

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Form **990**

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

2014

Department of the Treasury
Internal Revenue Service

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

Open to Public Inspection

A For the **2014** calendar year, or tax year beginning **07/01, 2014**, and ending **06/30, 2015**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization HARBOR HOSPITAL		D Employer identification number 52-0491660	
	Doing Business As		E Telephone number (410) 772-6721	
	Number and street (or P.O. box if mail is not delivered to street address) Room/suite 3001 SOUTH HANOVER STREET		G Gross receipts \$ 207,470,651.	
	City or town, state or province, country, and ZIP or foreign postal code BALTIMORE, MD 21225-1233		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)	
F Name and address of principal officer: DENNIS PULLIN 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225				
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c)() ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527				
J Website: ▶ WWW.HARBORHOSPITAL.ORG				
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶				
			L Year of formation: 1903	
			M State of legal domicile: MD	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: <u>HARBOR HOSPITAL IS COMMITTED TO QUALITY, CARING, AND SERVICE FOR OUR PATIENTS AND OUR COMMUNITIES.</u>			
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.			
	3	Number of voting members of the governing body (Part VI, line 1a)	16.	
	4	Number of independent voting members of the governing body (Part VI, line 1b)	12.	
	5	Total number of individuals employed in calendar year 2014 (Part V, line 2a)	1,751.	
	6	Total number of volunteers (estimate if necessary)	45.	
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	2,068,001.	
7b	Net unrelated business taxable income from Form 990-T, line 34	-272,896.		
Revenue			Prior Year	Current Year
	8	Contributions and grants (Part VIII, line 1h)	1,104,097.	1,172,075.
	9	Program service revenue (Part VIII, line 2g)	204,812,518.	197,708,177.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	127,109.	137,563.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	7,946,778.	8,401,935.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	213,990,502.	207,419,750.	
Expenses	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)	95,204,932.	97,355,048.
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	16b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	96,979,321.	99,167,843.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	192,184,253.	196,522,891.
19	Revenue less expenses. Subtract line 18 from line 12	21,806,249.	10,896,859.	
Net Assets or Fund Balances			Beginning of Current Year	End of Year
	20	Total assets (Part X, line 16)	68,637,935.	67,207,200.
	21	Total liabilities (Part X, line 26)	37,400,224.	51,137,831.
22	Net assets or fund balances. Subtract line 21 from line 20	31,237,711.	16,069,369.	

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 <u>5/4/16</u>
	Type or print name and title Joel Bryan VP, Treasurer	

Paid Preparer Use Only	Print/Type preparer's name MARGARET A. BRADSHAW	Preparer's signature 	Date 5/11/16	Check <input type="checkbox"/> if self-employed	PTIN 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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2014)

Application for Extension of Time To File an Exempt Organization Return

Department of the Treasury
Internal Revenue Service

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

- If you are filing for an **Automatic 3-Month Extension**, complete only Part I and check this box
 - 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.

Type or print <small>File by the due date for filing your return. See instructions.</small>	Name of exempt organization or other filer, see instructions. HARBOR HOSPITAL, INC.	Employer identification number (EIN) or 52-0491660
	Number, street, and room or suite no. If a P.O. box, see instructions. 3001 SOUTH HANOVER STREET	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. BALTIMORE, MD 21225-1233	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

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 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.

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 02/15, 2016, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

▶ calendar year 20____ or

▶ tax year beginning 07/01, 2014, and ending 06/30, 2015.

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 <small>File by the due date for filing your return. See instructions.</small>	Name of exempt organization or other filer, see instructions.	Enter filer's identifying number, see instructions Employer identification number (EIN) or
	HARBOR HOSPITAL, INC.	52-0491660
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	3001 SOUTH HANOVER STREET	
City, town or post office, state, and ZIP code. For a foreign address, see instructions.		
BALTIMORE, MD 21225-1233		

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, 2016.

5 For calendar year , or other tax year beginning 07/01, 2014, and ending 06/30, 2015.

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

7 State in detail why you need the extension 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 **▶** Margot A. Brockhaus 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 \$ 135,370,332. including grants of \$) (Revenue \$ 189,892,971.)

ATTACHMENT 2

4b (Code:) (Expenses \$ 13,812,042. including grants of \$) (Revenue \$ 7,812,046.)

MEDSTAR HARBOR PROVIDED \$13.8M IN SUBSIDIZED (MISSION DRIVEN) HEALTH SERVICES IN FISCAL YEAR 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 OUTPATIENT PRIMARY CARE, WOMEN'S AND CHILDREN'S SERVICES, PSYCHIATRY, HOSPITALISTS, AND EMERGENCY DEPARTMENT COVERAGE.

4c (Code:) (Expenses \$ 8,421,948. including grants of \$) (Revenue \$ 3,160.)

MEDSTAR HARBOR PROVIDED \$8.4M 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 157,604,322.

Part IV Checklist of Required Schedules

Table with 3 columns: Question number, Yes, No. Rows include questions 1 through 20b regarding organizational requirements and financial reporting.

Part IV Checklist of Required Schedules (continued)

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

Table with columns for question numbers (1a-14b), Yes/No checkboxes, and numerical input fields. Contains questions about Form 1096, Form W-2G, backup withholding, Form W-3, unrelated business gross income, foreign accounts, prohibited tax shelter transactions, deductible contributions, and Form 990 filings.

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

Section A. Governing Body and Management

		Yes	No
1a Enter the number of voting members of the governing body at the end of the tax year	1a 16		
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.			
b Enter the number of voting members included in line 1a, above, who are independent	1b 12		
2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	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? <i>If "Yes," provide the names and addresses in Schedule O</i>	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? <i>If "No," go to line 13</i>	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? <i>If "Yes," describe in Schedule O how this was done</i>	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 FLOOR, 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) DENNIS W PULLIN PRESIDENT/DIRECTOR	40.00 1.00	X		X				770,407.	0	29,123.
(2) KENNETH A SAMET DIRECTOR	1.00 39.00	X						0	4,325,505.	64,424.
(3) LEIGH ANN CURL MD DIRECTOR	40.00 1.00	X						746,116.	0	22,648.
(4) GREGORY GURFINCHEL MD DIRECTOR	40.00 1.00	X						270,622.	0	18,608.
(5) KAISER ROBERTSON MD DIRECTOR	1.00 0	X						0	0	0
(6) EDWARD P CAREY CHAIR	1.00 0	X						0	0	0
(7) PETER MACNAB VICE CHAIR	1.00 0	X						0	0	0
(8) CHARLES F OBRECHT JR DIRECTOR	1.00 0	X						0	0	0
(9) DAWN M. GRETZ, MD DIRECTOR	1.00 0	X						0	0	0
(10) ELMER SNYDER DIRECTOR	1.00 0	X						0	0	0
(11) COURTNEY B. WILSON DIRECTOR	1.00 0	X						0	0	0
(12) VINCENT CONNELLY DIRECTOR	1.00 0	X						0	0	0
(13) CARLOS D. ZIGEL, M.D. DIRECTOR	1.00 0	X						0	0	0
(14) TIMOTHY BARNHILL DIRECTOR	1.00 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) THOMAS A. GEDDES DIRECTOR	1.00 0	X					0	0	0	
16) GEORGE WILLIAMSON, M.D. DIRECTOR	1.00 0	X					0	0	0	
17) DAVID PITMAN VICE PRESIDENT/CFO	40.00 0			X			285,318.	0	24,097.	
18) ALLAN BIRENBERG VICE PRESIDENT	40.00 0			X			436,881.	0	20,408.	
19) LENORA ADDISON VICE PRESIDENT	40.00 0			X			266,098.	0	53,397.	
20) JILL DONALDSON VICE PRESIDENT	40.00 0			X			251,488.	0	20,577.	
21) JOHN CARBONE, M.D. PHYSICIAN	40.00 0				X		735,880.	0	26,764.	
22) JAMES WOOD, M.D. CHIEF	40.00 0				X		676,600.	0	24,788.	
23) DENNIS STERN, M.D. PHYSICIAN	40.00 0				X		592,287.	0	30,813.	
24) CHUKA JENKINS, M.D. PHYSICIAN	40.00 0				X		574,295.	0	27,796.	
25) HOWARD POPKIN, M.D. PHYSICIAN	40.00 0				X		531,705.	0	27,225.	
1b Sub-total							1,787,145.	4,325,505.	134,803.	
c Total from continuation sheets to Part VII, Section A							4,350,552.	0	255,865.	
d Total (add lines 1b and 1c)							6,137,697.	4,325,505.	390,668.	

