[redacted]

APPLICATION FOR CERTIFICATE OF NEED

HOSPICE SERVICES
September 14th, 2018

SUBMITTED BY:

CARROLL HOSPICE

292 Stoner Avenue, Westminster, MD 21157

Table of Contents

LIST OF EXHIBITS

MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

APPLICATION FOR CERTIFICATE OF NEED: HOSPICE SERVICES

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Hospice Provider : Carroll Hospice

Address:

292 Stoner Avenue	Westminster	21157	Carroll
Street	City	Zip	County

Name of Owner (if differs from applicant):
Carroll Hospital Center, Inc.

2. OWNER

Name of owner: Carroll Hospital Center Inc. , 200 Memorial Ave, Westminster, MD 21157

3. APPLICANT. *If the application has a co-applicant, provide the detail in section 3 and 4 as an attachment.*

Legal Name of Project Applicant (Licensee or Proposed Licensee):
Carroll Hospice, Inc.

Address:

292 Stoner Avenue	Westminster	21157	MD	Carroll
Street	City	Zip	State	County

Telephone: 410-871-8000

Name of Owner/Chief Executive: Carroll Hospital Center, Inc./Leslie Simmons, President

Is this applicant one of the following? (Circle or highlight description that applies.)

Licensed and Medicare certified general hospice in Maryland
Licensed and Medicare certified hospice in another state
Licensed hospital in Maryland/ other state
Licensed nursing home in Maryland/other state
Licensed and Medicare certified home health agency in Maryland/other state

Limited license hospice in Maryland
IF NONE OF THE ABOVE, NOT ELIGIBLE TO APPLY (See COMAR 10.24.13.04A.)
DO NOT COMPLETE REMAINDER OF APPLICATION

4. LEGAL STRUCTURE OF LICENSEE

Check ☑ or fill in one category below.

A.	Governmental	☐
B.	Corporation	
	(1) Non-profit	X
	(2) For-profit	☐
C.	Partnership	
	General	☐
	Limited	☐
	Other (Specify):	
D.	Limited Liability Company	☐
E.	Other (Specify):	

5. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Regina Bodnar, Executive Director, Carroll Hospice
Mailing Address:

292 Stoner Avenue	Westminster	21157	MD
Street	City	Zip	State

Telephone: 410-871-7650
E-mail Address (required): RBodnar@carrollhospitalcenter.org
Fax: 410-871-7242

B. Additional or alternate contact: Patrick F. McMahon, Manager of Business Development

Mailing Address:

535 Old Westminster Pike	Westminster	21157	MD
Street	City	Zip	State

Telephone: 410-871-6302
E-mail Address (required): pmcmahon@carrollhospitalcenter.org
Fax: 410-871-6226

6. Brief Project Description (for identification only; see also item #13):

APPLICANT RESPONSE:

Carroll Hospice is proposing to add 6 beds to its existing inpatient hospice facility, increasing the

total bed count from 8 to 14. The existing inpatient facility has shell space which would be finished as part of this project to accommodate the additional beds.

7. Project Services (check applicable description):

Service	(check if description applies)
Establish a general hospice	
Establish a General Inpatient Unit (GIP)	
Add beds to a GIP	X

8. Current Capacity and Proposed Changes:

A) List the jurisdictions in which the applicant is currently authorized to provide general hospice services. (If services provided in other state(s), list them.)

Applicant Response: Carroll, Frederick and Baltimore Counties.

B) Jurisdiction applicant is applying to be authorized in:

Applicant Response: Carroll County

9. Project Location and Site Control *(Applies only to applications proposing establishment or expansion of a GIP unit):*

A. Site Size _2.3 acres

B. Have all necessary State and Local land use approvals, including zoning, for the project as proposed been obtained? YES_X____ NO _____ (If NO, describe below the current status and timetable for receiving necessary approvals.)

_____

_____

_____

_____

_____

C. Site Control and utilities:

(1) Title held by: __Carroll Hospital, Inc.

(2) Options to purchase held by: N/A_____

(i) Expiration Date of Option _____
(ii) Is Option Renewable? _____ If yes, Please explain

(iii) Cost of Option _____

(3) Land Lease held by: N/A_____
(i) Expiration Date of Lease _____
(ii) Is Lease Renewable _____ If yes, please explain

(iii) Cost of Lease _____

(4) Option to lease held by: N/A_____
(i) Expiration date of Option _____
(ii) Is Option Renewable?_____ If yes, please explain

(iii) Cost of Option _____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained.

N/A

(6) Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.
All utilities exist for the project

(INSTRUCTION: IN COMPLETING THE APPLICABLE OF ITEMS 10, 11 or 12, PLEASE CONSULT THE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

10. For new construction or renovation projects.

Project Implementation Target Dates

A. Obligation of Capital Expenditure **12-18** months from approval date.
B. Beginning Construction **6** months from capital obligation.
C. Pre-Licensure/First Use **12** months from capital obligation.
D. Full Utilization **14** months from first use.

11. For projects not involving construction or renovations.
Project Implementation Target Dates

A. Obligation or expenditure of 51% of Capital Expenditure _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

12. For projects not involving capital expenditures.
Project Implementation Target Dates

A. Obligation or expenditure of 51% Project Budget _____ months from CON approval date.
B. Pre-Licensure/First Use _____ months from CON approval.
C. Full Utilization _____ months from first use.

13. PROJECT DESCRIPTION

Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is, why you need to do it, and what it will cost. A one-page response will suffice. Please include:

(1) *Brief Description of the project –*

APPLICANT RESPONSE:

Carroll Hospice, an affiliate of Carroll Hospital, is a Medicare-certified, Maryland licensed, general hospice program located at 292 Stoner Ave, Westminster, MD, on the campus of Carroll Hospital. Carroll Hospice provides both home/facility-based hospice services and inpatient care in its "Dove House" facility at its Westminster location. Carroll Hospice's Dove House has been operating for nearly 12 years and is the only inpatient hospice facility in Carroll County, the applicant's primary service area.

Carroll Hospice is proposing to add 6 beds to its existing inpatient hospice facility, increasing the total bed count from 8 to 14. The existing inpatient facility has shell space which would be finished as part of this project to accommodate the additional beds.

The six additional new rooms will be identical to the eight existing rooms at Dove House. Each room will be spacious (at 330 square feet) and private, with a private balcony and bath, sleep sofa, additional seating, and flat screen television. The rooms will provide patients and families with the privacy, comfort and space for which hospice is known. Families also have the convenience of daily food service, sitting areas, a spacious dining area, chapel and support library.

(2) *Rationale for the project –*

APPLICANT RESPONSE:
The request is being made in response to the growing demand for inpatient hospice services.

Inpatient admissions at Carroll Hospice have grown 38% over the past four years, from 259 in FY14 to 358 in FY18. (See **Table 1**) Over the same time period, the average daily inpatient census (ADC) has grown from 4.6 to nearly 7, an average year-over-year growth rate of 10.5% since 2014. (See **Table 2**)

TABLE1

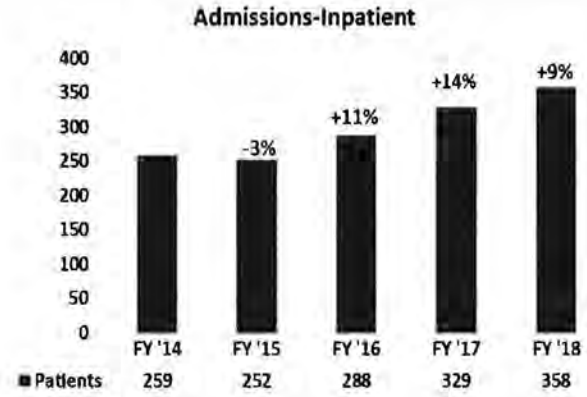
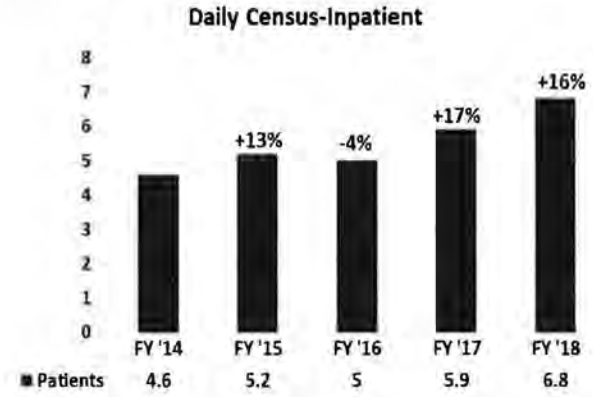


TABLE 2



Home/Facility-based services also have experienced significant growth over the past four years, from 417 admissions in FY14 to 769 in FY18, an increase of 84%. (See **Table 3**) The ADC grew 146% for this patient population from 62.5 to 153.9 over the same time period. In FY18 the ADC was up 32%, a second consecutive year of growth in excess of 30% for home/facility-based patients. (See **Table 4**)

TABLE 3

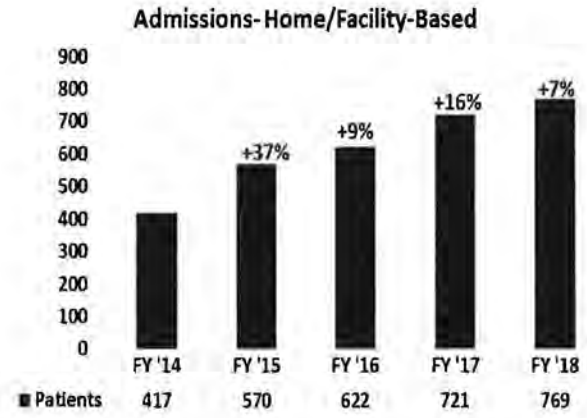
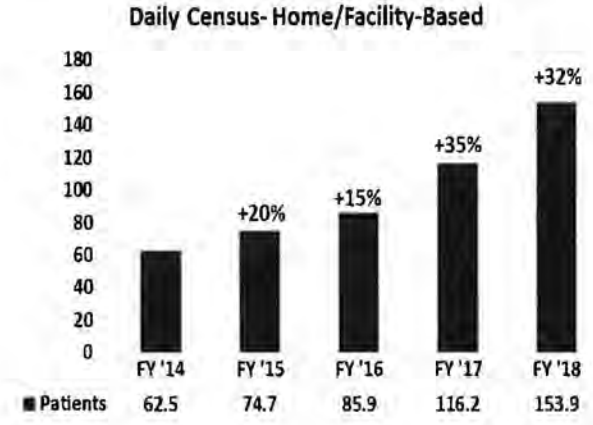


TABLE 4



This continuous growth has impacted Carroll Hospice's ability to admit patients to its inpatient facility and has, on occasion, resulted in patients too frail to return home, to remain in the hospital. It also has created increased occurrences of respite patients needing to be diverted to alternative facilities in the community.

The increased capacity of six beds will allow Carroll Hospice to better serve the growing demand for inpatient hospice and respite services by improving its ability to admit patients to the inpatient unit. Being able to admit patients more quickly also will help eliminate the need to provide interim hospice services within the hospital. Caring for hospice patients within the hospital is not only costlier but is much less beneficial to patients and their families by limiting their access to the comfort, care and support services more readily available in the inpatient hospice setting.

(3) ***Cost –.*** The total cost of the Project is $ 1,815,000. Please refer to Table 1 on Page 37 for details regarding the project budget.

14. PROJECT DRAWINGS-

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

These drawings should include the following before (existing) and after (proposed), as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bath rooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space". For projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

B. For projects involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

Applicant Response: See **Exhibit 1** for our project drawings

15. FEATURES OF PROJECT CONSTRUCTION: - Maurice

A. Please Complete **"CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS and COSTS"** (next page) describing the applicable characteristics of the project, if the project involves new construction.

Applicant Response: See Table 1 on page 37

B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.

Applicant Response: N/A

C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

Applicant Response: All utilities exist for the project

PART II - PROJECT BUDGET: COMPLETE TABLE 1 - PROJECT BUDGET

Applicant Response: See Table 1-Project Budget on page 35

PART III - CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

(INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. Each criterion is listed below.)

10.24.01.08G(3)(a). The State Health Plan.

Applicant must address each standard from the applicable chapter of the State Health Plan (10.24.13 .05); these standards are excerpted below. (All applicants must address standards A. through O. Applicants proposing a General Inpatient facility must also address P.)

Please provide a direct and concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application. Copies of the State Health Plan are available on the Commission's web site
http://mhcc.dhmh.maryland.gov/shp/Pages/default.aspx

10.24.13 .05 Hospice Standards. The Commission shall use the following standards, as applicable, to review an application for a Certificate of Need to establish a new general hospice program, expand an existing hospice program to one or more additional jurisdictions, or to change the inpatient bed capacity operated by a general hospice.

A. Service Area. An applicant shall designate the jurisdiction in which it proposes to provide services.

Applicant Response:
Carroll Hospice's inpatient hospice facility is located in Carroll County. The location of the inpatient hospice facility will not change as a result of this project. The primary service area for Carroll Hospice's inpatient hospice is Carroll County. Carroll Hospice's inpatient unit also serves patients from surrounding counties, including Frederick County and Baltimore County. Carroll Hospice provides home/facility-based hospice services in Carroll, Baltimore and Frederick counties. The counties in which Carroll Hospice provides home/facility-based services will not change as a result of this project.

B. Admission Criteria. An applicant shall identify:
(1) Its admission criteria; and
(2) Proposed limits by age, disease, or caregiver.

Applicant Response: Carroll Hospice's Admission Criteria are attached as **Exhibit 2**. Carroll Hospice admits patients regardless of age, gender, nationality, race, creed, sexual orientation, disability, diagnosis, ethnicity, handicap, prior modality of treatment, availability of health care agent, or the ability to pay. The decision to admit is made by the patient's attending physician in conjunction with the Carroll Hospice Medical Director and is based on the patient's disease history and clinical status. Admissions are completed within 24-48 hours of the referral, unless otherwise specified by the physician, and/or the patient.

C. Minimum Services.

(1) An applicant shall provide the following services directly:

(a) Skilled nursing care;

APPLICANT RESPONSE: Carroll Hospice provides professional nursing staffing in numbers consistent with the National Hospice and Palliative Care Organization (NHPCO) guidelines and provides care to meet the assessed needs of the patient and family.

(b) Medical social services;

APPLICANT RESPONSE: Carroll Hospice provides medical social work services in numbers consistent with the NHPCO guidelines. Staffing of social workers is adjusted according to census and patient need.

(c) Counseling (including bereavement and nutrition counseling);

APPLICANT RESPONSE: Carroll Hospice provides comprehensive bereavement services through a designated bereavement counselor. Carroll Hospice continually assesses and adjusts staffing of counseling services based on census and the needs of the community and in accordance of NHPCO guidelines. Dietary counseling, when identified in the plan of care, is performed by a qualified individual which may include a registered dietician, a nurse or other individual who is able to address and assure that the dietary needs of the patient are met.

(2) An applicant shall provide the following services, either directly or through contractual arrangements:

(a) Physician services and medical direction;

APPLICANT RESPONSE: Carroll Hospice currently employs a medical director who provides clinical oversight for patients. Providing clinical leadership and guidance, the medical director ensures that every patient's unique medical needs are addressed through the development of individualized care plans. As volumes continue to grow, medical oversight will be expanded proportionally.

(b) Hospice aide and homemaker services;

APPLICANT RESPONSE: Carroll Hospice staffs hospice aides in numbers and ratios consistent with NHPCO guidelines and who provide services consistent for the assessed needs of patients.

(c) Spiritual services;

APPLICANT RESPONSE: Carroll Hospice employs spiritual care providers who serve all faiths and in numbers consistent with NHPCO guidelines.

(d) On-call nursing response

APPLICANT RESPONSE: Staffed by experienced RNs and LPNs, Carroll Hospice's after-hours clinical team is available 24-hours a day, seven days a week, 365 days a year to quickly address concerns from patients, family members and staff. Consistent with the Hospice Conditions of Participation, all clinical disciplines are on-call 24/7/365.

(e) Short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management);

APPLICANT RESPONSE: Carroll Hospice provides inpatient hospice and respite options to ensure short-term pain and symptom management and relief for patients and caregivers.

(f) Personal care;

APPLICANT RESPONSE: Carroll Hospice's aides provide a full range of personal care for patients consistent with the patients' assessed needs.

(g) Volunteer services;

APPLICANT RESPONSE: Carroll Hospice draws on the strength of its surrounding communities to recruit volunteers to assist with its patients. Carroll Hospice currently has nearly 300 volunteers serving in a variety of roles such as direct patient/family care, fundraising, administrative, and professional (i.e. chaplains, educators, pet therapy).

(h) Bereavement services;

APPLICANT RESPONSE: Carroll Hospice provides comprehensive bereavement services through a designated bereavement team, which includes social workers, and provides a robust program to assist families through the grieving process for up to 13 months following a loss. Bereavement services include on-on-one counseling, an educational library and support groups. Carroll Hospice also offers bereavement counseling to anyone in the community regardless of if they have utilized Carroll Hospice's services. In addition, educational classes are available for those interested in becoming grief companions for Carroll Hospice. See **Exhibit 3** for a recent ad on the different grief support groups Carroll Hospice provides the community, which ran in the Carroll County Times on August 27, 2018.

(i) Pharmacy services;

APPLICANT RESPONSE: For both inpatient and home/facility-based patients, Carroll Hospice coordinates safe pharmaceutical services upon admission. Pharmacy partners provide consultations for optimal pain management, formulary management tools and comprehensive compliance documentation

(j) Laboratory, radiology, and chemotherapy services as needed for palliative care;

APPLICANT RESPONSE: Working collaboratively with existing providers, Carroll Hospice ensures patients have access to all palliative care services consistent with the hospice care plan.

(k) Medical supplies and equipment; and

APPLICANT RESPONSE: Through a contractual arrangement with Anchor Pharmacy and Medical Supply, Carroll Hospice provides durable medical equipment and supplies to patients in a timely manner.

(l) Special therapies, such as physical therapy, occupational therapy, speech therapy, and dietary services.

APPLICANT RESPONSE: Carroll Hospice ensures that any special therapies included in a patient's plan of care are provided. A contractual arrangement with Pivot Physical Therapy ensure access to professionals skilled at compassionately providing care and interventions consistent with patient and family goals and the hospice plan of care.

(4) An applicant shall provide bereavement services to the family for a period of at least one year following the death of the patient.

APPLICANT RESPONSE: Carroll Hospice provides bereavement services to families for up to 13 months following a loss. In addition Carroll Hospice offers bereavement services free of charge to all community members. This is regardless of whether or not a loved one was a patient of Carroll Hospice.

D. Setting. An applicant shall specify where hospice services will be delivered: in a private home; a residential unit; an inpatient unit; or a combination of settings.

APPLICANT RESPONSE: Carroll Hospice delivers services in a combination of private homes, it's an inpatient facility (Dove House), as well as skilled nursing and assisted living communities.

E. Volunteers. An applicant shall have available sufficient trained caregiving volunteers to meet the needs of patients and families in the hospice program.

APPLICANT RESPONSE: Carroll Hospice will continue to draw on its existing volunteer network, as well as continue to develop its ties with the community to continue to meet the needs of its patients and their families. Every volunteer for Carroll Hospice is required to attend a six-week, 21-hour training program.

F. Caregivers. An applicant shall provide, in a patient's residence, appropriate instruction to, and support for, persons who are primary caretakers for a hospice patient.

APPLICANT RESPONSE: Carroll Hospice offers home hospice care 24 hours a day, seven days a week. Carroll Hospice currently employs and provides professional and non-clinical staffing in ratios consistent with the National Hospice and Palliative Care Organization (NHPCO) guidelines and provides individualized care that meets the assessed needs of the patient and family. That includes instruction and support for patients and caregivers.

While their loved one is enrolled in Carroll Hospice, the hospice staff provides support for family members with day-to-day caregiving responsibilities including:

- Training for the caregiver(s) to help them understand(s) the patient's individualized plan of care;
- Pain and symptom management;
- Personal care for the patient;
- What to expect during the dying process;
- When to call for help, and
- Resources available through Carroll Hospice.

If an immediate need arises, an on-call nurse will address the concern or make a home visit.

G. Impact. An applicant shall address the impact of its proposed hospice program, or change in inpatient bed capacity, on each existing general hospice authorized to serve each jurisdiction affected by the project. This shall include projections of the project's impact on future demand for the hospice services provided by the existing general hospices authorized to serve each jurisdiction affected by the proposed project.

APPLICANT RESPONSE: Carroll Hospice is the sole provider of inpatient hospice services in Carroll County, so there would be no impact on other providers in Carroll County. Additionally, with Carroll County residents accounting for 86% of patients admitted to Dove House, any impact to inpatient hospice facilities outside of Carroll County would be immaterial. See also the response to .05(P)(3) below.

H. Financial Accessibility. An applicant shall be or agree to become licensed and Medicare-certified, and agree to accept patients whose expected primary source of payment is Medicare or Medicaid.

APPLICANT RESPONSE: Carroll Hospice is licensed, Medicare-certified and accepts patients whose primary source of payment is Medicare or Medicaid.

I. Information to Providers and the General Public.

(1) General Information. An applicant shall document its process for informing the following entities about the program's services, service area, reimbursement policy, office location, and telephone number:

(a) Each hospital, nursing home, home health agency, local health department, and assisted living provider within its proposed service area;

(b) At least five physicians who practice in its proposed service area;

(c) The Senior Information and Assistance Offices located in its proposed service area; and

(d) The general public in its proposed service area.

APPLICANT RESPONSE: Carroll Hospice provides information about its services, service area, reimbursement policy, office location and telephone number to each (a) hospital, nursing home, assisted living community, home health agency, the health department in Carroll County

(b) nearly all of the more than 400 physicians who practice in Carroll County and at Carroll Hospital, (c) the Bureau of Aging & Disabilities and other senior services located in Carroll County and (d) the general public in Carroll County

Carroll Hospice also communicates this information by publishing the information on its website (www.carrollhospice.org), via public service announcements and written correspondence to hospitals, providers and agencies in Carroll County. Additionally, this information is disseminated through personal liaison activity and community education endeavors.

(5) Fees. An applicant shall make its fees known to prospective patients and their families before services are initiated.

APPLICANT RESPONSE: Carroll Hospice makes its fees known to prospective patients and their families before services are initiated.

J. **Charity Care and Sliding Fee Scale**. Each applicant shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to hospice services regardless of an individual's ability to pay and shall provide hospice services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:

(1) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospice shall make a determination of probable eligibility.

APPLICANT RESPONSE:
Carroll Hospice makes a determination of eligibility for Charity Care and/or Medical Assistance within two business days of a patient applying for either program.

