

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2013

Open to Public Inspection

Form **990**

Department of the Treasury
Internal Revenue Service

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

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

A For the 2013 calendar year, or tax year beginning 07/01, 2013, and ending 06/30, 2014

| | | |
|--|--|--|
| B Check if applicable: | C Name of organization THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC. Doing Business As MEDSTAR GOOD SAMARITAN HOSPITAL Number and street (or P.O. box if mail is not delivered to street address) Room/suite 5601 LOCH RAVEN BLVD. City or town, state or province, country, and ZIP or foreign postal code BALTIMORE, MD 21239 | D Employer identification number 52-0591607 E Telephone number (410) 772-6721 |
| <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 | F Name and address of principal officer: JEFFREY MATTON 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 | G Gross receipts \$ 318,385,443. H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) H(c) Group exemption number ▶ |
| I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527 | | |
| J Website: ▶ WWW.GOODSAM-MD.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: 1920 | | M State of legal domicile: MD |

Part I Summary

| | | | |
|-----------------------------|---|--------------|--------------|
| | 1 Briefly describe the organization's mission or most significant activities: <u>WE ARE GOOD SAMARITANS, GUIDED BY CATHOLIC TRADITION AND TRUSTED TO DELIVER IDEAL HEALTH EXPERIENCES.</u> | | |
| | 2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets. | | |
| Activities & Governance | 3 Number of voting members of the governing body (Part VI, line 1a) | 3 | 23. |
| | 4 Number of independent voting members of the governing body (Part VI, line 1b) | 4 | 15. |
| | 5 Total number of individuals employed in calendar year 2013 (Part V, line 2a) | 5 | 2,658. |
| | 6 Total number of volunteers (estimate if necessary) | 6 | 140. |
| | 7a Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 168,172. |
| | b Net unrelated business taxable income from Form 990-T, line 34 | 7b | 0 |
| | | | 7b |
| Revenue | 8 Contributions and grants (Part VIII, line 1h) | 419,802. | 493,970. |
| | 9 Program service revenue (Part VIII, line 2g) | 296,320,895. | 309,961,225. |
| | 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) | 3,004,907. | 4,442,981. |
| | 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 10,905,676. | 3,487,267. |
| | 12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 310,651,280. | 318,385,443. |
| 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) | 159,989,920. | 152,920,843. |
| | 16a Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| | b Total fundraising expenses (Part IX, column (D), line 25) | 0 | 0 |
| | 17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) | 154,257,025. | 156,017,497. |
| | 18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) | 314,246,945. | 308,938,340. |
| | 19 Revenue less expenses. Subtract line 18 from line 12 | -3,595,665. | 9,447,103. |
| Net Assets or Fund Balances | 20 Total assets (Part X, line 16) | 172,368,181. | 189,638,382. |
| | 21 Total liabilities (Part X, line 26) | 50,472,722. | 47,522,422. |
| | 22 Net assets or fund balances. Subtract line 21 from line 20. | 121,895,459. | 142,115,960. |

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: Type or print name and title: <u>Joel Bryan VP, Treasurer</u> | Date: <u>5/11/15</u> |
|------------------|--|----------------------|

| | | | | |
|-------------------------------|---|---------------------------------------|---|--|
| Paid Preparer Use Only | Print/Type preparer's name: MARGARET A BRADSHAW Firm's name: ▶ KPMG LLP Firm's address: ▶ 1676 INTERNATIONAL DRIVE MCLEAN, VA 22102 | Preparer's signature: Date: 5/6/15 | Check <input type="checkbox"/> If self-employed | PTIN: P00501222 Firm's EIN: ▶ 13-5565207 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 (2013)

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.

Enter filer's identifying number, see instructions

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

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

| 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 02/16, 2015, 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, 2013, and ending 06/30, 2014.

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

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

| 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 _____ 05/15, 20 15 .

5 For calendar year _____, or other tax year beginning _____ 07/01, 20 13, and ending _____ 06/30, 20 14 .

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. Bracklow Title PAID PREPARER Date 2/09/15

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 [X] 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 [X] 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 \$ 224,546,141. including grants of \$ 0) (Revenue \$ 286,468,353.)

ATTACHMENT 2

4b (Code:) (Expenses \$ 29,122,684. including grants of \$ 0) (Revenue \$ 23,492,872.)

MEDSTAR GOOD SAMARITAN HOSPITAL PROVIDED \$29.1M IN SUBSIDIZED (MISSION DRIVEN) HEALTH SERVICES IN FISCAL 2014. 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 WOMEN'S HEALTH SERVICES, HOSPITALISTS, PSYCHIATRY, UROLOGY, EMERGENCY DEPARTMENT COVERAGE, OUTPATIENT RENAL CARE, AND CERTAIN SUB-ACUTE PROGRAM SUBSIDIES.

4c (Code:) (Expenses \$ 8,172,088. including grants of \$ 0) (Revenue \$ 0)

MEDSTAR GOOD SAMARITAN HOSPITAL PROVIDED \$8.2M IN HEALTH PROFESSIONS EDUCATION IN FISCAL YEAR 2014. 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 261,840,913.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

| | | Yes | No |
|------|---|-----|----|
| 21 | Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or 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 individuals in the United States 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 | |
| 24 a | 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? | | |
| 25 a | Section 501(c)(3) and 501(c)(4) 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 payable to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If so, complete Schedule L, Part II. | | 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 | |
| 35 a | 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 number, description, and Yes/No checkboxes. Includes questions 1a through 14b regarding IRS filings and tax compliance.

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

Section A. Governing Body and Management

Table with columns for question number, question text, and Yes/No checkboxes. Includes questions 1a-9 regarding governing body members, relationships, and documentation.

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

Table with columns for question number, question text, and Yes/No checkboxes. Includes questions 10a-16b regarding local chapters, policies, conflict of interest, whistleblower, and joint ventures.

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.
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, physical address, and telephone number of the person who possesses the books and records of the organization: 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) DANIEL P CAHILL BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (2) MOIRA P LARSEN BOARD MEMBER | 1.00 | X | | | | | 45,136. | 0 | 226. | |
| (3) JEFFREY A MATTON PRESIDENT/BOARD MEMBER | 40.00 | X | | X | | | 710,465. | 0 | 32,396. | |
| (4) KENNETH A SAMET BOARD MEMBER | 1.00 39.00 | X | | | | | 0 | 3,334,799. | 61,007. | |
| (5) WILMOT C BALL JR MD BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (6) LUIS GIMENEZ MD BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (7) DAVIS M HAHN MD BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (8) JEREMY P WEINER MD BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (9) ANTHONY READ BOARD CHAIR | 1.00 | X | | | | | 0 | 0 | 0 | |
| (10) CHARLES L BAUERMANN BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (11) KAY G BEE BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (12) JEFFREY R DONNELLY BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (13) SONYA H GRAY BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (14) REV DENIS J MADDEN BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |

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

| (A) Name and title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|--|---|-----------------------|---------|--------------|------------------------------|------------|--|---|---|
| | | Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (15) DR ALLAN NOONAN BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (16) T EDGIE RUSSELL BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (17) REV PM SMITH BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (18) JOHN C SMYTH BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (19) KATHLEEN J WHITING BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (20) ELIAS SHAYA MEDICAL DIRECTOR | 40.00 | X | | | | | 352,055. | 0 | 8,858. | |
| (21) DAVID WEISMAN PRESIDENT/BOARD MEMBER | 40.00 | X | | | | | 183,918. | 0 | 21,572. | |
| (22) CHRISTOPHER T HELMRATH BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (23) REV LAWRENCE M JOHNSON BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (24) MSGR. ADAM J PARKER BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (25) THOMAS L. OWSLEY BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| 1b Sub-total | | | | | | | 755,601. | 3,334,799. | 93,629. | |
| c Total from continuation sheets to Part VII, Section A | | | | | | | 5,174,852. | 0 | 253,080. | |
| d Total (add lines 1b and 1c) | | | | | | | 5,930,453. | 3,334,799. | 346,709. | |

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 **119**

| | 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 **18**

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

| (A) Name and title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|--|---|-----------------------|---------|--------------|------------------------------|----------|--|---|---|
| | | Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (26) CAROL J. PACIONE BOARD MEMBER | 1.00 | X | | | | | 0 | 0 | 0 | |
| (27) THOMAS SENKER VICE PRESIDENT | 40.00 | | | X | | | 210,934. | 0 | 21,236. | |
| (28) MARTIN BINSTOCK VICE PRESIDENT | 40.00 | | | X | | | 469,821. | 0 | 29,898. | |
| (29) DEANA STOUT VICE PRESIDENT | 40.00 | | | X | | | 291,184. | 0 | 35,908. | |
| (30) SHIRLEY ROTH CHIEF NURSING OFFICER | 40.00 | | | | X | | 214,901. | 0 | 21,043. | |
| (31) MICHAEL JACOBS PHYSICIAN | 40.00 | | | | | X | 796,776. | 0 | 23,522. | |
| (32) DAVID COLL PHYSICIAN | 40.00 | | | | | X | 559,963. | 0 | 21,795. | |
| (33) ROBERT BRESLIN PHYSICIAN | 40.00 | | | | | X | 542,907. | 0 | 18,832. | |
| (34) DALE BUCHBINDER CHIEF | 40.00 | | | | | X | 679,876. | 0 | 19,236. | |
| (35) KAPIL SIMLOTE PHYSICIAN | 40.00 | | | | | X | 516,261. | 0 | 14,262. | |
| (36) JENNIFER WILKERSON FORMER OFFICER | 0 | | | | | X | 162,722. | 0 | 16,918. | |
| 1b Sub-total | | | | | | | | | | |
| c Total from continuation sheets to Part VII, Section A | | | | | | | | | | |
| d Total (add lines 1b and 1c) | | | | | | | | | | |