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 **193**

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
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 **30**

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	126,662.			
	d	Related organizations	1d				
	e	Government grants (contributions)	1e	555,394.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	490,019.			
	g	Noncash contributions included in lines 1a-1f: \$					
	h	Total. Add lines 1a-1f ▶		1,172,075.			
Program Service Revenue	2a	<u>NET PATIENT SERVICE REVENUE</u>	<u>Business Code</u>				
			621400	193,476,213.	193,476,213.		
	b	<u>PHARMACY</u>	900099	2,221,614.	2,221,614.		
	c	<u>MEANINGFUL USE INCOME</u>	900099	2,010,350.	2,010,350.		
	d						
	e						
	f	All other program service revenue					
g	Total. Add lines 2a-2f ▶		197,708,177.				
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts). ▶		111,483.		111,483.	
	4	Income from investment of tax-exempt bond proceeds ▶		0			
	5	Royalties ▶		0			
	6a	Gross rents	(i) Real				
			(ii) Personal				
				3,093,058.			
	b	Less: rental expenses					
	c	Rental income or (loss)		3,093,058.			
	d	Net rental income or (loss) ▶		3,093,058.		3,093,058.	
	7a	Gross amount from sales of assets other than inventory	(i) Securities				
			(ii) Other				
				17,861.	8,219.		
	b	Less: cost or other basis and sales expenses					
c	Gain or (loss)		17,861.	8,219.			
d	Net gain or (loss) ▶		26,080.		26,080.		
8a	Gross income from fundraising events (not including \$ <u>126,662.</u> of contributions reported on line 1c). See Part IV, line 18 a						
			33,350.				
		b	Less: direct expenses b		50,901.		
c	Net income or (loss) from fundraising events. ▶		-17,551.		-17,551.		
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	<u>OUTSIDE LAB REVENUE</u>	621500	2,068,001.		2,068,001.		
b	<u>OPERATING EXPENSE RECOVERY</u>	900099	1,226,791.			1,226,791.	
c	<u>REBATE INCOME</u>	900099	625,927.			625,927.	
d	All other revenue	900099	1,405,709.			1,405,709.	
e	Total. Add lines 11a-11d ▶		5,326,428.				
12	Total revenue. See instructions ▶		207,419,750.	197,708,177.	2,068,001.	6,471,497.	

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	3,044,678.	2,707,620.	337,058.	
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	77,405,039.	68,835,589.	8,569,450.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,348,689.	1,199,646.	149,043.	
9 Other employee benefits	10,202,529.	9,074,032.	1,128,497.	
10 Payroll taxes	5,354,113.	4,697,865.	656,248.	
11 Fees for services (non-employees):				
a Management	22,365,150.	2,260,115.	20,105,035.	
b Legal	637.		637.	
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	20,265,088.	19,649,018.	616,070.	
12 Advertising and promotion	413,332.	2,798.	410,534.	
13 Office expenses	1,434,492.	1,200,505.	233,987.	
14 Information technology	0			
15 Royalties	0			
16 Occupancy	651,011.	1,306,405.	-655,394.	
17 Travel	96,257.		96,257.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	118,234.	118,234.		
19 Conferences, conventions, and meetings	1,905.	1,295.	610.	
20 Interest	1,920,812.		1,920,812.	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	7,621,202.	4,051,119.	3,570,083.	
23 Insurance	4,214,845.	4,587,071.	-372,226.	
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 <u>MEDICAL/SURGICAL SUPPLIES</u>	18,035,849.	17,993,874.	41,975.	
b <u>IMPLANTS/PROSTHESES</u>	6,864,361.	6,864,361.		
c <u>UTILITIES</u>	4,490,695.	4,156,571.	334,124.	
d <u>FOOD SERVICES</u>	3,156,628.	2,988,775.	167,853.	
e All other expenses	7,517,345.	5,909,429.	1,607,916.	
25 Total functional expenses. Add lines 1 through 24e	196,522,891.	157,604,322.	38,918,569.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).	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	2,800.	1	2,770.
	2 Savings and temporary cash investments	0	2	0
	3 Pledges and grants receivable, net	281,854.	3	66,163.
	4 Accounts receivable, net	26,120,704.	4	25,687,810.
	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	2,366,444.	8	2,218,450.
	9 Prepaid expenses and deferred charges	841,727.	9	283,405.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 192,298,662.		
	b Less: accumulated depreciation	10b 155,295,296.	38,166,585.	10c 37,003,366.
	11 Investments - publicly traded securities	0	11	0
	12 Investments - other securities. See Part IV, line 11	228,940.	12	560,890.
	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	628,881.	15	1,384,346.
16 Total assets. Add lines 1 through 15 (must equal line 34)	68,637,935.	16	67,207,200.	
Liabilities	17 Accounts payable and accrued expenses	16,704,284.	17	16,674,866.
	18 Grants payable	63,840.	18	43,128.
	19 Deferred revenue	731,799.	19	655,783.
	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	19,900,301.	25	33,764,054.
	26 Total liabilities. Add lines 17 through 25	37,400,224.	26	51,137,831.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	31,008,772.	27	15,508,478.
	28 Temporarily restricted net assets	228,939.	28	560,891.
	29 Permanently restricted net assets	0	29	0
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
33 Total net assets or fund balances	31,237,711.	33	16,069,369.	
34 Total liabilities and net assets/fund balances	68,637,935.	34	67,207,200.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	207,419,750.
2	Total expenses (must equal Part IX, column (A), line 25)	2	196,522,891.
3	Revenue less expenses. Subtract line 2 from line 1	3	10,896,859.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	31,237,711.
5	Net unrealized gains (losses) on investments	5	-18,906.
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	-26,046,295.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	16,069,369.

Part XII Financial Statements and Reporting

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

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

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

2014

Department of the Treasury
Internal Revenue Service

▶ Attach to Form 990 or Form 990-EZ.

Open to Public Inspection

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

Name of the organization HARBOR HOSPITAL	Employer identification number 52-0491660
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Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

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

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

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

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

Schedule A (Form 990 or 990-EZ) 2014

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

Table with 7 columns: Calendar year (or fiscal year beginning in), (a) 2010, (b) 2011, (c) 2012, (d) 2013, (e) 2014, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: Calendar year (or fiscal year beginning in), (a) 2010, (b) 2011, (c) 2012, (d) 2013, (e) 2014, (f) Total. Rows include: 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; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 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

Table with 3 columns: Description, Value, Percentage. Rows include: 14 Public support percentage for 2014 (line 6, column (f) divided by line 11, column (f)); 15 Public support percentage from 2013 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2014; b 33 1/3% support test - 2013; 17a 10%-facts-and-circumstances test - 2014; b 10%-facts-and-circumstances test - 2013; 18 Private foundation.

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

Table with 7 columns: (a) 2010, (b) 2011, (c) 2012, (d) 2013, (e) 2014, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Gross receipts from admissions, merchandise sold or services performed; 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; 5 The value of services or facilities furnished by a governmental unit; 6 Total. Add lines 1 through 5; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 7c Add lines 7a and 7b; 8 Public support (Subtract line 7c from line 6).

Section B. Total Support

Table with 7 columns: (a) 2010, (b) 2011, (c) 2012, (d) 2013, (e) 2014, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 10b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975; 10c 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.

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

Table with 3 columns: Line number, Description, Percentage. Row 15: Public support percentage for 2014 (line 8, column (f) divided by line 13, column (f)). Row 16: Public support percentage from 2013 Schedule A, Part III, line 15.

Section D. Computation of Investment Income Percentage

Table with 3 columns: Line number, Description, Percentage. Row 17: Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f)). Row 18: Investment income percentage from 2013 Schedule A, Part III, line 17.

