARE ADMITTED THROUGH OUR ADMISSIONS PROCESS FOR NON-URGENT, MEDICALLY NECESSARY CARE WHO CANNOT PAY FOR PART OF ALL OF THE CARE THEY RECEIVE.
* BALANCE NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH BROADER FISCAL RESPONSIBILITIES IN ORDER TO KEEP ITS HOSPITALS' DOORS OPEN FOR ALL WHO MAY NEED CARE IN THE COMMUNITY.

Part VI Supplemental Information

Provide the following information.

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IN MEETING ITS COMMITMENTS, MEDSTAR HEALTH'S FACILITIES WORK WITH THEIR UNINSURED PATIENTS TO GAIN AN UNDERSTANDING OF EACH PATIENT'S FINANCIAL RESOURCES PRIOR TO ADMISSION (FOR SCHEDULED SERVICES) OR PRIOR TO BILLING (FOR EMERGENCY SERVICES). BASED ON THIS INFORMATION AND PATIENT ELIGIBILITY, MEDSTAR HEALTH'S FACILITIES ASSISTS UNINSURED PATIENTS WHO RESIDE WITHIN THE COMMUNITIES WE SERVE IN ONE OR MORE OF THE FOLLOWING WAYS:

* ASSIST WITH ENROLLMENT IN PUBLICLY-FUNDED ENTITLEMENT PROGRAMS (E.G., MEDICAID).
* ASSIST WITH CONSIDERATION OF FUNDING THAT MAY BE AVAILABLE FROM OTHER CHARITABLE ORGANIZATIONS.
* PROVIDE CHARITY CARE AND FINANCIAL ASSISTANCE ACCORDING TO APPLICABLE GUIDELINES.
* PROVIDE FINANCIAL ASSISTANCE FOR PAYMENT OF FACILITY CHARGES USING A SLIDING SCALE BASED ON PATIENT FAMILY INCOME AND FINANCIAL RESOURCES.
* OFFER PERIODIC PAYMENT PLANS TO ASSIST PATIENTS WITH FINANCING THEIR

Part VI Supplemental Information

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HEALTHCARE SERVICES.

EACH FACILITY POSTS THE POLICY, INCLUDING A DESCRIPTION OF THE APPLICABLE COMMUNITIES IT SERVES, IN EACH MAJOR PATIENT REGISTRATION AREA AND IN ANY OTHER AREAS REQUIRED BY APPLICABLE REGULATIONS, COMMUNICATES THE INFORMATION TO PATIENTS AS REQUIRED BY THIS POLICY AND APPLICABLE REGULATIONS AND MAKES A COPY OF THE POLICY AVAILABLE TO ALL PATIENTS. ADDITIONALLY, THE MARYLAND PATIENT INFORMATION SHEET/MEDSTAR'S PATIENT INFORMATION SHEET IS PROVIDED TO INPATIENTS ON ADMISSION AND AT TIME OF FINAL ACCOUNT BILLING.

MEDSTAR HEALTH BELIEVES THAT ITS PATIENTS HAVE PERSONAL RESPONSIBILITIES RELATED TO THE FINANCIAL ASPECTS OF THEIR HEALTHCARE NEEDS. THE CHARITY CARE, FINANCIAL ASSISTANCE, AND PERIODIC PAYMENT PLANS AVAILABLE UNDER THIS POLICY ARE NOT AVAILABLE TO THOSE PATIENTS WHO FAIL TO FULFILL THEIR RESPONSIBILITIES. FOR PURPOSES OF THIS POLICY, PATIENT RESPONSIBILITIES INCLUDE:

Part VI Supplemental Information

Provide the following information.

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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.

* COMPLETING FINANCIAL DISCLOSURE FORMS NECESSARY TO EVALUATE THEIR ELIGIBILITY FOR PUBLICLY-FUNDED HEALTHCARE PROGRAMS, CHARITY CARE PROGRAMS, AND OTHER FORMS OF FINANCIAL ASSISTANCE. THESE DISCLOSURE FORMS MUST BE COMPLETED ACCURATELY, TRUTHFULLY, AND TIMELY TO ALLOW MEDSTAR HEALTH'S FACILITIES TO PROPERLY COUNSEL PATIENTS CONCERNING THE AVAILABILITY OF FINANCIAL ASSISTANCE.

* WORKING WITH THE FACILITY'S FINANCIAL COUNSELORS AND OTHER FINANCIAL SERVICES STAFF TO ENSURE THERE IS A COMPLETE UNDERSTANDING OF THE PATIENT'S FINANCIAL SITUATION AND CONSTRAINTS.

* COMPLETING APPROPRIATE APPLICATIONS FOR PUBLICLY-FUNDED HEALTHCARE PROGRAMS. THIS RESPONSIBILITY INCLUDES RESPONDING IN A TIMELY FASHION TO REQUESTS FOR DOCUMENTATION TO SUPPORT ELIGIBILITY.

* MAKING APPLICABLE PAYMENTS FOR SERVICES IN A TIMELY FASHION, INCLUDING ANY PAYMENTS MADE PURSUANT TO DEFERRED AND PERIODIC PAYMENT SCHEDULES.

* PROVIDING UPDATED FINANCIAL INFORMATION TO THE FACILITY'S FINANCIAL COUNSELORS ON A TIMELY BASIS AS THE PATIENT'S CIRCUMSTANCES MAY CHANGE.

Part VI Supplemental Information

Provide the following information.

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* IT IS THE RESPONSIBILITY OF THE PATIENT TO INFORM THE MEDSTAR HOSPITAL OF THEIR EXISTING ELIGIBILITY UNDER A MEDICAL HARDSHIP DURING THE 12-MONTH PERIOD.

UNINSURED PATIENTS OF MEDSTAR HEALTH'S FACILITIES MAY BE ELIGIBLE FOR CHARITY CARE OR SLIDING-SCALE FINANCIAL ASSISTANCE UNDER THIS POLICY. THE FINANCIAL COUNSELORS AND FINANCIAL SERVICES STAFF DETERMINE ELIGIBILITY FOR CHARITY CARE AND SLIDING-SCALE FINANCIAL ASSISTANCE BASED ON REVIEW OF INCOME FOR THE PATIENT AND THEIR FAMILY (HOUSEHOLD), OTHER FINANCIAL RESOURCES AVAILABLE TO THE PATIENT'S FAMILY, FAMILY SIZE, AND THE EXTENT OF THE MEDICAL COSTS TO BE INCURRED BY THE PATIENT.