Carroll Hospice is a non-profit organization that provides hospice care and services to all individuals in need. Regardless of insurance coverage or financial situation, no one is refused or denied hospice care and every patient receives the same comprehensive high-quality service.

Initially, Carroll Hospice assists families in determining if the patient is eligible for any medical or insurance coverage. Hospice coverage is widely available and is covered by most private insurance plans, Medicare, Medicaid and the Veterans Administration.

If a person in need does not have coverage, Carroll Hospice will work with each family on a case by case basis. In addition, Carroll Hospice handles all billing of services and supplies as they relate to the terminal diagnosis.

See **Exhibit 4** for Carroll Hospice's complete Financial Assistance Policy and **Exhibit 5** for Financial Assistance Application.

(2) Notice of Charity Care Policy. Public notice and information regarding the hospice's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the population in the hospice's service area, and in a format understandable by the service area population.

Notices regarding the hospice's charity care policy shall be posted in the business office of the hospice and on the hospice's website, if such a site is maintained. Prior to the provision of hospice services, a hospice shall address any financial concerns of patients and patient families, and provide individual notice regarding the hospice's charity care policy to the patient and family.

APPLICANT RESPONSE: Carroll Hospital runs its Charity Care notice annually in its primary market. The notice is easy to understand and directs patients to Carroll Hospice for more information. The most recent notice appeared in the *Carroll County Times* on September 12th, 2018. (See **Exhibit 6).** Carroll Hospice and Carroll Hospital both have financial assistance sections on their respective websites. On the Carroll Hospital website there are links for the financial assistance application, policy, credit and collection policy, and a summary of the financial assistance policy for ease of use by patients and their families.

(3) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each hospice's charity care policy shall include provisions for a sliding fee scale and time payment plans for low-income patients who do not qualify for full charity care, but are unable to bear the full cost of services.

APPLICANT RESPONSE: In its Financial Assistance Policy, Carroll Hospice utilizes a sliding income scale, based on Federal Poverty Guidelines, in part to determine eligibility for Charity Care. (See **Exhibit 7**).

(4) Policy Provisions. An applicant proposing to establish a general hospice, expand hospice services to a previously unauthorized jurisdiction, or change or establish inpatient bed capacity in a previously authorized jurisdiction shall make a commitment to provide charity care in its hospice to indigent patients. The applicant shall demonstrate that:
(a) Its track record in the provision of charity care services, if any, supports the credibility of its commitment; and
(b) It has a specific plan for achieving the level of charity care to which it is committed.

Applicant Response: Carroll Hospice provides charity care and will continue to do so for its patients. In addition to providing Charity Care, Carroll Hospice also offers free Medicaid enrollment assistance for patients.
The table below identifies Carroll Hospice charity care for fiscal years 2014 thru 2018 and the percentage of charity care as a % of operating expenses for each year. Carroll Hospice has not denied hospice services to any eligible patient based on their ability to pay for services rendered. **See Table 5**

Table 5

Carroll Hospice Charity Care by Year: FY 2014-FY 2018		
Fiscal Year	Charity Care Provided	% of Annual Operating Expenses
2014	1,418	0.03%
2015	10,055	0.19%
2016	10,226	0.16%
2017	12,396	0.16%
2018	21,877	0.25%
Total 2014-2018	**55,972**	**0.17%**

K. Quality.

(1) An applicant that is an existing Maryland licensed general hospice provider shall document compliance with all federal and State quality of care standards.

APPLICANT RESPONSE:

Carroll Hospice complies with all Federal and State quality of care standards. Carroll Hospice is in excellent standing and holds deemed status with the Community Health Accreditation Program (CHAP). Carroll Hospice submits 100% of the required Hospice Item Set (HIS) data to CMS and participates in the Hospice CAHPS survey to identify opportunity for improvement within our own program and in support of CMS priorities for improving hospice care on a national level.

Carroll Hospice has built a comprehensive Quality and Patient Safety Program dedicated to continuous quality improvement for our staff, patients and families. Much of the quality and performance improvement work taken on by the organization is based on the "Lean" management principles of performance improvement, which focuses on identifying measurable goals, completing tests of process improvement, and continual evaluation of results. The Carroll Hospice Quality Assessment Performance Improvement (QAPI) Committee identifies and defines goals and specific objectives to be accomplished each year in consideration of the Lean process, the current regulatory climate, organizational committee work, accreditation survey results and anecdotal information from stakeholders. Our Quality Improvement and Patient Safety Plan **(see Exhibit 8),** details the objectives, goals and performance measures that will guide our quality improvement work in fiscal year 2019.

2) An applicant that is not an existing Maryland licensed general hospice provider shall document compliance with federal and applicable state standards in all states in which it, or its subsidiaries or related entities, is licensed to provide hospice services or other applicable licensed health care services.

APPLICANT RESPONSE: This standard is not applicable.

(3) An applicant that is not a current licensed hospice provider in any state shall demonstrate how it will comply with all federal and State quality of care standards.

APPLICANT RESPONSE: This standard is not applicable.

(4) An applicant shall document the availability of a quality assurance and improvement program consistent with the requirements of COMAR 10.07.21.09.

APPLICANT RESPONSE: Carroll Hospice has adopted a quality assurance and improvement program consistent with COMAR 10.07.21.09. See **Exhibit 8** for our Quality Improvement and Patient Safety Plan.

(5) An applicant shall demonstrate how it will comply with federal and State hospice quality measures that have been published and adopted by the Commission.

APPLICANT RESPONSE:
Carroll Hospice complies with Federal and State hospice quality measures and will comply with any and all future quality initiatives adopted by the Commission.

We have a robust audit program. Monthly direct supervisory visits for each program leader provides regular opportunity to identify best practices, and areas of improvement.

Currently, through Deyta Analytics, Carroll Hospice participates in the Hospice CAHPS quality measures as required by CMS. In FY18 (July 2017 – June 2018) Carroll Hospice met or exceed the national and state benchmarks in all eight domains that includes global and composite measures for, Rating of Patient Care; Recommending This Hospice Team; Communication; Getting Timely Care; Treating Family Members with Respect; Getting Emotional and Religious Support; Getting Help with Symptoms and Getting Hospice Care Training. See **Exhibit 9.**

In April of 2018, Carroll Hospice was awarded the 2018 Hospice Honors Award (based on October 2016 through September 2017 data) by Deyta. The prestigious award recognizes hospices across the county that provide the highest level of quality as measured from the caregiver's point of view.

It is important to note that Carroll Hospice experienced 15% volume growth (combined inpatient and home/facility-based) between FY16 and FY17, from 910 to 1,050, yet was able to maintain the highest level of quality. Serving the ever-increasing patient population that could benefit from hospice services is the mission of Carroll Hospice, and quality always remains at the forefront of all we do. Our track record of being able to maintain such a high level of patient satisfaction, service and safety, while managing major shifts in patient census, indicates Carroll Hospice is well qualified to serve the critical need for hospice services in Carroll County.

L. Linkages with Other Service Providers.

(1) An applicant shall identify how inpatient hospice care will be provided to

patients, either directly, or through a contract with an inpatient provider that ensures continuity of patient care.

APPLICANT RESPONSE:
Carroll Hospice provides inpatient hospice care through its existing facility, Dove House.

(2) An applicant shall agree to document, before licensure, that it has established links with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services (AERS), Senior Information and Assistance Programs, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

APPLICANT RESPONSE: Carroll Hospice is currently licensed and a subsidiary of Carroll Hospital. In addition, it has very strong links to other hospitals (those both in the LifeBridge Health system and throughout our service areas), nursing homes, home health agencies, assisted living providers, Senior Center and Assistance Programs, and the local Department of Social Services for Veterans Services,

M. Respite Care. An applicant shall document its system for providing respite care for the family and other caregivers of patients.

APPLICANT RESPONSE:
Carroll Hospice has a process in place for providing respite care for family and caregivers of patients. (See **Exhibit 10**)

N. Public Education Programs. An applicant shall document its plan to provide public education programs designed to increase awareness and consciousness of the needs of dying individuals and their caregivers, to increase the provision of hospice services to minorities and the underserved, and to reduce the disparities in hospice utilization. Such a plan shall detail the appropriate methods it will use to reach and educate diverse racial, religious, and ethnic groups that have used hospice services at a lower rate than the overall population in the proposed hospice's service area.

APPLICANT RESPONSE:
Carroll Hospice's educational initiatives are ongoing. Initiatives are multi-pronged and include, but are not limited to, providers, facility partners, patients, families and communities. Some of those programs are included in a monthly calendar created and distributed by Carroll Hospital. See **Exhibit 12**

An endowed fund was established to provide community and physician education and is personalized to meet specific needs of the patient and his or her family. The platform for education is based on the renowned work of Atul Gawande MD "Being Mortal." Since being published in 2014, Dr. Gawande's philosophy has quickly become a standard for providing care for the frail elderly and the chronically ill. It aids providers in addressing key decision points in the care of this patient population by offering a profound perspective on the end of life.

Within our inpatient facility setting, regular education is offered to family members and will continue to be woven into our program of care. A family member's firm understanding of the array of services and support, options available are key to the hospice care plan. The hospital staff also helps patients and families understand the importance of advanced care planning so that patients can not only better advocate for themselves but designate decision makers who can advocate for them when they are no longer able to.

Across the community, Carroll Hospice responds to requests by hospitals, health systems and community-based organizations to provide education to community health workers/navigators so that they are better prepared to provide basic information and direction to those clients who express interest in more information.

Carroll Hospice also has a calendar on their website which details when various support groups are offered as well as having an education section for patients and their families.

O. Patients' Rights. An applicant shall document its ability to comply with the patients' rights requirements as defined in COMAR 10.07.21.21.

APPLICANT RESPONSE:
Carroll Hospice has a comprehensive Patients' Rights and Responsibilities Policy that is hard wired into our work flows and practiced in every patient encounter. It ensures every patient is provided with quality, safe care and is treated with the utmost respect and compassion throughout his or her experience with Carroll Hospice. See **Exhibit 11** for Carroll Hospice's Patients' Rights and Responsibilities Policy.

P. Inpatient Unit: In addition to the applicable standards in .05A through O above, the Commission will use the following standards to review an application by a licensed general hospice to establish inpatient hospice capacity or to increase the applicant's inpatient bed capacity.

(1) Need. An applicant shall quantitatively demonstrate the specific unmet need for inpatient hospice care that it proposes to meet in its service area, including but not limited to:

(a) The number of patients to be served and where they currently reside;

APPLICANT RESPONSE:

Inpatient admissions at Carroll Hospice have grown 38% over the past four years, from 259 in FY14 to 358 in FY18. (See **Table 6**) Over the same time period, the average daily inpatient census (ADC) has grown from 4.6 in to nearly 7, an average year-over-year growth rate of 10.5%. (See **Table 7**)

TABLE 6

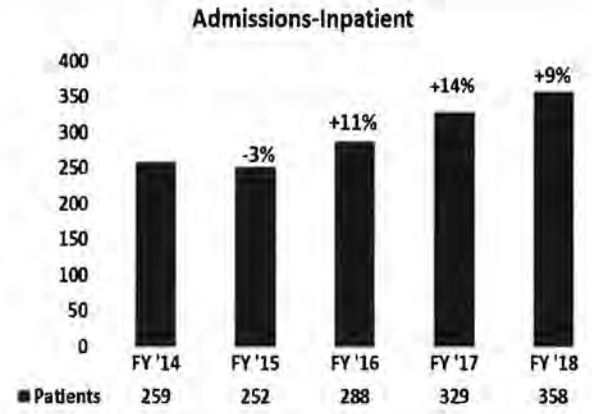
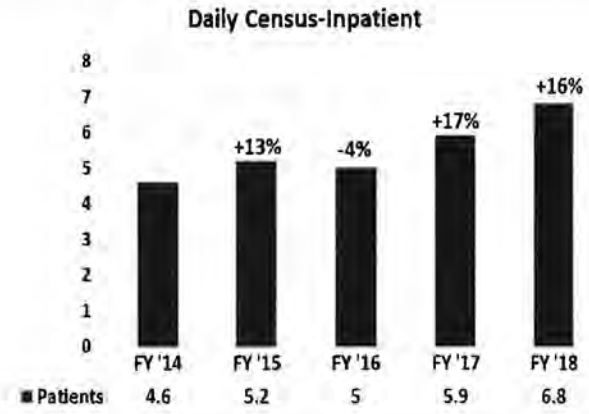


TABLE 7



Home/Facility-based services also have experienced significant growth over the past four years, from 417 patients in FY14 to 769 in FY18, an increase of 84%. (See **Table 8**) The ADC grew 146% for this patient population from 62.5 to 153.9 over the same time period. In FY18 the ADC was up 32%, a second consecutive year of growth in excess of 30% for home/facility-based patients. (See **Table 9**)

TABLE 8

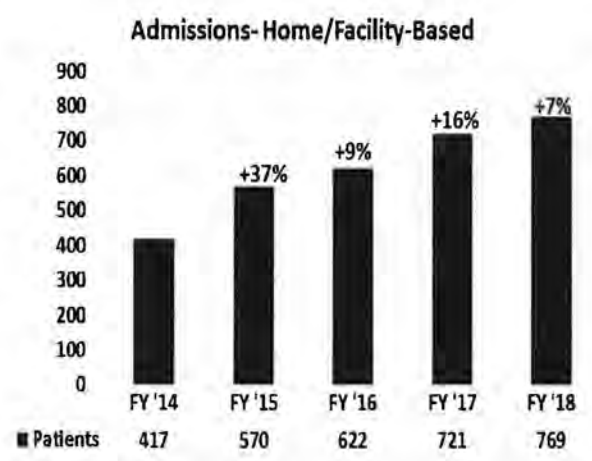
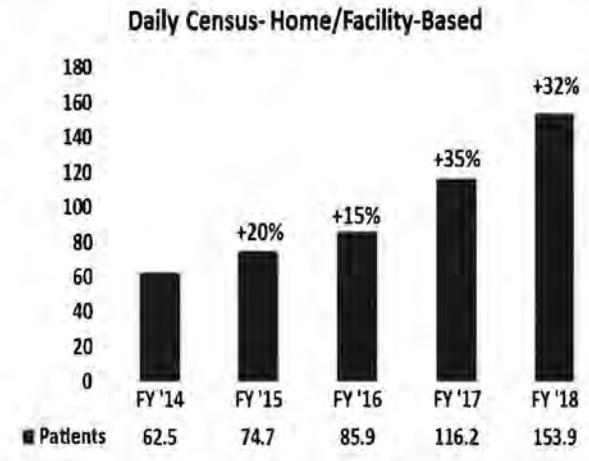


TABLE 9



Home/Facility based volumes and trends are important because in **FY18 26%/ 127** patients of Carroll Hospice's admissions were individuals who were already receiving in-home/facility-based hospice care. See **Table 10**.

TABLE 10

	Historical				
	FY '14	**FY '15**	**FY '16**	**FY '17**	**FY '18**
Carroll Hospice Inpatient Admissions					
Direct Admissions	259	252	288	329	358
Transfers-In from Outpatient Program	141	159	151	168	127
Total	**400**	**411**	**439**	**497**	**485**
Transfer Rate	***35%***	***39%***	***34%***	***34%***	***26%***
Carroll Hospice Outpatient Admissions					
Admissions	417	570	622	721	769
Transfers-In from Inpatient Program	103	97	90	112	102
Total	**520**	**667**	**712**	**833**	**871**
Transfer Rate	***20%***	***15%***	***13%***	***13%***	***12%***

In FY18 Carroll Hospice had 1,127 total admissions (including both inpatients and home/facility-based patients). Of these, 971/86% were residents of Carroll County with the remaining 156/14% admissions coming from other counties. See **Table 11.**

TABLE 11

		FY '14 thru FY '18						
		FY '14	**FY '15**	**FY '16**	**FY '17**	**FY '18**	**FY '18% of Total**	**4 Yr Growth %**
Service								
	Home/Nursing Facility Based	417	570	622	721	769	68%	84%
	Inpatient (Dove House)	259	252	288	329	358	32%	38%
	Total Admissions (Undup)	**676**	**822**	**910**	**1,050**	**1,127**	**100%**	**67%**
County								
	Carroll	**572**	**695**	**745**	**857**	**971**	**86%**	**70%**
	Frederick	55	80	109	120	69	6%	25%
	Baltimore	34	33	45	54	62	6%	82%
	All Other	15	14	10	19	25	2%	67%
	Subtotal Non-Carroll	**104**	**127**	**164**	**193**	**156**	**14%**	**50%**
	Total Admissions (Undup)	**676**	**822**	**909**	**1,050**	**1,127**	**100%**	**67%**

(b) The source of inpatient hospice care currently used by the patients identified in subsection (1) (a); and

Applicant Response: The source of inpatient hospice care currently utilized by the patients identified above is Carroll Hospice

(c) The projected average length of stay for the hospice inpatients identified in subsection (1) (a).

Applicant Response:
While historically the Length of Stay (LOS) for both Inpatient and Home/Facility-based patients has remained relatively consistent, between FY17 and FY18 Carroll Hospice has seen its LOS for inpatients increase by 19%, from 4.3 days to 5.1 days; and by 27% for its home/facility-based patients from 43.9 days to 64.5 days. (See **Tables 12 and 13**)

Table 12

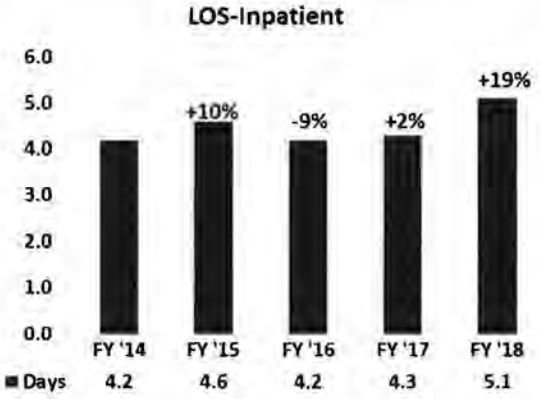
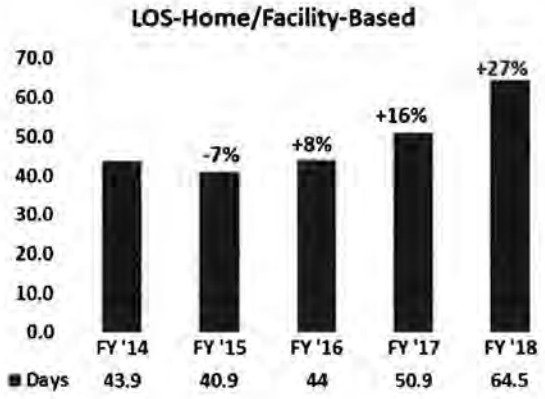


Table 13



Carroll Hospice is projecting that length of stay will remain at current levels during the projection period.

(2) Impact. An applicant shall quantitatively demonstrate the impact of the establishment or expansion of the inpatient hospice capacity on existing general hospices in each jurisdiction affected by the project, that provide either home-based or inpatient hospice care, and, in doing so, shall project the impact of its inpatient unit on future demand for hospice services provided by these existing general hospices.

Applicant Response: Carroll Hospice is the sole provider of inpatient hospice services in Carroll County, so there would be no impact in the applicant's Jurisdiction. Additionally, with Carroll County residents accounting for 86% of patients admitted to Dove House, any impact to inpatient hospice facilities outside of Carroll County would be immaterial. The bed expansion, however, could have a positive impact by the elimination of or decrease in stays for patients boarding at Carroll Hospital.

According to the MHCC FY16 hospice survey there are three other providers of hospice services in Carroll County. These three providers are Gilchrist Center, Stella Maris, and Seasons Hospice Medstar Franklin Square. Carroll Hospice is not anticipating any impact to those providers' inpatient or home-based care volumes, because they do not provide inpatient services in Carroll County. Furthermore Carroll Hospice believes the proposed expansion can assist by providing an expanded inpatient option for other agencies Carroll County in home hospice patients. **See Table 14** for the distance these other inpatient options are from Carroll Hospice.

Table 14

IP Hospice Facility	Distance from Carroll Hospice
Gilchrist Center Towson	27.0 miles
Gilchrist Center Howard County	32.8 miles
Gilchrist Center Baltimore	34.5 miles
Seasons Northwest Hospital	21.3 miles
Seasons Sinai Hospital	27.7 miles
Stella Maris	26.9 miles

(3) Cost Effectiveness. An applicant shall demonstrate that:

(a) It has evaluated other options for the provision of inpatient hospice care, including home-based hospice care, as well as contracts with existing hospices that operate inpatient facilities and other licensed facilities, including hospitals and comprehensive care facilities; and

(d) Based on the costs or the effectiveness of the available options, the applicant's proposal to establish or increase inpatient bed capacity is the most cost-effective alternative for providing care to hospice patients.

Applicant Response:

Carroll Hospice does provide care both in patients' homes and in skilled nursing and assisted living facilities. But there are times when hospice patients' symptoms, most often pain and associated nausea, can no longer be managed effectively at home. This can lead patients requiring inpatient hospice care. The same is true when a patient is in the hospital or a skilled nursing or assisted living facility.

Carroll Hospice has evaluated other reasonable options for the provision of inpatient hospice care, including continuing to board patients at Carroll Hospital and requiring patients and their families to travel outside Carroll County for inpatient hospice care. (See Section **10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives**.)

It is our determination that, beyond the irrefutable, proven benefit of keeping hospice services close to home for patients and their families, utilizing existing shelled space is the most cost-effective solution to ensuring this vital, end-of-life service continues to be available in the most appropriate setting and where and when it's required.

10.24.01.08G(3)(b). Need.