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

	Yes	No
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	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? <i>If "Yes" to a, b, or c, provide detail in Part VI.</i>	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? <i>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.</i>	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? <i>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.</i>	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)? <i>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).</i>	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? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>	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? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>	3	

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):			
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.			
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.			
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).			
2 Activities Test. Answer (a) and (b) below.		Yes	No
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>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.</i>	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? <i>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.</i>	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? <i>Provide details in Part VI.</i>	3a		
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>	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

OMB No. 1545-0047

2014

▶ 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.

Name of the organization

HARBOR HOSPITAL

Employer identification number

52-0491660

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

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

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or 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 **HARBOR HOSPITAL**

Employer identification number
52-0491660

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	----- ----- -----	\$ 194,527.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	----- ----- -----	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	----- ----- -----	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	----- ----- -----	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	----- ----- -----	\$ 16,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	----- ----- -----	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **HARBOR HOSPITAL**

Employer identification number
52-0491660

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	----- ----- -----	\$ ----- 11,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	----- ----- -----	\$ ----- 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	----- ----- -----	\$ ----- 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10	----- ----- -----	\$ ----- 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11	----- ----- -----	\$ ----- 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12	----- ----- -----	\$ ----- 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **HARBOR HOSPITAL**

Employer identification number
52-0491660

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
13	----- ----- -----	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14	----- ----- -----	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15	----- ----- -----	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16	----- ----- -----	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17	----- ----- -----	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18	----- ----- -----	\$ 426,005.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **HARBOR HOSPITAL**

Employer identification number
52-0491660

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
19	----- ----- -----	\$ 128,573.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
20	----- ----- -----	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
-----	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
-----	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
-----	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
-----	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **HARBOR HOSPITAL**

Employer identification number

52-0491660

Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

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

Name of organization **HARBOR HOSPITAL**

Employer identification number

52-0491660

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)

Supplemental Financial Statements

OMB No. 1545-0047

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.

2014

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Attach to Form 990.

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

Name of the organization

Employer identification number

HARBOR HOSPITAL

52-0491660

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.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 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?, 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?

Part II Conservation Easements.

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

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 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, 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year, 4 Number of states where property subject to conservation easement is located, 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?, 6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year, 7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year, 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?, 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

Table with 2 columns: Revenue, Assets. Rows include: 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. 1b 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.

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

Schedule D (Form 990) 2014

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?

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?
b If "Yes," explain the arrangement in Part XIII and complete the following table:
Table with columns: Amount, 1c Beginning balance, 1d Additions during the year, 1e Distributions during the year, 1f Ending balance
2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?
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.

Table with 6 columns: (a) Current year, (b) Prior year, (c) Two years back, (d) Three years back, (e) Four years back. Rows include: 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:
(i) unrelated organizations
(ii) related organizations
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?
Table with columns: Yes, No. Rows: 3a(i), 3a(ii), 3b.

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.

Table with 5 columns: (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows include: 1a Land, b Buildings, c Leasehold improvements, d Equipment, e Other, Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)

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)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	

Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	

Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶

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

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include line numbers and a final total column.

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.

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include line numbers and a final total column.

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

Series of horizontal dashed lines for providing supplemental information.

Part XIII Supplemental Information (continued)

FIN 48 FOOTNOTE

SCHEDULE D, PART X

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 G
(Form 990 or 990-EZ)**

Department of the Treasury
Internal Revenue Service

Name of the organization

HARBOR HOSPITAL

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a.

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2014

**Open to Public
Inspection**

Employer identification number

52-0491660

Part I

Fundraising Activities. Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

- a Mail solicitations
- b Internet and email solicitations
- c Phone solicitations
- d In-person solicitations
- e Solicitation of non-government grants
- f Solicitation of government grants
- g Special fundraising events

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? Yes No

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col. (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Total						

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

Part II Fundraising Events. Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events
		CAPSTONE EVENT (event type)	(event type)	(total number)	(add col. (a) through col. (c))
Revenue	1	Gross receipts	160,012.		160,012.
	2	Less: Contributions	126,662.		126,662.
	3	Gross income (line 1 minus line 2).	33,350.		33,350.
Direct Expenses	4	Cash prizes			
	5	Noncash prizes			
	6	Rent/facility costs			
	7	Food and beverages			
	8	Entertainment			
	9	Other direct expenses	50,901.		50,901.
	10	Direct expense summary. Add lines 4 through 9 in column (d) ▶			50,901.
11	Net income summary. Subtract line 10 from line 3, column (d) ▶			-17,551.	

Part III Gaming. Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1	Gross revenue			
Direct Expenses	2	Cash prizes			
	3	Noncash prizes			
	4	Rent/facility costs			
	5	Other direct expenses			
	6	Volunteer labor	Yes _____ % No _____ %	Yes _____ % No _____ %	Yes _____ % No _____ %
	7	Direct expense summary. Add lines 2 through 5 in column (d) ▶			
	8	Net gaming income summary. Subtract line 7 from line 1, column (d) ▶			

9 Enter the state(s) in which the organization conducts gaming activities: _____
 a Is the organization licensed to conduct gaming activities in each of these states? Yes No
 b If "No," explain: _____

10 a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? Yes No
 b If "Yes," explain: _____

- 11 Does the organization conduct gaming activities with nonmembers? Yes No
- 12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? Yes No
- 13 Indicate the percentage of gaming activity conducted in:

a The organization's facility	13a	%
b An outside facility	13b	%
- 14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

- 15 a Does the organization have a contract with a third party from whom the organization receives gaming revenue? Yes No
- b If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ _____ and the amount of gaming revenue retained by the third party ▶ \$ _____
- c If "Yes," enter name and address of the third party:

Name ▶ _____

Address ▶ _____

- 16 Gaming manager information:
- Name ▶ _____
- Gaming manager compensation ▶ \$ _____
- Description of services provided ▶ _____
- Director/officer Employee Independent contractor

- 17 Mandatory distributions:
- a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? Yes No
- b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ _____

Part IV Supplemental Information. Provide the explanation required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional information (see instructions).

SCHEDULE H
(Form 990)

Hospitals

OMB No. 1545-0047

2014

Open to Public Inspection

▶ 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.

Department of the Treasury
Internal Revenue Service

Name of the organization

HARBOR HOSPITAL

Employer identification number

52-0491660

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> 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: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> 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)			2,456,400.		2,456,400.	1.25
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			2,456,400.		2,456,400.	1.25
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			1,472,924.	558,997.	913,927.	.47
f Health professions education (from Worksheet 5)			8,421,948.	3,160.	8,418,788.	4.28
g Subsidized health services (from Worksheet 6)			13,812,042.	7,812,046.	5,999,996.	3.05
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			70,484.		70,484.	.04
j Total Other Benefits			23,777,398.	8,374,203.	15,403,195.	7.84
k Total. Add lines 7d and 7j.			26,233,798.	8,374,203.	17,859,595.	9.09

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			6,760.		6,760.	
3 Community support			4,115.		4,115.	
4 Environmental improvements			60,997.		60,997.	.03
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy			31,039.		31,039.	.02
8 Workforce development			6,071.		6,071.	
9 Other			105.		105.	
10 Total			109,087.		109,087.	.05

Part III Bad Debt, Medicare, & Collection Practices

		Yes	No
Section A. Bad Debt Expense			
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.		
			8,884,360.
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		
Section B. Medicare			
5	Enter total revenue received from Medicare (including DSH and IME)		
6	Enter Medicare allowable costs of care relating to payments on line 5		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		
Section C. Collection Practices			
9a	Did the organization have a written debt collection policy during the tax year?	X	
9b	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	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)

1 HARBOR HOSPITAL, INC.
3001 SOUTH HANOVER STREET
BALTIMORE MD 21225

ER/other	ER-24 hours	Research facility	Critical access hospital	Teaching hospital	Children's hospital	General medical & surgical	Licensed hospital	Other (describe)	Facility reporting group
	X			X		X	X		

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 HARBOR HOSPITAL, INC.