COMMUNITY INFORMATION

PART VI, LINE 4

GEOGRAPHIC:

MEDSTAR GOOD SAMARITAN HOSPITAL'S CBSA INCLUDES RESIDENTS IN ZIP CODE 21212, THE GOVANS AREA OF BALTIMORE. WHILE THE PRIMARY FOCUS FOR TARGETED

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PROGRAMMING WILL BE IN THIS NEIGHBORHOOD, MGSH WILL ALSO LOOK TO PROVIDE SERVICES TO INDIVIDUALS IN NEED IN THE HOSPITAL'S WHOLE SERVICE AREA WHICH INCLUDES ZIP CODES 21234, 21239, 21206, AND 21214. THE CBSA WAS SELECTED DUE TO ITS CLOSE PROXIMITY TO THE HOSPITAL, COUPLED WITH A HIGH DENSITY OF RESIDENTS WITH LOW INCOMES. THE GOVANS NEIGHBORHOOD IS LOCATED IN NORTH CENTRAL BALTIMORE CITY, APPROXIMATELY TWO MILES FROM GOOD SAMARITAN HOSPITAL. THE NEIGHBORHOOD FEATURES MANY DIFFERENT HOUSING TYPES, BUSINESSES, CHURCHES, A CHARTER SCHOOL AND A NEIGHBORHOOD PARK. GOVANS HAS ALWAYS BEEN ASSOCIATED WITH YORK ROAD, FIRST AS AN INDIAN TRAIL, AND THEN AS AN IMPORTANT COMMERCIAL ROAD AND TURNPIKE LINKING THE PORT OF BALTIMORE TO PENNSYLVANIA.

DEMOGRAPHICS:

ACCORDING TO STATISTICS FROM THE BALTIMORE CITY 2011 NEIGHBORHOODS HEALTH PROFILE, THE TOTAL POPULATION IN GOVANS IS 10,680, THE MAJORITY OF WHICH IS BLACK/AFRICAN AMERICAN (91.3%). WHITES ACCOUNT FOR 5.7% OF THE POPULATION, ASIANS ACCOUNT FOR 0.5% AND 2.5% OF THE POPULATION SELF-REPORTS AS TWO OR MORE RACES. SLIGHTLY MORE THAN ONE PERCENT (1.3%)

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OF THE POPULATION IS OF HISPANIC OR LATINO ORIGIN. ADULTS OVER THE AGE OF 18 YEARS OLD MAKE UP THREE-QUARTERS (75.6%) OF THE POPULATION, WITH SENIORS OVER AGE 65 YEARS AT 12.8%. CHILDREN UNDER THE AGE OF 18 ACCOUNT FOR 24.4% OF THE GOVANS POPULATION. THE MEDIAN ANNUAL HOUSEHOLD INCOME IS $37,000, COMPARABLE TO BALTIMORE CITY, WHILE UNEMPLOYMENT IS 14.9%, HIGHER THAN THE AVERAGE OF BALTIMORE CITY (11.0%). JUST OVER ONE-QUARTER (26.9%) OF HOUSEHOLDS ARE HEADED BY A SINGLE-PARENT. THE POVERTY RATE IS 11.6%, LESS THAN THAT OF BALTIMORE CITY (15.7%). IN 2011, APPROXIMATELY 1,400 LOCAL FAMILIES IN THE GOVANS AREA RECEIVED ASSISTANCE FROM CARES, A COMBINATION FOOD PANTRY AND EMERGENCY FINANCIAL ASSISTANCE CENTER. APPROXIMATELY TWO-THIRDS (62.2%) OF RESIDENTS OVER 25 YEARS OF AGE HAVE AT MOST A HIGH SCHOOL DIPLOMA. LIFE EXPECTANCY IS 73.9, LONGER THAN THAT OF BALTIMORE CITY (71.8). THE TOP CAUSES OF DEATH ARE HEART DISEASE (24.9 PER 10,000), CANCER (19.5 PER 10,000), HIV/AIDS (4.9 PER 10,000), STROKE (4.2 PER 10,000), AND DIABETES (2.6 PER 10,000).

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PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

AS A COMMUNITY PARTNER, MEDSTAR GOOD SAMARITAN ENGAGES IN A NUMBER OF COMMUNITY BENEFIT ACTIVITIES TO IMPROVE AND PROMOTE THE HEALTH AND WELL-BEING OF THE COMMUNITY. THE PRIORITY AREA OF FOCUS, AS DETERMINED BY THE COMMUNITY HEALTH NEEDS ASSESSMENT IS CHRONIC DISEASE, SPECIFICALLY TARGETING HEART DISEASE, DIABETES, AND OBESITY. MEDSTAR GOOD SAMARITAN WILL CONTINUE TO PARTNER WITH COMMUNITY ORGANIZATIONS, SUCH AS SENIOR CENTERS, CHURCHES AND SENIOR HOUSING TO PROVIDE HEALTH EDUCATION CLASSES, EXERCISE AND WEIGHT LOSS PROGRAMS AND BLOOD PRESSURE SCREENINGS. DIABETES EDUCATION AND HEART HEALTH CLASSES WILL BE HELD AT VARIOUS LOCATIONS IN THE GOVANS AREA OF BALTIMORE CITY. SITES INCLUDE CARES, A FOOD PANTRY AND FINANCIAL ASSISTANCE CENTER, A LOCAL SENIOR CENTER AND A LOCAL CHURCH. THE LIFE BALANCE/WEIGHT MANAGEMENT PROGRAM, AN EVIDENCED BASED PROGRAM TO PREVENT TYPE 2 DIABETES, WILL BE HELD WEEKLY AT A SENIOR CENTER. BLOOD PRESSURE SCREENINGS WILL BE HELD AT VARIOUS LOCATIONS IN THE NORTHEAST AREA OF BALTIMORE AND PERSONS IDENTIFIED WITH HIGH BLOOD PRESSURE WILL BE REFERRED TO THEIR PRIMARY CARE PROVIDER, AND THOSE WITHOUT INSURANCE WILL

Part VI Supplemental Information

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BE NAVIGATED TO A SAFETY NET PROVIDER. SENIOR FITNESS PROGRAMS WILL ALSO

BE OFFERED AT LOCAL COMMUNITY SENIOR CENTERS AND WILL INCLUDE AEROBICS,

STRENGTH TRAINING AND FLEXIBILITY. ALL COMPONENTS WILL BE DESIGNED TO

MEET THE FITNESS LEVEL OF THE PARTICIPANTS.

AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR GOOD SAMARITAN IS ABLE TO

EXPAND ITS CAPACITY TO MEET THE NEEDS OF THE COMMUNITY BY PARTNERING WITH

OTHER MEDSTAR HOSPITALS AND ASSOCIATED ENTITIES. MEDSTAR HEALTH RESOURCES

ASSIST THE HOSPITAL IN COMMUNITY HEALTH PLANNING TO MEET THE NEEDS OF THE

UNINSURED AND OTHER VULNERABLE POPULATIONS. THROUGH ITS COMMUNITY HEALTH

FUNCTION, MEDSTAR HEALTH PROVIDES MEDSTAR GOOD SAMARITAN WITH TECHNICAL

SUPPORT TO ENHANCE COMMUNITY HEALTH PROGRAMMING AND EVALUATION. MEDSTAR'S

CORPORATE PHILANTHROPY DEPARTMENT IDENTIFIES AND SEEKS PUBLIC AND PRIVATE

FUNDING SOURCES TO ENSURE THE AVAILABILITY OF HIGH QUALITY HEALTH

SERVICES, REGARDLESS OF ABILITY TO PAY.

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STATE FILING OF COMMUNITY BENEFIT REPORT

PART VI, LINE 7

THE COMMUNITY BENEFIT REPORT FOR MEDSTAR GOOD SAMARITAN HOSPITAL IS ONLY

FILED IN THE STATE OF MARYLAND.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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.*

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

Part I Questions Regarding Compensation

			Yes	No
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.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ 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	1b		
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?	2		
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.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☒ Form 990 of other organizations	☒ 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?	4a		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	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?	5a		X
b	Any related organization?	5b		X
	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?	6a		X
b	Any related organization?	6b		X
	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	7		X
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	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

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				
	JEFFREY A. MATTON	(i)	455,770.	385,432.	0	15,928.	18,453.	875,583.	0
1	PRESIDENT/BOARD MEMBER	(ii)	0	0	0	0	0	0	0
	KENNETH A. SAMET	(i)	0	0	0	0	0	0	0
2	BOARD MEMBER	(ii)	1,526,829.	2,783,911.	14,765.	43,766.	20,658.	4,389,929.	0
	DAVID WEISMAN	(i)	171,596.	14,620.	0	8,463.	14,382.	209,061.	0
3	BOARD MEMBER	(ii)	0	0	0	0	0	0	0
	ELIAS SHAYA , M.D.	(i)	353,055.	2,500.	0	8,098.	926.	364,579.	0
4	BOARD MEMBER	(ii)	0	0	0	0	0	0	0
	MICHAEL JACOBS, M.D.	(i)	800,517.	2,500.	0	7,650.	11,749.	822,416.	0
5	BOARD MEMBER	(ii)	0	0	0	0	0	0	0
	THOMAS SENKER	(i)	209,402.	42,462.	0	6,535.	15,454.	273,853.	0
6	SECRETARY	(ii)	0	0	0	0	0	0	0
	MARTIN BINSTOCK	(i)	334,937.	196,348.	0	12,448.	20,425.	564,158.	0
7	VP MEDICAL AFFAIRS	(ii)	0	0	0	0	0	0	0
	DEANA STOUT	(i)	257,489.	108,738.	0	22,353.	17,796.	406,376.	0
8	TREASURER	(ii)	0	0	0	0	0	0	0
	SHIRLEY ROTH	(i)	201,099.	33,872.	0	6,584.	11,618.	253,173.	0
9	CHIEF NURSING OFFICER	(ii)	0	0	0	0	0	0	0
	ROBERT PEROUTKA, M.D.	(i)	188,286.	464,338.	0	0	6,808.	659,432.	0
10	PHYSICIAN	(ii)	0	0	0	0	0	0	0
	DALE BUCHBINDER, M.D.	(i)	604,068.	36,000.	0	7,650.	11,625.	659,343.	0
11	VICE PRESIDENT	(ii)	0	0	0	0	0	0	0
	MESFIN LEMMA, M.D.	(i)	234,032.	353,472.	0	0	969.	588,473.	0
12	PHYSICIAN	(ii)	0	0	0	0	0	0	0
	DAVID COLL, M.D.	(i)	507,641.	6,000.	0	7,650.	14,583.	535,874.	0
13	CHIEF	(ii)	0	0	0	0	0	0	0
	LAWRENCE BECK	(i)	2,874.	0	208,436.	0	0	211,310.	0
14	FORMER OFFICER	(ii)	0	0	0	0	0	0	0
	JENNIFER WILKERSON	(i)	188,001.	38,556.	0	5,666.	13,322.	245,545.	0
15	FORMER OFFICER	(ii)	0	0	0	0	0	0	0
		(i)							
16		(ii)							

Part III Supplemental Information

Complete this part to 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.

FORM 990, SCHEDULE J, PART I, LINE 4B

LAWRENCE BECK'S (RETIRED) OTHER REPORTABLE COMPENSATION IN PART II, COLUMN (B) (III) INCLUDES $208,436 REPRESENTING THE AMOUNT OF SUPPLEMENTAL RETIREMENT BENEFIT PAYMENTS RELATING TO PRIOR YEARS OF SERVICE.

MR. SAMET'S BONUS AND INCENTIVE COMPENSATION IN PART II, COLUMN (B) (II) INCLUDES $620,610 REPRESENTING BENEFITS RECEIVED FROM EXECUTIVE RETIREMENT PLANS THAT ARE COMPRISED OF TARGET BENEFITS DETERMINED ANNUALLY BASED ON COMPENSATION AND YEARS OF SERVICE.