For purposes of evaluating an application under this subsection, the Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

Applicant Response:

There is no applicable need analysis for inpatient hospice care in the State Health Plan. Carroll Hospice's request to increase its inpatient bed inventory from eight to 14 was based on several primary factors:

1. Projected Population Growth for the Elderly in Carroll County
2. Hospice Penetration Rates
3. Carroll Hospice Demand Profile
4. Increase in Palliative Care

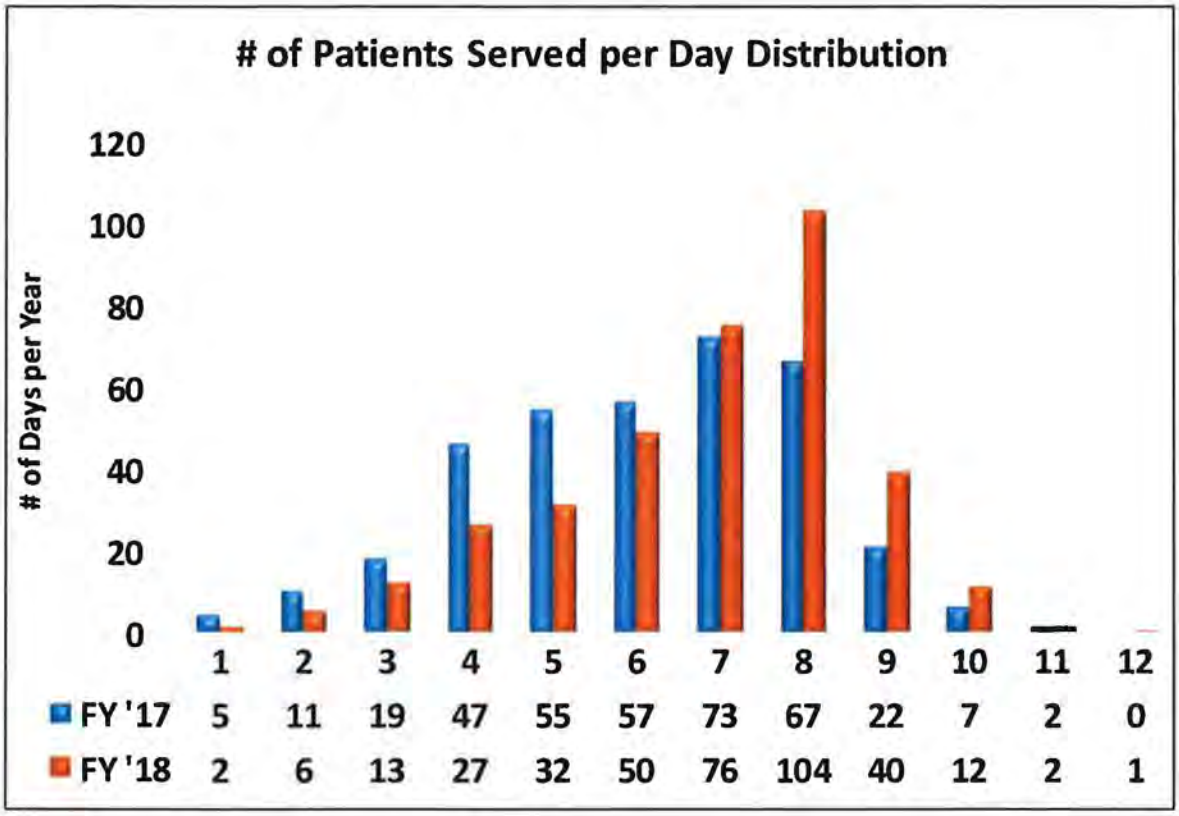
1. **Projected Population Growth for the Elderly in Carroll County**

According to CMS, the number of patients utilizing hospice services has grown nationally from 513,000 patients in 2000 to nearly 1.4 million patients in 2015, an increase of 173%. That number is supported by the National Hospice and Palliative Care Organization, which reported that there were 1.43 million Medicare beneficiaries enrolled in hospice in 2016.

Carroll County has one of the highest hospice utilization rates in the state. According to the MHCC's Maryland Hospice Need Projections for Target Year 2019, Carroll County has a baseline use rate of 0.50, which is the second highest in the Western Maryland Region and the fourth highest in the state. See **Exhibit 13.**

The number of patients being served per day is increasing. In FY17, Carroll Hospice had seven or more patients 47% of the time; in FY18 that number increased to 64%. Of those times, Carroll Hospice was at full capacity (eight patients) 27% of the time in FY17, and that jumped to 44% of the time in FY18. A trended view is also provided for reference. See **Table 15.**

TABLE 15



Between FY15 and FY20 the population of residents age 65 and over in Carroll County is estimated to grow by 23%/6,164 residents. From 2020 to 2025, the growth rate is 23%/7,602 residents. **See Table 16**

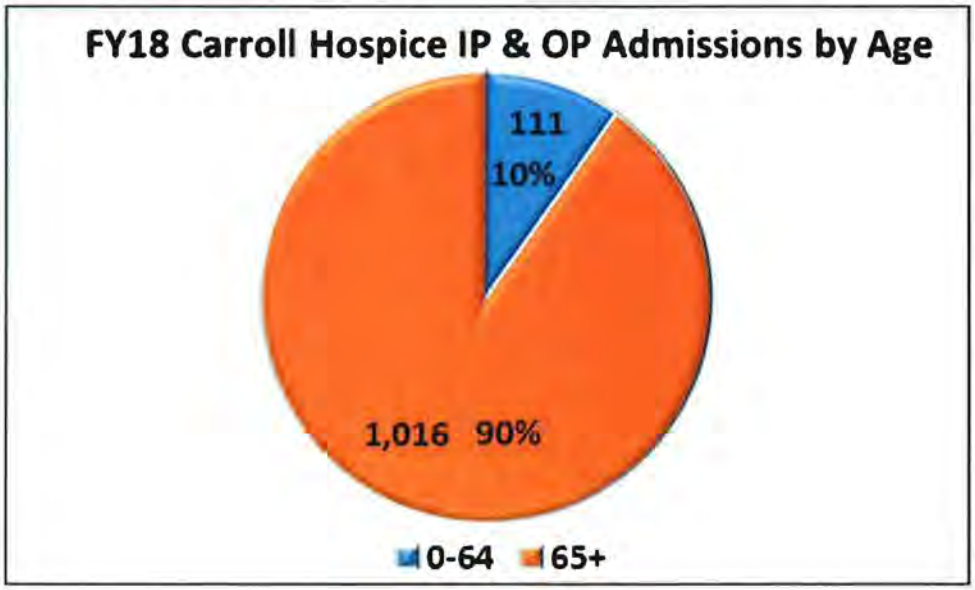
Table 16

	Population Estimate			Annual Growth Rate		Deaths per 1000	Carroll Hospice
	FY '15	FY '20	FY '25	FY '15-'20	FY '20-'25	FY '14-'16	% of Deaths
Age Cohort							
Under 55	115,579	107,407	102,909	-1.5%	-0.9%	1.51	**3%**
55-64	24,637	28,296	27,685	2.8%	-0.4%	7.42	7%
65-74	15,893	19,122	22,254	3.8%	3.1%	17.01	15%
75-84	7,559	9,792	13,291	5.3%	6.3%	51.71	27%
85+	3,880	4,582	5,553	3.4%	3.9%	159.78	48%
Over 55	**51,969**	**61,792**	**68,783**	**3.5%**	**2.2%**	**27.43**	**97%**
Over 75	**11,439**	**14,374**	**18,844**	**4.7%**	**5.1%**	**86.70**	**75%**
Total	167,548	169,199	171,692	0.2%	0.3%	9.25	100%

Source: Maryland Department of Planning, Projections, and State Data Center, "2017 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Other, and Hispanic by Age and Gender."

Patients, age 65 and over are the highest utilizers of hospice services. In FY18, 90% of Carroll Hospice patients were age 65 and over. As that demographic continues to grow in Carroll County, it is reasonable to assume that it will impact hospice utilization.
See **Table 17**.

Table 17



2) **Hospice Penetration Rates:**

Carroll County Hospice Utilization Projections

Between FY16 – FY18 total annual deaths in Carroll County grew 13%, from 1,599 to 1,808 and total hospice deaths grew 18%, from 841 to 994 according to the Maryland Department of Vital Statistics Annual Report for 2016. Over the same period, Carroll Hospice's volumes have grown 27%, from 693 to 877. Carroll Hospice projects the hospice penetration level will stay consistent from FY18 to FY24 at an estimated 55%. Estimated market share is expected to be 86% in FY24 continuing Carroll Hospice's dominant position.

With 877 deaths in FY18, Carroll Hospice currently holds an estimated 88% market share in Carroll County. (See Table 16) Carroll Hospice's market share in Carroll County has grown steadily over the past four years, a total of 6% since FY14, when it was 693 deaths representing an 82% market share.
See **Table 18.**

TABLE 18

	Historical			Outlook
Carroll County	**FY '16**	**FY '17**	**FY '18**	**FY '24**
Population Estimates	167,140	167,682	168,012	170,853
x Death Rate per 1,000	9.57	10.43	10.76	13.05
Total Annual Deaths	1,599	1,749	1,808	2,230
x Hospice Penetration Rates	53%	53%	55%	55%
Total Hospice Deaths	841	927	994	1,235
x Carroll Hospice Market Share	82%	85%	88%	86%
Carroll Hospice Deaths (Carroll Cty)	693	789	877	1,061
x Admission Factor	1.08	1.09	1.11	1.11
Carroll Hospice Admissions (Carroll Cty)	**745**	**857**	**971**	**1,182**
+ (Total Non-Carroll County Admissions)	165	193	156	233
Carroll Hospice Total Admissions	**910**	**1,050**	**1,127**	**1,415**
Annual Growth Rate		**15%**	**7.3%**	**3.9%**

Source: MHCC Hospice Survey FY16.
Maryland Vital Statistics Annual Report 2016.
Maryland Department of Planning, Projections, and State Data Center, "2017 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Other, and Hispanic by Age and Gender."
Note: FY'17 and FY'18 Hospice penetration rates and market share are internal estimates at this time

3) Carroll Hospice's Demand Profile

Carroll Hospice has experienced tremendous growth in its inpatient, and home/facility-based admissions over the past three fiscal years.

A consequence of the relatively high census of Dove House is that patients have had to board at Carroll Hospital until a space became available in Dove House. In FY18, there were 32 hospice patients who spent a total of 66 days in a general inpatient unit in Carroll Hospital because they were too frail to go home and there were no beds available at the Carroll Hospice inpatient unit. These patients were able to receive care which managed their symptoms, but did not benefit from the full benefits of hospice care.

Another consequence of the high census has been patients having to respite in other facilities. Most recently (June-August 2018) Carroll Hospices' inpatient unit had 12 patients that needed to respite in other facilities because of no bed availability at Dove House. That would annualize out to 48 patients that would require other facilities for their respite care options.

As a result of Carroll County's aging population and high demand for hospice services, Carroll Hospice anticipates demand for its services to continue to expand for the foreseeable future. **See Table 19**

Table 19

	Historical			Outlook
	FY '16	**FY '17**	**FY '18**	**FY '24**
Carroll Hospice Total Admissions	**910**	**1,050**	**1,127**	**1,415**
Annual Growth Rate		***15%***	***7.3%***	***3.9%***
Length of Stay				
Outpatient	44.0	50.9	64.5	64.5
Inpatient	4.2	4.3	5.1	5.1
Total	**36.5**	**42.4**	**52.0**	**52.0**
Annual Growth Rate		***16%***	***23%***	
Average Daily Census				
Outpatient	85.9	116.2	153.9	189.4
Inpatient	5.0	5.9	6.8	9.0
Total	**90.9**	**122.1**	**160.7**	198.4
Annual Growth Rate		***34%***	***32%***	***3.9%***

4. Increase in Palliative Care

Palliative care programs also are a main driver of hospice volumes. Carroll Hospital provided palliative care to 914 patients in FY18. Of the patients who are receiving palliative care, Carroll clinicians estimate that 30% will transition to hospice care. As the elderly population of Carroll County increases, the demand for palliative care services will increase, as will the number of those patients seeking Hospice care.

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project that will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics the Commission should take into account.

Applicant Response:

Hospice care is recognized to improve the quality of care by providing emotional and spiritual support, providing symptom management, empowering patients in a decision-making role, and reducing readmissions/emergency room visits. There is growing evidence to demonstrate that hospice care is correlated with reduced hospital care at the end of life and reduced Medicare expenditures for most enrollees. A recent study reported that hospice use over 2 weeks was associated with decreased hospital days for all beneficiaries (1-5 days overall), with greater decreases for longer hospice use (citation: Journals of Gerontology: Social Sciences 2015).

Carroll Hospice has a rich 30-year history of caring for patients and families through end of life. Our nursing and hospice aide team members are certified in Hospice and Palliative Care and our supportive services staff members credentialed consistent with NHPCO recommendations.

As mentioned previously, Carroll Hospice is CHAP accredited and has received accolades for the quality of the care it provides based on Hospice CAHPS survey results. In FY18 (July 2017 – June 2018) Carroll Hospice met or exceed the national and state benchmarks in all eight domains that includes global and composite measures for, Rating of Patient Care; Recommending This Hospice Team; Communication; Getting Timely Care; Treating Family Members with Respect; Getting Emotional and Religious Support; Getting Help with Symptoms and Getting Hospice Care Training. **See Exhibit 9**.

In evaluating options for addressing the increased demand for inpatient hospice services, Carroll Hospice considered the following three alternatives to overcome current barriers to access:

Option 1: Continue to board patients at Carroll Hospital

As mentioned previously, the robust and sustained growth Carroll Hospice has experienced has impacted its ability to admit patients to its inpatient facility and has, on occasion, resulted in

patients too frail to return home, to remain in the hospital.
Carroll Hospice could continue to board Hospice patients within Carroll Hospital and transfer them to Dove house when there is space. However, caring for patients within the hospital is much less beneficial to patients and their families by limiting their access to the comfort, care and support services more readily available in the inpatient hospice setting. While the care provided at Carroll Hospital is excellent, inpatient hospital care is not intended or designed to duplicate a true Hospice model.

Option 2: Transfer Patients to Other Facilities

While transferring patients to facilities outside of Carroll Hospice's primary service area (Carroll County) would be more cost effective by eliminating the costs of renovating the current facility, making patients and their families travel farther from their support systems, friends and providers goes against the mission of Carroll Hospice and the philosophy of hospice care in general. A key component to helping patients "to live as fully and comfortably as possible" is providing the care, comfort and support they need close to home.

Carroll Hospice is the only hospice provider in Carroll County which means patients and their families would need to travel a minimum of 22 miles, and 35 minutes under the most optimal travel conditions, to the next closest inpatient hospice facility, or farther depending on the availability of beds.

Option 3: Renovate Current Carroll Hospice Inpatient Facility

An affiliate of Carroll Hospital, Carroll Hospice established its inpatient facility in late 2006. Carroll Hospice has been operating for nearly 12 years in its current location and is the only inpatient hospice facility in Carroll County, the applicant's primary service area.

As explained and illustrated in this application Carroll Hospice has experienced exceptional growth over the past three to five years and can no longer accommodate the needs of its community. As a result, Carroll Hospice is proposing to add six beds to its existing inpatient facility, increasing the total bed count from eight to 14.

When the original inpatient facility was built, it included shelled space for future expansion. As a result, now that Carroll Hospice has a need for more space to better serve its community, it is able to expand its capacity for a much lower cost compared to a major expansion or building a new facility. As outlined in this application, by utilizing the existing space in the current Carroll Hospice Inpatient facility, Carroll Hospice will be positioned well to continue to meet the growing demand of inpatient hospice services for patients from Carroll and surrounding counties.

By utilizing shelled space already available, Carroll Hospice also will be able to implement a solution and get the project completed quickly.

Beyond the irrefutable, proven benefit of keeping hospice services close to home for patients and their families, utilizing existing shelled space is the most cost-effective solution to ensuring this vital, end-of-life service continues to be available in the most appropriate setting and where and when it's required.

10.24.01.08G(3)(d). Viability of the Proposal.

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

a. Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.

Applicant Response: Audited financial statements for the past two years are attached as **Exhibit 14.** For sources of funding for the project see Table 1 on page 37.

b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.

Applicant Response: The proposed project will not have any impact on current charges at Carroll Hospice. Approximately 90% of Hospice patients are Medicare patients therefore the reimbursement for incremental hospice patients will be based on Medicare per diem rate for hospice services. Other payment rates will be consistent with current contracts between Carroll Hospice and commercial payers.

c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

Applicant Response: Carroll Hospice is the only inpatient hospice in Carroll County, so this project will have no impact on charges for other facilities in Carroll County, and there is no impact expected on the charges for inpatient facilities in other counties.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

Applicant Response: Please see **Table 20** below for the list of charges for our Inpatient services.

Table 20

CARROLL HOSPICE
CURRENT RATES FOR SERVICES
As of 9/6/18

	DAY 1-60 Routine Care	DAY 61+ Routine Care	Continuous Care	Inpatient Respite	General Inpatient	Physician Visit-IPF
MEDICARE (CBSA 12580)	**$ 187.26**	**$ 147.07**	**$ 948.44** per hour: **$ 39.52**	**$ 168.88**	**$ 723.70**	**$105-$195**
MD MEDICAID (CBSA 12580)	**$ 187.50**	**$ 147.27**	**$ 948.81** per hour: **$ 39.53**	**$ 177.76**	**$ 723.70**	**$105-$195**
Commercial*	**$ 135.28**	**$ 135.28**	**$ 829.68** per hour: **$ 34.57**	**$ 135.56**	**$ 587.32**	**$105-$195**

*Commercial rates are based on an average of our three largest commercial payers

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1995, and their status.

Applicant Response: This standard is not applicable. Carroll Hospital Center acquired Carroll Hospice as an existing health care facility in 1995 without a Certificate of Need. Its authorization to serve in Carroll, Baltimore and Frederick Counties pursuant to Chapter 404 of the 2003 Laws of Maryland is set forth in the August 18, 2003 letter from the Department of Health and Mental Hygiene attached as **Exhibit 15.**

10.24.01.08G(3)(f). Impact on Existing Providers.

For evaluation under this subsection, an applicant shall provide information and analysis with

respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

Applicant Response:

The project will have a positive impact on the health care system because it will address the growing demand for inpatient hospice services that Carroll Hospice is experiencing and cannot accommodate in its existing beds, as described above under the Need criterion (.08G(3)(b)). This will keep hospice services close to home for patients and their families, ensuring this vital, end-of-life service continues to be available in the most appropriate setting and where and when it's required. Further, the increase in inpatient hospice beds is also expected to have a positive impact by the elimination of or decrease in stays for patients boarding at Carroll Hospital, as described further above.

Carroll Hospice is the sole provider of inpatient hospice services in Carroll County and its existing bed compliment does not meet the growing need for beds. Accordingly, the project will not duplicate existing health care resources, and there are no other inpatient hospice providers in Carroll County that could be impacted by the project. Additionally, with Carroll County residents accounting for 86% of patients admitted to Dove House, any impact to inpatient hospice facilities outside of Carroll County would be immaterial.

As part of this criterion, complete Table 5, and provide:

1. **an assessment of the sources available for recruiting additional personnel;**

2. **recruitment and retention plans for those personnel believed to be in short supply;**

Applicant Response: Carroll Hospice's recruitment for staff members to meet the needs of a growing census will involve the committed corps of recruiters and human resources professionals that presently support our work. Carroll Hospice utilizes recruitment fairs, online applications via the Carroll Hospital website and incentivizing employee referrals to recruit new personnel. Carroll Hospice does not anticipate difficulty in recruiting new staff members or shortages in any position or discipline that would be needed for the expanded census of Dove House.

3. **(for existing facilities) a report on average vacancy rate and turnover rates for affected positions,**

Applicant Response: Carroll Hospice is extremely successful at hiring, and supporting staff. In FY18 (thru May) Carroll Hospice's turnover rate was 20% and the vacancy rate was 4%. This reflects 5 staff members leaving our employment and all related to personal life events (retirement, graduations and an untimely death in the family). This speaks to the organization's

ability to manage growth, change and maintain a common vision and sense of accountability to the patients and families we serve. Our care team is guided by Carroll Hospital's overarching organizational philosophy focused on SPIRIT values that are deeply imbedded in our culture. We can attribute our success, in part, to having our actions and decisions guided by these values.

Service...exceed customer expectations.
Performance... deliver efficient, high quality service and achieve excellence in all we do.
Innovation... take the initiative to make it better.
Respect... honor the dignity and worth of all.
Integrity... uphold the highest standards of ethics and honesty.
Teamwork... work together, win together.

PART IV - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identity and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

Applicant Response:

Carroll Hospice, Inc., 292 Stoner Avenue, Westminster MD 21157, is the entity responsible for the proposed project and its implementation. Carroll Hospice was formed on April 26, 1988.

Carroll Hospice is owned by Carroll Hospital, Inc., 200 Memorial Avenue, Westminster MD 21157. Carroll Hospital, Inc. was formed on March 5, 1988. Carroll Hospital, Inc., is owned by Carroll County Health Services Corporation. Carroll County Health Services Corporation is owned by LifeBridge Health, Inc.

Please refer to the Organizational Chart attached as **Exhibit 16**

2. Is the applicant, or any person listed above now involved, or ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each facility, including facility name, address, and dates of involvement.

Applicant Response:

Carroll Hospice, Inc. operates general hospice programs in Baltimore, Carroll and Frederick Counties. Carroll Hospital Center, Inc., owns and operates an acute care general hospital in Westminster, Maryland.

Please refer to **Exhibit 16** for the health care facilities in the LifeBridge Health system.

2. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner or other person responsible for implementation of the Project was not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

Applicant Response: No

4. Is any facility with which the applicant is involved, or has any facility with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition reached by the applicable governmental authority.

Applicant Response: No

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or any health care facility listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

6.

Applicant Response: No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed or existing facility.