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

- 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?
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?
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)?
a A definition of the community served by the hospital facility
b Demographics of the community
c Existing health care facilities and resources within the community that are available to respond to the health needs of the community
d How data was obtained
e The significant health needs of the community
f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
g The process for identifying and prioritizing community health needs and services to meet the community health needs
h The process for consulting with persons representing the community's interests
i 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?
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities?
6b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?
7 Did the hospital facility make its CHNA report widely available to the public?
a Hospital facility's website (list url): HTTP://WWW.MEDSTARHARBOR.ORG/
b Other website (list url):
c 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?
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?
a If "Yes," (list url): HTTP://WWW.MEDSTARHARBOR.ORG/
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?
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)?
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

Table with 3 columns: Question ID, Yes, No. Rows correspond to questions 1 through 12c.

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group HARBOR HOSPITAL, INC.

		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	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> 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? 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):	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>HTTP://WWW.MEDSTARHARBOR.ORG/</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>HTTP://WWW.MEDSTARHARBOR.ORG/</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>HTTP://WWW.MEDSTARHARBOR.ORG</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input type="checkbox"/> 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?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
e	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

Part V Facility Information (continued)

Name of hospital facility or letter of facility reporting group HARBOR HOSPITAL, INC.

		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? If "Yes," check all actions in which the hospital facility or a third party engaged:		X
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Actions that require a legal or judicial process		
d	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a	<input type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b	<input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c	<input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d	<input type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

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

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

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
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Part VI Supplemental 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.

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

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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

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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,

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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 AND GEORGETOWN UNIVERSITY. THE LEAD ALSO WORKS CLOSELY WITH THE WRITER. HE/SHE REVIEWS ALL NARRATIVES PRIOR TO PUBLICATION.

NAME OF HOSPITAL LEAD: LESLIE HUGHAN

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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: JILL JOHNSON

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.

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

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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	NAME OF ORGANIZATION
ANTIGONE VICKERY	DIRECTOR, OFFICE OF ASSESSMENT, PLANNING & RESPONSE	ANNE ARUNDEL COUNTY DEPARTMENT OF HEALTH
ARUNA CHANDRAN, MD, MPH	CHIEF OF EPIDEMIOLOGY	BALTIMORE CITY HEALTH DEPARTMENT
BRENT FLICKINGER	DIRECTOR, OFFICE ASSESSMENT, PLANNING & RESPONSE	BALTIMORE CITY DEPARTMENT OF PLANNING

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JOANNE ROBINSON	CHAIRPERSON	CHERRY HILL COMMUNITY ACTION CENTER
MICHAEL MIDDLETON	CHAIRPERSON	CHERRY HILL COMMUNITY COALITION
CATHY MCCLAIN	EXECUTIVE DIRECTOR	CHERRY HILL TRUST
WILL SEBREE	COMMUNITY OUTREACH ADVOCATE	FAMILY HEALTH CENTERS OF BALTIMORE
TRACEY GARRETT	PRESIDENT	FRIENDSHIP ACADEMY AT CHERRY HILL ELEMENTARY/MIDDLE SCHOOL
KERUNNE		
KETLOGETSWE, MD	CARDIOLOGIST	MEDSTAR HARBOR HOSPITAL

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NED CAREY	CHAIRMAN, BOARD OF DIRECTORS	MARYLAND AVIATION ADMINISTRATION
DAVID HAGER, MD	CHAIRMAN DEPT. OF EMERGENCY MED.	MEDSTAR HARBOR HOSPITAL
LUIS RIVERA- RAMIREZ, MD	ENDOCRINOLOGIST	MEDSTAR HARBOR HOSPITAL
LESLIE HUGHAN	MANAGER, COMMUNITY RELATIONS	MEDSTAR HARBOR HOSPITAL
CALVERT MOORE, DNP, RN, APHN-BC	SCHOOL HEALTH RESOURCE COORDINATOR	MEDSTAR HARBOR HOSPITAL
JILL JOHNSON	VICE PRESIDENT, OPERATIONS	MEDSTAR HARBOR HOSPITAL
ROBERT DART, MD	PRIMARY CARE PHYSICIAN	MEDSTAR HARBOR PRIMARY

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CARE

IMPLEMENTATION STRATEGIES

PART V, SECTION B, LINE 8

THE IMPLEMENTATION STRATEGIES SERVE AS A ROADMAP FOR HOW COMMUNITY 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.

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NEEDS ASSESSMENT

PART VI, LINE 2

IN FY15, MEDSTAR HARBOR 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 SERVICE.

THE HOSPITAL'S CHNA WAS LED BY AN ADVISORY TASK FORCE (ATF) COMPRISED OF A DIVERSE GROUP OF 16 INDIVIDUALS, INCLUDING 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, ATF MEMBERS 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

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ATTENDING A COMMUNITY INPUT SESSION OR COMPLETING IT ONLINE OR VIA
HARDCOPY.

BASED ON THE ATF'S RECOMMENDATION, THE HOSPITAL IDENTIFIED SOUTHERN
BALTIMORE AND NORTHERN ANNE ARUNDEL COUNTY AS ITS COMMUNITY BENEFIT
SERVICE AREA (CBSA) - A 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,
CANCER, DIABETES, AND OBESITY), AND CHILD AND FAMILY WELLNESS.

THE HOSPITAL'S FY15 CHNA AND THREE-YEAR IMPLEMENTATION STRATEGIES WERE
ENDORSED BY MEDSTAR HARBOR'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 HARBOR
ROUTINELY PARTICIPATE IN THE MEDSTAR HEALTH COMMUNITY BENEFIT WORKGROUP.
THE WORKGROUP IS COMPRISED OF COMMUNITY HEALTH PROFESSIONALS WHO

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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.

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. 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

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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.

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.

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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.

* 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 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

Part VI Supplemental Information

Provide the following information.

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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:

* 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,

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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.

* 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.

Part VI Supplemental Information

Provide the following information.

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COMMUNITY INFORMATION

PART VI, LINE 4

GEOGRAPHIC:

MEDSTAR HARBOR HOSPITAL'S CBSA INCLUDES ALL RESIDENTS OF ZIP CODE 21225, THE HOSPITAL'S HOME ZIP CODE. THE CBSA SPANS SOUTHERN BALTIMORE CITY AND NORTHERN ANNE ARUNDEL COUNTY, AND INCLUDES FOUR NEIGHBORHOODS: BROOKLYN, BROOKLYN PARK, CHERRY HILL AND PUMPHREY. IN PARTICULAR, THE HOSPITAL WILL FOCUS ON THE CHERRY HILL COMMUNITY. THIS AREA WAS SELECTED DUE TO ITS VERY HIGH POVERTY RATE AND ITS CLOSE PROXIMITY TO THE HOSPITAL, AS WELL AS THE OPPORTUNITY TO BUILD ON PRE-EXISTING PROGRAMS, SERVICES, AND PARTNERSHIPS.

DEMOGRAPHIC:

CHERRY HILL IS HISTORICALLY A BLACK/AFRICAN AMERICAN NEIGHBORHOOD, WITH ROOTS GOING BACK TO THE 17TH CENTURY. AFTER WORLD WAR II, MORE THAN 600 HOUSING UNITS WERE BUILT THERE BY THE UNITED STATES WAR HOUSING ADMINISTRATION, SPECIFICALLY FOR AFRICAN AMERICAN WAR WORKERS. SHORTLY AFTER THE WAR, THESE UNITS WERE MADE INTO LOW-INCOME HOUSING. ADDITIONAL

Part VI Supplemental Information

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LOW-INCOME HOUSING UNITS HAVE BEEN ADDED THROUGHOUT THE YEARS, MAKING CHERRY HILL ONE OF THE LARGEST HOUSING PROJECTS EAST OF CHICAGO.

THE AMERICAN COMMUNITY SURVEY ESTIMATES THE POPULATION OF ZIP CODE 21225 AT 35,401. THE POPULATION IN CHERRY HILL IS 9,285, AND 95% OF CHERRY HILL RESIDENTS ARE BLACK/AFRICAN AMERICAN, AS COMPARED WITH 63.3% OF BALTIMORE AS A WHOLE. APPROXIMATELY 52% OF CHERRY HILL HOUSEHOLDS WITH CHILDREN WERE HEADED BY A SINGLE PARENT, HIGHER THAN THE CITYWIDE PERCENTAGE OF 26%.