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 119

| | 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 |
|----------------------------------|--------------------------------|---------------------|
| | | |
| | | |
| | | |
| | | |

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

Part 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 | | | |
| (37) LAWRENCE BECK FORMER OFFICER | 0 | | | | | | X | 193,534. | 0 | 0 |
| | | | | | | | | | | |
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| | | | | | | | | | | |
| 1b Sub-total | | | | | | | | | | |
| c Total from continuation sheets to Part VII, Section A | | | | | | | | | | |
| d Total (add lines 1b and 1c) | | | | | | | | | | |

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 119

| | 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 |
|----------------------------------|--------------------------------|---------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

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

Part VIII Statement of Revenue

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

| | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512-514 | |
|---|---|---|--------------------------------|--|---|--|--|
| Contributions, Gifts, Grants and Other Similar Amounts | 1a | Federated campaigns | 1a | | | | |
| | b | Membership dues | 1b | | | | |
| | c | Fundraising events | 1c | | | | |
| | d | Related organizations | 1d | | | | |
| | e | Government grants (contributions) | 1e | 51,384. | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above | 1f | 442,586. | | | |
| | g | Noncash contributions included in lines 1a-1f: \$ | | | | | |
| | h | Total. Add lines 1a-1f | | 493,970. | | | |
| Program Service Revenue | 2a | NET PATIENT SERVICE REVENUE | Business Code 621400 | 299,577,409. | 299,577,409. | | |
| | b | PHARMACY REVENUE | 900099 | 6,280,688. | 6,280,688. | | |
| | c | MEANINGFUL USE INCOME | 900099 | 4,103,128. | 4,103,128. | | |
| | d | | | | | | |
| | e | | | | | | |
| | f | All other program service revenue | | | | | |
| | g | Total. Add lines 2a-2f | | 309,961,225. | | | |
| Other Revenue | 3 | Investment income (including dividends, interest, and other similar amounts) | | 1,215,791. | | 1,215,791. | |
| | 4 | Income from investment of tax-exempt bond proceeds | | 0 | | | |
| | 5 | Royalties | | 0 | | | |
| | 6a | Gross rents | (i) Real | 403,062. | | | |
| | | | (ii) Personal | | | | |
| | | | | | | | |
| | b | Less: rental expenses | | | | | |
| | c | Rental income or (loss) | | 403,062. | | | |
| | d | Net rental income or (loss) | | 403,062. | | 403,062. | |
| | 7a | Gross amount from sales of assets other than inventory | (i) Securities | 3,267,255. | | | |
| | | | (ii) Other | | -40,065. | | |
| | | | | | | | |
| | | | | | | | |
| | b | Less: cost or other basis and sales expenses | | | | | |
| | c | Gain or (loss) | | 3,267,255. | -40,065. | | |
| d | Net gain or (loss) | | 3,227,190. | | 3,227,190. | | |
| 8a | Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 | a | | | | | |
| b | Less: direct expenses | b | | | | | |
| c | Net income or (loss) from fundraising events | | | 0 | | | |
| 9a | Gross income from gaming activities. See Part IV, line 19 | a | | | | | |
| b | Less: direct expenses | b | | | | | |
| c | Net income or (loss) from gaming activities | | | 0 | | | |
| 10a | Gross sales of inventory, less returns and allowances | a | | | | | |
| b | Less: cost of goods sold | b | | | | | |
| c | Net income or (loss) from sales of inventory | | | 0 | | | |
| Miscellaneous Revenue | | | Business Code | | | | |
| 11a | CHILD DAY CARE | | 900099 | 798,810. | | 798,810. | |
| b | REBATE INCOME | | 900099 | 352,635. | | 352,635. | |
| c | MEALS ON WHEELS | | 900099 | 95,119. | | 95,119. | |
| d | All other revenue | | 900099 | 1,837,641. | 168,172. | 1,669,469. | |
| e | Total. Add lines 11a-11d | | | 3,084,205. | | | |
| 12 | Total revenue. See instructions | | | 318,385,443. | 309,961,225. | 168,172. | |
| | | | | | | 7,762,076. | |

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

| <i>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</i> | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|---|-----------------------|---------------------------------|--|-----------------------------|
| 1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21 | 0 | | | |
| 2 Grants and other assistance to individuals in the United States. See Part IV, line 22 | 0 | | | |
| 3 Grants and other assistance to governments, organizations, and individuals outside the United States. 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 | 2,241,668. | 2,016,625. | 225,043. | |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 0 | | | |
| 7 Other salaries and wages | 122,562,745. | 110,709,066. | 11,853,679. | |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 2,913,490. | 2,622,141. | 291,349. | |
| 9 Other employee benefits | 16,211,480. | 13,843,113. | 2,368,367. | |
| 10 Payroll taxes | 8,991,460. | 7,916,019. | 1,075,441. | |
| 11 Fees for services (non-employees): | | | | |
| a Management | 23,683,547. | 11,117,687. | 12,565,860. | |
| b Legal | 7,000. | | 7,000. | |
| 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 | 43,607,496. | 44,705,280. | -1,097,784. | |
| 12 Advertising and promotion | 783,479. | 33,099. | 750,380. | |
| 13 Office expenses | 1,721,822. | 1,276,695. | 445,127. | |
| 14 Information technology | 0 | | | |
| 15 Royalties | 0 | | | |
| 16 Occupancy | 2,127,181. | 803,476. | 1,323,705. | |
| 17 Travel | 503,509. | 324,584. | 178,925. | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | 0 | | | |
| 19 Conferences, conventions, and meetings | 19,951. | 16,140. | 3,811. | |
| 20 Interest | 2,696,085. | | 2,696,085. | |
| 21 Payments to affiliates | 0 | | | |
| 22 Depreciation, depletion, and amortization | 13,500,822. | 5,492,315. | 8,008,507. | |
| 23 Insurance | 4,467,928. | 59,589. | 4,408,339. | |
| 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>MED /SURG SUPPLIES</u> | 35,863,344. | 35,834,781. | 28,563. | |
| b <u>MAINTENANCE</u> | 17,889,921. | 16,306,517. | 1,583,404. | |
| c <u>UTILITIES</u> | 4,861,425. | 4,605,574. | 255,851. | |
| d <u>FOOD SERVICES/SUPPLIES</u> | 4,115,615. | 3,989,951. | 125,664. | |
| e All other expenses | 168,372. | 168,261. | 111. | |
| 25 Total functional expenses. Add lines 1 through 24e | 308,938,340. | 261,840,913. | 47,097,427. | |
| 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 | 3,900. | 1 | 3,998. |
| | 2 Savings and temporary cash investments | 0 | 2 | 0 |
| | 3 Pledges and grants receivable, net | 0 | 3 | 0 |
| | 4 Accounts receivable, net | 36,913,542. | 4 | 42,364,355. |
| | 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 | 2,856,912. | 8 | 2,755,453. |
| | 9 Prepaid expenses and deferred charges | 574,030. | 9 | 1,244,286. |
| | 10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a 238,501,896. | | |
| | b Less: accumulated depreciation | 10b 161,492,166. | 76,145,735. | 10c 77,009,730. |
| | 11 Investments - publicly traded securities | 0 | 11 | 0 |
| | 12 Investments - other securities. See Part IV, line 11 | 216,703. | 12 | 480,332. |
| | 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 | 55,657,359. | 15 | 65,780,228. |
| 16 Total assets. Add lines 1 through 15 (must equal line 34) | 172,368,181. | 16 | 189,638,382. | |
| Liabilities | 17 Accounts payable and accrued expenses | 29,039,397. | 17 | 25,416,341. |
| | 18 Grants payable | 0 | 18 | 0 |
| | 19 Deferred revenue | 70,623. | 19 | 115,467. |
| | 20 Tax-exempt bond liabilities | 0 | 20 | 0 |
| | 21 Escrow or custodial account liability. Complete Part IV of Schedule D | 0 | 21 | 0 |
| | 22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L | 0 | 22 | 0 |
| | 23 Secured mortgages and notes payable to unrelated third parties | 0 | 23 | 0 |
| | 24 Unsecured notes and loans payable to unrelated third parties | 0 | 24 | 0 |
| | 25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D | 21,362,702. | 25 | 21,990,614. |
| | 26 Total liabilities. Add lines 17 through 25 | 50,472,722. | 26 | 47,522,422. |
| 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 | 66,926,520. | 27 | 76,740,419. |
| | 28 Temporarily restricted net assets | 54,968,939. | 28 | 65,375,541. |
| | 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 | 121,895,459. | 33 | 142,115,960. | |
| 34 Total liabilities and net assets/fund balances | 172,368,181. | 34 | 189,638,382. | |

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 | 318,385,443. |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 308,938,340. |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 9,447,103. |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 121,895,459. |
| 5 | Net unrealized gains (losses) on investments | 5 | 7,046,913. |
| 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 | 3,726,485. |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 142,115,960. |

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 | 2a | X |
| b Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | 2b | X |
| c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O. | 2c | X |
| 3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? | 3a | X |
| b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits. | 3b | |

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047

2013

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

▶ Attach to Form 990 or Form 990-EZ.