Applicant Response: Please refer to **Exhibit 17** for this authorization.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

Regina M. Bodnar

Regina Bodnar, Executive Director, Carroll Hospice

Date: September 10, 2018

Hospice Application: Charts and Tables Supplement

TABLE 1 - PROJECT BUDGET

TABLE 2A: STATISTICAL PROJECTIONS – ENTIRE FACILITY

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

TABLE 5: MANPOWER INFORMATION

TABLE 1: Project Budget

A. USE OF FUNDS	
1. CAPITAL COSTS (if applicable):	
a. New Construction	
1) Building	$
2) Fixed Equipment (not included in construction)	
3) Architect/Engineering Fees	
4) Permits, (Building, Utilities, Etc)	
a. SUBTOTAL New Construction	**$**
b. Renovations	
1) Building	$1,075,000
2) Fixed Equipment (not included in construction)	
3) Architect/Engineering Fees	150,000
4) Permits, (Building, Utilities, Etc.)	20,000
b. SUBTOTAL Renovations	**$1,245,000**
c. Other Capital Costs	
1) Movable Equipment	490,000
2) Contingency Allowance	75,000
3) Gross Interest During Construction	
4) Other (Specify)	
c. SUBTOTAL Other Capital Cost	**$565,000**
TOTAL CURRENT CAPITAL COSTS (sum of a - c)	**$1,810,000**
Non-Current Capital Cost	
d. Land Purchase Cost or Value of Donated Land	$
e. Inflation (state all assumptions, including time period and rate	$
TOTAL PROPOSED CAPITAL COSTS (sum of a - e)	**$**
2. FINANCING COST AND OTHER CASH REQUIREMENTS	
a. Loan Placement Fees	$
b. Bond Discount	
c. CON Application Assistance	
c1. Legal Fees	$5,000
c2 Other (Specify and add lines as needed)	
d. Non-CON Consulting Fees	
d1. Legal Fees	
d2. Other (Specify and add lines as needed)	
e. Debt Service Reserve Fund	
f. Other (Specify)	
TOTAL (a - e)	**$5,000**
3. WORKING CAPITAL STARTUP COSTS	**$**
TOTAL USES OF FUNDS (sum of 1 - 3)	**$1,815,000**

B. SOURCES OF FUNDS FOR PROJECT	
1. Cash	
2. Pledges: Gross _____,less allowance for uncollectables _____ = Net	
3. Gifts, bequests (Fundraising)	$1,815,000
4. Authorized Bonds	
5. Interest income (gross)	
6. Mortgage	
7. Working capital loans	
8. Grants or Appropriation	
a. Federal	
b. State	
c. Local	
9. Other (Specify)	
TOTAL SOURCES OF FUNDS (sum of 1-9)	**$1,815,000**
ANNUAL LEASE COSTS (if applicable)	
• Land	
• Building	
• Moveable equipment	
• Other (specify)	

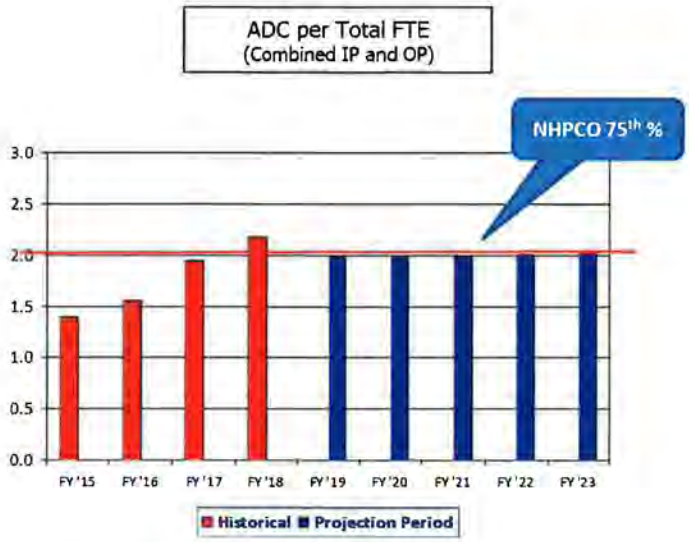
Carroll Hospice
Statement of Key Assumptions
Financial Projections

- **Entire Facility:** The following key financial assumptions were used to develop the financial outlook for Carroll Hospice operations (inpatient and outpatient services).

1. **Census Days / Average Daily Census:** Total census days (inpatient and outpatient) are projected to reach approximately 72,000 days (ADC of 198) by FY 2024. Carroll Hospice outlook regarding patient need/demand has been included within the CON application. Length of stay for inpatient and outpatient services has been projected to remain at current levels throughout the projection period.
2. **Gross Revenue:** Gross revenues are projected to increase to $13.8 million by FY 2024 - $2.2 million higher than projected FY 2019. This revenue growth is consistent with projected growth in census days. Gross revenue per census day has been projected to remain consistent with current levels of $166/day (outpatient) and $707/day (inpatient). Medicare accounts for 94% of Carroll Hospice total patient revenue stream.
3. **Deductions from Revenue:** Deductions from revenue are projected to total 4.2% of gross revenue throughout the projection period – consistent with current experience. Deductions from revenue include: contractual allowances (3.1%), bad debt and other uncollectible (.9%), and charity care (.2%).
4. **Program Expenses (Non-Capital) / Variable Expense Factor:** Program expenses are projected to increase to $10.7 million by FY 2024 - $1.5 million higher than projected FY 2019 levels. This represents a variable expense factor ranging from 63% - 72% during the projection period. Additional details regarding Hospice operating expense categories is provided below.

	Incremental Impact (000's)				
	FY '20	FY '21	FY '22	FY '23	FY '24
Average Daily Census	6.0	12.0	18.3	25.0	31.9
% Growth	*3.6%*	*7.1%*	*10.5%*	*14.1%*	*17.7%*
Patient Days	2,201	4,378	6,665	9,119	11,641
Net Patient Revenues	$412	$797	$1,219	$1,666	$2,143
Program Expenses (Non-Cap)	$259	$571	$855	$1,161	$1,466
Variable Expense Factor	*63%*	*72%*	*70%*	*70%*	*68%*
Operating Cash Flow (Programs)	$153	$226	$364	$505	$677

5. **Salaries and Benefits:** Salaries and benefits account for approximately 71% of total operating cost and are projected to total $7.6 million by FY 2024 – an increase of $1.1 million from projected FY 2019 levels. Carroll Hospice program workforce is projected to total 97 FTE's by FY 2024 – an increase of approximately 13 FTE's from current levels. This FTE requirement assumes ADC per FTE will remain at current levels (2.0) during the projection period as illustrated in the chart below. This productivity level is in the 75th % range as published by the NHPCO.



In addition, workforce requirements have been projected to maintain the current mix of direct care FTE's (65%) to support FTE's (35%). The table below further illustrates Carroll Hospice current and projected workforce mix for all services.

	Current Year		Proj FY '24	
Direct FTE's				
Skilled Nursing	23.5		28.3	
Hospice Aides	18.5		20.0	
Social Work	7.1		9.6	
Chaplain Services	3.7		5.2	
Subtotal	52.8	63%	63.1	65%
Indirect FTE's	31.0	37%	34.0	35%
Total	**83.8**		**97.1**	

6. **Contractual Services:** Contractual services include medical director and physician coverage expenses, linen processing, nutritional services, and patient transportation and other medical services. Consistent with current experience, these costs have been estimated at approximately $7 per census day throughout the projection period.
7. **Supplies, Drugs, DME:** These costs are estimated to total approximately $1.47 million by FY 2024, $238k higher than projected FY 2019 levels. Consistent with current experience, these costs have been estimated at approximately $20 per census day throughout the projection period.
8. **Other Expenses:** Other expenses represent primarily fixed operating cost and include the following: utilities, insurance, maintenance contracts, equipment rentals,

advertising, employee travel expenses and other support functions (accounting, tax, human resources, recruitment, and information systems).

9. **Non-operating activities:** Non-operating activities primarily include unrestricted annual fundraising proceeds (net of expense) and rental income. These activities are projected to support Hospice operating activities by $420k per year throughout the projection period.

- **Project: Inpatient Hospice (Dove House Expansion):** The following key financial assumptions were used to develop the financial outlook for the expansion of Carroll Hospice inpatient operations.

1. **Census Days / Average Daily Census:** Inpatient census days are projected to reach approximately 3,285 days (ADC of 9) by FY 2024. Carroll Hospice outlook regarding patient need/demand has been included within the CON application. Length of stay has been projected to remain at current levels (5 days) throughout the projection period.
2. **Gross Revenue:** Gross inpatient revenues are projected to increase to $2.3 million by FY 2024 - $393k higher than projected FY 2019. This revenue growth is consistent with projected growth in census days. Gross revenue per census day has been projected to remain consistent with current levels ($707/day). Medicare accounts for 87% of Carroll Hospice inpatient services revenue stream.
3. **Deductions from Revenue:** Deductions from revenue are projected to total 7.8% of gross revenue throughout the projection period – consistent with current experience. Deductions from revenue include: contractual allowances (5.8%), bad debt and other uncollectible (1.6%), and charity care (.4%).
4. **Program Expenses (Non-Capital) / Variable Expense Factor:** Program expenses are projected to increase to $2.6 million by FY 2024 - $288k higher than projected FY 2019 levels. This represents a variable expense factor of 79% by FY 2024. Additional details regarding Hospice inpatient expense categories is provided below.

	Incremental Impact (000's)				
	FY'20	FY'21	FY'22	FY'23	FY'24
Average Daily Census	0.3	0.5	0.8	1.1	1.5
% Growth	*4.4%*	*7.0%*	*11.1%*	*15.1%*	*20.4%*
Patient Days	119	192	302	411	557
Net Patient Revenues	$78	$125	$197	$268	$363
Program Expenses (Non-Cap)	$77	$135	$182	$228	$288
Variable Expense Factor	*99%*	*108%*	*92%*	*85%*	*79%*
Operating Cash Flow (Programs)	$1	($10)	$15	$40	$75

5. **Salaries and Benefits:** Salaries and benefits for inpatient hospice services account for approximately 65% of total operating cost and are projected to total $1.9 million by FY 2024 – an increase of $200k from projected FY 2019 levels. Carroll

Hospice inpatient program workforce is projected to total 26.3 FTE's by FY 2024 – an increase of approximately 1.5 FTE's from current levels. As volumes increase, Carroll Hospice anticipates a higher mix of RN's to Aides. The table below provides additional details regarding Carroll Hospital projected inpatient workforce.

	Current Year		Proj FY '24	
Direct FTE's				
Skilled Nursing	5.9		8.2	
Hospice Aides	6.7		5.7	
Social Work	1.0		1.0	
Chaplain Services	0.3		0.5	
Subtotal	13.9	56%	15.4	59%
Indirect FTE's	10.9	44%	10.9	41%
Total	**24.8**		**26.3**	

6. **Contractual Services:** Contractual services include medical director and physician coverage expenses, linen processing, nutritional services, and patient transportation and other medical services. Consistent with current experience, these costs have been estimated to average approximately $92 per census day throughout the projection period.
7. **Supplies, Drugs, DME:** These costs are estimated to total approximately $200k by FY 2024. Consistent with current experience, these costs have been estimated at approximately $60 per census day throughout the projection period.
8. **Other Expenses:** Other expenses represent primarily fixed operating cost and include the following: utilities, insurance, maintenance contracts, equipment rentals, advertising. These costs have been estimated to average approximately $70 per census day throughout the projection period.
9. **Project Depreciation:** Annual depreciation expense of $149k has been based on total project costs of $1.8 million with depreciation periods ranging from 7 years for furnishings and fixtures to 20 years for renovation costs.

TABLE 2A: STATISTICAL PROJECTIONS – ENTIRE Hospice Program

	Two Most Current Actual Years		Current Yr Projected	Projection Period				
CY or (FY) (circle)	2017	2018	2019	2020	2021	2022	2023	2024
Admissions	1,050	1,127	1,187	1,232	1,276	1,319	1,367	1,415
Deaths	959	1,020	1,071	1,113	1,152	1,191	1,234	1,278
Non-death discharges	66	69	72	75	78	80	83	86
Patients served	1,163	1,266	1,359	1,409	1,458	1,506	1,559	1,612
Patient days	44,540	58,644	60,770	62,971	65,148	67,435	69,889	72,411
Average length of stay	42.4	52.0	51.2	51.1	51.1	51.1	51.1	51.2
Average daily hospice census	122.0	160.7	166.5	172.5	178.5	184.8	191.5	198.4
Visits by discipline								
Skilled nursing	67,245	80,075	87,120	90,739	93,277	96,669	100,151	104,491
Social work	4,923	6,178	6,670	6,927	7,161	7,398	7,655	7,922
Hospice aides	45,187	54,740	59,522	61,986	63,730	66,042	68,421	71,369
Physicians - paid	1,664	2,076	2,269	2,361	2,439	2,520	2,606	2,699
Physicians - volunteer	-	-	-	-	-	-	-	-
Chaplain	3,226	4,203	4,519	4,689	4,849	5,009	5,185	5,364
Other clinical	266	380	406	420	435	449	465	481
Licensed beds								
Number of licensed GIP beds	8	8	8	14	14	14	14	14
Number of licensed Hospice House beds	-	-	-	-	-	-	-	-
Occupancy %								
GIP(inpatient unit)	73.5%	85.2%	93.4%	55.7%	57.1%	59.3%	61.4%	64.3%
Hospice House	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT (Total)

	Two Most Current Actual Years		Current Yr Projected	Projection Period				
CY or FY (circle)	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Admissions (Excluding Transfers In)	329	358	392	410	423	437	453	469
Admissions (Including Transfers-In)	496	485	531	555	573	593	613	635
Deaths	365	367	404	422	436	450	466	483
Non-death discharges	12	8	9	9	9	10	10	10
Patients served	503	492	538	562	580	600	620	642
Patient days	2,145	2,488	2,728	2,847	2,920	3,030	3,139	3,285
Average length of stay	4.32	5.13	5.14	5.13	5.09	5.11	5.12	5.17
Average daily hospice census	5.9	6.8	7.5	7.8	8.0	8.3	8.6	9.0
Visits by discipline								
Skilled nursing	51,480	59,712	65,472	68,328	70,080	72,708	75,336	78,840
Social work	2,926	2,880	3,164	3,297	3,404	3,517	3,636	3,767
Hospice aides	34,320	39,808	43,648	45,552	46,720	48,472	50,224	52,560
Physicians - paid	1,389	1,729	1,900	1,979	2,043	2,111	2,183	2,262
Physicians - volunteer	0	0	0	0	0	0	0	0
Chaplain	970	1,426	1,567	1,632	1,685	1,741	1,800	1,865
Other clinical	25	51	56	58	60	62	64	67
Licensed beds								
Number of licensed GIP beds	8	8	8	14	14	14	14	14
Number of licensed Hospice House beds	0	0	0	0	0	0	0	0
Occupancy %								
GIP(inpatient unit)	73.5%	85.2%	93.4%	55.7%	57.1%	59.3%	61.4%	64.3%
Hospice House	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

TABLE 3: REVENUES AND EXPENSES - ENTIRE Hospice Program (including proposed project)

	Two Most Recent Years - Actual		Current Year Projected	Projection Period				
CY or (FY) Circle)	2017	2018	2019	2020	2021	2022	2023	2024
1. Revenue								
a. a. Inpatient services	$1,485,406	$1,702,841	$ 1,929,533	$2,013,703	$2,065,336	$2,142,787	$2,220,237	$2,323,503
b. Hospice house services	-	-	-	-	-	-	-	-
c. Home care services	7,015,985	9,242,188	9,648,128	9,994,124	10,343,918	10,705,955	11,095,624	11,490,620
d. Gross Patient Service Revenue	8,501,391	10,945,029	11,577,661	12,007,827	12,409,254	12,848,742	13,315,861	13,814,123
e. Allowance for Bad Debt	(57,867)	(95,457)	(100,975)	(104,726)	(108,227)	(112,060)	(116,134)	(120,480)
f. Contractual Allowance	(266,581)	(332,330)	(357,214)	(371,039)	(382,749)	(396,495)	(410,889)	(427,157)
g. Charity Care	(12,396)	(21,877)	(23,141)	(24,001)	(24,803)	(25,682)	(26,616)	(27,612)
h. Net Patient Services Revenue	8,164,547	10,495,365	11,096,331	11,508,061	11,893,475	12,314,505	12,762,221	13,238,874
i. Other Operating Revenues (Specify)	-	-	-	-	-	-	-	-
j. Net Operating Revenue	8,164,547	10,495,365	11,096,331	11,508,061	11,893,475	12,314,505	12,762,221	13,238,874
2. Expenses								
a. Salaries, Wages (incl fringe benefits)	4,982,227	5,805,577	6,527,374	6,717,438	6,944,403	7,157,663	7,388,202	7,612,108
b. Contractual Services, Pro Fees	294,818	466,640	431,017	445,190	455,976	469,252	482,754	498,761
c. Interest on Current Debt	-	-	-	-	-	-	-	-
d. Interest on Project Debt	-	-	-	-	-	-	-	-
e. Current Depreciation	170,102	173,087	174,936	193,811	212,686	212,686	212,686	212,686
f. Project Depreciation	-	-	-	74,250	148,500	148,500	148,500	148,500
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies, Drugs, DME	1,152,405	1,220,564	1,236,317	1,281,926	1,325,191	1,372,012	1,421,903	1,474,581
j. Other Expenses (Specify) - See Table 3a	-	-	-	-	-	-	-	-
k. Total Operating Expenses	6,599,552	7,665,869	8,369,644	8,712,615	9,086,757	9,360,113	9,654,046	9,946,637
3. Income								
a. Income from Operation	**1,564,995**	**2,829,496**	**2,726,687**	**2,795,446**	**2,806,718**	**2,954,392**	**3,108,176**	**3,292,238**
b. Non-Operating Income	625,616	1,020,067	419,210	420,000	420,000	420,000	420,000	420,000
c. Subtotal	2,190,611	3,849,563	3,145,897	3,215,446	3,226,718	3,374,392	3,528,176	3,712,237
d. Income Taxes	-	-	-	-	-	-	-	-
e. Net Income (Loss)	**$2,190,611**	**$3,849,563**	**$ 3,145,897**	**$3,215,446**	**$3,226,718**	**$3,374,392**	**$3,528,176**	**$3,712,237**

Table 3 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)				
CY or (FY) (Circle)	2017	2018	2019	2020	2021	2022	2023	2024
4. Patient Mix								
A. As Percent of Total Revenue								
1. Medicare	92%	94%	94%	94%	94%	94%	94%	94%
2. Medicaid	1%	1%	1%	2%	2%	2%	2%	2%
3. Blue Cross	2%	2%	2%	2%	2%	2%	2%	2%
4. Other Commercial Insurance	4%	3%	2%	2%	2%	2%	2%	2%
5. Self-Pay	0%	0%	0%	0%	0%	0%	0%	0%
6. Other (Specify)	0%	0%	0%	0%	0%	0%	0%	0%
7. TOTAL	100%	100%	100%	100%	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)								
1. Medicare	92%	94%	94%	94%	94%	94%	94%	94%
2. Medicaid	1%	1%	1%	1%	1%	1%	1%	1%
3. Blue Cross	3%	2%	2%	3%	3%	3%	3%	3%
4. Other Commercial Insurance	4%	3%	2%	2%	2%	2%	2%	2%
5. Self-Pay	0%	0%	0%	0%	0%	0%	0%	0%
6. Other (Specify)	0%	0%	0%	0%	0%	0%	0%	0%
7. TOTAL	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

	Two Most Recent Years -- Actual		Current Yr Projected	Projection Period				
CY or (FY) (Circle)	2017	2018	2019	2020	2021	2022	2023	2024
1. Revenue								
a. Inpatient services	$1,485,406	$1,702,841	$1,929,533	$2,013,703	$2,065,336	$2,142,787	$2,220,237	$2,323,503
b. Hospice House services	-	-	-	-	-	-	-	-
c. Home care services	-	-	-	-	-	-	-	-
d. Gross Patient Service Revenue	1,485,406	1,702,841	1,929,533	2,013,703	2,065,336	2,142,787	2,220,237	2,323,503
e. Allowance for Bad Debt	(16,930)	(28,358)	(31,754)	(33,102)	(33,997)	(35,259)	(36,535)	(38,175)
f. Contractual Allowance	(77,991)	(98,726)	(112,334)	(117,279)	(120,230)	(124,754)	(129,262)	(135,347)
g. Charity Care	(3,627)	(6,499)	(7,277)	(7,586)	(7,791)	(8,081)	(8,373)	(8,749)
h. Net Patient Services Revenue	1,386,859	1,569,259	1,778,168	1,855,735	1,903,318	1,974,692	2,046,067	2,141,233
i. Other Operating Revenues (Specify)	-	-	-	-	-	-	-	-
j. Net Operating Revenue	1,386,859	1,569,259	1,778,168	1,855,735	1,903,318	1,974,692	2,046,067	2,141,233
2. Expenses								
a. Salaries, Wages (incl fringe benefits)	1,289,944	1,457,749	1,739,686	1,801,743	1,831,651	1,864,215	1,896,779	1,939,176
b. Contractual Services, Pro Fees	138,543	225,514	258,637	266,776	271,317	278,130	284,943	294,027
c. Interest on Current Debt	-	-	-	-	-	-	-	-
d. Interest on Project Debt	-	-	-	-	-	-	-	-
e. Current Depreciation	170,102	173,087	174,936	174,936	174,936	174,936	174,936	174,936
f. Project Depreciation	-	-	-	74,250	148,500	148,500	148,500	148,500
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies, Drugs, DME	131,904	149,576	164,005	171,159	175,548	182,131	188,714	197,491
j. Other Expenses (Specify)	-	-	-	-	-	-	-	-
k. Total Operating Expenses	1,730,493	2,005,926	2,337,264	2,488,864	2,601,952	2,647,912	2,693,872	2,754,130
3. Income								
a. Income from Operation	**(343,634)**	**(436,667)**	**(559,096)**	**(633,129)**	**(698,634)**	**(673,220)**	**(647,805)**	**(612,897)**
b. Non-Operating Income	-	-	-	-	-	-	-	-
c. Subtotal	(343,634)	(436,667)	(559,096)	(633,129)	(698,634)	(673,220)	(647,805)	(612,897)
d. Income Taxes	-	-	-	-	-	-	-	-
e. Net Income (Loss)	**$ (343,634)**	**$ (436,667)**	**$ (559,096)**	**$ (633,129)**	**$ (698,634)**	**$ (673,220)**	**$ (647,805)**	**$ (612,897)**

Table 4 Cont.	Two Most Recent Years -- Actual		Current Yr Projected	Projected Years (ending with first full year at full utilization)				
CY or (FY) (Circle)	2017	2018	2019	2020	2021	2022	2023	2024
4. Patient Mix								
A. As Percent of Total Revenue								
1. Medicare	86%	87%	88%	87%	87%	87%	87%	87%
2. Medicaid	1%	3%	3%	3%	3%	3%	3%	3%
3. Blue Cross	3%	3%	3%	3%	3%	3%	3%	3%
4. Other Commercial Insurance	10%	8%	6%	7%	7%	7%	7%	7%
6. Other (Specify)	0%	0%	0%	0%	0%	0%	0%	0%
7. TOTAL	100%	100%	100%	100%	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)								
1. Medicare	84%	87%	87%	87%	87%	87%	87%	87%
2. Medicaid	1%	2%	3%	3%	3%	3%	3%	3%
3. Blue Cross	3%	3%	3%	3%	3%	3%	3%	3%
4. Other Commercial Insurance	11%	7%	7%	8%	8%	8%	8%	8%
5. Self-Pay	0%	1%	0%	0%	0%	0%	0%	0%
6. Other (Specify)	0%	0%	0%	0%	0%	0%	0%	0%
7. TOTAL	100%	100%	100%	100%	100%	100%	100%	100%