TWENTY-SEVEN PERCENT OF CHERRY HILL RESIDENTS AGES 25 YEARS AND OLDER DO NOT HAVE A HIGH SCHOOL EDUCATION, WHILE LESS THAN 6% OF ADULTS 25 AND OLDER HAVE A BACHELOR'S DEGREE OR HIGHER. THE MEDIAN HOUSEHOLD INCOME FOR CHERRY HILL IN IS \$18,118, WHICH IS LESS THAN HALF OF THE MEDIAN HOUSEHOLD INCOME FOR THE ENTIRE CBSA (\$37,149) , AND APPROXIMATELY 44.5% OF CHERRY HILL FAMILIES LIVE IN POVERTY.

IN TERMS OF HEALTH CARE, THE CHERRY HILL COMMUNITY HOUSES MHH, AS WELL AS

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A LOCAL BRANCH OF THE FAMILY HEALTH CENTERS OF BALTIMORE, WHICH IS A
 FEDERALLY QUALIFIED HEALTH CENTER (FQHC) PROVIDING HEALTH CARE SERVICES
 ON A SLIDING FEE SCALE. IN ADDITION, BALTIMORE CITY HEALTH DEPARTMENT
 PROGRAMS OPERATE CITY-WIDE, AND VARIOUS MOBILE SERVICES-SUCH AS A NEEDLE
 EXCHANGE PROGRAM, VIOLENCE PREVENTION, MATERNAL AND INFANT NURSING, LEAD
 POISONING AND ABATEMENT PROGRAMS AND OTHERS-IN THE CHERRY HILL AREA.

ACCORDING TO THE CHERRY HILL HEALTH PROFILE, THE LIFE EXPECTANCY AT BIRTH
 OF A CHERRY HILL RESIDENT IS 67.8, AS COMPARED TO 71.8 IN BALTIMORE CITY
 AS A WHOLE AND 78.5 IN THE UNITED STATES. HEART DISEASE ACCOUNTS FOR 25%
 OF ALL DEATHS, AND CANCER ACCOUNTS FOR 17%. STROKE, HIV/AIDS AND HOMICIDE
 ARE LESS COMMON BUT, WHEN COMBINED, CAUSE 20%OF DEATHS IN THIS AREA.

HIGH RATES OF TYPE 2 DIABETES AND HEART DISEASE, INCLUDING STROKE, ALSO
 OCCUR IN THIS COMMUNITY. FOR A VARIETY OF REASONS, INCLUDING THE HIGH
 POVERTY RATE AND LOW RATE OF HEALTH CARE INSURANCE COVERAGE, MANY CHERRY
 HILL RESIDENTS OFTEN USE THE MEDSTAR HARBOR HOSPITAL EMERGENCY DEPARTMENT
 FOR PRIMARY CARE SERVICES. A STEADY DECREASE IS ANTICIPATED IN THIS AREA

Part VI Supplemental Information

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OVER THE NEXT FEW FISCAL YEARS AS PATIENTS BECOME INSURED THROUGH THE AFFORDABLE CARE ACT. DESPITE THE CONVENIENT NEIGHBORHOOD LOCATION OF A FQHC, MANY RESIDENTS DO NOT UTILIZE A PRIMARY CARE PHYSICIAN. TYPICALLY, A CHRONIC CONDITION, SUCH AS DIABETES OR HEART DISEASE, PRESENTS SEVERE ENOUGH SYMPTOMS TO WARRANT A TRIP TO THE EMERGENCY DEPARTMENT. IN MANY CASES, SEVERAL CO-MORBIDITIES ARE FOUND TO BE PRESENT AT THIS TIME. WITHOUT PRIMARY CARE FOLLOW-UP, HOWEVER, THESE CONDITIONS USUALLY CANNOT BE ADDRESSED FULLY IN THE TIME ALLOTTED FOR THE EMERGENT ISSUE. IN OTHER CASES, PATIENTS MAY HAVE SYMPTOMS OF A MUCH LESS SERIOUS ILLNESS-A SIMPLE COLD, FOR EXAMPLE-BUT, SINCE THEY DO NOT HAVE A PRIMARY HEALTH CARE PROVIDER, THEY ALSO VISIT THE EMERGENCY DEPARTMENT FOR THESE AILMENTS. AS A RESULT, MANY OF THEIR MOST BASIC HEALTH NEEDS OFTEN ARE NOT MET.

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

AS A COMMUNITY PARTNER, MEDSTAR HARBOR PROVIDED SERVICES TO IMPROVE THE HEALTH AND WELL-BEING OF RESIDENTS IN ONE OF THE MOST UNDERSERVED COMMUNITIES IN BALTIMORE CITY - CHERRY HILL. PRIORITY AREAS OF FOCUS, AS

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DETERMINED BY THE COMMUNITY HEALTH NEEDS ASSESSMENT, ARE CHRONIC DISEASE, SPECIFICALLY TARGETING HEART DISEASE/STROKE, CANCER, DIABETES, AND OBESITY; AND CHILD AND FAMILY WELLNESS. IN EFFORT TO REDUCE THE INCIDENCE, PREVALENCE AND RISK FACTORS CONTRIBUTING TO CHRONIC DISEASES, THE HOSPITAL WILL OFFER A WALKING PROGRAM THAT WILL FOCUS ON INCREASING PHYSICAL ACTIVITY.

MEDSTAR HARBOR WILL ALSO COLLABORATE WITH THE MEDSTAR VISITING NURSES ASSOCIATION TO PROVIDE FREE BLOOD PRESSURE AND DIABETES SCREENINGS IN COMMUNITY SETTINGS. PARTICIPANTS WITH ELEVATED BLOOD PRESSURE AND BLOOD/GLUCOSE LEVELS WILL BE NAVIGATED TO A PRIMARY CARE PROVIDER. MEDSTAR HARBOR WILL ALSO OFFER FREE AND LOW-COST COMMUNITY-BASED HEALTH EDUCATION LECTURES. LECTURES WILL BE ORGANIZED AND TAUGHT BY PHYSICIANS, NURSES, AND SPECIALIZED CONTENT EXPERTS; DISCUSSION TOPICS WILL INCLUDE BUT WILL NOT BE LIMITED TO HEART HEALTH, DIABETES MANAGEMENT, AND CANCER PREVENTION. THE HOSPITAL WILL ALSO WORK TO ESTABLISH A COMMUNITY CANCER CENTER THAT PROVIDES SUPPORT, EDUCATION AND RESOURCES TO PATIENTS AND FAMILY MEMBERS EXPERIENCING CANCER. ADDITIONALLY, CANCER SCREENING AND

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SMOKING CESSATION CLASSES WILL BE OFFERED.

THROUGH ITS CHERRY HILL HEALTHY SCHOOLS HEALTHY FAMILIES PROGRAM, THE HOSPITAL WILL ALSO PROVIDE A NURSE TO WORK CLOSELY WITH AT-RISK MIDDLE AND HIGH SCHOOL STUDENTS AT FOUR SCHOOLS. THE NURSE WILL DEVELOP LESSON PLANS AND TEACH CLASSES THAT TARGET CHILDREN, PARENTS AND SCHOOL STAFF. SHE WILL ALSO MANAGE RELATIONSHIPS WITH COMMUNITY PARTNERS AND SERVE AS A LIAISON BETWEEN THE HOSPITAL AND THE COMMUNITY.

AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR HARBOR 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 HARBOR WITH TECHNICAL SUPPORT TO ENHANCE COMMUNITY HEALTH PROGRAMMING AND EVALUATION. MEDSTAR'S

Part VI Supplemental Information

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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.