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

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

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

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

- 1 A church, convention of churches, or association of churches described in section 170(b)(1)(A)(i).
- 2 A school described in section 170(b)(1)(A)(ii). (Attach Schedule E.)
- 3 A hospital or a cooperative hospital service organization described in section 170(b)(1)(A)(iii).
- 4 A medical research organization operated in conjunction with a hospital described in section 170(b)(1)(A)(iii). Enter the hospital's name, city, and state: _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in section 170(b)(1)(A)(iv). (Complete Part II.)
- 6 A federal, state, or local government or governmental unit described in section 170(b)(1)(A)(v).
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in section 170(b)(1)(A)(vi). (Complete Part II.)
- 8 A community trust described in section 170(b)(1)(A)(vi). (Complete Part II.)
- 9 An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See section 509(a)(2). (Complete Part III.)
- 10 An organization organized and operated exclusively to test for public safety. See section 509(a)(4).
- 11 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See section 509(a)(3). Check the box that describes the type of supporting organization and complete lines 11e through 11h.
 - a Type I b Type II c Type III-Functionally integrated d Type III-Non-functionally integrated
- e By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).
- f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box
- g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

- (i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization? _____
- (ii) A family member of a person described in (i) above? _____
- (iii) A 35% controlled entity of a person described in (i) or (ii) above? _____

| | Yes | No |
|----------|-----|----|
| 11g(i) | | |
| 11g(ii) | | |
| 11g(iii) | | |

h 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 in col. (i) listed in your governing document? | | (v) Did you notify the organization in col. (i) of your support? | | (vi) Is the organization in col. (i) organized in the U.S.? | | (vii) Amount of monetary support |
|------------------------------------|----------|---|---|----|--|----|---|----|----------------------------------|
| | | | Yes | No | Yes | No | 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) 2013

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: (a) 2009, (b) 2010, (c) 2011, (d) 2012, (e) 2013, (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: (a) 2009, (b) 2010, (c) 2011, (d) 2012, (e) 2013, (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; 11 Total support; 12 Gross receipts from related activities; 13 First five years. Includes checkboxes for 501(c)(3) organization.

Section C. Computation of Public Support Percentage

Table with 2 columns: Description, Percentage. Rows include: 14 Public support percentage for 2013; 15 Public support percentage from 2012 Schedule A; 16a 33 1/3% support test - 2013; 16b 33 1/3% support test - 2012; 17a 10%-facts-and-circumstances test - 2013; 17b 10%-facts-and-circumstances test - 2012; 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

| Calendar year (or fiscal year beginning in) ▶ | (a) 2009 | (b) 2010 | (c) 2011 | (d) 2012 | (e) 2013 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") | | | | | | |
| 2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose | | | | | | |
| 3 Gross receipts from activities that are not an unrelated trade or business under section 513 | | | | | | |
| 4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 5 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 6 Total. Add lines 1 through 5 | | | | | | |
| 7a Amounts included on lines 1, 2, and 3 received from disqualified persons | | | | | | |
| b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year | | | | | | |
| c Add lines 7a and 7b. | | | | | | |
| 8 Public support (Subtract line 7c from line 6.) | | | | | | |

Section B. Total Support

| Calendar year (or fiscal year beginning in) ▶ | (a) 2009 | (b) 2010 | (c) 2011 | (d) 2012 | (e) 2013 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 9 Amounts from line 6. | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.) | | | | | | |
| 13 Total support. (Add lines 9, 10c, 11, and 12.) | | | | | | |

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

Section C. Computation of Public Support Percentage

| | | |
|--|----|---|
| 15 Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f)). | 15 | % |
| 16 Public support percentage from 2012 Schedule A, Part III, line 15. | 16 | % |

Section D. Computation of Investment Income Percentage

| | | |
|--|----|---|
| 17 Investment income percentage for 2013 (line 10c, column (f) divided by line 13, column (f)) | 17 | % |
| 18 Investment income percentage from 2012 Schedule A, Part III, line 17 | 18 | % |

19a 33 1/3% support tests - 2013. 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 - 2012. 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 **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 of Contributors

2013

▶ 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
THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number
52-0591607

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, \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

For a section 501(c)(3) organization 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) and received from any one contributor, during the year, a contribution 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 a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 for use *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 a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to 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 of \$5,000 or more during the year ▶ \$ _____

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

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

Employer identification number
52-0591607

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

| (a) No. | (b) Name, address, and ZIP + 4 | (c) Total contributions | (d) Type of contribution |
|------------|-----------------------------------|----------------------------|---|
| 1 | ----- ----- ----- | \$ ----- 200,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| 2 | ----- ----- ----- | \$ ----- 100,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| 3 | ----- ----- ----- | \$ ----- 50,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| 4 | ----- ----- ----- | \$ ----- 26,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| 5 | ----- ----- ----- | \$ ----- 15,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| 6 | ----- ----- ----- | \$ ----- 10,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |

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

Employer identification number
52-0591607

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

| (a) No. | (b) Name, address, and ZIP + 4 | (c) Total contributions | (d) Type of contribution |
|------------|-----------------------------------|----------------------------|---|
| 7 | ----- ----- ----- | \$ 10,000. | 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 | ----- ----- ----- | \$ 5,000. | Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.) |
| 10 | ----- ----- ----- | \$ 5,000. | 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.) |

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

Employer identification number

52-0591607

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

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

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

Employer identification number

52-0591607

Part III Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than \$1,000 for the year. 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 | |
| ----- ----- ----- | | ----- ----- ----- | |
| --- | ----- ----- ----- | ----- ----- ----- | ----- ----- ----- |
| (e) Transfer of gift | | | |
| Transferee's name, address, and ZIP + 4 | | Relationship of transferor to transferee | |
| ----- ----- ----- | | ----- ----- ----- | |
| --- | ----- ----- ----- | ----- ----- ----- | ----- ----- ----- |
| (e) Transfer of gift | | | |
| Transferee's name, address, and ZIP + 4 | | Relationship of transferor to transferee | |
| ----- ----- ----- | | ----- ----- ----- | |
| --- | ----- ----- ----- | ----- ----- ----- | ----- ----- ----- |
| (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

2013

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990.

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

Name of the organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows 1-4: Total number at end of year, Aggregate contributions to (during year), Aggregate grants from (during year), 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.

- 1 Purpose(s) of conservation easements held by the organization (check all that apply).
Preservation of land for public use (e.g., recreation or education)
Protection of natural habitat
Preservation of open space
Preservation of an historically important land area
Preservation of a certified historic structure

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.

Table with 2 columns: Held at the End of the Tax Year. Rows 2a-2d: Total number of conservation easements, Total acreage restricted by conservation easements, Number of conservation easements on a certified historic structure included in (a), Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register.

- 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year
4 Number of states where property subject to conservation easement is located
5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues 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 Revenues included in Form 990, Part VIII, line 1
b Assets included in Form 990, Part X

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

- 3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):
a Public exhibition
b Scholarly research
c Preservation for future generations
d Loan or exchange programs
e Other
4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

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 2 columns: Description, Amount. Rows: 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?
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: 1a-1g (Beginning of year balance, Contributions, Net investment earnings, gains, and losses, Grants or scholarships, Other expenditures for facilities and programs, Administrative expenses, 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?

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: 1a Land, 1b Buildings, 1c Leasehold improvements, 1d Equipment, 1e 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) INTEREST IN THOMAS O'NEILL | |
| (2) CATHOLIC HEALTH CARE FUND | 64,895,210. |
| (3) OPTION IT ASSET | 634,187. |
| (4) OTHER ASSETS | 250,831. |
| (5) _____ | |
| (6) _____ | |
| (7) _____ | |
| (8) _____ | |
| (9) _____ | |
| Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶ | 65,780,228. |

Part X Other Liabilities.

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

| 1. (a) Description of liability | (b) Book value |
|--|----------------|
| (1) Federal income taxes | |
| (2) ADVANCES FROM 3RD PARTY PAYORS | 6,704,512. |
| (3) ASBESTOS ABATEMENT LIABILITY | 2,773,906. |
| (4) STOCK OPTION PLAN | 563,077. |
| (5) WORKERS COMP | 2,643,663. |
| (6) CREDIT BALANCE PATIENT A/R | 1,137,341. |
| (7) DEFERRED COMPENSATION LIABILITY | 225,831. |
| (8) INTERCOMPANY DUE TO | 196,970. |
| (9) OTHER LIABILITIES | 7,745,314. |
| Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶ | 21,990,614. |

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 description, sub-labels (2a-2d, 3, 4a-4b, 4c, 5), and a final column for totals.

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 description, sub-labels (2a-2d, 3, 4a-4b, 4c, 5), and a final column for totals.

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, 2014.

SCHEDULE H
(Form 990)

Hospitals

OMB No. 1545-0047

2013

Open to Public Inspection

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.

▶ Attach to Form 990. ▶ See separate instructions.