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule L (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
THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number
52-0591607

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected? Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 . . . . . ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	No	(h) Approved by board or committee? Yes	No	(i) Written agreement? Yes	No
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												
Total . . . . . ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				

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	(e) Sharing of organization's revenues? No
(1)	PATHOLOGY ASSOCIATES LABORATORIES	DIRECTOR		LAB SERVICES		X
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

Part V Supplemental Information

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

BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

DR. MOIRA LARSEN, A BOARD MEMBER AT MEDSTAR GOOD SAMARITAN HOSPITAL, OWNS 50% OF PATHOLOGY ASSOCIATES LABORATORIES, PC (PAL), WHICH PROVIDES LAB SERVICES TO MEDSTAR GOOD SAMARITAN HOSPITAL. PAL'S GROSS REVENUES RECEIVED FROM THE HOSPITAL FOR THE YEAR WAS $0.7 MILLION.

ORGANIZATION MEMBERS

PART VI, LINE 6

THE ORGANIZATION IS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT MARYLAND NON-STOCK CORPORATION. MEDSTAR HEALTH, INC., OR ONE OF ITS AFFILIATES AND SUBSIDIARIES, IS THE SOLE MEMBER OF THE ORGANIZATION.

DESCRIPTION OF MEMBERS

PART VI, LINE 7A

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT MARYLAND NON-STOCK CORPORATION, THE ORGANIZATION MAY RECOMMEND PERSON(S) FOR MEMBERSHIP ON THE ORGANIZATION'S GOVERNING BODY. ANY SUCH RECOMMENDATION BY THE ORGANIZATION IS SUBJECT TO APPROVAL BY THE GOVERNANCE COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR HEALTH, INC. THE BOARD OF MEDSTAR HEALTH, INC. HAS DELEGATED CERTAIN APPROVAL AUTHORITY TO THE GOVERNANCE COMMITTEE AND THE PRESIDENT & CEO OF MEDSTAR HEALTH, INC.

DECISIONS OF GOVERNING BODY

PART VI, LINE 7B

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT MARYLAND NON-STOCK CORPORATION, THE BYLAWS OF THE ORGANIZATION ARE SUBJECT TO CERTAIN RESERVED POWERS, WHICH PROVIDE THAT THE SOLE MEMBER OF THE ORGANIZATION MUST APPROVE CERTAIN DECISIONS, INCLUDING BUT NOT

Name of the organization: THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

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LIMITED TO MATTERS CONCERNING THE SALE OR PURCHASE OF REAL OR PERSONAL PROPERTY, CAPITAL BUDGETS, STRATEGIC PLANNING, INVESTMENTS, AND CORPORATE GOVERNANCE.

PROCESS FOR REVIEWING FORM 990

PART VI, LINE 11A

THE PROCESS FOR REVIEWING THE FORM 990 INCLUDED EDUCATION AND TRANSPARENCY. SENIOR FINANCIAL EXECUTIVES, WORKING WITH INDEPENDENT OUTSIDE EXPERTS, THOROUGHLY REVIEWED FORM 990 AND ACCOMPANYING INSTRUCTIONS. IN ADDITION, SENIOR EXECUTIVES REVIEWED THE RELEVANT SECTIONS OF THE FORM 990 WITH THE FOLLOWING COMMITTEES OF THE ORGANIZATION'S GOVERNING BODY: FINANCE, AUDIT, GOVERNANCE, STRATEGIC PLANNING, AND EXECUTIVE COMPENSATION. FOLLOWING THESE MEETINGS, THE GOVERNING BODY WAS PROVIDED A COPY OF THE FORM 990 IN ITS FINAL FORM AND GIVEN AN OPPORTUNITY TO PROVIDE ANY INPUT OR COMMENTS RELATING TO THE FORM 990 PRIOR TO ITS FILING.

CONFLICT OF INTEREST POLICY

PART VI, LINE 12C

APPOINTMENT OF BOARDS OF DIRECTORS

MEDSTAR HEALTH (AND ITS SUBSIDIARIES) REQUIRE ALL NOMINATED DIRECTORS, PRIOR TO THEIR APPOINTMENT OR ELECTION, TO DISCLOSE THE EXISTENCE OF (OR POTENTIAL EXISTENCE OF) ANY TRANSACTION WITH MEDSTAR THAT WOULD RESULT IN A CONFLICT OF INTEREST. SUCH DISCLOSURES (IF ANY) ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE RESOLVED.

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ANNUAL DISCLOSURES - ALL OFFICERS, DIRECTORS, AND SENIOR MANAGERS

ALL OFFICERS, DIRECTORS AND SENIOR MANAGERS ARE REQUIRED, NOT LESS THAN ANNUALLY, TO COMPLETE A SURVEY OF QUESTIONS CONCERNING ANY TRANSACTIONS OR RELATIONSHIPS WHICH WOULD OR COULD REPRESENT A CONFLICT OF INTEREST. SUCH DISCLOSURES (IF ANY) RELATED TO DIRECTORS ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE RESOLVED. SUCH DISCLOSURES (IF ANY) RELATED TO OFFICERS AND SENIOR MANAGERS ARE REVIEWED BY AN APPROPRIATE EXECUTIVE WHO DETERMINES HOW THE MATTER SHOULD BE RESOLVED IN ADDITION, OFFICERS AND DIRECTORS OF MARYLAND HOSPITALS AND NURSING CENTERS ARE REQUIRED TO ANNUALLY DISCLOSE ADDITIONAL INFORMATION RELATING TO POTENTIAL CONFLICTS OF INTEREST AND SUCH DISCLOSURES ARE REPORTED TO THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION (HSCRC).