TABLE 5. MANPOWER INFORMATION

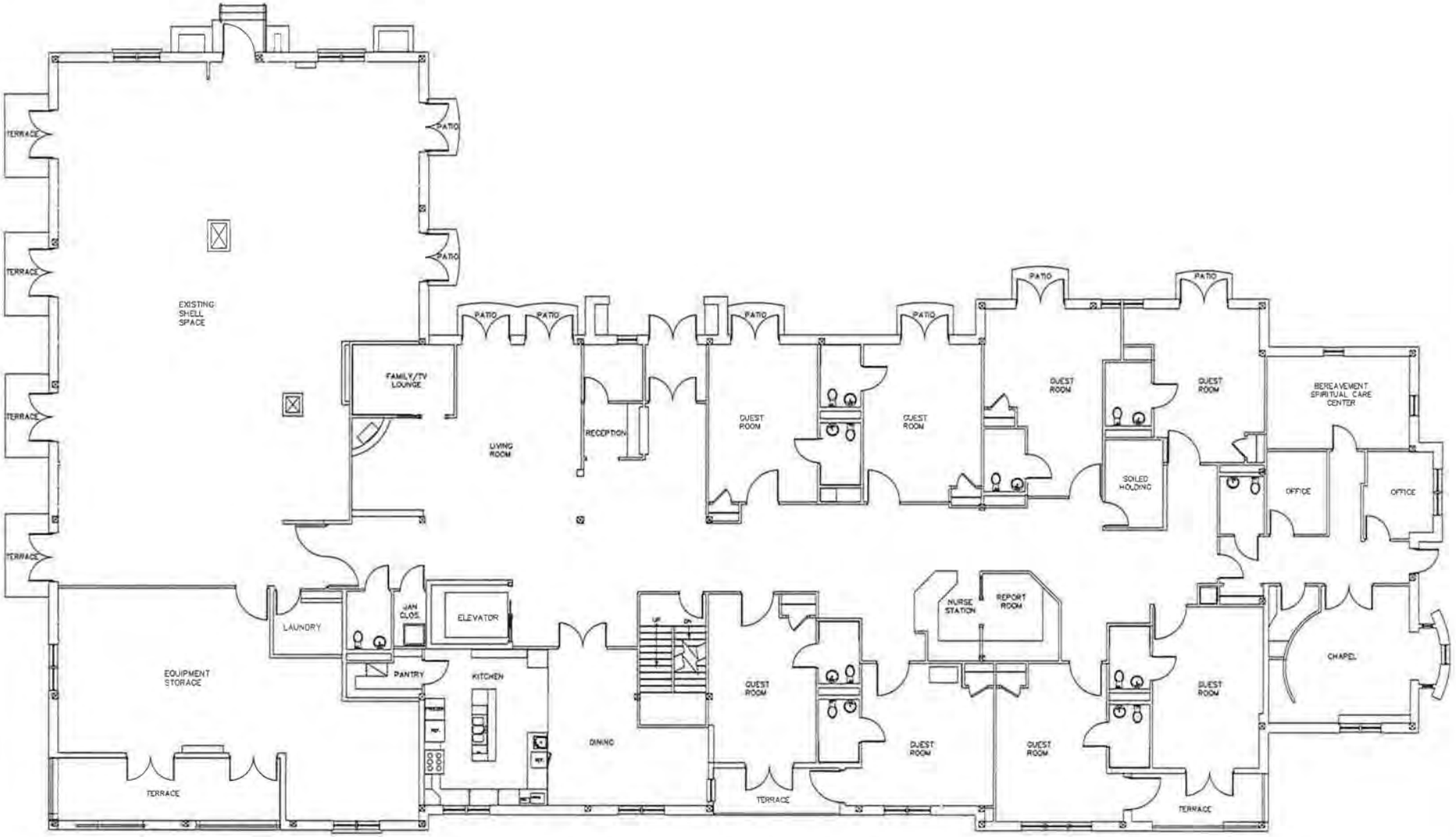
Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
Administration	3.50	-	$83,255	Employee	$ 291,392
Direct Care					
Nursing	5.40	2.30	$84,177	Employee	$ 648,393
Social work/services	1.00	-	$78,892	Employee	$ 78,892
Hospice aides	6.70	(1.00)	$37,139	Employee	$ 211,653
Physicians-paid	-	-			
Physicians-volunteer	-	-			
Chaplains	0.30	0.20	$69,290	Employee	$ 34,798
Bereavement staff	1.00	-	$57,517	Employee	$ 57,517
Other clinical	0.50	-	$84,022	Employee	$ 42,011
Support					
Other support	6.40	-	$39,269	$ -	$ 251,324
				Total Salaries	$1,615,980
				Benefits*	$ 323,196
				TOTAL	$1,939,176

* Indicate method of calculating benefits cost 20% of Salaries

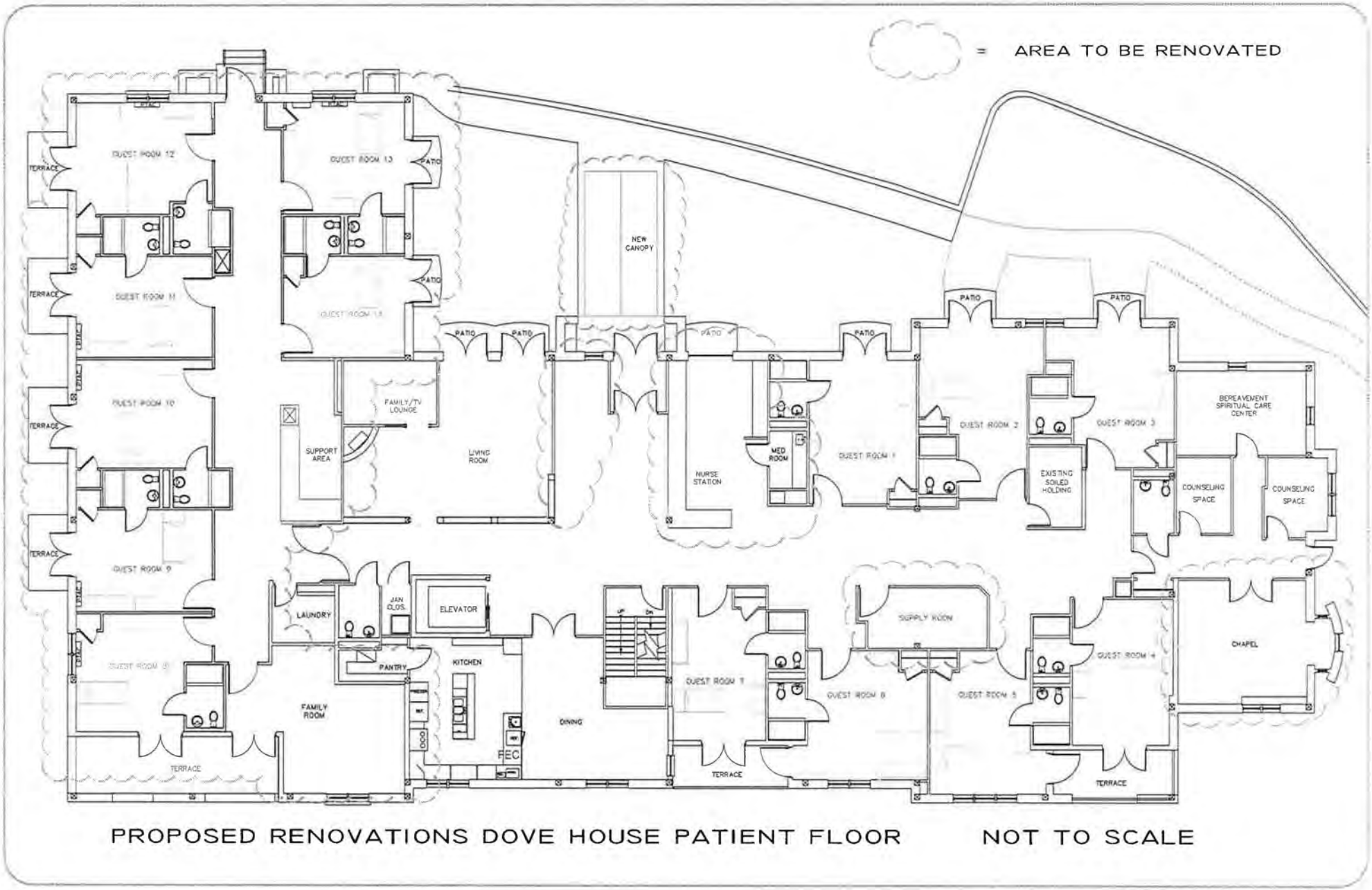
* Worked hours approximately 90% of paid hours

EXHIBIT 1

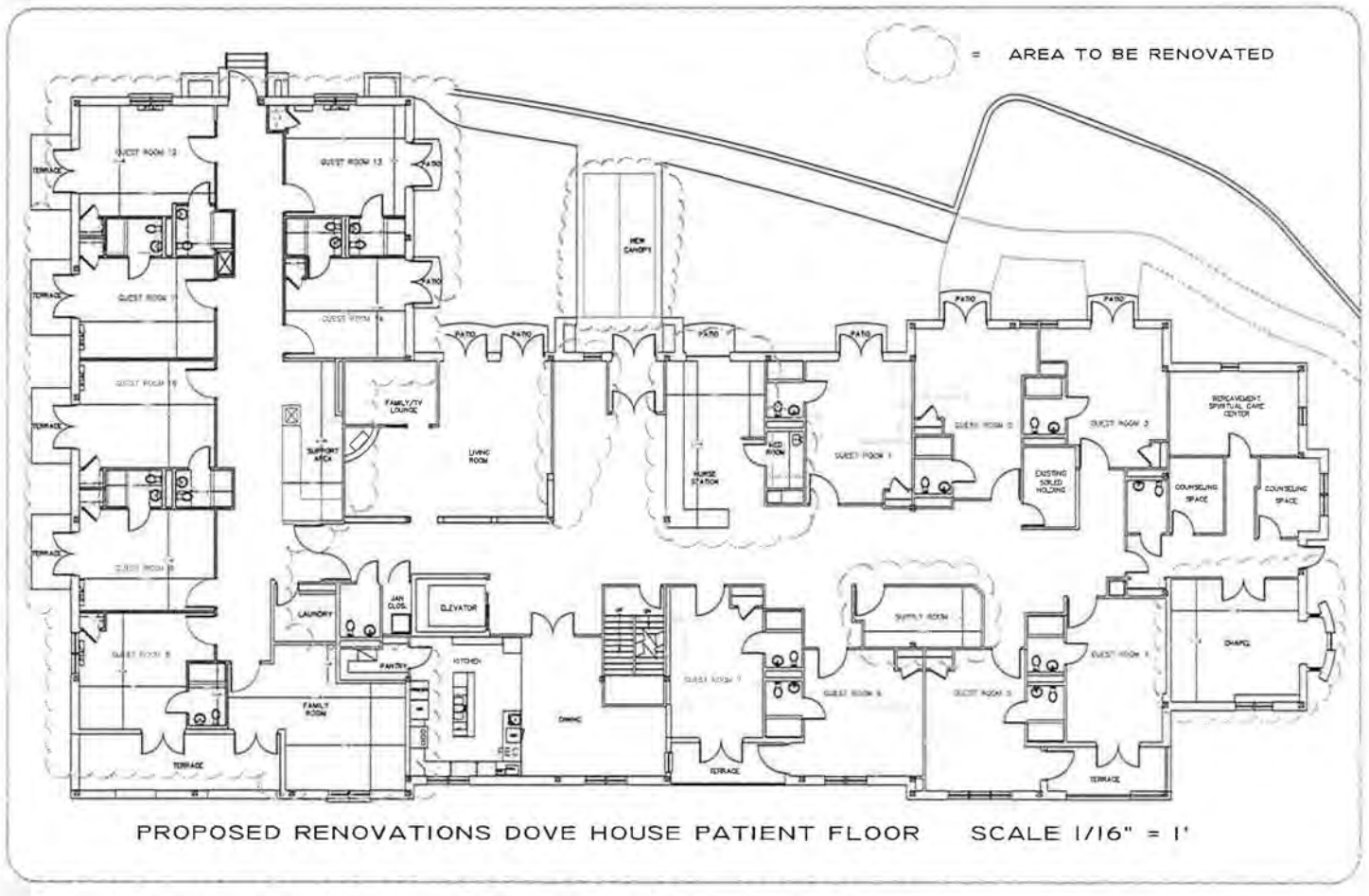
Exhibit 1



EXISTING CONDITIONS DOVE HOUSE PATIENT FLOOR



PROPOSED RENOVATIONS DOVE HOUSE PATIENT FLOOR NOT TO SCALE



PROPOSED RENOVATIONS DOVE HOUSE PATIENT FLOOR SCALE 1/16" = 1'

EXHIBIT 2

Exhibit 2

CARROLL HOSPICE

Title: Admission Criteria - Hospice	Effective Date: 05/06/2016
Document Owner: Gail Forsyth	
Approver(s): Bridget Krautwurst, Regina Bodnar	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Policy: It is the policy of Carroll Hospice (CH) to have established admission criteria which clearly state requirements and eligibility limitations.

Purpose: To identify patients who meet criteria for admission to the Carroll Hospice program.

Definitions:

- None

Procedure/Process/Guidelines:

The decision to admit is made by the patient's attending physician, Carroll Hospice Medical Director and Clinical Manager based on the patient disease history and clinical status. Admissions are completed within 24-48 hours of the referral, unless otherwise specified by the physician, and/or patient.

A. The patient has a confirmed diagnosis of a life limiting illness and a life expectancy of 6 months or less, and of which the patient has been informed.

B. The patient and/or family agree with hospice philosophy and care. Care will be provided in the patient's choice of residence. At time of admission, the patient will be asked to identify the healthcare agent who will communicate care decisions/choices should the patient not be able.

C. The patient is a resident of Carroll, Baltimore or Frederick Counties.

D. The patient/family is encouraged to participate in decision-making throughout all phases of the disease process and participate in the plan of care.

E. The patient must be under the care of an attending physician who consents to hospice admission and who will continue to assume responsibility for medical care. Should the patient not have an attending physician, the hospice Medical Director, or his designee is available to assume responsibility for the patient's care. (See policy for Transfer of Patient from Private Attending to service of Carroll Hospice Medical Director).

F. The attending physician and patient have determined that no curative therapy is available or desirable. The physician and patient/family agree that comfort is now the primary goal.

G. The patient has a terminal illness with a limited life expectancy of generally six months from the date of admission to Carroll Hospice. Should a patient live beyond the six months

CARROLL HOSPICE

prognosis and continue to meet established hospice recertification criteria, he/she shall not be disqualified from hospice care.

H. Hospice care may be discontinued at any time with the agreement of the patient/family and the attending physician.

I. Carroll Hospice admits patients regardless, according to age, gender, nationality, race, creed or sexual orientation, disability, diagnosis, ethnic origin, handicap, prior modality of treatment, or availability of health care agent or ability to pay.

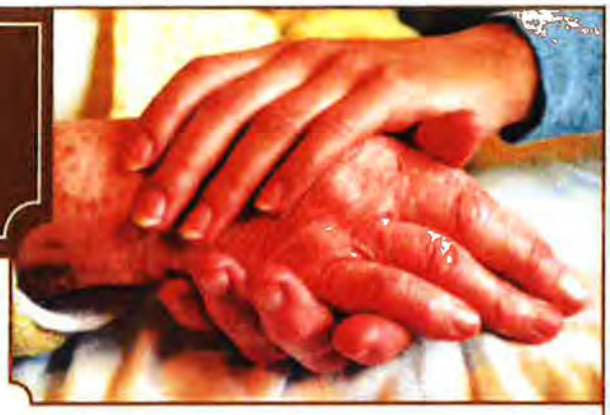
References:

- None

EXHIBIT 3

Exhibit 3

Grief Support



Reaching out to you in your time of loss

All support groups are free, do not require registration and are offered at Carroll Hospice, 292 Stoner Avenue, Westminster, unless otherwise noted.

Bereavement Luncheon
Open to any adult who has experienced the death of a loved one
Last Tuesday of each month, noon
Baugher's Restaurant
289 W. Main St., Westminster

Grief Support After a Substance Abuse Loss
A grief support group for adults who have lost a loved one from an overdose or addiction
First Tuesday of each month
5 – 6:30 p.m.
Carroll Hospice
Registration required

Mending Hearts
For parents who have lost a child
Third Monday of each month
6:30 – 8 p.m.
Carroll Hospice
Dove House Chapel

Pet Loss
Addressing the emotional issues and coping strategies concerning the death of a pet
Saturdays, October 13 & January 12
10:30 a.m. – noon
Carroll Hospice
Registration required

Suicide Loss Support Group
Open to those who have experienced the death of a loved one related to suicide. This group addresses the unique emotional issues surrounding the loss and offers coping strategies.
Second Tuesday of each month
6:30 – 8 p.m.
Carroll Hospice
Registration required

Widows & Widowers
Open to women and men whose spouses have died
First Tuesday of each month
6:30 – 8 p.m.
Carroll Hospice

For more information,
call 410-871-7656 or visit CarrollHospice.org

CARROLL HOSPICE
CarrollHospice.org
Facebook.com/CarrollHospice

EXHIBIT 4

Exhibit 4

CARROLL HOSPITAL CENTER

Title: Financial Assistance Policy	Effective Date: 05/30/2017
Document Owner: Lori Buxton	
Approver(s): Bridget Krautwurst, James Miller	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

This policy may not be materially changed without the approval of the Board of Directors.

THIS POLICY WAS APPROVED BY THE BOARD OF DIRECTORS AND ALL APPROVERS ON 2/7/2017.

I. Policy:

It is the policy of the Carroll Hospital Center, Carroll Home Care, and Carroll Hospice (collectively "CHC") to adhere to our obligation to the communities we serve to provide medically necessary care to individuals who do not have the resources to pay for medical care. Services will be provided without discrimination on the grounds of race, color, sex, national origin or creed.

Any patient seeking urgent, emergent care, or chronic care at CHC will be treated without regard to a patient's ability to pay for care. CHC will operate in accordance with all federal and state requirements for the provision of healthcare services, including screening and transfer requirements under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). Financial Assistance is available to patients who qualify in accordance to this policy.

II. Purpose:

This policy describes the criteria to be used in determining patient eligibility and outlines the guidelines to be used in completion of the financial assistance application process. The Hospital will use a number of methods to communicate the policy such as signage, notices, an annual advertisement in the local newspaper and the hospital website.

III. Definitions

A. Emergent Care: Care that is provided to a patient with an emergent medical condition and must be delivered within one to two hours of presentation to the Hospital in order to prevent harm to the patient. This includes: A medical condition manifesting itself by acute symptoms of sufficient severity (e.g. severe pain, psychiatric disturbances and/or symptoms of substance abuse, the health of a pregnant woman and/or her unborn child etc.) such that the absence of immediate medical attention could seriously jeopardize the patient's health.

B. Urgent Care: Care that must be delivered within a reasonable time in order to prevent harm to the patient. This includes care that is provided to a patient with a medical condition that is not life/limb threatening or not likely to cause permanent harm, but

C. The CHC hospital website, all patient bills, and patient information sheet shall include the following information:
   1. A description of CHC's financial assistance policy;
   2. Contact information for the individual and/or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:
      a. The patient's hospital bill;
      b. The patient's rights and obligations with respect to the hospital bill;
      c. How to apply for the Maryland Medical Assistance Program, CHC Financial Assistance, Maryland Healthcare Connect, and any other programs that may help pay the bill.
   3. A description of the patient's rights and obligations regarding billing and collection practices under law.
   4. An explanation that physician charges are not included in the hospital bill and are billed separately.

D. An information sheet explaining patient's rights and responsibilities shall be provided to the patient, the patient's family, or the patient's authorized representative before discharge, with the hospital bill, and upon request.

V. Eligibility Criteria:

A. Patients seeking emergent, urgent, or chronic care services shall qualify for financial assistance consideration. CHC will use a consistent methodology to determine eligibility to include: income, family size, and available resources.

B. CHC will utilize the *Carroll Hospital Center Service Area (Exhibit A)* to determine the scope of the financial assistance program. All hospital, home care, and hospice services considered medically necessary for patients living in the service area are included in the program.

C. CHC will utilize the *Income Scale for CHC Financial Assistance (Exhibit B)* which is based on the most current Federal Poverty Guidelines to determine financial assistance eligibility.

D. CHC will utilize the *Maryland State Uniform Financial Assistance Application (Exhibit C).*

E. Non-United States citizens are not covered for financial assistance under this program.

F. All available financial resources shall be evaluated before determining financial assistance eligibility. This includes resources of other persons and entities who may have legal responsibility for the patient. These parties shall be referred to as guarantors for the purpose of this policy.

G. Applicants who meet eligibility criteria for Medicaid must apply and be determined ineligible prior to Financial Assistance consideration. Applicants that do not meet eligibility after the initial screening are waived from this requirement.

M. Financial assistance eligibility decisions can be made at any time during the patient's interaction with the Hospital or the hospital's billing agents as pertinent information becomes available. The Financial Assistance Committee may grant financial assistance outside of the terms of this policy in response to the specific needs of a patient as needed.

N. Emergency room patients with a healthcare credit score below 534 will qualify for financial assistance for that visit only.

O. Patients referred to Carroll Home Care or Carroll Hospice from Carroll Hospital Center will be automatically eligible based on qualifying for hospital financial assistance. In addition, hospital based physician charges billed under the Carroll Health Group (CHG) will also be eligible.

VI. Medical Financial Hardship

Maryland law requires identifying whether a patient has incurred a medical financial hardship. A financial hardship means medical debt, incurred by a family over a 12 month period that exceeds 25% of family income. Medical debt is defined as out of pocket expenses, excluding copayments, co-insurance, and deductibles, for medical costs billed by CHC. Services provided by the Hospital as well as those provided by hospital based physicians and billed by CHG are included in this policy and in consideration for medical financial hardship. Other hospitals' fees and professional fees (i.e. other physician charges) that are not provided by the CHC and CHG are not included in this policy. For patients who have been deemed to have incurred a financial hardship, the hospital will provide reduced cost medically necessary care to patients with family income below 500% of the Federal Poverty Level.

If a patient qualifies for medical financial hardship, the patient or any immediate family member of the patient living in the same household shall remain eligible for reduced cost care when seeking subsequent care at CHC during the 12 month period beginning on the date on which the reduced cost care was initially received. It is the responsibility of the patient to inform the Hospital of their existing eligibility under a medical financial hardship for 12 months. In cases where a patient's amount of reduced cost care may be calculated using more than one of the above approaches, the amount which best favors the patient shall be used.