▶ 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

Employer identification number

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

52-0591607

Part I Financial Assistance and Certain Other Community Benefits at Cost

| | Yes | No |
|--|-----|----|
| 1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | X | |
| 1b 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: | X | |
| <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ % | | |
| 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: | X | |
| <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 _____ % | | |
| c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria 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 | |
| 5b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | X | |
| 5c 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 | |
| 6b 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) | | | 5,686,617. | | 5,686,617. | 1.84 |
| 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 | | | 5,686,617. | | 5,686,617. | 1.84 |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | 1,157,460. | 47,889. | 1,109,571. | .36 |
| f Health professions education (from Worksheet 5) | | | 8,172,088. | | 8,172,088. | 2.65 |
| g Subsidized health services (from Worksheet 6) | | | 29,122,684. | 23,492,872. | 5,629,812. | 1.82 |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 35,686. | 2,000. | 33,686. | .01 |
| j Total, Other Benefits | | | 38,487,918. | 23,542,761. | 14,945,157. | 4.84 |
| k Total. Add lines 7d and 7j. | | | 44,174,535. | 23,542,761. | 20,631,774. | 6.68 |

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

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|---|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 Physical improvements and housing | | | | | | |
| 2 Economic development | | | | | | |
| 3 Community support | | | 708,936. | 358,944. | 349,992. | .11 |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | | | | | | |
| 6 Coalition building | | | | | | |
| 7 Community health improvement advocacy | | | 26,385. | | 26,385. | .01 |
| 8 Workforce development | | | 14,462. | | 14,462. | .01 |
| 9 Other | | | | | | |
| 10 Total | | | 749,783. | 358,944. | 390,839. | .13 |

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

| | | |
|---|---|--|
| 5 Enter total revenue received from Medicare (including DSH and IME) | 5 | |
| 6 Enter Medicare allowable costs of care relating to payments on line 5 | 6 | |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall) | 7 | |
| 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <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? | 9a | X | |
| b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI | 9b | X | |

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

| (a) Name of entity | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|--------------------|---|--|--|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, primary website address, and state license number

1 MAIN HOSPITAL BUILDING
5601 LOCH RAVEN BLVD
BALTIMORE MD 21239

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

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 facility reporting group MAIN HOSPITAL BUILDING

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

| Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | Yes | No |
|---|--|-----|----|
| 1 | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9. If "Yes," indicate what the CHNA report describes (check all that apply): | X | |
| a | <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b | <input checked="" type="checkbox"/> Demographics of the community | | |
| c | <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d | <input checked="" type="checkbox"/> How data was obtained | | |
| e | <input checked="" type="checkbox"/> The health needs of the community | | |
| f | <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g | <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h | <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i | <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs | | |
| j | <input type="checkbox"/> Other (describe in Section C) | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>1 1</u> | | |
| 3 | In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | X | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | | X |
| 5 | Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply): | X | |
| a | <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.MEDSTARGOODSAM.ORG</u> | | |
| b | <input type="checkbox"/> Other website (list url): _____ | | |
| c | <input checked="" type="checkbox"/> Available upon request from the hospital facility | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | |
| a | <input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | |
| b | <input checked="" type="checkbox"/> Execution of the implementation strategy | | |
| c | <input checked="" type="checkbox"/> Participation in the development of a community-wide plan | | |
| d | <input checked="" type="checkbox"/> Participation in the execution of a community-wide plan | | |
| e | <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans | | |
| f | <input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA | | |
| g | <input checked="" type="checkbox"/> Prioritization of health needs in its community | | |
| h | <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community | | |
| i | <input type="checkbox"/> Other (describe in Section C) | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | X | |
| 8a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | | X |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | | |
| c | If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ | | |

Part V Facility Information (continued)

| Financial Assistance Policy | | MAIN HOSPITAL BUILDING | Yes | No |
|---|--|------------------------|-----|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | | |
| 9 | Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | | X | |
| 10 | Used federal poverty guidelines (FPG) to determine eligibility for providing free care? If "Yes," indicate the FPG family income limit for eligibility for free care: <u>2</u> <u>0</u> <u>0</u> % If "No," explain in Section C the criteria the hospital facility used. | | X | |
| 11 | Used FPG to determine eligibility for providing discounted care? If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>4</u> <u>0</u> <u>0</u> % If "No," explain in Section C the criteria the hospital facility used. | | X | |
| 12 | Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply): | | X | |
| a | <input checked="" type="checkbox"/> Income level | | | |
| b | <input checked="" type="checkbox"/> Asset level | | | |
| c | <input checked="" type="checkbox"/> Medical indigency | | | |
| d | <input checked="" type="checkbox"/> Insurance status | | | |
| e | <input checked="" type="checkbox"/> Uninsured discount | | | |
| f | <input checked="" type="checkbox"/> Medicaid/Medicare | | | |
| g | <input type="checkbox"/> State regulation | | | |
| h | <input type="checkbox"/> Residency | | | |
| i | <input type="checkbox"/> Other (describe in Section C) | | | |
| 13 | Explained the method for applying for financial assistance? | | X | |
| 14 | 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 policy was posted on the hospital facility's website | | | |
| b | <input type="checkbox"/> The policy was attached to billing invoices | | | |
| c | <input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d | <input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices | | | |
| e | <input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f | <input checked="" type="checkbox"/> The policy was available on request | | | |
| g | <input type="checkbox"/> Other (describe in Section C) | | | |
| Billing and Collections | | | | |
| 15 | 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 actions the hospital facility may take upon non-payment? | | X | |
| 16 | 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 | | | |
| b | <input type="checkbox"/> Lawsuits | | | |
| c | <input type="checkbox"/> Liens on residences | | | |
| d | <input type="checkbox"/> Body attachments | | | |
| e | <input type="checkbox"/> Other similar actions (describe in Section C) | | | |
| 17 | Did the hospital facility or an authorized third 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 | | | |
| b | <input type="checkbox"/> Lawsuits | | | |
| c | <input type="checkbox"/> Liens on residences | | | |
| d | <input type="checkbox"/> Body attachments | | | |
| e | <input type="checkbox"/> Other similar actions (describe in Section C) | | | |

Part V Facility Information (continued) MAIN HOSPITAL BUILDING

- 18** Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):
- a Notified individuals of the financial assistance policy on admission
 - b Notified individuals of the financial assistance policy prior to discharge
 - c Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
 - d Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
 - e Other (describe in Section C)

Policy Relating to Emergency Medical Care

| | | Yes | No |
|------------------------|---|-----|----|
| 19 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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? | | X |
| If "No," indicate why: | | | |
| a | <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions | | |
| b | <input type="checkbox"/> The hospital facility's policy was not in writing | | |
| c | <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | |
| d | <input type="checkbox"/> Other (describe in Section C) | | |

Changes to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

| | | | | |
|---------------------------------|--|--|--|---|
| 20 | 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) | | | |
| 21 | 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? | | | X |
| If "Yes," explain in Section C. | | | | |
| 22 | 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? | | | X |
| If "Yes," explain in Section C. | | | | |

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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? 1

| Name and address | Type of Facility (describe) |
|---|-----------------------------|
| 1 TRANSITIONAL CARE AT GOOD SAMARITAN 5601 LOCH RAVEN BLVD BALTIMORE MD 21239 | COMPREHENSIVE CARE FACILITY |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |
| 10 | |

Part VI Supplemental Information

Provide the following information.

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

CHARITY CARE AT COST

PART I, LINE 7A

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

UNREIMBURSED MEDICAID

PART I, LINE 7B

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S

Part VI Supplemental Information

Provide the following information.

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

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.

HEALTH PROFESSIONS EDUCATION

PART I, LINE 7F

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

Part VI Supplemental Information

Provide the following information.

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

BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

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 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

Part VI Supplemental Information

Provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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

Part VI Supplemental Information

Provide the following information.

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- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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CHNA INPUT

PART V, SECTION B, LINE 3

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: DEBORAH BENA, MITCH HERBERT

EXECUTIVE SPONSOR

ROLE DESCRIPTION

Part VI Supplemental Information

Provide the following information.

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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: JEFF MATTON

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.

Part VI Supplemental information

Provide the following information.

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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

NOTE:

THE ATF SHOULD BE A COMBINATION OF COMMUNITY REPRESENTATIVES AND STAFF.

COMMUNITY REPRESENTATIVES SHOULD MAKEUP AT LEAST 50% OF TOTAL

PARTICIPANTS.

| NAME: | TITLE: | AFFLIATION | HOSPITAL |
|-------|--------|--|----------|
| | | WITH HOSPITAL EMPLOYEE | |
| | | (I.E., BOARD MEMBER, VOLUNTEER, COMMUNITY ADVOCATE, STAFF) | (YES/NO) |

| | | | |
|------------------|--|-------|-----|
| MITCHELL HERBERT | REGIONAL DIRECTOR, STRATEGIC AND BUSINESS PLANNING | STAFF | YES |
|------------------|--|-------|-----|

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.

| | | | |
|-----------------------|---|-----------------------|--------------|
| DEBORAH BENA | HEALTH MINISTRIES | STAFF | YES |
| | COORDINATOR | | |
| JEFFREY MATTON | PRESIDENT | STAFF | YES |
| ALLAN NOONAN | BOARD CHAIR | BOARD MEMBER | NO/ BOARD |
| SONYA GRAY | BOARD MEMBER | BOARD MEMBER | NO/ BOARD |
| CAROL PACIONE | PASTORAL LIFE DIRECTOR, ST. PIUS CHURCH | COMMUNITY ADVOCATE | NO |
| DAVID WEISMAN, MD | PHYSICIAN | STAFF | YES |
| MICHELLE ZIKUSOKA, MD | PHYSICIAN | STAFF | YES |
| ANDREW DZIUBAN | DIRECTOR OF PHILANTHROPY | STAFF | YES |
| BERNADETTE KROL, RN | REGISTERED NURSE | STAFF | YES |
| MOIRA LARSEN, MD | PHYSICIAN | STAFF | YES |
| RACHEL V. NEILL | GOVANS ECUMENICAL DEVELOPMENT CORPORATION (GEDCO) - CARES PROGRAM | COMMUNITY ADVOCATE | NO |
| LORETHA MYERS | PRESIDENT, LOCH RAVEN | COMMUNITY | NO |

Part VI Supplemental Information

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IMPROVEMENT ASSOCIATION, ADVOCATE

NORTHEAST COMMUNITY

ASSOCIATION

PATRICIA STABILE PROGRAM DIRECTOR, HARBEL COMMUNITY NO

PREVENTION AND RECOVERY ADVOCATE

CENTER

RANDOLPH ROWEL, PHD CHAIR AND ASSOCIATE COMMUNITY NO

PROFESSOR, DEPARTMENT OF ADVOCATE

BEHAVIOURAL HEALTH

SCIENCES, MORGAN STATE

UNIVERSITY

NEEDS ASSESSMENT

PART V, SECTION B, LINE 7

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.