STATE FILING OF COMMUNITY BENEFIT REPORT

PART VI, LINE 7

THE COMMUNITY BENEFIT REPORT FOR MEDSTAR HARBOR 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

HARBOR HOSPITAL

Employer identification number

52-0491660

Part I Questions Regarding Compensation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Schedule J (Form 990) 2014

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 DENNIS W PULLJIN PRESIDENT/DIRECTOR	(i) 408,196.	(ii) 362,211.	(iii) 0	7,650.	21,473.	799,530.	0
KENNETH A SAMET	0	0	0	0	0	0	0
2 DIRECTOR	1,526,829.	2,783,911.	14,765.	43,766.	20,658.	4,389,929.	0
LEIGH ANN CURL MD	690,594.	55,522.	0	7,650.	14,998.	768,764.	0
3 DIRECTOR	0	0	0	0	0	0	0
GREGORY GURFINCHEL MD	246,603.	2,500.	21,519.	6,949.	11,659.	289,230.	0
4 DIRECTOR	0	0	0	0	0	0	0
DAVID PITMAN	199,965.	85,353.	0	7,650.	16,447.	309,415.	0
5 VICE PRESIDENT/CFO	0	0	0	0	0	0	0
ALLAN BIRENBERG	256,311.	143,983.	36,587.	4,702.	15,706.	457,289.	0
6 VICE PRESIDENT	0	0	0	0	0	0	0
LENORA ADDISON	207,804.	58,294.	0	46,630.	6,767.	319,495.	0
7 VICE PRESIDENT	0	0	0	0	0	0	0
JOHN CARBONE, M.D.	714,986.	20,894.	0	11,692.	15,072.	762,644.	0
8 PHYSICIAN	0	0	0	0	0	0	0
JAMES WOOD, M.D.	674,100.	2,500.	0	12,778.	12,010.	701,388.	0
9 CHIEF	0	0	0	0	0	0	0
DENNIS STERN, M.D.	391,458.	200,829.	0	16,348.	14,465.	623,100.	0
10 PHYSICIAN	0	0	0	0	0	0	0
CHUKA JENKINS, M.D.	378,267.	196,028.	0	13,289.	14,507.	602,091.	0
11 PHYSICIAN	0	0	0	0	0	0	0
HOWARD POPKIN, M.D.	387,475.	144,230.	0	17,325.	9,900.	558,930.	0
12 PHYSICIAN	0	0	0	0	0	0	0
JILL DONALDSON	209,732.	41,756.	0	12,309.	8,268.	272,065.	0
13 VICE PRESIDENT	0	0	0	0	0	0	0
14							
15							
16							

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.

SOCIAL CLUB DUES

SCHEDULE J, PART I, LINE 1A

THE ORGANIZATION PAID SOCIAL CLUB DUES FOR ONE OF ITS OFFICERS DURING THIS YEAR. PARTICIPATION IN THESE ACTIVITIES BY THE OFFICERS WAS FOR BUSINESS PURPOSES, AND HELPED THE ORGANIZATION FURTHER ITS EXEMPT PURPOSES.

SCHEDULE J, PART I, LINE 4B

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)

Transactions With Interested Persons

OMB No. 1545-0047

2014

Open To Public Inspection

Department of the Treasury
Internal Revenue Service

▶ **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.**

Name of the organization
HARBOR HOSPITAL

Employer identification number
52-0491660

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?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	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	No
(1) HARBORVIEW ANESTHESIA ASSOCIATES	SEE PART V		ANESTHESIA SERVICES		X
(2) MORRISON HEALTHCARE FOOD SERVICES	SEE PART V	2,152,151.	FOOD SERVICES		X
(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 TRANSACTION INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV, COLUMN (B)

DR. ALLAN BIRENBERG, VICE PRESIDENT OF MEDICAL AFFAIRS AT MEDSTAR HARBOR HOSPITAL, OWNS MORE THAN 5% OF HARBORVIEW ANESTHESIA ASSOCIATES (HAA), WHICH PROVIDES SERVICES TO MEDSTAR HARBOR HOSPITAL. HAA'S GROSS REVENUES RECEIVED FROM THE HOSPITAL FOR THE YEAR WAS \$1.7 MILLION. (LY - \$5.5M)

MORRISON HEALTHCARE FOOD SERVICES IS A SUBSTANTIAL CONTRIBUTOR THAT ALSO PROVIDED FOOD SERVICES TO THE HOSPITAL. PER THE CONFLICT OF INTEREST POLICY, ALL TRANSACTIONS BETWEEN THE HOSPITAL AND OUTSIDE VENDORS SHOULD BE AT ARMS-LENGTH FOR FAIR MARKET VALUE.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2014

**Open to Public
Inspection**

Name of the organization

HARBOR HOSPITAL

Employer identification number

52-0491660

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.

DESCRIPTION OF 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 HARBOR HOSPITAL	Employer identification number 52-0491660
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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 11B

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 ENFORCEMENT

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

Name of the organization HARBOR HOSPITAL	Employer identification number 52-0491660
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DETERMINES HOW THE MATTER SHOULD BE RESOLVED.

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

Name of the organization HARBOR HOSPITAL	Employer identification number 52-0491660
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INDEPENDENT FROM ALL OF THE PARTICIPANTS IN THE PROGRAM.

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 HARBOR HOSPITAL	Employer identification number 52-0491660
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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.

OTHER CHANGES IN NET ASSETS

PART XI, LINE 9

EQUITY TRANSFER- NET ASSETS.....\$ (26,046,295)

ATTACHMENT 1

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

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR HARBOR HOSPITAL'S (MEDSTAR HARBOR) MISSION IS TO PROVIDE QUALITY, CARING AND SERVICE FOR OUR PATIENTS AND OUR COMMUNITIES. MEDSTAR HARBOR IS LOCATED JUST SOUTH OF BALTIMORE'S INNER HARBOR, IN BALTIMORE CITY. IT IS AN ACUTE CARE HOSPITAL OFFERING CLINICAL SERVICES IN INTERNAL MEDICINE, SURGERY, CARDIOLOGY, OBSTETRICS AND GYNECOLOGY, ONCOLOGY, ORTHOPAEDICS AND PEDIATRICS. IN FISCAL YEAR 2015, MEDSTAR HARBOR HAD 8,571 INPATIENT ADMISSIONS, AND 175,162 OUTPATIENT VISITS INCLUDING 56,226 EMERGENCY VISITS.

ATTACHMENT 2

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

MEDSTAR HARBOR'S LARGEST PROGRAM IS ACCESS TO AND THE PROVISION OF ACUTE HOSPITAL SERVICES TO THE COMMUNITIES OF SOUTHERN BALTIMORE CITY, SOUTHWESTERN BALTIMORE COUNTY AND NORTHERN ANNE ARUNDEL

Name of the organization HARBOR HOSPITAL	Employer identification number 52-0491660
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ATTACHMENT 2 (CONT'D)

COUNTY, MARYLAND AND THE SURROUNDING AREAS. IN ADDITION TO THE PROGRAM SERVICE EXPENSES LISTED ABOVE, MEDSTAR HARBOR INCURRED \$39.0M OF MANAGEMENT AND GENERAL EXPENSES IN PROVIDING SERVICES TO ITS COMMUNITIES. COLLABORATION WITH THE NATIONAL INSTITUTE ON AGING (ONE OF THE NATIONAL INSTITUTES OF HEALTH) MAKES MEDSTAR HARBOR THE HOME OF THE BALTIMORE LONGITUDINAL STUDY ON AGING, THE NATION'S LONGEST RUNNING STUDY OF AGING AND CONDITIONS AFFECTING THE ELDERLY. PAREXEL, AN INTERNATIONAL CLINICAL RESEARCH ORGANIZATION, HAS ITS PHARMACOLOGY RESEARCH UNIT LOCATED AT MEDSTAR HARBOR. IN 2015, MEDSTAR HARBOR WAS RECOGNIZED WITH THE MARCH OF DIMES MARYLAND - NATIONAL CAPITAL AREA CHAPTER - HEALTHY BABIES ARE WORTH THE WAIT AWARD FOR BEING COMMITTED TO PROVIDING THE BEST CARE FOR MOTHERS AND THEIR BABIES BY REDUCING THE RATE OF PREMATURE BIRTHS AND DECREASING THE NUMBER OF NON-MEDICALLY INDICATED ELECTIVE DELIVERIES AND CESAREAN DELIVERIES. THE AMERICAN HEART ASSOCIATION AWARDED MEDSTAR HARBOR HOSPITAL'S COMMITMENT AND SUCCESS IN IMPLEMENTING A HIGHER STANDARD OF STROKE CARE WITH THE GET WITH THE GUIDELINES-QUALITY ACHIEVEMENT SILVER QUALITY ACHIEVEMENT AWARD. THE HOSPITAL EARNED THE QUALITY EXCELLENCE AWARD FROM THE DELMARVA FOUNDATION FOR AN UNPRECEDENTED NINTH TIME. MEDSTAR HARBOR WAS A GOLD LEVEL RECIPIENT OF THE AMERICAN HEART ASSOCIATION'S FIT-FRIENDLY WORKSITES RECOGNITION PROGRAM. THE HOSPITAL WAS HONORED BY PRACTICE GREENHEALTH WITH THE 2015 "PARTNER FOR CHANGE" AWARD FOR THE FOURTH TIME AND THE "MAKING MEDICINE MERCURY-FREE" AWARD. ADDITIONALLY, THE HOSPITAL