DESCRIPTION OF EXECUTIVE COMPENSATION PROCESS

PART VI, LINE 15

THE EXECUTIVE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR HEALTH, INC. (THE "COMMITTEE") HAS OVERSIGHT OVER THE EXECUTIVE COMPENSATION PROGRAM (THE "PROGRAM") OF MEDSTAR HEALTH, INC. AND ITS AFFILIATES. TOTAL COMPENSATION FOR THE TOP MANAGEMENT OFFICIALS, OFFICERS AND KEY EMPLOYEES OF MEDSTAR HEALTH, INC. AND ITS AFFILIATES ARE REVIEWED AND APPROVED BY THE COMMITTEE WITH ASSISTANCE AND GUIDANCE FROM AN INDEPENDENT THIRD PARTY ADVISOR. THE MEMBERS OF THE COMMITTEE ARE INDEPENDENT FROM ALL OF THE PARTICIPANTS IN THE PROGRAM.

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THE MAIN OBJECTIVE OF THE PROGRAM IS TO PROVIDE MARKET COMPETITIVE TOTAL COMPENSATION THAT IS INTERNALLY EQUITABLE AND HAS A STRONG PAY-FOR-PERFORMANCE LINKAGE. PERFORMANCE IS EVALUATED AT THE SYSTEM, OPERATING UNIT, AND INDIVIDUAL LEVELS. THE OVERALL TOTAL COMPENSATION PHILOSOPHY IS MANAGED AT THE 75TH PERCENTILE OF THE COMPETITIVE MARKET FOR COMPARABLE SIZE (NET REVENUE) AND TYPE (TAX-EXEMPT HEALTHCARE ORGANIZATIONS). WHERE APPROPRIATE, ADDITIONAL INDUSTRY DATA IS CONSIDERED (GENERAL BUSINESS AND/OR TAXABLE HEALTHCARE) FOR SELECTED POSITIONS THAT CAN BE RECRUITED FROM OR POTENTIALLY LOST TO THESE INDUSTRIES (E.G., INFORMATION TECHNOLOGY, FINANCE, ETC.).

THE COMMITTEE HAS ENGAGED ERNST & YOUNG LLP ("E&Y") TO SERVE AS AN ADVISOR ON THE REASONABLENESS AND COMPETITIVENESS OF THE PROGRAM. IN DETERMINING REASONABLENESS AND COMPETITIVENESS, E&Y REVIEWS MARKET PRACTICES AND TRENDS, AND MAKES RECOMMENDATIONS RELATED TO THE PROGRAM. E&Y UTILIZES INFORMATION FROM CUSTOM SURVEYS, NATIONAL COMPENSATION SURVEYS, PROPRIETARY DATABASES, AND CLIENT EXPERIENCES TO DETERMINE ITS FINAL RECOMMENDATIONS. E&Y PRESENTS THEIR FINDINGS AND RECOMMENDATIONS TO THE COMMITTEE. THE COMMITTEE MAKES THE FINAL DECISIONS ON ALL OF THE COMPENSATION DETERMINATIONS OF THE PROGRAM. ALL DECISIONS MADE BY THE COMMITTEE ARE CONTEMPORANEOUSLY DOCUMENTED.

FINANCIAL STATEMENT AVAILABILITY

PART VI, LINE 19

MEDSTAR HEALTH POSTS ITS ANNUAL FINANCIAL AUDIT AND QUARTERLY FINANCIAL

Name of the organization: THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

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REPORTS TO THE ELECTRONIC MUNICIPAL MARKET ACCESS (EMMA) SYSTEM. THE ORGANIZATION ALSO E-MAILS ITS ANNUAL AND QUARTERLY DISCLOSURES TO HOLDERS OF THE COMPANY'S PUBLICLY TRADED DEBT. THE COMPANY'S GOVERNANCE DOCUMENTS AND CONFLICTS OF INTEREST POLICIES ARE AVAILABLE UPON REQUEST THROUGH ITS CORPORATE (OR AS APPLICABLE ENTITY) PUBLIC INFORMATION OFFICES.

FINANCIAL STATEMENTS AND REPORTING

PART XII, LINE 2C

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC. IS AN AFFILIATE OF THE MEDSTAR HEALTH, INC. AUDIT AND SUBJECT TO OVERSIGHT BY THE AUDIT COMMITTEE OF THE MEDSTAR BOARD.

OTHER CHANGES IN NET ASSETS

PART XI, LINE 9

EQUITY TRANSFERS - NET ASSETS.....$ (24,684,123)

ATTACHMENT 1

FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR GOOD SAMARITAN HOSPITAL'S (MEDSTAR GOOD SAMARITAN) MISSION IS TO BE GOOD SAMARITANS, GUIDED BY CATHOLIC TRADITION AND TRUSTED TO DELIVER IDEAL HEALTH EXPERIENCES. MEDSTAR GOOD SAMARITAN, LOCATED IN NORTHEAST BALTIMORE CITY, MARYLAND, IS KNOWN FOR ITS SPECIALTIES IN ORTHOPAEDICS, RHEUMATOLOGY, NEPHROLOGY, AND PHYSICAL MEDICINE AND REHABILITATION PROGRAMS. IN ADDITION TO GENERAL ADULT ACUTE CARE SERVICES, MEDSTAR GOOD SAMARITAN HAS A COMPREHENSIVE INPATIENT REHABILITATION UNIT AND A SUB-ACUTE CARE UNIT. THROUGH MGSH'S CENTER FOR SUCCESSFUL AGING,

Name of the organization: THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

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ATTACHMENT 1 (CONT'D)

FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

INTEGRATED CARE IS PROVIDED TO PATIENTS WHO EXPERIENCE AGE-RELATED HEALTH CONDITIONS. IN FISCAL YEAR 2015, MEDSTAR GOOD SAMARITAN HAD 10,745 INPATIENT ADMISSIONS, AND 384,469 OUTPATIENT VISITS INCLUDING 58,116 EMERGENCY VISITS.