Part VI Supplemental Information

Provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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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.

PART VI, LINE 2

IN FY12, MEDSTAR GOOD SAMARITAN HOSPITAL CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN ACCORDANCE WITH THE GUIDELINES ESTABLISHED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE INTERNAL REVENUE SERVICE.

THE HOSPITAL'S CHNA WAS LED BY 11 ADVISORY TASK FORCE (ATF) MEMBERS,

Part VI Supplemental Information

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WHICH WAS COMPRISED OF A DIVERSE GROUP OF INDIVIDUALS, INCLUDING GRASSROOTS ACTIVISTS, COMMUNITY RESIDENTS, FAITH-BASED LEADERS, HOSPITAL REPRESENTATIVES, PUBLIC HEALTH LEADERS, AND OTHER STAKEHOLDER ORGANIZATIONS, SUCH AS REPRESENTATIVES FROM LOCAL HEALTH DEPARTMENTS. THE ATF REVIEWED QUANTITATIVE AND QUALITATIVE COMMUNITY HEALTH DATA, AS WELL AS LOCAL, REGIONAL AND NATIONAL HEALTH GOALS.

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

BASED ON THE ATF'S RECOMMENDATION, THE HOSPITAL IDENTIFIED GOVANS AS ITS COMMUNITY BENEFIT SERVICE AREA (CBSA) - GEOGRAPHY WITH A HIGH DENSITY OF LOW-INCOME OR VULNERABLE RESIDENTS WITHIN CLOSE PROXIMITY OF THE HOSPITAL. HEALTH PRIORITIES FOR THE CBSA INCLUDE HEART DISEASE AND

Part VI Supplemental Information

Provide the following information.

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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

DIABETES.

THE HOSPITAL'S FY12 CHNA AND 3-YEAR IMPLEMENTATION STRATEGIES WERE
 ENDORSED BY MEDSTAR GOOD SAMARITAN'S BOARD OF DIRECTORS AND APPROVED BY
 THE MEDSTAR HEALTH BOARD OF DIRECTORS. THE DOCUMENT WAS PUBLISHED ON THE
 HOSPITAL'S WEBSITE ON JUNE 30, 2012.

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

Part VI Supplemental Information

Provide the following information.

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PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

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

" TREAT ALL PATIENTS EQUITABLY, WITH DIGNITY, WITH RESPECT AND WITH COMPASSION.

" SERVE THE EMERGENCY HEALTH CARE NEEDS OF EVERYONE WHO PRESENTS AT OUR FACILITIES REGARDLESS OF A PATIENT'S ABILITY TO PAY FOR CARE.

" ASSIST THOSE PATIENTS WHO ARE ADMITTED THROUGH OUR ADMISSIONS PROCESS FOR NON-URGENT, MEDICALLY NECESSARY CARE WHO CANNOT PAY FOR PART OF ALL OF THE CARE THEY RECEIVE.

" BALANCE NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH BROADER FISCAL RESPONSIBILITIES IN ORDER TO KEEP ITS HOSPITALS' DOORS OPEN FOR ALL WHO MAY NEED CARE IN THE COMMUNITY.

Part VI Supplemental Information

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IN MEETING ITS COMMITMENTS, MEDSTAR HEALTH'S FACILITIES WILL 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 WILL ASSIST UNINSURED PATIENTS WHO RESIDE WITHIN THE COMMUNITIES WE SERVE IN ONE OR MORE OF THE FOLLOWING WAYS:

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

Part VI Supplemental Information

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THEIR HEALTHCARE SERVICES.

EACH FACILITY WILL POST 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, WILL COMMUNICATE THE INFORMATION TO PATIENTS AS REQUIRED BY THIS POLICY AND APPLICABLE REGULATIONS AND WILL MAKE A COPY OF THE POLICY AVAILABLE TO ALL PATIENTS. ADDITIONALLY, THE MARYLAND PATIENT INFORMATION SHEET/MEDSTAR'S PATIENT INFORMATION SHEET WILL BE PROVIDED TO INPATIENTS ON ADMISSION AND AT TIME OF FINAL ACCOUNT BILLING.

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

Part VI Supplemental Information

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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.

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

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

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

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

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

" IT IS THE RESPONSIBILITY OF THE PATIENT TO INFORM THE MEDSTAR

Part VI Supplemental Information

Provide the following information.

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

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 WILL DETERMINE
ELIGIBILITY FOR CHARITY CARE AND SLIDING-SCALE FINANCIAL ASSISTANCE BASED
ON REVIEW OF INCOME FOR THE PATIENT AND THEIR FAMILY (HOUSEHOLD), OTHER
FINANCIAL RESOURCES AVAILABLE TO THE PATIENT'S FAMILY, FAMILY SIZE, AND
THE EXTENT OF THE MEDICAL COSTS TO BE INCURRED BY THE PATIENT.

COMMUNITY INFORMATION

PART VI, LINE 4

GEOGRAPHIC

THE GOVANS NEIGHBORHOOD IS LOCATED IN NORTH CENTRAL BALTIMORE CITY,
APPROXIMATELY TWO MILES FROM MEDSTAR GOOD SAMARITAN. THE NEIGHBORHOOD
FEATURES MANY DIFFERENT HOUSING TYPES, BUSINESSES, CHURCHES, A CHARTER
SCHOOL AND A NEIGHBORHOOD PARK. GOVANS HAS ALWAYS BEEN ASSOCIATED WITH

Part VI Supplemental Information

Provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

YORK ROAD, FIRST AS AN INDIAN TRAIL, AND THEN AS AN IMPORTANT COMMERCIAL ROAD AND TURNPIKE LINKING THE PORT OF BALTIMORE TO PENNSYLVANIA.

DEMOGRAPHICS:

ACCORDING TO STATISTICS FROM THE BALTIMORE CITY 2011 NEIGHBORHOOD HEALTH PROFILE, THE TOTAL POPULATION IN GOVANS IS JUST OVER 10,000 AND THE MAJORITY OF RESIDENTS ARE AFRICAN AMERICAN (91.3%). CAUCASIANS MAKE UP 5.7% OF THE POPULATION, 0.5% IS ASIAN, 1.3% IS HISPANIC, AND 2.5% IS TWO OR MORE RACES OR OTHER. ADULTS OVER THE AGE OF 18 YEARS OLD MAKE UP THREE-QUARTERS (75.6%) OF THE POPULATION, WITH SENIORS OVER AGE 65 YEARS AT 12.8%. CHILDREN UNDER THE AGE OF 18 ACCOUNT FOR 24.4% OF THE GOVANS POPULATION. THE MEDIAN ANNUAL HOUSEHOLD INCOME IS \$37,000, ABOUT THE SAME AS BALTIMORE CITY, WHILE UNEMPLOYMENT IS 14.9%, HIGHER THAN THE BALTIMORE CITY AVERAGE (11.0%). JUST OVER ONE-QUARTER (26.9%) OF HOUSEHOLDS ARE HEADED BY A SINGLE-PARENT. THE POVERTY RATE IS 11.6%, SLIGHTLY LESS THAN BALTIMORE CITY (15.7%). IN 2011, APPROXIMATELY 1,400 FAMILIES IN THE GOVANS AREA RECEIVED ASSISTANCE FROM CARES, A COMBINATION FOOD PANTRY AND EMERGENCY FINANCIAL ASSISTANCE CENTER. OVER TWO-THIRDS (62.2%) OF

Part VI Supplemental Information

Provide the following information.

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

RESIDENTS OVER 25 YEARS OF AGE HAVE ATTAINED HIGH SCHOOL AS THE HIGHEST LEVEL OF EDUCATION. LIFE EXPECTANCY IS 73.9, JUST LONGER THAN THAT OF BALTIMORE CITY (71.8). THE LEADING CAUSES OF DEATH ARE HEART DISEASE (24.9 PER 10,000), CANCER (19.5 PER 10,000), HIV/AIDS (4.9 PER 10,000), STROKE (4.2 PER 10,000), AND DIABETES (2.6 PER 10,000).

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

AS A COMMUNITY PARTNER, MEDSTAR GOOD SAMARITAN ENGAGES IN A NUMBER OF COMMUNITY BENEFIT ACTIVITIES TO IMPROVE AND PROMOTE THE HEALTH AND WELL-BEING OF THE COMMUNITY. THE HOSPITAL PARTNERS WITH COMMUNITY ORGANIZATIONS, SUCH AS SENIOR CENTERS, CHURCHES AND SENIOR HOUSING TO PROVIDE HEALTH EDUCATION CLASSES, EXERCISE AND WEIGHT LOSS PROGRAMS AND BLOOD PRESSURE SCREENINGS. DIABETES EDUCATION AND HEART HEALTH CLASSES ARE HELD AT VARIOUS LOCATIONS IN THE GOVANS AREA OF BALTIMORE CITY. SITES INCLUDE CARES, A FOOD PANTRY AND FINANCIAL ASSISTANCE CENTER, A LOCAL SENIOR CENTER AND A LOCAL CHURCH. THE LIFE BALANCE / WEIGHT MANAGEMENT

Part VI Supplemental Information

Provide the following information.