Name of the organization HARBOR HOSPITAL	Employer identification number 52-0491660
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ATTACHMENT 2 (CONT'D)

RECEIVED RECERTIFICATION FOR THE PEDIATRIC ASTHMA CARE PROGRAM
FROM THE JOINT COMMISSION.

ATTACHMENT 3990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
HARBORVIEW ANESTHESIA ASSOC 4419 SOUTH MEADOW COURT ELLICOTT CITY, MD 21042	MEDICAL SERVICES	3,943,014.
MORRISON MANAGEMENT SPECIALIST 4721 MORRISON DRIVE MOBILE, AL 36609	FOOD SERVICES	2,271,059.
CROTHALL SVCS GROUP 13028 COLLECTIONS CENTER DRIVE CHICAGO, IL 60693	MEDICAL SERVICES	1,844,447.
GCHARIB HIGGINS BROWN & RAZA MD PO BOX 79733 BALTIMORE, MD 21279	PHYSICAN SERVICES	537,013.
SLEEP SERVICES OF AMERICA PO BOX 198320 ATLANTA, GA 30384	MEDICAL SERVICES	338,999.

ATTACHMENT 4FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	(A) <u>TOTAL FEES</u>	(B) <u>PROGRAM SERVICE EXP.</u>	(C) <u>MANAGEMENT AND GENERAL</u>	(D) <u>FUNDRAISING EXPENSES</u>
PURCHASED PROFESSIONAL SVCS	9,340,712.	8,926,803.	413,909.	
PROFESSIONAL FEES-OTHER	1,066,101.	1,065,972.	129.	
PHARMACY SERVICES	651,182.	651,182.		
LAB SERVICES	491,314.	487,017.	4,297.	

Name of the organization

HARBOR HOSPITAL

Employer identification number

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ATTACHMENT 4 (CONT'D)FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	(A) <u>TOTAL FEES</u>	(B) <u>PROGRAM SERVICE EXP.</u>	(C) <u>MANAGEMENT AND GENERAL</u>	(D) <u>FUNDRAISING EXPENSES</u>
BLOOD BANK FEES	590,464.	590,464.		
BILLING SERVICE EXPENSE	1,579,074.	1,578,833.	241.	
RECOVERY-VARIABLE PURCH SRVS	417,830.	418,685.	-855.	
MISC PURCHASED SERVICES	355,876.	354,376.	1,500.	
PHYSICAN SERVICES FIXED	4,849,625.	4,849,625.		
OFFICE SERVICES	164,678.	164,621.	57.	
TRANSCRIPTION-FIXED	156,676.	156,676.		
MISC FIXED PURCH SRVCS	304,236.	259,285.	44,951.	
CONSULTING FEES	107,096.		107,096.	
OTHER MISCELLANEOUS SVCS	190,224.	145,479.	44,745.	
TOTALS	<u>20,265,088.</u>	<u>19,649,018.</u>	<u>616,070.</u>	

**SCHEDULE R
(Form 990)**

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.

Department of the Treasury
Internal Revenue Service

Name of the organization

HARBOR HOSPITAL

Employer identification number

52-0491660

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 C LLC 20-5909818 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225	HEALTH SVCS	MD	3,770,996.	319,523.	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	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) MEDSTAR HEALTH, INC. 52-2087445 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SVCS	MD	501 (C) (3)	11C III	N/A		X
(4) MONTGOMERY GENERAL HOSPITAL 52-0646893 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	HOSPITAL	MD	501 (C) (3)	3	N/A		X
(5) THE GOOD SAMARITAN HOSPITAL OF MARYLAND, 52-0591607 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	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

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

Schedule R (Form 990) 2014

**SCHEDULE R
(Form 990)**

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.

Department of the Treasury
Internal Revenue Service

Name of the organization

HARBOR HOSPITAL

Employer identification number

52-0491660

Open to Public
Inspection

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

(1)	(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.

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	THE MEDSTAR-GEORGETOWN MEDICAL CENTER, I HOSPITAL ADMIN, 1 MAIN BLDG WASHINGTON, DC 20007 52-2218584	HOSPITAL	DC	501(C)(3)	3	N/A	X	
(2)	WASHINGTON HOSPITAL CENTER CORPORATION 110 IRVING STREET NW WASHINGTON, DC 20010 52-1272129	HOSPITAL	DC	501(C)(3)	3	N/A	X	
(3)	HH MEDSTAR HEALTH, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 52-1542230	MEDICAL SVCS	MD	501(C)(3)	11C III	N/A	X	
(4)	MEDSTAR AMBULATORY SERVICES INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 52-1132992	ADMIN SVCS	MD	501(C)(3)	11B II	N/A	X	
(5)	BAY LIFE SERVICES, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 52-1496539	MENTAL HEALTH	MD	501(C)(3)	9	N/A	X	
(6)	MEDSTAR SURGERY CENTER, INC. 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1061679	MEDICAL SVCS	MD	501(C)(3)	9	N/A	X	
(7)	CHURCH HOME AND HOSPITAL OF THE CITY OF 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 52-0591600	MEDICAL FUND	MD	501(C)(3)	11B II	N/A	X	

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

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

HARBOR HOSPITAL

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.

Open to Public
Inspection

Name of the organization

HARBOR HOSPITAL

Employer identification number

52-0491660

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

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

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service
Name of the organization
HARBOR HOSPITAL

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
Employer identification number
52-0491660

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

(1)	(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.

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	MEDSTAR HEALTH VISITING NURSES ASSOCIATI 4061 POWDERMILL ROAD CALVERTON, MD 20705 53-0196597	MEDICAL SVCS	MD	501 (C) (3)	9	N/A	X	
(2)	MEDSTAR VNA HEALTHCARE 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1458516	MEDICAL SVCS	MD	501 (C) (3)	9	N/A	X	
(3)	MGH COMMUNITY HEALTH, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1372467	MEDICAL SVCS	MD	501 (C) (3)	9	N/A	X	
(4)	MGH HEALTH FOUNDATION, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1129959	FOUNDATION	MD	501 (C) (3)	7	N/A	X	
(5)	MGH HEALTH SERVICES, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1366812	FOUNDATION	MD	501 (C) (3)	11B II	N/A	X	
(6)	MGH WOMEN'S BOARD 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-6039600	FOUNDATION	MD	501 (C) (3)	11B II	N/A	X	
(7)	NATIONAL REHABILITATION HOSPITAL 102 IRVING STREET NW WASHINGTON, DC 20010 52-1369749	HOSPITAL	DC	501 (C) (3)	3	N/A	X	

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

Schedule R (Form 990) 2014

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

HARBOR HOSPITAL

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.

Open to Public Inspection

Employer identification number

52-0491660

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

(1)	(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.