ATTACHMENT 2

FORM 990, PART III - PROGRAM SERVICE, LINE 4A

MEDSTAR GOOD SAMARITAN'S LARGEST PROGRAM IS ACCESS TO AND THE PROVISION OF ACUTE HOSPITAL SERVICES TO THE COMMUNITIES OF NORTHEASTERN BALTIMORE CITY, MARYLAND AND THE SURROUNDING AREAS. IN ADDITION TO THE PROGRAM SERVICE EXPENSES LISTED ABOVE, MEDSTAR GOOD SAMARITAN INCURRED $40.0M OF MANAGEMENT AND GENERAL EXPENSES IN PROVIDING SERVICES TO ITS COMMUNITIES. IT ALSO OFFERS COMMUNITY-BASED HEALTH SERVICES THROUGH THE GOOD HEALTH CENTER AND PROVIDES SENIOR LIVING SERVICES THROUGH THE GOOD SAMARITAN NURSING CENTER AND TWO SENIOR HOUSING COMPLEXES LOCATED ON ITS 43-ACRE CAMPUS. MEDSTAR GOOD SAMARITAN'S STROKE CARE PROGRAM HAS RECEIVED THE GOLD SEAL OF APPROVAL FROM THE JOINT COMMISSION FOR PRIMARY STROKE CENTERS. MEDSTAR GOOD SAMARITAN HAS RECEIVED THE BRONZE PERFORMANCE ACHIEVEMENT AWARD FROM THE AMERICAN STROKE ASSOCIATION FOR ITS EXCEPTIONAL CARE FOR STROKE PATIENTS. THE STROKE CENTER AT MEDSTAR GOOD SAMARITAN HOSPITAL HAS RECEIVED BOTH THE HONORED BRONZE AWARD AND SILVER PLUS AWARD FROM THE AMERICAN HEART ASSOCIATION FOR THE OUTSTANDING WORK OF THE CENTER AS WELL AS ITS PREVENTIVE AND COMMUNITY EDUCATION PROGRAMS. FOR THE LAST FOUR

Name of the organization: THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

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ATTACHMENT 2 (CONT'D)

YEARS, THE DELMARVA FOUNDATION FOR MEDICAL CARE, THE MEDICARE QUALITY IMPROVEMENT ORGANIZATION FOR MARYLAND, HAS AWARDED THE DELMARVA FOUNDATION EXCELLENCE AWARD FOR QUALITY IMPROVEMENT TO MEDSTAR GOOD SAMARITAN. THE HOSPITAL HAS ALSO RECEIVED THE 2015 "PARTNER FOR CHANGE" AWARD BY PRACTICE GREENHEALTH FOR OUR COMMITMENT TO ENVIRONMENTAL SUSTAINABILITY AND WAS RECOGNIZED FOR OUR SUSTAINABLE GARDEN INITIATIVES. MEDSTAR GOOD SAMARITAN WAS RECOGNIZED BY U.S. NEWS & WORLD REPORT AS ONE OF THE BEST HOSPITALS IN THE BALTIMORE REGION FOR NEPHROLOGY AND GASTROENTEROLOGY/GI SURGERY IN JULY OF 2015

ATTACHMENT 3

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
HUNT VALLEY ANES ASSOC PA PO BOX 20284 TOWSON, MD 21284	MEDICAL SERVICES	8,116,000.
JOHNS HOPKINS UNIVERSITY 12529 COLLECTIONS CENTER DRIVE CHICAGO, IL 60693	PROFESSIONAL SERVICE	3,718,840.
MORRISON MANAGEMENT SPECIALIST 4721 MORRISON DRIVE MOBILE, AL 36609	FOOD SERVICES	3,640,763.
UNIVERSITY OF MARYLAND 110 S PACA STREET BALTIMORE, MD 21201	PROFESSIONAL SERVICE	3,529,050.
GS SURGICAL SERVICES LLC 2400 VELVET RIDGE DRIVE OWINGS MILLS, MD 21117	PHYSICIAN SERVICES	1,038,000.

Name of the organization: THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

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ATTACHMENT 4

FORM 990, PART IX - OTHER FEES

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
MISC PURCHASED SERVICES	2,975,726.	2,472,011.	503,715.	
PHYSICIAN SERVICES	19,903,867.	19,820,361.	83,506.	
LAB SERVICES	877,423.	871,120.	6,303.	
CONSULTING FEES	865,194.	103,735.	761,459.	
BANK FEES	110,261.		110,261.	
BILLING SERVICES	2,007,948.	757,029.	1,250,919.	
TRANSCRIPTION-VARIABLE	480,850.	70,801.	410,049.	
PHARMACY SERVICES	1,102,356.	1,102,356.		
PROFESSIONAL FEES-OTHER	5,335,684.	5,332,766.	2,918.	
PURCHASED PROFESSIONAL SVCS	3,427,346.	3,252,385.	174,961.	
OTHER MISCELLANEOUS SERVICES	58,804.	14,455.	44,349.	
TOTALS	37,145,459.	33,797,019.	3,348,440.	

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.*

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Name of the organization

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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
(1) MEDSTAR HEALTH ANESTHESIA SERVICES A LLC 20-5909017 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	HEALTHCARE	MD	6,531,168.	1,584,983.	N/A
(2)					
(3)					
(4)					
(5)					
(6)					

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	(g) Section 512(b)(13) controlled entity? No
(1) CHURCH HOME CORPORATION 23-7374724 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL FUND	MD	501(C)(3)	PF	N/A	X	
(2) FRANKLIN SQUARE HOSPITAL CENTER, INC. 52-0608007 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237	HOSPITAL	MD	501(C)(3)	3	N/A	X	
(3) HARBOR HOSPITAL, INC. 52-0491660 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225	HOSPITAL	MD	501(C)(3)	3	N/A	X	
(4) MEDSTAR HEALTH, INC. 52-2087445 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SVCS	MD	501(C)(3)	11C III	N/A		X
(5) MONTGOMERY GENERAL HOSPITAL 52-0646893 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	HOSPITAL	MD	501(C)(3)	3	N/A	X	
(6) THE UNION MEMORIAL HOSPITAL 52-0591685 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218	HOSPITAL	MD	501(C)(3)	3	N/A	X	
(7) MEDSTAR HEALTH RESEARCH INSTITUTE 52-6056274 108 IRVING STREET NW WASHINGTON, DC 20010	HOSPITAL	DC	501(C)(3)	4	N/A	X	