VII. Presumptive Financial Assistance Eligibility

Some patients are presumed to be eligible for financial assistance discounts on the basis of individual life circumstances (e.g., homelessness, lack of income, qualification for applicable federal or state programs, etc.). CHC will grant 100% financial assistance to US citizens determined to have presumptive financial assistance eligibility. CHC will internally document any and all recommendations to provide presumptive financial assistance discounts from patients and other

CARROLL
HOSPITAL CENTER

Exhibit A

Carroll Hospital Center
Service Area

Primary

Finksburg (21048)
Hampstead (21074)
Manchester (21102)
Keymar (21757)
Taneytown (21787)
Mount Airy (21771)
New Windsor (21776)
Union Bridge (21791)
Westminster (21157)
Westminster (21158)
Woodbine (21797)
Upperco (21155)
Sykesville (21784)

Secondary

Reisterstown (21136)

Carroll Home Care and Carroll Hospice

Primary

Carroll County
Baltimore County
Frederick County
Howard County

CARROLL HOSPITAL CENTER

Exhibit C

Maryland State Uniform Financial Assistance Application

Information about You

Name

_____

First Middle Last

Social Security Number _____-_____-_____ Marital Status: Single Married Separated

US Citizen: Yes No Permanent Resident: Yes No

Home Address: _____ Phone: _____

_____

_____ Country: _____

City State Zip code

Employer Name: _____ Phone: _____

Work Address: _____

_____ Country: _____

City State Zip code

CARROLL
HOSPITAL CENTER

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

Monthly Amount	
Employment	_____
Retirement/Pension Benefits	_____
Social security benefits	_____
Public assistance benefits, i.e.: food stamps	_____
Disability benefits	_____
Unemployment benefits	_____
Veteran's benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self-employment	_____
Other income source	_____
TOTAL	_____

II. Liquid Assets	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
-$10,000 exclusion	_____
Total	_____

CARROLL
HOSPITAL CENTER

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant signature Date

_____

Relationship to Patient

EXHIBIT 5

Exhibit 5

Maryland State Uniform Financial Assistance Application

Information about You

Name

_____

First Middle Last

Social Security Number_____-____-_____Marital Status: Single Married Separated US

Citizen: Yes No Permanent Resident: Yes No

Home Address:_____ Phone:_____

_____

_____ Country: _____

City State Zip code

Employer Name:_____Phone:_____

Work Address: _____

_____ Country:_____

City State Zip code

Household members:

Name	Age	Relationship

Have you applied for Medical Assistance Yes No

If yes, what was the date you applied? _____

If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

Monthly Amount	
Employment	_____
Retirement/Pension Benefits	_____
Social security benefits	_____
Public assistance benefits, i.e.: food stamps	_____
Disability benefits	_____
Unemployment benefits	_____
Veteran's benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self-employment	_____
Other income source	_____
TOTAL	_____

II. Liquid Assets	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
-$10,000 exclusion	_____
Total	_____

CARROLL
HOSPITAL CENTER

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____	Approximate value _____
Automobile	Make_____Year_____	Approximate value _____
Additional vehicle	Make_____Year_____	Approximate value _____
Additional vehicle	Make_____Year _____	Approximate value _____
Other property		Approximate value _____
		Total _____

IV. Monthly Expenses	Amount
Rent or Mortgage	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
Total	_____

Do you have any other unpaid medical bills? Yes No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

Do you have medical debt that has been incurred by your family over a 12-month period that exceeds 25% of your family income? _____

CARROLL
HOSPITAL CENTER

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant signature Date

_____

Relationship to Patient

EXHIBIT 6

Exhibit 6

Financial Assistance Policy

Carroll Hospital is committed to providing accessible medical care to its community. Hospital care is available to all patients regardless of their race, color, national origin, age, gender or ability to pay.

To uphold its commitment to providing quality medical care to patients, Carroll Hospital has a program that offers financial assistance for the services it provides. Patients who are residents of Carroll County without the ability to pay their hospital medical expenses may apply for financial assistance through the program. Eligibility is determined on an individual basis, taking into consideration both income and assets. In addition, residents of Carroll County who have incurred medical debt over a 12-month period that exceeds 25 percent of their family income may apply for financial hardship.

If you require hospitalization and need information about Carroll Hospital's Financial Assistance Policy, please call the hospital's financial counselor at 410-871-6718 or visit CarrollHospitalCenter.org/financial-assistance.

CARROLL HOSPITAL

a LifeBridge Health center

200 Memorial Avenue, Westminster, MD 21157
410-876-3000 | CarrollHospitalCenter.org

EXHIBIT 7

Exhibit 7

Income Scale for Carroll Hospital Financial Assistance
Based on 2017 Federal Guidelines (A)

Financial Assistance %		100%	75%	50%	25%
Persons in Family/Household	**Income**	**Income Multiple**			
		300%	**325%**	**350%**	**375%**
1	$12,060	$36,180	$39,195	$42,210	$45,225
2	$16,240	$48,720	$52,780	$56,840	$60,900
3	$20,420	$61,260	$66,365	$71,470	$76,575
4	$24,600	$73,800	$79,950	$86,100	$92,250
5	$28,780	$86,340	$93,535	$100,730	$107,925
6	$32,960	$98,880	$107,120	$115,360	$123,600
7	$37,140	$111,420	$120,705	$129,990	$139,275
8	$41,320	$123,960	$134,290	$144,620	$154,950
For families/households with more than 8 persons, add $4,180 for each additional person.					

(A) SOURCE: Federal Register, Document # 2017-02076 Pgs. 8831-8832

Exhibit B

Income Scale for Carroll Hospital Medical Hardship Assistance
Based on 2017 Federal Guidelines

Financial Assistance %		100%	75%	50%	25%
Persons in Family/Household	**Income**	**Income Multiple**			
		350%	**400%**	**450%**	**500%**
1	$12,060	$42,210	$48,240	$54,270	$60,300
2	$16,240	$56,840	$64,960	$73,080	$81,200
3	$20,420	$71,470	$81,680	$91,890	$102,100
4	$24,600	$86,100	$98,400	$110,700	$123,000
5	$28,780	$100,730	$115,120	$129,510	$143,900
6	$32,960	$115,360	$131,840	$148,320	$164,800
7	$37,140	$129,990	$148,560	$167,130	$185,700
8	$41,320	$144,620	$165,280	$185,940	$206,600
For families/households with more than 8 persons, add $4,180 for each additional person.					

EXHIBIT 8

Exhibit 8

CARROLL HOSPICE

Carroll Hospice

Quality Improvement and Patient Safety Plan

FY2018

Revised 2/14/2017
Revised 9/21/2017

Quality Improvement and Patient Safety Plan
Carroll Hospice
FY 2018

Section 1 Introduction

Mission:

Carroll Hospice is non-profit organization dedicated to improving the quality of life for patients needing end-of-life care, allowing them to live as fully and comfortably as possible by providing quality palliative care, pain and symptom management and support for their families.

Our Philosophy

- Provide patients with palliative care and effective pain symptom management.
- Help patients experience peace, comfort and dignity during the end stage of life.
- Allow patients to make their own decisions regarding care and treatment.
- Promote a caring community sensitive to the needs of hospice patients and their families.
- Support family members and other caregivers in their efforts to care for their loved one.
- Coordinate community resources to ensure continuity of care.
- Offer bereavement support to families.

Scope of Service:

Carroll Hospice (CH) is a 501(c)3 hospice organization which has provided quality and compassionate hospice care to terminally ill patients and their families in Carroll County and the surrounding areas for thirty years. CH opened its doors in 1986 and has since expanded to serve more than 900 terminally-ill residents of Carroll, Frederick and Baltimore counties each year in their homes, independent living facilities, long term care residences and the Dove House inpatient unit.

In 2016, the Dove House inpatient unit became dually licensed as a Hospice House through the state of Maryland and has since been able to offer residential care in addition to general inpatient and inpatient respite levels of care.

CH is an affiliate of Carroll Hospital, which became a LifeBridge Health center in 2015. The CH Quality Improvement and Patient Safety Plan has been designed to address all stakeholders, including Carroll Hospital and the LifeBridge Health team, and in consideration of the culture of safety among the CH community. The plan will address the SPIRIT values, including Service, Performance, Innovation, Respect, Integrity and Teamwork. The scope of the Quality Improvement and Patient Safety Plan includes all paid and unpaid staff, including contractual staff not employed by the organization.

Continuous Quality Improvement Activities

CH and Carroll Hospital subscribe to Lean management principles of continuous performance improvement to track performance and ensure improvements are sustained. Performance Improvement Projects will be modeled after the institute for Healthcare Improvement's Plan-Do-Study-Act (PDSA) Model for Improvement.

Section 2 Leadership and Organization

The CH ***Quality Assessment Performance Improvement Committee*** provides ongoing operational leadership of continuous quality improvement activities. The QAPI Committee meets quarterly and is chaired by the Accreditation and Quality Specialist. The activities of the QAPI Committee serve to implement and maintain an effective, ongoing, hospice-wide data driven QAPI program.

The responsibilities of the Committee include:

- Developing and approving the Quality Assessment Performance Improvement Plan on at least an annual basis.
- Establishing measurable goals based upon problem prone, high risk or high volume areas of hospice care services.
- Developing indicators of quality on a priority basis.
- Ongoing evaluation of information based on indicators, taking action as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.
- Establishing and supporting specific quality improvement initiatives through the Lean principles of continuous performance.
- Maintaining documentary evidence of QAPI activities.
- Reporting to the Board of Directors on quality improvement activities at least on an annual basis.
- Communication of QAPI activities to the Leadership Team, staff and families as appropriate.

The ***Board of Directors*** also provides leadership for the Quality Improvement process as follows:

- Reviewing, evaluating and approving the Quality Improvement Plan annually.
- Supporting implementation of quality improvement activities.

The Leadership Team supports QAPI activities through the planned coordination and communication of the results of measurement activities related to QI initiatives and overall efforts to continually improve the quality of care provided. It is a function of the Leadership Team to ensure that the Board of Directors have knowledge of and input into ongoing QAPI initiatives.

Section 3 Objectives, Goals and Performance Measurement

The QAPI Committee identifies and defines goals and specific objectives to be accomplished each year in consideration of the current regulatory climate, completed or continued QAPI and Lean projects, organizational committee work, accreditation survey results and the scope, complexity and past performance of Carroll Hospice service and operations.

Objectives

The overarching quality strategy for FY2018 is to:

- Build a system in which high quality outcomes are the only option.
- Focus on staff development to support and grow staff strengths.
- Target ways to improve patient safety data collection.
- Further integrate lean principles into daily practice.

1. High Quality Outcomes

- Comply with regulatory requirements regarding quality reporting.
  - Reporting of Medicare HIS data
    - ❖ **GOAL**: 90% reporting of Medicare HIS data

- Improve CAHPS survey scores that fell below the national average scores in FY17 under the following domain.
  - Getting Hospice Care Training
    - Survey Question 18 (Hospice team discussed side effects of pain medication): FY17 score: 73.1%
      - ❖ **GOAL:** >74% (national benchmark)
    - Survey Question 19 (Provided training about side effects for pain medication): FY17 score: 62.9%
      - ❖ **GOAL:** >64.5% (national benchmark)

  - Hospice Team Communications
    - Survey Question 6 (Kept informed about when team would arrive): FY17 score: 68%
      - ❖ **GOAL:** >69% (national benchmark)

  - DEYTA Additional Question Set
    - Survey Question D58 (Special equipment picked up when no longer needed): FY17 score: 94.8%
      - ❖ **GOAL:** >96.8% (national benchmark)

2. Support and Grow Staff Strengths

- Redesign Utilization Review Committee and associated audits to focus on quality of documentation in addition to appropriate service utilization.
  - Identify criteria for assigning random UR audits and implement new system.
  - Use the UR Committee to approve all live discharges due to the patient no longer meeting eligibility guidelines for hospice care.
    - ❖ **GOAL:** 120 records audited

3. Improve Patient Safety Data Collection

- Identifying patient safety risks and increase same-day reporting of patient falls.
  - Increase reporting of falls and categorization of fall severity
    - ❖ **GOAL:** Increase falls reported by 20% per hospice care team

- Measure, analyze and track patients admitted in pain and the amount of time each of those patients is on service before pain is resolved to his or her satisfaction.
  - Establish and roll out a protocol and track progress toward the goal.
    - ❖ **GOAL:** Resolve pain within 24 hours of admission on the home and facility-based care teams.

4. Integrate Lean Principles into Daily Practice

- Assess current data collection tools and processes for redundancy and define a succinct set of measures for focus in the fiscal year.
- Continue to utilize Lean management principles to target performance improvement objectives.
- Continue use of daily huddle with new emphasis on identifying patient safety risks.
- Implement use of daily metrics for measurement of performance improvement as needed.
- Lean events for FY2018:
    - Interdisciplinary Group (IDG)
    - Admissions Process
    - Medical Records
    - Inpatient Unit Project (TBD)
    - ❖ **GOAL:** Engage 100% of Lead positions in a lean event in FY2018.

Performance Measures
High Quality Outcomes

Name	**HIS Data Submission**
Definition	Submission of HIS data for each admission and each discharge must be complete within 30 days of the date of admission or discharge. Beginning January 1, 2016, for the 2018 reporting year, hospices must submit at a minimum 70% of required HIS records. For the 2019 reporting year, 80%; for the 2020 reporting year, 90%.
Data Collection	**How:** CASPER data submission portal online. **Method:** Data is compiled through the CMS Extract module in McKesson and uploaded to CASPER. Validation reports will confirm data submission. **Frequency:** Twice per month. **Who:** Manager, Access and Compliance, or designee
Assessment Frequency	Total HIS submission will be reviewed by the QAPI Committee quarterly.

Name	**CAHPS Results** (Four Measures)
Definition	Question 18 of the CAHPS Survey states: Side effects of pain medicine include things like sleepiness. Did any member of the hospice team discuss side effects of pain medicine with you or your family member? Question 19 of the CAHPS Survey states: Did the hospice team give you the training you needed about what side effects to watch for from pain medicine? Question 6 of the CAHPS Survey states: While your family member was in hospice care, how often did the hospice team keep you informed about when they would arrive to care for your family member? Question D58 of the CAHPS Survey states: Was the equipment picked up in a timely manner when your family member no longer needed it?
Data Collection	**How:** DEYTA administers the Hospice CAHPS survey, collects responses and produces reports. **Method:** CAHPS survey results will be monitored through the DEYTA website. **Frequency:** Monthly for the duration of the fiscal year. **Who:** Gail Forsyth, Accreditation and Quality Specialist
Assessment Frequency	CAHPS survey results will be reviewed by the Leadership Team monthly and will be reported to the QAPI Committee quarterly.

Performance Measures

Support and Grow Staff Strengths

Name	Utilization Review
Definition	The UR Committee will be responsible for auditing the charts and approving the discharge of any patient who is discharged alive, prior to the discharge. Additionally, clinical records will randomly be assigned for review on a monthly basis.
Data Collection	**How:** The UR Committee will conduct UR audits. **Method:** The standing members of the UR Committee will review all clinical records for patients who are referred for live discharge. UR audits will be assigned randomly to equal 120 audits annually. **Frequency:** UR audits for discharge referrals will be completed as needed; random UR audits will be assigned and completed on a monthly basis. **Who:** Gail Forsyth, Accreditation and Quality Specialist
Assessment Frequency	UR audits will be will be reviewed by the Leadership Team monthly and will be reported to the QAPI Committee quarterly.

Improve Patient Safety Data Collection

Name	Falls Data
Definition	Submission of falls data will be required for each patient fall, regardless of whether the patient was injured. Falls will be reported for data collection in addition to documentation of the fall in the electronic medical record (EMR).
Data Collection	**How:** Data will be submitted for reporting at the daily Safety Huddle. **Method:** Reported falls will be recorded on the Safety Huddle spreadsheet. **Frequency:** Data will be collected daily basis. **Who:** Gail Forsyth, Accreditation and Quality Specialist, or designee
Assessment Frequency	The falls data submitted will be reported to the QAPI Committee quarterly.

Name	**Pain Measure** (Home Hospice and Facility-Based Care Teams Only)
Definition	Patients who are in pain on admission will be placed under the pain protocol, which will dictate care to resolve pain to the patient's satisfaction within 24 hours.
Data Collection	**How:** Pain management and data collection will be protocol-driven. **Method:** Record patients admitted in pain and require follow up from the team manager within 24 hours to report pain resolved or outstanding. **Frequency:** Data will be collected daily basis. **Who:** Gail Forsyth, Accreditation and Quality Specialist, or designee
Assessment Frequency	The pain data will be reviewed at the Safety Huddle daily, during the Leadership Team meeting monthly and reported to the QAPI Committee quarterly.

EXHIBIT 9

HEALTHCARE first powered by DEYTA ANALYTICS

Exhibit 9

Quality Measure Dashboard
Hospice CAHPS
Carroll Hospice

Timeframe: Jul 2017 - Jul 2018 (7/1/2017 - 7/13/2018)
Report by: Survey Return Date

Report Level: Carroll Hospice
Surveys Included: All Surveys

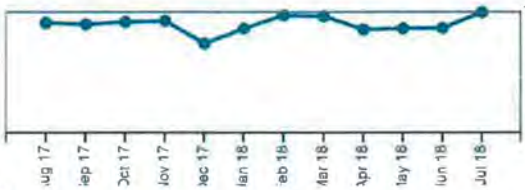
This report has been produced by HEALTHCAREfirst and does not represent official CAHPS Hospice Survey results.

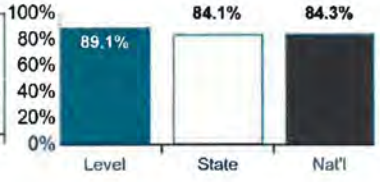
Surveys Returned: 437

GLOBAL MEASURES

Rating of Patient Care (Question: 39)

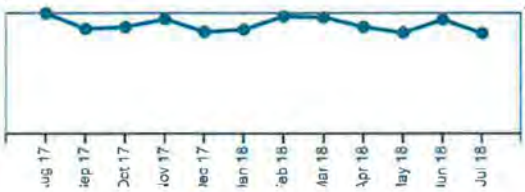
Top Box	**89.1%**
Middle Box	7.4%
Bottom Box	3.5%

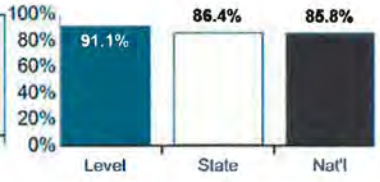




Would Recommend This Hospice (Question: 40)

Top Box	**91.1%**
Middle Box	7.7%
Bottom Box	1.2%

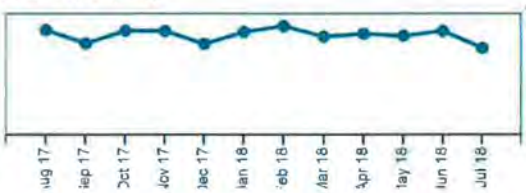


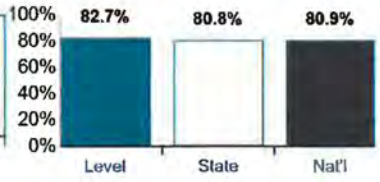


COMPOSITE MEASURES

Hospice Team Communications (Questions: 6, 8, 9, 10, 14, 35)

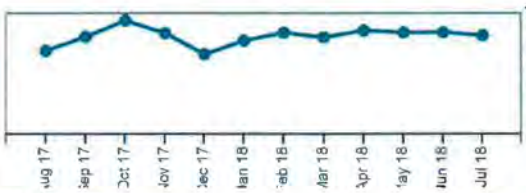
Top Box	**82.7%**
Middle Box	13.5%
Bottom Box	3.8%

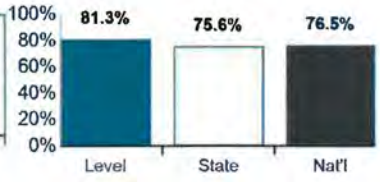




Getting Timely Care (Questions: 5, 7)

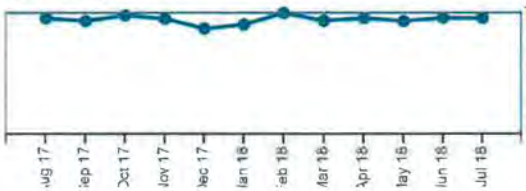
Top Box	**81.3%**
Middle Box	12.1%
Bottom Box	6.6%

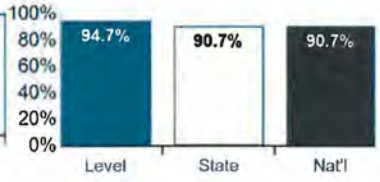




Treating Family Member with Respect (Questions: 11, 12)

Top Box	**94.7%**
Middle Box	4.6%
Bottom Box	0.6%





Timeframe: Jul 2017 - Jul 2018 (7/1/2017 - 7/13/2018)
Report by: Survey Return Date

Report Level: Carroll Hospice
Surveys Included: All Surveys

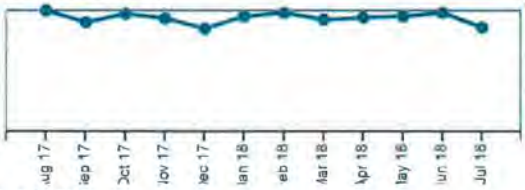
This report has been produced by HEALTHCAREfirst and does not represent official CAHPS Hospice Survey results.

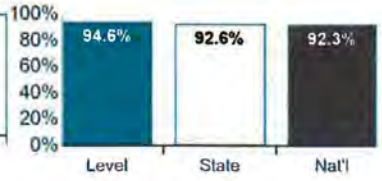
Surveys Returned: 437

COMPOSITE MEASURES (Continued)

Getting Emotional & Religious Support (Questions: 36, 37, 38)

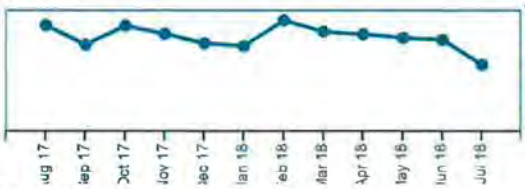
Top Box	**94.6%**
Middle Box	0.0%
Bottom Box	5.4%

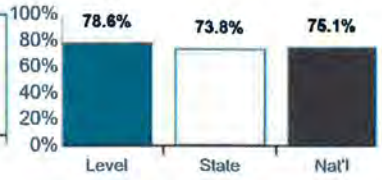




Getting Help with Symptoms (Questions: 16, 22, 25, 27)

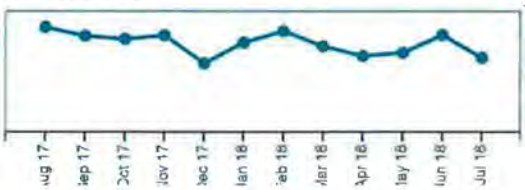
Top Box	**78.6%**
Middle Box	15.9%
Bottom Box	5.5%

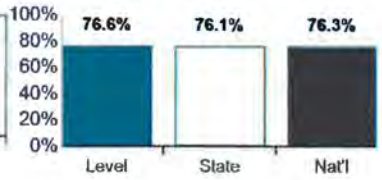




Getting Hospice Care Training (Questions: 18, 19, 20, 23, 29)

Top Box	**76.6%**
Middle Box	15.4%
Bottom Box	8.0%





TOP, MIDDLE & BOTTOM BOX RESPONSES BY QUESTION

Hospice CAHPS Question #	Response Scale	Top-Box Response	Middle-Box Response	Bottom-Box Response
5, 6, 7, 8, 9, 11, 12, 14, 22, 25, 27, 35	Always / Usually / Sometimes / Never	Always	Usually	Sometimes; Never
10	Never / Sometimes / Usually / Always	Never	Sometimes	Usually; Always
16, 18, 19, 20, 23, 29	Yes, definitely / Yes, somewhat / No	Yes, definitely	Yes, somewhat	No
40	Definitely yes / Probably yes / Probably no / Definitely no	Definitely yes	Probably yes	Probably no; Definitely no
39	Rating 0-10 (10 is most positive)	9 or 10	7 or 8	0 - 6
36, 37, 38	Right amount / Too little / Too much	Right amount	N/A *No middle-box score*	Too little; Too much

For more details about the calculations for Top-, Middle-, and Bottom-box scores, refer to the HEALTHCAREfirst Report Guide for the Quality Measure Dashboard Report.