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	REGIONAL REHAB AT OLNEY, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-2310902	MEDICAL SVCS	MD	501 (C) (3)	3	N/A	X	
(2)	SUBURBAN / NRH MEDICAL REHABILITATION, I 102 IRVING STREET NW WASHINGTON, DC 20010 52-1931151	MEDICAL SVCS	DC	501 (C) (3)	3	N/A	X	
(3)	THE THOMAS O'NEIL CATHOLIC HEALTH CARE F 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	FOUNDATION	MD	501 (C) (3)	11D III	N/A	X	
(4)	VNA, INC. 4061 FOWERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1332411	ADMIN SVCS	MD	501 (C) (3)	11B II	N/A	X	
(5)	WFC FOUNDATION, INC. 110 IRVING STREET NW WASHINGTON, DC 20010 52-1791670	FOUNDATION	DC	501 (C) (3)	7	N/A	X	
(6)	WOODBORNE WOODS, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ELDER HOUSING	MD	501 (C) (3)	9	N/A	X	
(7)	HOSPICE OF ST. MARY'S, INC. PO BOX 527 LEONARDTOWN, MD 20650 52-2153926	SUPPORT ORG	MD	501 (C) (3)	11A I	N/A	X	

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

**SCHEDULE R
(Form 990)**

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.

Department of the Treasury
Internal Revenue Service

Name of the organization

HARBOR HOSPITAL

Employer identification number

52-0491660

Open to Public
Inspection

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

(1)	(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.

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	ST. MARY'S HOSPITAL OF ST. MARY'S COUNTY 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650 52-0619006	HOSPITAL	MD	501(C)(3)	3	N/A		X
(2)	ST. MARY'S HOSPITAL FOUNDATION, INC. PO BOX 527 LEONARDTOWN, MD 20650 52-1051368	SUPPORT ORG	MD	501(C)(3)	11A I	N/A		X
(3)	MEDSTAR SOUTHERN MD HOSPITAL CENTER 7503 SURREATTS ROAD CLINTON, MD 20735 46-0726303	HOSPITAL	MD	501(C)(3)	3	N/A		X
(4)	MEDSTAR HEALTH INC AND AFFILIATES 5565 STERRETT PLACE COLUMBIA, MD 21044 47-7454613	RET. TRUST	MD	501(A)	N/A	N/A		X
(5)								
(6)								
(7)								

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) PHYSICIAN IMAGING OF WASHINGTON 6525 BELCREST ROAD, SUITE G 50	LAB SERVICES	MD	N/A					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	No
(1) MEDSTAR PHARMACIES, INC. 52-1513056 5665 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	DRUG SALES	MD	N/A	C CORP					
(2) EXTENCARE, INC. 52-1556228 5665 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SERVI	MD	N/A	C CORP					
(3) HELIX RESOURCES MANAGEMENT, INC. 52-1913070 5665 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	ADMIN SERVICE	MD	N/A	C CORP					
(4) HELIXCARE MEDICAL GROUP, LLC 52-1955580 5665 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SERVI	MD	N/A	C CORP					
(5) HELIXCARE PROPERTIES, LLC 52-1966695 5665 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SERVI	MD	N/A	C CORP					
(6) PARKWAY VENTURES, INC. 52-1893569 5665 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	HOLDING COMPA	MD	N/A	C CORP					
(7) PHYSICIANS ADMINISTRATIVE SERVICES, INC. 23-7042074 5665 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?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(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 No
(1) MEDSTAR FAMILY CHOICE, INC. 5565 STERRETT PLACE, 5TH FLOOR, COLUMBIA, MD 21044 52-1995521	MANAGED CARE	MD	N/A	C CORP				
(2) MEDSTAR ENTERPRISES, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 52-2139841	ADMIN SERVICE	MD	N/A	C CORP				
(3) SITEL, INC. 5565 STERRETT PLACE, 5TH FLOOR, COLUMBIA, MD 21044 90-0753340	EDUCATIONAL S	MD	N/A	C CORP				
(4) STAR BILLING, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 52-1850113	BILLING SERVI	MD	N/A	C CORP				
(5) WASHINGTON RISK NETWORK MANAGEMENT, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 52-2132677	MEDICAL SERVI	MD	N/A	C CORP				
(6) WASHINGTON HOSPITAL CENTER PHYSICIAN HOS 100 IRVING STREET NW WASHINGTON, DC 20010 52-1931000	MEDICAL SERVI	MD	N/A	C CORP				
(7) MEDSTAR PHYSICIAN PARTNERS, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 52-2030809	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.

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
								Yes	No		Yes	No	
(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.

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
									Yes	No
(1)	FRANKLIN SQUARE DRIVE LAND CONDO ASSOCIA 5565 STERRETT PLACE, 5TH FLOOR, COLUMBIA, MD 21044	CONDO OWNER A	MD	N/A	C CORP					
(2)	MGH DIVERSIFIED SERVICES, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SERVI	MD	N/A	C CORP					
(3)	ST. MARY'S HEALTH ALLIANCE, INC. 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650	MEDICAL SERVI	MD	N/A	C CORP					
(4)	GREENSPRING FINANCIAL INSURANCE LIMITED 23 LIME TREE BAY AVENUE PO BOX 1051 KY1-1002, GRAND CAYMA	INSURANCE	CJ	N/A	C CORP					
(5)	ST. MARY'S CONDO ASSOCIATION 25500 POINT LOOKOUT RD LEONARDTOWN, MD 20650	CONDOMINIUMS	MD	N/A	C CORP					
(6)	MEDSTAR HEALTH MASTER RETIREMENT TRUST 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.	X	
b Gift, grant, or capital contribution to related organization(s).	X	
c Gift, grant, or capital contribution from related organization(s).	X	
d Loans or loan guarantees to or for related organization(s).	X	
e Loans or loan guarantees by related organization(s).	X	
f Dividends from related organization(s).	X	
g Sale of assets to related organization(s).	X	
h Purchase of assets from related organization(s).	X	
i Exchange of assets with related organization(s).	X	
j Lease of facilities, equipment, or other assets to related organization(s).	X	
k Lease of facilities, equipment, or other assets from related organization(s).	X	
l Performance of services or membership or fundraising solicitations for related organization(s).	X	
m Performance of services or membership or fundraising solicitations by related organization(s).	X	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s).	X	
o Sharing of paid employees with related organization(s).	X	
p Reimbursement paid to related organization(s) for expenses.	X	
q Reimbursement paid by related organization(s) for expenses.	X	
r Other transfer of cash or property to related organization(s).	X	
s Other transfer of cash or property from related organization(s).	X	
2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.		

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) THE MEDSTAR-GEORGETOWN MEDICAL CENTER	P	62,301.	FMV
(2) HH MEDSTAR HEALTH, INC.	P	642,564.	FMV
(3) THE UNION MEMORIAL HOSPITAL	P	1,069,149.	FMV
(4) HH MEDSTAR HEALTH, INC.	Q	857,799.	FMV
(5) WASHINGTON HOSPITAL CENTER CORPORATION	Q	430,307.	FMV
(6) HARBOR HOSPITAL FOUNDATION, INC.	S	77,610.	FMV

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?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(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).

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

For calendar year 2014, or fiscal year beginning 07/01, 2014, and ending 06/30, 2015

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

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

2014

Department of the Treasury
Internal Revenue Service

Name of exempt organization

HARBOR HOSPITAL

Employer identification number

52-0491660

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 ▶	<input checked="" type="checkbox"/>	b	Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	<u>207419750.</u>
2a	Form 990-EZ check here ▶	<input type="checkbox"/>	b	Total revenue, if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here ▶	<input type="checkbox"/>	b	Total tax (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here ▶	<input type="checkbox"/>	b	Tax based on investment income (Form 990-PF, Part VI, line 5).	4b	
5a	Form 8868 check here ▶	<input type="checkbox"/>	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

I authorize KPMG LLP to enter my PIN

2	1	2	2	5
---	---	---	---	---

 as my signature

ERO firm name 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 ▶

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**

For Paperwork Reduction Act Notice, see back of form.

Cumulative e-File History 2014

Federal

Locator:	05468X
Taxpayer Name:	Harbor Hospital
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	05/11/2016 18:41:43
Acknowledgement Date:	05/11/2016 18:56:22
Status:	Accepted
Submission ID:	54028020161325000013