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

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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	(g) No
(1) THE MEDSTAR-GEORGETOWN MEDICAL CENTER, I 52-2218584 HOPSITAL ADMIN, 1 MAIN BLDG WASHINGTON, DC 20007	HOSPITAL	DC	501(C)(3)	3	N/A	X	
(2) WASHINGTON HOSPITAL CENTER CORPORATION 52-1272129 110 IRVING STREET NW WASHINGTON, DC 20010	HOSPITAL	DC	501(C)(3)	3	N/A	X	
(3) HH MEDSTAR HEALTH, INC. 52-1542230 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SVCS	MD	501(C)(3)	11C III	N/A	X	
(4) MEDSTAR AMBULATORY SERVICES, INC. 52-1132992 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	ADMIN SVCS	MD	501(C)(3)	11B II	N/A	X	
(5) BAY LIFE SERVICES, INC. 52-1496539 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MENTAL HEALTH	MD	501(C)(3)	9	N/A	X	
(6) MEDSTAR SURGERY CENTER, INC. 52-1061679 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705	MEDICAL SVCS	MD	501(C)(3)	9	N/A	X	
(7) CHURCH HOME AND HOSPITAL OF THE CITY OF 52-0591600 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	HOSPITAL	MD	501(C)(3)	11B II	N/A	X	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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(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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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	(g) No
(1) FRANKLIN SQUARE HOSPITAL CENTER FOUNDATI 52-2329546 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237	FOUNDATION	MD	501(C)(3)	7	N/A	X	
(2) GOOD SAMARITAN HOSPITAL FOUNDATION, INC. 52-2307122 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	FOUNDATION	MD	501(C)(3)	11A I	N/A	X	
(3) GOOD SAMARITAN NURSING CENTER, INC. 52-1672866 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	MEDICAL SVCS	MD	501(C)(3)	9	N/A	X	
(4) GS HOUSING, INC. 52-1481656 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ELDER HOUSING	MD	501(C)(3)	9	N/A	X	
(5) GS PROPERTIES, INC. 52-1429853 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ADMIN SVCS	MD	501(C)(3)	11A I	N/A	X	
(6) HARBOR HOSPITAL FOUNDATION, INC. 52-1284532 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225	FOUNDATION	MD	501(C)(3)	11A I	N/A	X	
(7) MEDSTAR HEALTH INFUSION, INC. 52-1980510 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705	MEDICAL SVCS	MD	501(C)(3)	9	N/A	X	

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.

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2014

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Name of the organization

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Employer identification number

52-0591607

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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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	(g) No
(1) MEDSTAR HEALTH VISITING NURSES ASSOCIATI 53-0196597 4061 POWDERMILL ROAD CALVERTON, MD 20705	MEDICAL SVCS	MD	501(C)(3)	9	N/A	X	
(2) MEDSTAR VNA HEALTHCARE 52-1458516 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705	MEDICAL SVCS	MD	501(C)(3)	9	N/A	X	
(3) MGH COMMUNITY HEALTH, INC. 52-1372467 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SVCS	MD	501(C)(3)	9	N/A	X	
(4) MGH HEALTH FOUNDATION, INC. 52-1129959 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	FOUNDATION	MD	501(C)(3)	7	N/A	X	
(5) MGH HEALTH SERVICES, INC. 52-1366812 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	FOUNDATION	MD	501(C)(3)	11B II	N/A	X	
(6) MGH WOMEN'S BOARD 52-6039600 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	FOUNDATION	MD	501(C)(3)	11B II	N/A	X	
(7) NATIONAL REHABILITATION HOSPITAL 52-1369749 102 IRVING STREET NW WASHINGTON, DC 20010	HOSPITAL	DC	501(C)(3)	3	N/A	X	

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.

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OMB No. 1545-0047

2014

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Name of the organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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	(g) Section 512(b)(13) controlled entity? No
(1) REGIONAL REHAB AT OLNEY, INC. 52-2310902 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SVCS	MD	501(C)(3)	3	N/A	X	
(2) SUBURBAN / NRH MEDICAL REHABILITATION, I 52-1931151 102 IRVING STREET NW WASHINGTON, DC 20010	MEDICAL SVCS	DC	501(C)(3)	3	N/A	X	
(3) THE THOMAS O'NEIL CATHOLIC HEALTH CARE F 52-1104382 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	FOUNDATION	MD	501(C)(3)	11D III	N/A	X	
(4) VNA, INC. 52-1332411 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705	ADMIN SVCS	MD	501(C)(3)	11B II	N/A	X	
(5) WHC FOUNDATION, INC. 52-1791670 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705	ADMIN SVCS	MD	501(C)(3)	7	N/A	X	
(6) WOODBOURNE WOODS, INC. 52-2299070 110 IRVING STREET NW WASHINGTON, DC 20010	FOUNDATION	DC	501(C)(3)	9	N/A	X	
(7) HOSPICE OF ST. MARY'S, INC. 52-2153926 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ELDER HOUSING	MD	501(C)(3)	11A I	N/A	X	

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.

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OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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	(g) Section 512(b)(13) controlled entity? No
(1) ST. MARY'S HOSPITAL OF ST. MARY'S COUNTY 52-0619006 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650	HOSPITAL	MD	501(C)(3)	3	N/A	X	
(2) ST. MARY'S HOSPITAL FOUNDATION, INC. 52-1051368 PO BOX 527 LEONARDTOWN, MD 20650	SUPPORT ORG	MD	501(C)(3)	11A I	N/A	X	
(3) MEDSTAR SOUTHERN MD HOSPITAL CENTER 46-0726303 7503 SURRATTS ROAD CLINTON, MD 20735	HOSPITAL	MD	501(C)(3)	3	N/A	X	
(4) MEDSTAR HEALTH INC & AFFILIATES MASTER 46-7454613 5565 STERRETT PLACE COLUMBIA, MD 21044	RETIREMENT TR	MD	501(A)	N/A	N/A	X	
(5)							
(6)							
(7)							