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

PROGRAM, AN EVIDENCED BASED PROGRAM TO PREVENT TYPE 2 DIABETES, IS HELD WEEKLY AT A SENIOR CENTER. BLOOD PRESSURE SCREENINGS ARE HELD AT VARIOUS LOCATIONS IN THE NORTHEAST AREA OF BALTIMORE AND PERSONS IDENTIFIED WITH HIGH BLOOD PRESSURE ARE REFERRED TO THEIR PRIMARY CARE PROVIDER AND THOSE WITHOUT INSURANCE ARE NAVIGATED TO A SAFETY NET PROVIDER. THE KNOW STROKE PROGRAM IS A ONE HOUR LECTURE ON STROKE PREVENTION PRESENTED BY A SPEECH PATHOLOGIST FROM THE MEDSTAR GOOD SAMARITAN REHABILITATION DEPARTMENT. THE PROGRAM IS PRESENTED IN SENIOR CENTERS AND LIBRARIES. TOPICS INCLUDE RISK FACTORS, SIGNS AND SYMPTOMS, TREATMENTS, AND LIFESTYLE CHOICES RELATED TO STROKE PREVENTION.

AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR GOOD SAMARITAN IS ABLE TO EXPAND ITS CAPACITY TO MEET THE NEEDS OF THE COMMUNITY BY PARTNERING WITH OTHER MEDSTAR HOSPITALS AND ASSOCIATED ENTITIES. MEDSTAR HEALTH RESOURCES ASSIST THE HOSPITAL IN COMMUNITY HEALTH PLANNING TO MEET THE NEEDS OF THE UNINSURED AND OTHER VULNERABLE POPULATIONS. THROUGH ITS COMMUNITY HEALTH

Part VI Supplemental Information

Provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
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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.

FUNCTION, MEDSTAR HEALTH PROVIDES MEDSTAR GOOD SAMARITAN WITH TECHNICAL SUPPORT TO ENHANCE COMMUNITY HEALTH PROGRAMMING AND EVALUATION. MEDSTAR'S CORPORATE PHILANTHROPY DEPARTMENT IDENTIFIES AND SEEKS PUBLIC AND PRIVATE FUNDING SOURCES TO ENSURE THE AVAILABILITY OF HIGH QUALITY HEALTH SERVICES, REGARDLESS OF ABILITY TO PAY.

STATE FILING OF COMMUNITY BENEFIT REPORT

PART VI, LINE 7

THE COMMUNITY BENEFIT REPORT FOR MEDSTAR GOOD SAMARITAN HOSPITAL IS ONLY FILED IN THE STATE OF MARYLAND.

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

For certain Officers, Directors, Trustees, Key Employees, and Highest
Compensated Employees
▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

Part I Questions Regarding Compensation

| | Yes | No | | | | | | | | |
|---|---|--|---|--|---|---|---|--|--|--|
| <p>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.</p> <table border="0"> <tr> <td><input type="checkbox"/> First-class or charter travel</td> <td><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table> | <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 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) | | |
| <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 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) | | | | | | | | | |
| <p>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</p> | | | | | | | | | | |
| <p>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?</p> | | | | | | | | | | |
| <p>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.</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> Compensation committee</td> <td><input checked="" type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input checked="" type="checkbox"/> Independent compensation consultant</td> <td><input checked="" type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input checked="" type="checkbox"/> Form 990 of other organizations</td> <td><input checked="" type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table> | <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 | | | | |
| <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 | | | | | | | | | |
| <p>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:</p> <p>a Receive a severance payment or change-of-control payment?</p> <p>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p> <p>c Participate in, or receive payment from, an equity-based compensation arrangement?</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p> | | | | | | | | | | |
| <p>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:</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes" to line 5a or 5b, describe in Part III.</p> | | | | | | | | | | |
| <p>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:</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes" to line 6a or 6b, describe in Part III.</p> | | | | | | | | | | |
| <p>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.</p> | | | | | | | | | | |
| <p>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.</p> | | | | | | | | | | |
| <p>9 If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p> | | | | | | | | | | |

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

Schedule J (Form 990) 2013

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 reported as deferred in prior Form 990 |
|--|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| 1 JEFFREY A MATTON PRESIDENT/BOARD MEMBER | (i) 446,411. (ii) 0 (iii) 0 | 264,054. | 0 | 15,384. | 17,012. | 742,861. | 0 |
| 2 KENNETH A SAMET BOARD MEMBER | (i) 1,447,427. (ii) 1,873,804. (iii) 13,568. | 0 | 0 | 41,896. | 19,111. | 3,395,806. | 0 |
| 3 ELIAS SHAYA MEDICAL DIRECTOR | (i) 352,055. (ii) 0 (iii) 0 | 0 | 0 | 7,955. | 903. | 360,913. | 0 |
| 4 DAVID WEISMAN PRESIDENT/BOARD MEMBER | (i) 170,036. (ii) 13,882. (iii) 0 | 0 | 0 | 7,483. | 14,089. | 205,490. | 0 |
| 5 MICHAEL JACOBS PHYSICIAN | (i) 796,776. (ii) 0 (iii) 0 | 0 | 0 | 8,738. | 14,784. | 820,298. | 0 |
| 6 DAVID COLL PHYSICIAN | (i) 559,963. (ii) 0 (iii) 0 | 0 | 0 | 7,500. | 14,295. | 581,758. | 0 |
| 7 ROBERT BRESLIN PHYSICIAN | (i) 542,907. (ii) 0 (iii) 0 | 0 | 0 | 7,500. | 11,332. | 561,739. | 0 |
| 8 DALE BUCHBINDER CHIEF | (i) 630,876. (ii) 49,000. (iii) 0 | 0 | 0 | 7,500. | 11,736. | 699,112. | 0 |
| 9 KAPIL SIMLOTE PHYSICIAN | (i) 516,261. (ii) 0 (iii) 0 | 0 | 0 | 7,500. | 6,762. | 530,523. | 0 |
| 10 THOMAS SENKER VICE PRESIDENT | (i) 189,934. (ii) 21,000. (iii) 0 | 0 | 0 | 6,939. | 14,297. | 232,170. | 0 |
| 11 SHIRLEY ROTH CHIEF NURSING OFFICER | (i) 196,901. (ii) 18,000. (iii) 0 | 0 | 0 | 6,930. | 14,113. | 235,944. | 0 |
| 12 MARTIN BINSTOCK VICE PRESIDENT | (i) 328,992. (ii) 140,829. (iii) 0 | 0 | 0 | 17,523. | 12,375. | 499,719. | 0 |
| 13 DEANA STOUT VICE PRESIDENT | (i) 224,944. (ii) 66,240. (iii) 0 | 0 | 0 | 21,503. | 14,405. | 327,092. | 0 |
| 14 LAWRENCE BECK FORMER OFFICER | (i) 0 (ii) 0 (iii) 193,534. | 0 | 0 | 0 | 0 | 193,534. | 0 |
| 15 JENNIFER WILKERSON FORMER OFFICER | (i) 126,122. (ii) 36,600. (iii) 0 | 0 | 0 | 5,020. | 11,898. | 179,640. | 0 |
| 16 | (i) 0 (ii) 0 (iii) 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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.

OTHER REPORTABLE COMPENSATION

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

LAWRENCE BECK

LAWRENCE BECK'S OTHER REPORTABLE COMPENSATION IN PART II, COLUMN (B)

(III) INCLUDES \$193,534 REPRESENTING THE AMOUNT OF SUPPLEMENTAL

RETIREMENT BENEFIT PAYMENTS RELATING TO PRIOR YEARS OF SERVICE.

SCHEDULE L
(Form 990 or 990-EZ)

Transactions With Interested Persons

OMB No. 1545-0047

2013

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

Name of the organization **THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.** Employer Identification number **52-0591607**

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) 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) DRS HAHN & PADGETT, P.C. | SEE PART V | | ONCOLOGY SERVICES | | X |
| (2) GS SURGICAL SERVICES, LLC | SEE PART V | | SURGICAL SERVICES | | X |
| (3) PATHOLOGY ASSOCIATES LABORATORIES | SEE PART V | | LAB SERVICES | | X |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |
| (7) | | | | | |
| (8) | | | | | |
| (9) | | | | | |
| (10) | | | | | |

Part V Supplemental Information

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

BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

DR. JEREMY WEINER, A BOARD MEMBER AT MEDSTAR GOOD SAMARITAN HOSPITAL, OWNS MORE THAN 5% OF GS SURGICAL SERVICES, LLC (GSS), WHICH PROVIDES MEDICAL AND SURGICAL SERVICES TO MEDSTAR GOOD SAMARITAN HOSPITAL. GSS'S GROSS REVENUES RECEIVED FROM THE HOSPITAL FOR THE YEAR WAS \$1.0 MILLION.

DR. DAVIS HAHN, A BOARD MEMBER AT MEDSTAR GOOD SAMARITAN HOSPITAL, OWNS MORE THAN 5% OF DRS. HAHN & PADGETT, P.C. (HP), WHICH PROVIDES ONCOLOGY SERVICES TO MEDSTAR GOOD SAMARITAN HOSPITAL. HP'S GROSS REVENUES RECEIVED FROM THE HOSPITAL FOR THE YEAR WAS \$1.0 MILLION.

DR. MOIRA LARSEN, A BOARD MEMBER AT MEDSTAR GOOD SAMARITAN HOSPITAL, OWNS MORE THAN 5% OF PATHOLOGY ASSOCIATES LABORATORIES, PC (PAL), WHICH PROVIDES LAB SERVICES TO MEDSTAR GOOD SAMARITAN HOSPITAL. PAL'S GROSS REVENUES RECEIVED FROM THE HOSPITAL FOR THE YEAR WAS \$0.7 MILLION.

SCHEDULE O
(Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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.