EXHIBIT 10

Exhibit 10

Carroll Hospice
Clinical Protocol

Protocol #: 4-411
Effective Date: 09/07
Reviewed Date: 12/07
Revised Date: 12/07,02/12, 02/14, 2/16
Directors Approval date: 05/15/12

Title: **RESPITE CARE**

Purpose: The purpose of a respite stay is to provide care for a stable patient in an alternate care setting for up to five (5) days when a break from care is needed by the caregiver. A respite stay will be provided in a Medicare-approved facility, consistent with our conditions of participation and terms of contract with private insurance.

Procedure/Process:

A. Assessment

Assessment regarding the need for a respite stay will be a collaborative process by the interdisciplinary team. The IDT will assess that:

1. The patient's clinical status is favorable for a transfer to an alternate care setting.
2. The caregiver has need for a temporary relief from care giving responsibilities.
3. There is an appropriate facility to meet patient needs. Patients with complex clinical care needs such as ALS patients may respite at the Dove House upon approval of the RN Clinical Lead or designee.

B. Procedures and Responsibilities

1. Responsibilities of the Clinical Social Worker:
   a. Assess with the family and patient the need for respite; review care plan and care giver support. Factors to considered include:
      - Nature of need (e.g. family trip, care giver not sleeping)
      - Patient preferences about care
      - Alternative "in home respite" (e.g. hired care givers, additional family relief)
   b. Educate family on respite benefit, and role in meeting need. Coordinate plan with interdisciplinary team.
   c. Promote family discussion and decision making, possible care plan changes after respite stay and facilitate transfer.
   d. After coordinating plan with IDT, the clinical social worker will:
      - Determine a time frame for respite stay as well as transportation needs with the patient and/or family.
      - Review with the patient and family any length of respite stay limitations based upon insurance provider.
      - Contact the admissions department at the identified facility to ascertain bed availability.
      - Facilitate transfer with Program Assistant who will arrange for transport. Family may choose to provide transport.

- Facilitate the completion of appropriate forms as dictated by the specific respite facility.
- Confirm details of the respite with facility admissions staff and family. Provide family with documentation of the same.
- Advise the Interdisciplinary Team of details of respite plan via email.
- Visit facility on the first day of the respite stay to ensure a smooth transition to respite. The Clinical Social Worker will place hospice packet in the patient's chart at facilities other than Dove House. This packet includes: Sticker for chart, Hospice Care in a Long Term Care Facility, The Team Approach to Facility Based Care, Sign In Sheet, Facility Admission Note, Facility Progress Note, Hospice Aide Visit Note and Hospice Aide Schedule.
- Counsel patient on adjustment to respite and continue ongoing supportive interventions.
- Assess and discuss with family and IDT discharge plan, adequacy of current care giving and support in home setting, need for revised plan of care, and need for additional services , supplies and/or supplies

2. <u>Responsibilities of the Nurse Case Manager:</u>
   a. Call the attending physician to obtain an order for respite stay and document the same.
   b. Administer TB test as necessary. All first-time respite patients will need the two-step test. Provide documentation of results to be forwarded to facility. The TB test will be documented in the Plan of Care under 019 Labs/Tests.
   c. Reconcile medications in the patient's chart the day prior to patient transfer
   d. Discuss with patient/ family timing of medications before leaving home on day of respite.
   e. Make face to face handoff to facility staff within one hour of patient arrival at the facility. This visit should include a brief history of patient's disease, current status and symptoms, resuscitation status, care plan including medications and schedule for same, DME needs, visit schedule, and assessment that patient is at high risk for falls,
   f. Provide education regarding how concerns and questions should be referred to hospice.
   g. Visit the patient in the facility consistent with visit orders.
   h. Assure continuity of care for patient and family and determine appropriateness of visit frequency of all interdisciplinary team members.

3. <u>Responsibilities of the Program Assistant II</u>

   a. No later than one day prior to transfer, the Program Assistant or designee will fax the following information to respite facility:

- Admission Profile
- Physician Admission Note
- 2 most recent SNV notes
- ID Screen (if required by facility)
- Evidence of TB screening/chest X-ray
- Copy of MOLST
- Copy of Advance Directives, if available
- A reconciled listing of patient medications updated to day before transfer.
- Care Plan
- "Hospice care in a Long term Care Facility" form faxed to business office

4. Responsibilities of the Clinical Manager
   a. Verify that appropriate documentation is in the electronic documentation system.
   b. Communicate with the PBM the change in level of care, facility that patient is transferred to and name of facility pharmacy provider.
   c. When a respite begins after hours, transmit all information that was faxed to the facility and any additional patient specific information that may be helpful to the After Hours Manager for nursing visit or to the Clinical Manager at the Dove House.

C. Respite Stays at Dove House

1. The Clinical Social Worker will notify Clinical Lead by e-mail that a clinically appropriate patient/family is requesting respite at Dove House
2. RN Clinical Lead notifies the requesting Clinical team manager, Social Worker and the Referral Center that the respite has been approved or declined due to bed availability.
3. Team manager notifies Team of patient respite by email
4. The Nurse Case Manager will provide a transfer report by phone to the Dove House receiving nurse.
5. The HC/FBC Case Manager or Social Worker will submit a request for volunteer services if the patient has anticipated needs.
6. The clinical social worker notifies Dove House social work of respite transfer.
7. Social work visits for planning discharge care plan and continuity of care are to be in coordination with Dove House social worker.

D. PATIENT AND FAMILY EDUCATION

1. IDT will educate the patient and/or family on the details of respite care as provided by their insurance coverage and the process of arranging a respite stay.
2. The patient and/or family will be informed of contracted facilities utilized for respite care.

E. DOCUMENTATION

1. All disciplines involved will document their contacts in the electronic medical record and will update the care plan
2. The Hospice Care in a Long Term Facility form will be completed by the Clinical Social Worker. When completed, the document is distributed in the following manner: the white copy to the facility representative, the yellow copy to hospice billing, and the pink copy to the patient's chart.
3. The change in Level of Care care plan is changed in the electronic medical record upon admission and return home by the Nurse Case Manager.

EVALUATION

1. The interdisciplinary team will evaluate the effectiveness of the respite stay in reducing the patient and family's stress.
2. The interdisciplinary team will collaborate with the patient and family to address any ongoing care giving issues.

REFERENCES

U.S. Department of Health and Human Services
Medicare Benefit Policy Manual (*Rev. 141, 03-02-11*) 40.2.2 - Respite Care

EXHIBIT 11

Exhibit 11

Carroll Hospice

Title: Patient Rights and Responsibilities - Carroll Hospice	Effective Date: 10/07/2015
Document Owner: Gail Forsyth	
Approver(s): Laura Welty, Leslie Gee	

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Policy: Carroll Hospice is committed to delivering high quality hospice care to all people regardless of gender, race, age, disability, religion, sexual orientation, national origin, marital/economic status, or the source of payment for their care. Carroll Hospice also can expect respect and cooperation from the patients and their families in order to be able to deliver quality, efficient care. This document defines Patient Rights and Patient Responsibilities to achieve the best possible care for Carroll Hospice patients.

Purpose: As a hospice provider, Carroll Hospice has an obligation to protect your rights and to provide these rights to you or your representative verbally and in writing in a language and manner you can understand, during the initial assessment visit before care is provided and on an ongoing basis as needed. As a hospice patient, you, or your representative on your behalf, have the right to exercise these rights. There are also responsibilities you have as a hospice patient.

Definitions:

- NONE

Procedure/Process/Guidelines:

A. RIGHTS AND RESPONSIBILITIES RELATED TO COMMUNICATION, DECISION MAKING AND ADVANCE DIRECTIVES

1. As a hospice patient you have the right to exercise your rights without discrimination or reprisal for doing so. Self-appointed or court appointed representative may exercise these rights for you in the event that you are not capable of decision making. If you do not have an appointed representative, Carroll Hospice will follow the State of Maryland's Health Care Decisions Act guidelines to determine who may make medical decisions on your behalf.
2. As a hospice patient you have the right to choose your hospice provider and, within the confines of the law, accept, refuse or discontinue any portion of planned treatment or services without relinquishing other portions of the treatment plan, except where medical contraindications to partial treatment exists; and to be given information concerning consequences of refusing all or partial treatment. You may do with without fear of reprisal or discrimination.

Carroll Hospice

a. You, or your representative on your behalf, can choose whether or not to participate in research, investigational or experimental studies or clinical trials.

3. You, or your representative on your behalf, have the responsibility to give accurate and complete health information to the best of your knowledge concerning present complaints, past illnesses, hospitalizations, medications, allergies and all other pertinent information.
4. You have the right to receive information in a manner you can understand and have access to interpreters as indicated and necessary to ensure accurate communication.
5. You have the right to formulate advance directives and receive written information about Carroll Hospice's policy and procedures on advance directives, including a description of applicable Maryland law. This information is available in this orientation booklet. Blank and sample documents are available from Carroll Hospice nurses and social workers, upon request.
    a. If advance directives have been previously completed, or are completed or amended during your hospice treatment, it is your responsibility to provide a copy of those documents to Carroll Hospice. Nursing and social work staff will assist you in arranging for copying, if needed.
    b. Carroll Hospice will follow the instructions provided in your advance directives or consult the person you designated for medical decision making when you are unable to make decisions on your behalf.
6. You, or your representative on your behalf, have the right and the responsibility to be involved in developing your hospice plan of care which addresses your unique health needs and to participate in updates and changes in the plan whenever necessary.
7. You, or your representative on you behalf, have the responsibility to ask questions or voice concerns when you do not understand something about your care, treatment, services or other instruction about what you are expected to do. If you cannot comply with the care plan, please inform Carroll Hospice staff.

B. RIGHTS AND RESPONSIBILITIES RELATED TO PATIENT SERVICES AND HOSPICE PLAN OF CARE AND PAIN MANAGEMENT

1. As a hospice patient you have the right to timely response from Carroll Hospice regarding any request for services.
2. You have the right to be informed in advance of care being provided about the services covered under the hospice benefit and the scope of services Carroll Hospice will provide including:
    a. name(s) and responsibilities of staff members who are providing and responsible for your care, treatment or services

Carroll
Hospice

b. clear and understandable explanation of your medical problems, treatments and procedures to be provided
c. expected/unexpected outcomes or potential risks or problems
d. barriers to treatment
e. how to contact the supervisor
f. service limitations

3. You have the right to choose your attending physician and other health care providers and communicate with those providers. Should your attending physician decline to participate in your hospice care, Carroll Hospice's Medical Director will be available to supervise your care or arrange for an alternate physician.
4. You have the right to receive pastoral and spiritual services. If you do not have services already in place and wish to have support services, Carroll Hospice will arrange for a hospice spiritual counselor (e.g., chaplain) or contact a clergy member of your particular faith to contact you to offer visits and support.
5. You, or your representative on your behalf, have the right to be informed about Carroll Hospice's discharge policy. This includes your right to revoke hospice services and to transfer your care to another hospice provider.
6. You have the right to receive effective pain management and symptom control from Carroll Hospice for conditions related to your terminal illness; and to receive education about your role and your caregiver's role in managing your pain when appropriate, as well as potential limitation and side effects of pain treatments.
7. You, or your representative on your behalf, have the responsibility to discuss your pain, pain relief options, and your questions, worries or concerns about pain medication with Carroll Hospice staff and appropriate medical personnel.

C. RIGHTS AND RESPONSIBILITIES REGARDING RESPECT, VOICING GRIEVENCES AND PROTECTION FROM MISTREATMENT, DISCRIMINATION AND REPRISAL

1. You have the right to receive appropriate and professional quality care and to have your cultural, psychosocial, spiritual and personal values, beliefs and preferences respected without fear of discrimination on the basis of race, creed, color, religion, sex, national origin, sexual preference, disability, age, social status, political beliefs or ability to pay.
2. You have the right to have your person and property treated with courtesy and respect by all who provide hospice services to you. You have the right to unlimited contact with visitors and others of your choosing and to communicate privately with these persons.
3. You have a right to an environment that preserves your dignity and contributes to a positive self-image.

Carroll Hospice

4. It is your responsibility (or that of your representative) to show respect and consideration for Carroll Hospice staff and equipment.
5. You, or your representative on your behalf, have the right to voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of Carroll Hospice without fear of coercion, discrimination, reprisal or an unreasonable interruption in care, treatment or services for doing so. Carroll Hospice must document both the existence of a complaint and the resolution of the complaint. Our complaint resolution process is explained in our Patient Orientation booklet. When accepted for treatment or care, be advised of the availability of the State's toll-free home care "Hotline" number, its purpose and hours of operation. The hotline receives complaints or questions about local hospice agencies and is also used to lodge complaints concerning the implementation of the advance directives requirements. Hotline hours are 8:30 a.m. to 5:00 p.m., Monday through Friday.
    a. The State hotline may be reached at 1-800-492-6005
    b. You may also call the CHAP hotline 24 hours a day at 1-800-656-9656
6. You have the right to be free from mistreatment, abuse, neglect, verbal, mental, sexual and physical abuse, injuries of unknown source and misappropriation of your property. All mistreatment, abuse, neglect, injury and exploitation complaints by anyone furnishing service on behalf of Carroll Hospice are reported immediately by our staff to Carroll Hospice's Executive Director (or designee.) All reports will be promptly investigated and immediate action taken to prevent potential violations during our investigation. Carroll Hospice will take appropriate corrective action in accordance with Maryland law. All verified violations will be reported to the appropriate Maryland and Carroll County authorities (including state survey and certification agencies) within 5 working days of becoming aware of the violation.
7. It is your responsibility to follow Carroll Hospice's rules and regulations.

D. RIGHTS AND RESPONSIBILITIES REGARDING PRIVACY AND CONFIDENTIALITY

1. You have the right to confidentiality of written, verbal and electronic information including your medical records, information about your health, social and financial circumstances or about what takes place in your home.
    a. You, or your representative on your behalf, have the right to consent, refuse or revoke consent for filming or recording of care, treatment and services for purposes other than identification, diagnosis and treatment.
2. You, or your representative on your behalf, have the right to request that Carroll Hospice release information written about you only as required by law or your written authorization and to be advised of our policies and procedures regarding clinical records.

Carroll Hospice

Our Notice of Privacy Practices is included in this orientation booklet and describes your rights in detail.

a. You, or your representative on your behalf, have the right to access, request changes to and receive an accounting of disclosures regarding your health information as permitted by law.

E. RIGHTS AND RESPONSIBILITIES REGARDING PAYMENT FOR SERVICES AND AGENCY OWNERSHIP

1. You have the right to be advised verbally, in writing and before care is initiated, of our billing policies and payment procedures and the extent to which payment may be expected from Medicare, Medicaid, any other federally funded or aided program or any other sources known to us. This includes information about charges for services that will not be covered by these programs or your health insurance and charges that you may have to pay.

    a. If changes in payment, charges or patient payment liability occur, Carroll Hospice will advise you of these changes as soon as possible, but no later than 30 calendar days from the date Carroll Hospice is notified of the change.

2. You have the right to receive upon your request or that of your representative, Carroll Hospice's policy on uncompensated care.
3. You, or your representative on your behalf, have the right to receive a fully itemized billing statement, upon request.
4. You, or your representative on your behalf, have the responsibility to promptly meet your financial obligations and responsibilities agreed upon with Carroll Hospice. This includes cooperation with Carroll Hospice staff that will assist you in applying for available benefits that may help you meet these financial obligations and responsibilities.
5. You have the right to receive information about Carroll Hospice's ownership and control.

References:

- None

EXHIBIT 12

September 2018

Health & Wellness Calendar

CPR

Basic Life Support (BLS) Providers
This American Heart Association class is for health care professionals and professional rescuers, and it supports both the initial and the renewal requirements of CPR certification.
Thursday, September 20, 8 a.m. – noon
Shauck Auditorium; $80 per person

Childbirth Education

Breastfeeding Class
Tuesday, September 18, 6:30 – 9 p.m.
Shauck Auditorium; $30 per couple

Prepared Childbirth Education and Family Birthplace Tours (3-night session)
Tuesday & Thursday, September 4, 6 & 11
6 – 9 p.m.
Shauck Auditorium; $70 per couple

Prepared Childbirth Weekend
Friday, September 28, 6 – 9 p.m.
& Saturday, September 29, 9 a.m. – 3 p.m.
Shauck Auditorium; $100 per couple
Includes a lunch coupon on Saturday

What to Expect During Your Hospital Stay in The Family Birthplace: Triage to Discharge
A Family Birthplace tour will be given at the conclusion of class.
Monday, September 10
10:15 a.m. – noon or 6 – 8 p.m.
Shauck Auditorium

Special Programs

Carroll Hospital Farmers Market
Thursdays, 11:30 a.m. – 3:30 p.m.
Third level of hospital's parking garage through September 20
Shop for a range of locally grown foods and other items including fruits, vegetables, flowers, homemade baked goods and more while supporting local farmers.
For more information, contact Meghan Gonzalez at 410-871-6472.

Cooking for Wellness Cooking Class℠
Join Barb Walsh, R.D., community nutrition educator, to prepare Pan-Seared Tilapia Piccata with Vegetables
Thursday, September 27, 5:30 – 7 p.m.
Shauck Auditorium
$22; Registration required

Grocery Store Tour
Ever wonder if you really know what foods are better for you? Join Melanie Berdych, R.D., for a fun and informative tour of Giant Food in Westminster.
Tuesday, September 11, 10 – 11:30 a.m.
Giant Food, 405 N. Center St., Westminster

Kidney Smart
Friday, September 7, 3 – 4:30 p.m.
Carroll County Home Dialysis Clinic
Fisher Medical Building
193 Stoner Ave., Suite 120, Westminster
For more information or to register, call 888-695-4363 or 410-751-3785.

Look Good...Feel Better
A class to help women combat the appearance-related side effects of cancer treatments
Monday, September 10, 9 – 11 a.m.
Tevis Center for Wellness

Mind and Body

Guided Imagery
A quiet space is provided for you to try a recorded guided imagery meditation.
Monday – Friday
noon – 12:30 p.m. (except holidays)
Tevis Center for Wellness
No registration required

Screenings

All screenings are free, by appointment only and conducted at the Tevis Center for Wellness unless otherwise noted.

Balance Screening
Conducted by PIVOT Physical Therapy
Thursday, September 13
9 – 11 a.m.

Memory Screening
Conducted by a registered nurse, this simple and safe evaluation tool checks memory and other thinking skills. It can indicate whether additional follow-up with a health care professional is needed.
Monday, September 10, 9 – 11 a.m.
Westminster Senior & Community Center
125 Stoner Ave., Westminster
Call 410-386-3850 for more information or to register.

Support Groups

All support groups are located in the Shauck Auditorium and do not require registration unless otherwise noted.

Breast Cancer Support Group
Tuesday, September 11, 7 – 8:30 p.m.
Tevis Center for Wellness

Breastfeeding Support Group
Thursdays, noon – 1 p.m. (except holidays)

Caregiver Support Group
Tuesday, September 11, 4 – 5:30 p.m.
Carroll County Bureau of Aging and Disabilities
125 Stoner Ave., Westminster

Evening Breastfeeding Support Group
Thursday, September 20, 6:15 – 7:15 p.m.

Gather & Connect
For those living with cancer (and their families) to share their experiences
Monday, September 24, 4:30 – 6 p.m.

Multiple Sclerosis Support Group
Monday, September 17, 10 a.m. – 12:30 p.m.

Ostomy Support Group
Wednesday, September 12, 7 – 8 p.m.

Parkinson's Disease Support Group
Thursday, September 27, 1 – 2:30 p.m.

(continued on back)

All programs are free of charge, take place at Carroll Hospital and require pre-registration unless otherwise noted. All fees are nonrefundable. To register or for more information, call Care Connect at 410-871-7000 or visit CarrollHospitalCenter.org

September 2018 Health & Wellness Calendar continued

Postpartum Support Group
New moms who are feeling overwhelmed, hopeless, sad or out of control can share experiences, connect with needed resources and get support.
Thursdays, September 13 & September 27
1 – 2 p.m.
For more information, call 410-871-7403.

Stroke Survivors Support Group
Thursday, September 13, 2:30 – 3:30 p.m.
Registration required

Weight Management Peer Support Group
Designed for individuals who have begun a weight management program and looking for peer support. The meeting provides a forum for participants to share ideas to promote continued weight loss success and provide accountability.
Wednesday, September 19, 5:15 – 6:15 p.m.
Tevis Center for Wellness

Bereavement Support Services

Offered at Carroll Hospice, 292 Stoner Ave., Westminster, and do not require registration unless otherwise noted. For more information, call 410-871-8000.

Bereavement Luncheon
Open to adults suffering from the passing of someone close
Tuesday, September 25, noon – 1:30 p.m.
Baugher's Restaurant
289 W. Main St., Westminster

Grief Support after a Substance Abuse Loss
Open to adults who have lost a loved one from an overdose or addiction
Tuesday, September 4, 5 – 6:30 p.m.

Mending Hearts
Open to parents who have lost a child
Monday, September 17, 6:30 – 8 p.m.

Suicide Loss Support Group
Open to adults whose loved one died by suicide. This group addresses the unique emotional issues surrounding the loss and offers coping strategies.
Tuesday, September 11, 6:30 – 8 p.m.

Widows & Widowers Support Group
Open to adults who have lost a spouse
Tuesday, September 4, 6:30 – 8 p.m.

Special Services

By appointment only unless otherwise noted.