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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) PHYSICIAN IMAGING OF WASHINGTO 6525 BELCREST ROAD, SUITE G 50	LAB SERVICES	MD	N/A	RELATED				X			X	
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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	(i) No
(1) MEDSTAR PHARMACIES, INC. 52-1513056 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	DRUG SALES	MD	N/A	C CORP					
(2) EXTENCARE, INC. 52-1556228 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SERVI	MD	N/A	C CORP					
(3) HELIX RESOURCES MANAGEMENT, INC. 52-1913070 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	ADMIN SERVICE	MD	N/A	C CORP					
(4) HELIXCARE MEDICAL GROUP, LLC 52-1955580 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SERVI	MD	N/A	C CORP					
(5) HELIXCARE PROPERTIES, LLC 52-1966695 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SERVI	MD	N/A	C CORP					
(6) PARKWAY VENTURES, INC. 52-1893569 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	HOLDING COMPA	MD	N/A	C CORP					
(7) PHYSICIANS ADMINISTRATIVE SERVICES, INC. 23-7042074 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	BILLING SERVI	MD	N/A	C CORP					

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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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	(i) No
(1) MEDSTAR FAMILY CHOICE, INC. 52-1995521 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MANAGED CARE	MD	N/A	C CORP					
(2) MEDSTAR ENTERPRISES, INC. 52-2139841 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	ADMIN SERVICE	MD	N/A	C CORP					
(3) SITEL, INC. 90-0753340 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	EDUCATIONAL SVCS	MD	N/A	C CORP					
(4) STAR BILLING, INC. 52-1850113 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	BILLING SERVI	MD	N/A	C CORP					
(5) WASHINGTON RISK NETWORK MANAGEMENT, INC. 52-2132677 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SERVI	MD	N/A	C CORP					
(6) WASHINGTON HOSPITAL CENTER PHYSICIAN HOS 52-1931000 100 IRVING STREET NW WASHINGTON, DC 20010	MEDICAL SERVI	MD	N/A	C CORP					
(7) MEDSTAR PHYSICIAN PARTNERS, INC. 52-2030809 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SERVI	MD	N/A	C CORP					

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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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	(i) No
(1) FRANKLIN SQUARE DRIVE LAND CONDO ASSOCIA 76-0756352 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	CONDO OWNER A	MD	N/A	C CORP					
(2) MGH DIVERSIFIED SERVICES, INC. 52-1943602 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SERVI	MD	N/A	C CORP					
(3) ST. MARY'S HEALTH ALLIANCE, INC. 52-1930331 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650	MEDICAL SERVI	MD	N/A	C CORP					
(4) GREENSPRING FINANCIAL INSURANCE LIMITED 98-0188617 23 LIME TREE BAY AVENUE PO BOX 1051 KY1-1102, GRAND CAYMA	INSURANCE	CJ	N/A	C CORP					
(5) ST MARY'S CONDO ASSOCIATION 27-3377216 25500 POINT LOOKOUT RD LEONARDTOWN, MD 20650	CONDOMINIUMS	MD	N/A	C CORP					
(6) MEDSTAR HEALTH MASTER RETIREMENT TRUST I 99-9999999 5565 STERRETT PLACE COLUMBIA, MD 21044	INVESTMENTS	CJ	N/A	C CORP					
(7)									

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.		Yes	No
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?			
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity	1a		X
b Gift, grant, or capital contribution to related organization(s)	1b		X
c Gift, grant, or capital contribution from related organization(s)	1c		X
d Loans or loan guarantees to or for related organization(s)	1d		X
e Loans or loan guarantees by related organization(s)	1e		X
f Dividends from related organization(s)	1f		X
g Sale of assets to related organization(s)	1g		X
h Purchase of assets from related organization(s)	1h		X
i Exchange of assets with related organization(s)	1i		X
j Lease of facilities, equipment, or other assets to related organization(s)	1j		X
k Lease of facilities, equipment, or other assets from related organization(s)	1k		X
l Performance of services or membership or fundraising solicitations for related organization(s)	1l		X
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	X	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		X
o Sharing of paid employees with related organization(s)	1o		X
p Reimbursement paid to related organization(s) for expenses	1p	X	
q Reimbursement paid by related organization(s) for expenses	1q	X	
r Other transfer of cash or property to related organization(s)	1r		X
s Other transfer of cash or property from related organization(s)	1s	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)	HH MEDSTAR HEALTH, INC.	P	295,938.	FMV
(2)	THE UNION MEMORIAL HOSPITAL	P	786,602.	FMV
(3)	EXTENCARE, INC.	Q	96,991.	FMV
(4)	HH MEDSTAR HEALTH, INC.	Q	1,241,137.	FMV
(5)	GOOD SAMARITAN HOSPITAL FOUNDATION, INC.	S	279,379.	FMV
(6)				

Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Part VII **Supplemental Information**

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

Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS *e-file* Signature Authorization for an Exempt Organization

For calendar year 2014, or fiscal year beginning 07/01, 2014, and ending 06/30, 20 15

▶ Do not send to the IRS. Keep for your records.

▶ Information about Form 8879-EO and its instructions is at *www.irs.gov/form8879eo.*

OMB No. 1545-1878

2014

Name of exempt organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

Name and title of officer

JOEL BRYAN, VICE PRESIDENT/TREASURER

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line **1a, 2a, 3a, 4a,** or **5a,** below, and the amount on that line for the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b,** or **5b,** whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than 1 line in Part I.

1a	Form 990 check here ▶ [X]	b Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	325029362.
2a	Form 990-EZ check here ▶ [ ]	b Total revenue, if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here ▶ [ ]	b Total tax (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here ▶ [ ]	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b	
5a	Form 8868 check here ▶ [ ]	b Balance Due (Form 8868, Part I, line 3c or Part II, line 8c)	5b	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2014 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize KPMG LLP (ERO firm name) to enter my PIN 2 1 2 3 9 as my signature

Enter five numbers, but do not enter all zeros

on the organization's tax year 2014 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2014 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ Joel Bryan Date ▶ 04/26/2016

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN.

5 4 0 2 8 0 2 2 1 0 2

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2014 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ Margaret A. Bradshaw Date ▶ 04/26/2016

ERO Must Retain This Form - See Instructions
Do Not Submit This Form To the IRS Unless Requested To Do So

Cumulative e-File History 2014	
Federal	
Locator:	05462X
Taxpayer Name:	The Good Samaritan Hospital of Maryland, Inc.
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	05/11/2016 15:52:38
Acknowledgement Date:	05/11/2016 16:27:53
Status:	Accepted
Submission ID:	54028020161325000004