Name of the organization

Employer identification number

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

52-0591607

ORGANIZATION MEMBERS

PART VI, LINE 6

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

DESCRIPTION OF MEMBERS

PART VI, LINE 7A

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

DECISIONS OF GOVERNING BODY

PART VI, LINE 7B

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT
MARYLAND NON-STOCK CORPORATION, THE BYLAWS OF THE ORGANIZATION ARE
SUBJECT TO CERTAIN RESERVED POWERS, WHICH PROVIDE THAT THE SOLE MEMBER OF

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

THE ORGANIZATION MUST APPROVE CERTAIN DECISIONS, INCLUDING BUT NOT LIMITED TO MATTERS CONCERNING THE SALE OR PURCHASE OF REAL OR PERSONAL PROPERTY, CAPITAL BUDGETS, STRATEGIC PLANNING, INVESTMENTS, AND CORPORATE GOVERNANCE.

PROCESS FOR REVIEWING FORM 990

PART VI, LINE 11A

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

CONFLICT OF INTEREST POLICY

PART VI, LINE 12C

APPOINTMENT OF BOARDS OF DIRECTORS

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

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

GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD OF DIRECTORS WHICH 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

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

AND APPROVED BY THE COMMITTEE WITH ASSISTANCE AND GUIDANCE FROM AN INDEPENDENT THIRD PARTY ADVISOR. THE MEMBERS OF THE COMMITTEE ARE INDEPENDENT FROM ALL OF THE PARTICIPANTS IN THE PROGRAM.

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.

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

COMMITTEE ARE CONTEMPORANEOUSLY DOCUMENTED.

FINANCIAL STATEMENT AVAILABILITY

PART VI, LINE 19

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

FINANCIAL STATEMENTS AND REPORTING

PART XII, LINE 2C

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

OTHER CHANGES IN NET ASSETS

PART XI, LINE 9

EQUITY TRANSFERS - NET ASSETS.....\$ 3,726,485.

ATTACHMENT 1

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

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR GOOD SAMARITAN HOSPITAL'S (MEDSTAR GOOD SAMARITAN) MISSION IS TO BE GOOD SAMARITANS, GUIDED BY CATHOLIC TRADITION AND TRUSTED TO DELIVER IDEAL HEALTH EXPERIENCES. MEDSTAR GOOD SAMARITAN, LOCATED IN NORTHEAST BALTIMORE

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

ATTACHMENT 1 (CONT'D)FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

CITY, MARYLAND, IS KNOWN FOR ITS SPECIALTIES IN ORTHOPAEDICS, RHEUMATOLOGY, NEPHROLOGY, AND PHYSICAL MEDICINE AND REHABILITATION PROGRAMS. IN ADDITION TO GENERAL ADULT ACUTE CARE SERVICES, MEDSTAR GOOD SAMARITAN HAS A COMPREHENSIVE INPATIENT REHABILITATION UNIT AND A SUB-ACUTE CARE UNIT. THROUGH MGSB'S CENTER FOR SUCCESSFUL AGING, INTEGRATED CARE IS PROVIDED TO PATIENTS WHO EXPERIENCE AGE-RELATED HEALTH CONDITIONS. IN FISCAL YEAR 2014, MEDSTAR GOOD SAMARITAN HAD 11,759 INPATIENT ADMISSIONS, 316,816 OUTPATIENT VISITS, AND 57,700 EMERGENCY VISITS.

ATTACHMENT 2FORM 990, PART III - PROGRAM SERVICE, LINE 4A

MEDSTAR GOOD SAMARITAN HOSPITAL'S LARGEST PROGRAM IS ACCESS TO AND THE PROVISION OF ACUTE HOSPITAL SERVICES TO THE COMMUNITIES OF NORTHEASTERN BALTIMORE CITY, MARYLAND AND THE SURROUNDING AREAS. IN ADDITION TO THE PROGRAM SERVICE EXPENSES LISTED ABOVE, MEDSTAR GOOD SAMARITAN INCURRED \$46.9M OF MANAGEMENT AND GENERAL EXPENSES IN PROVIDING SERVICES TO ITS COMMUNITIES. IT ALSO OFFERS COMMUNITY-BASED HEALTH SERVICES THROUGH THE GOOD HEALTH CENTER AND PROVIDES SENIOR LIVING SERVICES THROUGH THE GOOD SAMARITAN NURSING CENTER AND TWO SENIOR HOUSING COMPLEXES LOCATED ON ITS 43-ACRE CAMPUS. MEDSTAR GOOD SAMARITAN IS RECOGNIZED BY THE JOINT COMMISSION AS AN ADVANCED PRIMARY STROKE CENTER AND CERTIFIED IN JOINT REPLACEMENT OF THE HIP AND KNEE. IN 2014, US NEWS AND WORLD REPORT RECOGNIZED MEDSTAR GOOD SAMARITAN AS A TOP BALTIMORE

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

ATTACHMENT 2 (CONT'D)

REGIONAL HOSPITAL THAT IS HIGH PERFORMING IN EIGHT SPECIALTIES:
 DIABETES AND ENDOCRINOLOGY, GASTROENTEROLOGY AND GI SURGERY,
 GERIATRICS, NEPHROLOGY, ORTHOPAEDICS, NEUROLOGY AND NEUROSURGERY,
 PULMONOLOGY, AND UROLOGY.

ATTACHMENT 3

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

| <u>NAME AND ADDRESS</u> | <u>DESCRIPTION OF SERVICES</u> | <u>COMPENSATION</u> |
|---|--------------------------------|---------------------|
| HUNT VALLEY ANES ASSOC PA PO BOX 20284 TOWSON, MD 21284 | MEDICAL SERVICES | 8,316,000. |
| JOHNS HOPKINS UNIVERSITY 3910 KESWICK ROAD BALTIMORE, MD 21218 | PROFESSIONAL SVCS | 7,494,312. |
| MORRISON MANAGEMENT SPECIALIST 5801 PEACHTREE DUNWOODY ROAD ATLANTA, GA 30342 | NUTRITION SERVICES | 4,098,120. |
| UNIVERSITY OF MARYLAND 2119 MAIN ADMINISTRATION BUILDING COLLEGE PARK, MD 20742 | PROFESSIONAL SVCS | 3,463,858. |
| GS SURGICAL SERVICES LLC 5601 LOCH RAVEN BOULEVARD BALTIMORE, MD 21239 | PHYSICAN SERVICES | 1,035,252. |

ATTACHMENT 4

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> |
|-------------------------|--------------------------|------------------------------------|--------------------------------------|------------------------------------|
| PHYSICAN SERVICES FIXED | 26,906,678. | 26,906,678. | | |
| PROFESSIONAL FEES-OTHER | 5,112,283. | 5,107,125. | 5,158. | |

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

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> |
|--------------------------------|------------------------------|--|--|--|
| MISC PURCHASED SERVICES | 2,962,192. | 2,848,031. | 114,161. | |
| PURCHASED PROFESSIONAL SERVICE | 2,379,071. | 1,986,230. | 392,841. | |
| PHARMACY SERVICES | 1,022,539. | 1,022,539. | | |
| BLOOD BANK FEES | 1,105,900. | 1,105,900. | | |
| BILLING SERVICE EXPENSE | 1,747,432. | 1,747,432. | | |
| ALL OTHER | 2,371,401. | 3,981,345. | -1,609,944. | |
| TOTALS | <u>43,607,496.</u> | <u>44,705,280.</u> | <u>-1,097,784.</u> | |

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

OMB No. 1545-0047

2013

Open to Public
Inspection

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

Name of the organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

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

| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
|---|-------------------------|--|---------------------|---------------------------|----------------------------------|
| (1) MEDSTAR HEALTH ANESTHESIA SERVICES A LLC 20-5909017 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 | HEALTHCARE | MD | 7,236,083. | 1,489,963. | 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) HARBOR HOSPITAL, INC. 52-0491660 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225 | HOSPITAL | MD | 501 (C) (3) | 3 | N/A | | X |
| (4) MEDSTAR HEALTH, INC. 52-2087445 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | MEDICAL SVCS | MD | 501 (C) (3) | 11B II | N/A | | X |
| (5) MONTGOMERY GENERAL HOSPITAL 52-0646893 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 | HOSPITAL | MD | 501 (C) (3) | 3 | N/A | | X |
| (6) THE UNION MEMORIAL HOSPITAL 52-0591685 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218 | HOSPITAL | MD | 501 (C) (3) | 3 | N/A | | X |
| (7) MEDSTAR HEALTH RESEARCH INSTITUTE 52-6056274 106 IRVING STREET NW WASHINGTON, DC 20010 | HOSPITAL | DC | 501 (C) (3) | 3 | N/A | | X |

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

Schedule R (Form 990) 2013

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2013

Open to Public
Inspection

Name of the organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

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

| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
|---|-------------------------|--|---------------------|---------------------------|----------------------------------|
| (1) ----- | | | | | |
| (2) ----- | | | | | |
| (3) ----- | | | | | |
| (4) ----- | | | | | |
| (5) ----- | | | | | |
| (6) ----- | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|-------------------------|--|----------------------------|---|----------------------------------|--|----|
| | | | | | | Yes | No |
| (1) THE MEDSTAR-GEORGETOWN MEDICAL CENTER, I 52-2218584 HOSPITAL ADMIN, 1 MAIN BLDG WASHINGTON, DC 20007 | HOSPITAL | DC | 501 (C) (3) | 3 | N/A | | X |
| (2) WASHINGTON HOSPITAL CENTER CORPORATION 52-1272129 110 IRVING STREET NW WASHINGTON, DC 20010 | HOSPITAL | DC | 501 (C) (3) | 3 | N/A | | X |
| (3) HH MEDSTAR HEALTH, INC. 52-1542230 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | MEDICAL SVCS | MD | 501 (C) (3) | 11B II | N/A | | X |
| (4) MEDSTAR AMBULATORY SERVICES, INC. 52-1132992 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | FOUNDATION | MD | 501 (C) (3) | 11A I | N/A | | X |
| (5) BAY LIFE SERVICES, INC. 52-1496539 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | MENTAL HEALTH | MD | 501 (C) (3) | 9 | N/A | | X |
| (6) MEDSTAR SURGERY CENTER, INC. 52-1061679 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 | MEDICAL SVCS | MD | 501 (C) (3) | 9 | N/A | | X |
| (7) CHURCH HOME AND HOSPITAL OF THE CITY OF 52-0591600 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | 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) 2013

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2013

Open to Public
Inspection

Name of the organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number
52-0591607

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

| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
|---|-------------------------|--|---------------------|---------------------------|----------------------------------|
| (1) ----- | | | | | |
| (2) ----- | | | | | |
| (3) ----- | | | | | |
| (4) ----- | | | | | |
| (5) ----- | | | | | |
| (6) ----- | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|-------------------------|--|----------------------------|---|----------------------------------|--|----|
| | | | | | | Yes | 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) 2013

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
- ▶ Attach to Form 990. ▶ See separate instructions.
- ▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

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2013

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Inspection

Name of the organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number
52-0591607

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

| (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 POWDERHILL ROAD CALVERTON, MD 20705 53-0196597 | MEDICAL SVCS | MD | 501 (C) (3) | 9 | N/A | X | |
| (2) | MEDSTAR VNA HEALTHCARE 4061 POWDERHILL 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) | 11A I | 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) 2013

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service
Name of the organization

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

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number
52-0591607

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

| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
|---|-------------------------|--|---------------------|---------------------------|----------------------------------|
| (1) ----- | | | | | |
| (2) ----- | | | | | |
| (3) ----- | | | | | |
| (4) ----- | | | | | |
| (5) ----- | | | | | |
| (6) ----- | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|-------------------------|--|----------------------------|---|----------------------------------|--|----|
| | | | | | | Yes | 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 52-1104382 | FOUNDATION | MD | 501 (C) (3) | 11D III | N/A | | X |
| (4) UNION MEMORIAL HOSPITAL FOUNDATION, INC. 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218 52-1446828 | FOUNDATION | MD | 501 (C) (3) | 11A I | N/A | | X |
| (5) VNA, INC. 4061 PONDERRILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1332411 | ADMIN SVCS | MD | 501 (C) (3) | 11A I | N/A | | X |
| (6) MHC FOUNDATION, INC. 4061 PONDERRILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1791670 | ADMIN SVCS | MD | 501 (C) (3) | 11A I | N/A | | X |
| (7) WOODBOURNE WOODS, INC. 110 IRVING STREET NW WASHINGTON, DC 20010 52-2299070 | FOUNDATION | DC | 501 (C) (3) | 9 | N/A | | X |

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

Schedule R (Form 990) 2013

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990. ▶ See separate instructions.

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

OMB No. 1545-0047

2013

Open to Public
Inspection

Name of the organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

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

| (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) | HOSPICE OF ST. MARY'S, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-2153926 | ELDER HOUSING | MD | 501 (C) (3) | 11A I | N/A | | X |
| (2) | 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 |
| (3) | 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 |
| (4) | MEDSTAR SOUTHERN MD HOSPITAL CENTER 7503 SURREATTS ROAD CLINTON, MD 20735 46-0726303 | HOSPITAL | MD | 501 (C) (3) | 3 | N/A | | X |
| (5) | ----- | ----- | ----- | ----- | ----- | ----- | ----- | ----- |
| (6) | ----- | ----- | ----- | ----- | ----- | ----- | ----- | ----- |
| (7) | ----- | ----- | ----- | ----- | ----- | ----- | ----- | ----- |

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

Schedule R (Form 990) 2013

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) SURGICENTER AT PASADENA, LLC 5565 STERRETT PLACE, 5TH FLOOR MEDICAL SERVI | | MD | N/A | RELATED | | | | | | | X | |
| (2) PHYSICIAN IMAGING OF WASHINGTON 6525 BELCREST ROAD, SUITE G 50 LAB SERVICES | | MD | N/A | RELATED | | | | | | | X | |
| (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. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | DRUG SALES | MD | N/A | C CORP | | | | | |
| (2) EXTENCARE, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | MEDICAL SERVI | MD | N/A | C CORP | | | | | |
| (3) HELIX RESOURCES MANAGEMENT, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | ADMIN SERVICE | MD | N/A | C CORP | | | | | |
| (4) HELIXCARE MEDICAL GROUP, LLC 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | MEDICAL SERVI | MD | N/A | C CORP | | | | | |
| (5) HELIXCARE PROPERTIES, LLC 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | MEDICAL SERVI | MD | N/A | C CORP | | | | | |
| (6) PARKWAY VENTURES, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | HOLDING COMPA | MD | N/A | C CORP | | | | | |
| (7) PHYSICIANS ADMINISTRATIVE SERVICES, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | BILLING SERVI | MD | N/A | C CORP | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? | | (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. 52-1995521 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | MANAGED CARE | MD | N/A | C CORP | | | | | |
| (2) MEDSTAR ENTERPRISES, INC. 52-2138841 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 | ADMIN SERVICE | MD | N/A | C CORP | | | | | |
| (3) SITEL, INC. 90-0753340 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 | EDUCATIONAL SVCS | MD | N/A | C CORP | | | | | |
| (4) STAR BILLING, INC. 52-1850113 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 | BILLING SERVI | MD | N/A | C CORP | | | | | |
| (5) WASHINGTON RISK NETWORK MANAGEMENT, INC. 52-2132677 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 | MEDICAL SERVI | MD | N/A | C CORP | | | | | |
| (6) WASHINGTON HOSPITAL CENTER PHYSICIAN HOS 52-1911000 100 IRVING STREET NW WASHINGTON, DC 20010 | MEDICAL SERVI | MD | N/A | C CORP | | | | | |
| (7) MEDSTAR PHYSICIAN PARTNERS, INC. 52-2030809 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 | MEDICAL SERVI | MD | N/A | C CORP | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? | | (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) FRANKLIN SQUARE DRIVE LAND CONDO ASSOCIA 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 76-0756352 | CONDO OWNER A | MD | N/A | C CORP | | | | | |
| (2) MGH DIVERSIFIED SERVICES, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1941602 | MEDICAL SERVI | MD | N/A | C CORP | | | | | |
| (3) ST. MARY'S HEALTH ALLIANCE, INC. 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650 52-1920331 | MEDICAL SERVI | MD | N/A | C CORP | | | | | |
| (4) GREENSPRING FINANCIAL INSURANCE LIMITED 23 LIME TREE BAY AVENUE PO BOX 1051 KY1-1102, GRAND CAYMA 98-0188617 | INSURANCE | CJ | N/A | C CORP | | | | | |
| (5) ST MARY'S CONDO ASSOCIATION 25500 POINT LOOKOUT RD LEONARDTOWN, MD 20650 27-3377216 | CONDOMINIUMS | MD | N/A | C CORP | | | | | |
| (6) ----- | | | | | | | | | |
| (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 |

| | (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
|---|-------------------------------------|-------------------------------|------------------------|--|
| 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. | | | | |
| (1) | WOODBOURNE WOODS | Q | 152,582. | FMV |
| (2) | HH MEDSTAR HEALTH | P | 945,200. | FMV |
| (3) | THE UNION MEMORIAL HOSPITAL | Q | 776,602. | FMV |
| (4) | EXTENCARE | P | 67,832. | FMV |
| (5) | GS HOUSING | Q | 469,322. | FMV |
| (6) | GS HOUSING | L | 58,527. | 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 section 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 | |
| <u>1</u> | | | | | | | | | | | | | |
| <u>2</u> | | | | | | | | | | | | | |
| <u>3</u> | | | | | | | | | | | | | |
| <u>4</u> | | | | | | | | | | | | | |
| <u>5</u> | | | | | | | | | | | | | |
| <u>6</u> | | | | | | | | | | | | | |
| <u>7</u> | | | | | | | | | | | | | |
| <u>8</u> | | | | | | | | | | | | | |
| <u>9</u> | | | | | | | | | | | | | |
| <u>10</u> | | | | | | | | | | | | | |
| <u>11</u> | | | | | | | | | | | | | |
| <u>12</u> | | | | | | | | | | | | | |
| <u>13</u> | | | | | | | | | | | | | |
| <u>14</u> | | | | | | | | | | | | | |
| <u>15</u> | | | | | | | | | | | | | |
| <u>16</u> | | | | | | | | | | | | | |

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 2013, or fiscal year beginning 07/01, 2013, and ending 06/30, 2014

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

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

2013

Department of the Treasury Internal Revenue Service

Name of exempt organization

THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC.

Employer identification number

52-0591607

Name and title of officer

JOEL BRYAN, VICE PRESIDENT/TREASURER

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

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

Table with 5 rows (1a-5a) and 2 columns (b Total revenue, b Total tax, b Tax based on investment income, b Balance Due). Includes handwritten values like 318385443.

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 2013 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize KPMG LLP to enter my PIN 21239 as my signature

on the organization's tax year 2013 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 2013 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature: Joel Bryan

Date: 4/30/15

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.

54028022102

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2013 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4183, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature: Margaret A. Buckshaw

Date: 4/28/15

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 2013 | |
|---------------------------------------|---|
| Federal | |
| Locator: | 05462X |
| Taxpayer Name: | THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC. |
| Return Type: | 990, 990 & 990T (Corp) |
| | |
| Submitted Date: | 05/06/2015 15:32:10 |
| Acknowledgement Date: | 05/06/2015 15:57:46 |
| Status: | Accepted |
| Submission ID: | 54028020151265000006 |