Care Connect Navigation Services
Support and guidance for people living with health conditions
Call 410-871-7000 for more information.

Cancer Navigation Services
A free, comprehensive resource for those pending a diagnosis or in any stage of all types of cancer
Call 410-871-7000 for more information.

Center for Breast Health
A free, comprehensive resource for those pending a diagnosis, at any stage of breast cancer or for general breast health needs
Call 410-871-7080 for more information.

Complementary Health Services

By appointment only. Call 410-871-7000 for pricing or more information.

- **Acupuncture**
- **Auricular Acupuncture for Weight Loss and Addictions**
- **Community Acupuncture**
- **Facials** *(full, mini, gentlemen's, cancer)*
- **Hot Stone Body Massage**
- **Infant Massage**
- **Integrative Reflexology®**
- **Japanese Hot Stone Facial Massage**
- **Lymph Massage**
- **Massage** *(general, pregnancy, cancer and mastectomy)*
- **Reiki**
- **Zero Balancing Treatments**

Genetic Counseling
For cancer patients and those at risk for the disease. A physician referral is required.
Call 410-871-7000 for more information.

Lymphedema Therapy
In partnership with Pivot Physical Therapy
844 Washington Road, Suite 209, Westminster
For more information or to schedule an appointment, call 410-876-5600.

The Resource Center
A comprehensive health library
Monday – Friday, 8:30 a.m. – 5 p.m.
Tevis Center for Wellness
No appointment required

The Wellness Boutique
Featuring health and wellness merchandise and holistic items designed to bring comfort or promote a healthy lifestyle. Studio YOU, a specialty area, features a wide selection of support items, including wigs and head coverings for those with cancer and medical hair loss; mastectomy bras and breast prostheses; and more. Limited quantities of wigs and head coverings are available free of charge.
Tevis Center for Wellness
Appointments required for Studio YOU
Call 410-871-7000 for more information.

Gift Certificates
Available for all special services.
Call 410-871-7000 for more information or visit CarrollHospitalCenter.org/GiftCert

Our community programs require a minimum number of registered attendees. Occasionally, excellent programs must be canceled when too many people wait until the last moment to register. If you're interested, don't wait—register today!

CARROLL HOSPITAL
a LifeBridge Health center
Tevis Center for Wellness

200 Memorial Avenue | Westminster, MD 21157

All programs are free of charge, take place at Carroll Hospital and require pre-registration unless otherwise noted. All fees are nonrefundable. To register or for more information, call Care Connect at 410-871-7000 or visit CarrollHospitalCenter.org

EXHIBIT 13

Exhibit 13

MARYLAND HOSPICE NEED PROJECTIONS FOR TARGET YEAR 2019

Region	Jurisdiction	Hospice Deaths 2014	Population Deaths Age 35+ 2014	Baseline Use Rate 2014	Compound Annual Growth Rate in Hospice Deaths 2010-2014	Target Year Capacity 2019	Gross Need 2019 @ Target Use Rate of 0.473	Net Need 2019	Need Recognized Based on Volume Threshold of 359
Western Maryland	Allegany	195	886	0.22	0.03	231	427	196	No
	Carroll	730	1,470	0.50	0.02	805	722	(83)	No
	Frederick	735	1,611	0.46	0.11	1,259	817	(442)	No
	Garrett	63	275	0.23	-0.05	48	133	85	No
	Washington	817	1,441	0.57	0.16	1,727	719	(1,008)	No
Central Maryland	Anne Arundel	1,926	3,922	0.49	0.04	2,365	1,947	(418)	No
	Baltimore City	1,434	5,707	0.25	0.01	1,522	2,756	1,233	Yes
	Baltimore Co.	4,321	7,706	0.56	0.05	5,429	3,752	(1,677)	No
	Harford	966	1,900	0.51	0.07	1,385	935	(450)	No
	Howard	766	1,548	0.49	0.08	1,116	791	(324)	No
Montgomery	Montgomery	2,601	5,505	0.47	0.03	2,945	2,745	(200)	No
Southern Maryland	Calvert	223	609	0.37	0.02	248	304	56	No
	Charles	265	914	0.29	0.02	286	479	192	No
	Prince George's	1,430	5,025	0.28	0.05	1,812	2,474	662	Yes
	St. Mary's	338	718	0.47	0.06	458	378	(80)	No
Eastern Shore	Caroline	89	329	0.27	0.04	108	167	59	No
	Cecil	379	817	0.46	0.00	374	408	34	No
	Dorchester	75	381	0.20	0.05	95	189	94	No
	Kent	111	240	0.46	0.09	173	121	(52)	No
	Queen Anne's	200	412	0.49	0.08	291	210	(81)	No
	Somerset	66	260	0.25	-0.02	59	126	67	No
	Talbot	167	453	0.37	0.02	188	226	38	No
	Wicomico	422	914	0.46	0.06	553	457	(96)	No
	Worcester	235	588	0.40	0.03	275	296	20	No
State of Maryland		18,554	43,631	0.43	0.05	23,199	21,640	(1,560)	

Sources:
Methodology: COMAR 10.24.13.06
Hospice Deaths: MHCC Annual Hospice Survey
Population Deaths: Maryland Vital Statistics Administration
Target Year Use Rate: MedPAC (2013 Medicare use rate published March 2015)
Household Population Projections: Maryland Department of Planning, January, 2015 series

[16-11-29]

EXHIBIT 14

Exhibit 14

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Financial Statements and
Supplementary Financial Information

June 30, 2017 and 2016

(With Independent Auditors' Report Thereon)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Table of Contents

KPMG LLP
1 East Pratt Street
Baltimore, MD 21202-1128

Independent Auditors' Report

The Board of Directors
LifeBridge Health, Inc. and Subsidiaries:

We have audited the accompanying consolidated financial statements of LifeBridge Health, Inc. and Subsidiaries (the Corporation), which comprise the consolidated balance sheets as of June 30, 2017 and 2016, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this responsibility includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly in all material respects, the financial position of LifeBridge Health, Inc. and Subsidiaries as of June 30, 2017 and 2016, and the results of their operations, changes in their net assets and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG

Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

October 18, 2017

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2017 and 2016

(Dollars in thousands)

Assets		2017	2016
Current assets:			
Cash and cash equivalents	$	356,365	322,937
Investments		24,583	23,352
Assets limited as to use, current portion		68,496	67,660
Patient service receivables, net of allowance for doubtful accounts of $67,941 in 2017 and $62,213 in 2016		145,639	141,651
Other receivables		17,011	11,508
Inventory		30,515	31,514
Prepaid expenses		15,185	18,761
Pledges receivable, current portion		2,671	3,296
Total current assets		660,465	620,679
Board-designated investments		238,677	243,289
Long-term investments		315,320	253,757
Donor-restricted investments		21,389	20,541
Reinsurance recovery receivable		15,548	15,694
Assets limited as to use, net of current portion		33,039	43,601
Pledges receivable, net of current portion		5,122	3,405
Property and equipment, net		651,173	629,477
Beneficial interest in split interest agreement		4,757	4,477
Investment in unconsolidated affiliates		50,882	44,040
Other assets, net		63,941	48,142
Total assets	$	2,060,313	1,927,102

(Continued)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2017 and 2016

(Dollars in thousands)

Liabilities and Net Assets		2017	2016
Current liabilities:			
Accounts payable and accrued liabilities	$	128,730	119,225
Accrued salaries, wages and benefits		79,444	80,361
Advances from third-party payors		41,935	46,246
Current portion of long-term debt and capital lease obligations, net		13,928	12,921
Other current liabilities		20,135	16,871
Total current liabilities		284,172	275,624
Other long-term liabilities		135,704	167,009
Long-term debt and capital lease obligations, net		571,178	560,422
Total liabilities		991,054	1,003,055
Net assets:			
Unrestricted		983,910	849,676
Noncontrolling interest in consolidated subsidiaries		14,626	5,099
Total unrestricted net assets		998,536	854,775
Temporarily restricted		54,532	53,385
Permanently restricted		16,191	15,887
		1,069,259	924,047
Total liabilities and net assets	$	2,060,313	1,927,102

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	2017	2016
Unrestricted revenues, gains and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 1,508,948	1,473,620
Provision for bad debts	(47,341)	(56,982)
Net patient service revenue	1,461,607	1,416,638
Net assets released from restrictions used for operations	3,879	3,537
Other operating revenue	61,568	57,250
Total operating revenues	1,527,054	1,477,425
Expenses:		
Salaries and employee benefits	809,022	795,094
Supplies	258,614	253,599
Purchased services	278,077	254,211
Depreciation, amortization and gain/loss on sale of assets	77,214	75,699
Repairs and maintenance	21,306	20,538
Interest	28,567	28,574
Total expenses	1,472,800	1,427,715
Operating income	54,254	49,710
Other income (loss), net:		
Investment income	30,908	16,028
Unrealized gain (loss) on trading investments	36,654	(22,110)
Other	(10)	779
Loss on refinancing of debt	(10,802)	(3,720)
Total other income (expense), net	56,750	(9,023)
Excess of revenues over expenses	$ 111,004	40,687

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	Unrestricted	Temporarily restricted	Permanently restricted	Total net assets
Net assets at June 30, 2015	$ 848,829	61,660	15,816	926,305
Excess of revenues over expenses	40,687	—	—	40,687
Unrealized loss on investments	—	(1,842)	(5)	(1,847)
Net assets released from restrictions used for the purchase of property and equipment	7,613	(7,613)	—	—
Restricted gifts and bequests	—	4,908	76	4,984
Net assets released from restrictions used for operations	—	(3,537)	—	(3,537)
Net change in value of beneficial interest in split interest agreement	—	(151)	—	(151)
Adjustment to pension liability	(41,513)	—	—	(41,513)
Other	(841)	(40)	—	(881)
Change in net assets	5,946	(8,275)	71	(2,258)
Net assets at June 30, 2016	854,775	53,385	15,887	924,047
Excess of revenues over expenses	111,004	—	—	111,004
Unrealized gain on investments	—	3,305	—	3,305
Net assets released from restrictions used for the purchase of property and equipment	4,147	(4,147)	—	—
Restricted gifts and bequests	—	5,640	304	5,944
Net assets released from restrictions used for operations	—	(3,879)	—	(3,879)
Net change in value of beneficial interest in split interest agreement	—	280	—	280
Adjustment to pension liability	20,341	—	—	20,341
Fair value of noncontrolling interests in acquisitions	9,754	—	—	9,754
Other	(1,485)	(52)	—	(1,537)
Change in net assets	143,761	1,147	304	145,212
Net assets at June 30, 2017	$ 998,536	54,532	16,191	1,069,259

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2017 and 2016

(Dollars in thousands)

	2017	2016
Cash flows from operating activities:		
Change in net assets	$ 145,212	(2,258)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	77,193	76,059
Loss (gain) on disposal of equipment	21	(360)
Change in pension liability	(20,341)	41,513
Provision for bad debts	47,341	56,982
Realized and unrealized gains (loss) on investments, net	(63,501)	17,593
Restricted gifts and bequests	(5,944)	(4,984)
Change in beneficial interest of split interest agreement	(280)	151
Earnings on investments in unconsolidated affiliates	(3,527)	(3,277)
Distributions to noncontrolling interest owners	2,400	—
Fair value of noncontrolling interests in acquisitions	(9,754)	—
Amortization of deferred financing costs and discounts	894	—
Loss on refinancing of debt	10,802	3,720
Change in operating assets and liabilities:		
Increase in patient service receivables, net	(51,329)	(56,421)
Increase in other receivables	(5,503)	(1,344)
Decrease (increase) in pledges receivable	(1,092)	5,469
Decrease (increase) in inventory	999	(2,032)
Decrease in prepaid expenses	3,576	318
Decrease in reinsurance recovery receivable	146	241
Increase in other assets	(5,155)	(5,637)
(Increase) decrease in accounts payable and accrued liabilities, and accrued salaries, wages, and benefits	9,457	(7,491)
(Decrease) increase in advances from third-party payors	(4,311)	4,466
Decrease in other current and long-term liabilities	(8,195)	(2,907)
Net cash provided by operating activities	119,109	119,811
Cash flows from investing activities:		
Change in donor-restricted investments	3,764	1,103
Change in current and long-term investments	707	(3,698)
Change in assets limited as to use	(38,021)	(49,356)
Investment in/distributions from unconsolidated affiliates, net	(3,315)	(6,898)
Additions to operating property	(75,064)	(101,221)
Purchases of alternative investments	(3,939)	—
Proceeds from sales of alternative investments	51,686	—
Proceeds from the sale of property	—	360
Cash paid for acquisitions	(11,047)	—
Net cash used in investing activities	(75,229)	(159,710)
Cash flows from financing activities:		
Payment on debt and capital lease obligations	(144,708)	(182,127)
Payment of deferred financing costs	(1,176)	—
Proceeds from issuance of debt	131,888	183,006
Distributions to noncontrolling interest owners	(2,400)	—
Restricted gifts and bequests	5,944	4,984
Net cash (used in) provided by financing activities	(10,452)	5,863
Net increase (decrease) in cash and cash equivalents	33,428	(34,036)
Cash and cash equivalents:		
Beginning of year	322,937	356,973
End of year	$ 356,365	322,937
Supplemental cash flow disclosures:		
Cash paid during the year for interest	$ 20,569	24,444
Cash paid during the year for income taxes	72	52
Accounts payable related to purchase of operating property	7,791	8,659

See accompanying notes to consolidated financial statements.

(1) Organization

On October 1, 1998, Sinai Health System, Inc. merged with Northwest Health System, Inc. to form LifeBridge Health, Inc. (LifeBridge). LifeBridge is a not-for-profit, nonstock Maryland corporation.

LifeBridge's subsidiaries include Sinai Hospital of Baltimore, Inc. (Sinai); Northwest Hospital Center, Inc. (Northwest); Levindale Hebrew Geriatric Center and Hospital, Inc. (Levindale); Children's Hospital of Baltimore City, Inc.; The Baltimore Jewish Health Foundation, Inc. (BJHF); The Baltimore Jewish Eldercare Foundation, Inc. (BJEF); Children's Hospital at Sinai Foundation, Inc. (CHSF); LifeBridge Anesthesia Associates, LLC (LAA); LifeBridge Insurance Company, Ltd. (LifeBridge Insurance); Courtland Gardens Nursing and Rehabilitation Center, Inc. (Courtland); LifeBridge Investments, Inc. (Investments); LifeBridge Health ACO, LLC; LifeBridge Physician Network, LLC; 8600 Liberty Road, LLC; and LifeBridge 23 Crossroads Drive Medical Office Building, LLC. Except for LifeBridge Insurance and Investments, all of the entities named above are not-for-profit and tax-exempt. Sinai and Levindale are constituent agencies of THE ASSOCIATED: Jewish Community Federation of Baltimore, Inc. (AJCF), a charitable corporation.

Effective April 1, 2015, Carroll County Health Services Corporation (CCHS), the parent of Carroll Hospital Center, Inc. (Carroll) and other related entities, became a subsidiary of LifeBridge. CCHS is further discussed below.

Investments is a for-profit corporation that holds, directly and indirectly, interests in a variety of for-profit businesses. Investments' wholly owned subsidiaries include:

- *Practice Dynamics, Inc.*
- *LifeBridge Health and Fitness, LLC*
- *Sinai Eldersburg Real Estate, LLC*
- *General Surgery Specialists, LLC*
- *BW Primary Care, LLC*
- *LifeBridge Community Practices, LLC*
- *The Center for Urologic Specialties, LLC*
- *LifeBridge Community Physicians, Inc. (Community Physicians)*

Investments also holds interests in numerous other health-related businesses.

Community Physicians is a for-profit corporation that provides physician and related services through numerous subsidiaries.

CCHS is a not-for-profit, nonstock Maryland corporation. The accompanying consolidated financial statements include the accounts of CCHS and its wholly or partially owned subsidiaries.

Wholly owned subsidiaries of Carroll include Carroll Hospital Center Foundation, Inc. (Carroll Foundation); Carroll Hospice, Inc. (CH); Carroll Regional Cancer Center Physicians, LLC (CRCCP); and Carroll Hospital Center MOB Investment, LLC. Carroll also holds interests in various health-related companies.

(Continued)

Prior to June 30, 2016, Carroll owned Cen-Mar Assurance Company (Cen-Mar). Cen-Mar was merged into LifeBridge Insurance on June 30, 2016.

Carroll County Med-Services, Inc. (CCMS) is a wholly owned, for-profit subsidiary of CCHS that is involved in real estate holdings, physician services, and other activities, and also maintains ownership interests in various joint ventures. Wholly owned subsidiaries of CCMS include: Carroll Health Group, LLC; Carroll PHO, LLC; and Carroll ACO, LLC. CCMS also holds interests in various health-related companies.

(2) Significant Accounting Policies

(a) Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. All controlled and direct member entities are consolidated. The accompanying consolidated financial statements include the accounts of LifeBridge Health, Inc. and Subsidiaries (the Corporation). All entities where the Corporation exercises significant influence, but does not have control, are accounted for under the equity method. All other unconsolidated entities are accounted for under the cost method. All significant intercompany accounts and transactions have been eliminated.

(b) Cash and Cash Equivalents

Cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less at the date of purchase.

(c) Assets Limited as to Use

Assets limited as to use primarily consists of assets held by trustees under bond indenture agreements, a self-insured workers' compensation reserve fund, and designated assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes. A portion of the designated assets set aside by the Board of Directors is contractually designated.

(d) Inventory

Inventories, which consist primarily of medical supplies and pharmaceuticals, are stated at the lower of cost (using the moving average cost method of valuation) or market.

(e) Investments, Long-Term Investments and Donor-Restricted Investments

The Corporation's investment portfolio is considered a trading portfolio and is classified as current or noncurrent assets based on management's intention as to use. All debt and equity securities are reported in the consolidated balance sheets at fair value, principally based on quoted market prices.

(Continued)

The Corporation has investments in alternative investments, primarily funds of hedge funds, totaling $99,451 and $138,838 at June 30, 2017 and 2016, respectively. These funds utilize various types of debt and equity securities and derivative instruments in their investment strategies. Also included in alternative investments are BJEF's and BJHF's funds that are invested on their behalf by the Associated Jewish Charities (AJC), an affiliate of AJCF. Alternative investments are recorded under the equity method which is based on the Net Asset Value (NAV) of the shares in each Investment Company or partnership.

Investments in unconsolidated affiliates are accounted for under the cost or equity method of accounting as appropriate and are included in other assets and investment in unconsolidated affiliates, respectively, in the consolidated balance sheets. The Corporation's equity income or loss is recognized in other operating revenue within the excess of revenue over expenses in the accompanying consolidated statements of operations.

Investments also include assets restricted by donor, and assets designated by the Board of Directors for future capital improvements and other purposes over which it retains control and may, at its discretion, use for other purposes. Purchases and sales of securities are recorded on a trade-date basis.

Investment income (interest and dividends) including realized gains and losses on investment sales is reported as other income (expense) within the excess of revenues over expenses in the accompanying consolidated statements of operations and changes in net assets unless the income or loss is restricted by the donor or law. Investment income on funds held in trust for self-insurance purposes is included in other operating revenue. Investment income and net gains (losses) that are restricted by the donor are recorded as a component of changes in temporarily or permanently restricted net assets, in accordance with donor-imposed restrictions. Realized gains and losses are determined based on the specific security's original purchase price. Unrealized gains and losses are included in other income, net within the excess of revenue over expenses.

Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 Inputs – Unadjusted quoted prices in active markets for identical assets or liabilities accessible to the reporting entity at the measurement date.
- Level 2 Inputs – Other than quoted prices included in Level 1 inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the asset or liability.
- Level 3 Inputs – Unobservable inputs for the asset or liability used to measure fair value to the extent that observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at measurement date.

(Continued)

The hierarchy requires the use of observable market data when available. Assets and liabilities are classified in their entirety based on the lowest level input that is significant to the fair value measurements.

(f) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter of the period of the lease term or the estimated useful life of the equipment. Maintenance and repair costs are expensed as incurred. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(g) Impairment of Long-Lived Assets

Management regularly evaluates whether events or changes in circumstances have occurred that could indicate impairment in the value of long-lived assets. In accordance with the provisions of ASC 360, if there is an indication that the carrying value of an asset is not recoverable, the Corporation estimates the projected undiscounted cash flows, excluding interest and taxes, of the related individual entities to determine if an impairment loss should be recognized. The amount of impairment loss is determined by comparing the historical carrying value of the asset to its estimated fair value. Estimated fair value is determined through an evaluation of recent and projected financial performance of facilities using standard industry valuation techniques.

In addition to consideration of impairment upon the events or changes in circumstances described above, management regularly evaluates the remaining lives of its long-lived assets. If estimates are changed, the carrying value of affected assets is allocated over the remaining lives. In estimating the future cash flows for determining whether an asset is impaired and if expected future cash flows used in measuring assets are impaired, the Corporation groups its assets at the lowest level for which there are identifiable cash flows independent of other groups of assets. The Corporation did not record a loss on impairment during the years ended June 30, 2017 and 2016.

(h) Goodwill and Other Assets, Net

Other assets consist primarily of goodwill and other intangibles related to practice acquisitions, notes receivable, and the cash surrender value of split dollar life insurance.

(Continued)

Goodwill represents the excess of the aggregate purchase price over the fair value of the net assets acquired in a business combination. ASC Topic 350, *Intangibles – Goodwill and Other*, requires that tangible and indefinite-lived assets, as well as goodwill must be analyzed in order to determine whether their value has been impaired.

Goodwill is assessed annually for impairment at the reporting unit. As of June 30, 2017 and 2016, the Corporation had one reporting unit, which included all subsidiaries. The Corporation first assesses qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment tests as described in Topic 350. The more-likely than-not threshold is defined as having a likelihood of more than 50%. The Corporation determined that it was not more likely than not that the fair value of its reporting unit was less than its carrying amount. Accordingly, the Corporation concluded that goodwill was not impaired as of June 30, 2017 and 2016 without having to perform the two-step impairment test.

(i) Beneficial Interest in Split Interest Agreement

CHSF holds a 25% interest in a trust, of which management has estimated the present value of the future income stream. CHSF will receive 25% of the net annual income until 2024, when the trust will terminate, and 25% of the principal will be distributed to CHSF. Management has reported the beneficial interest at fair value based on the fair value of the underlying trust investments.

(j) Advances from Third-Party Payors

Advances from third-party payors are comprised of advance funding from CareFirst BlueCross BlueShield, Medicaid, Aetna, United/MAMSI, and other insurance providers.

(k) Self-Insurance Programs

The Corporation maintains self-insurance programs for professional and general liability, workers' compensation, and employee health benefits. The provision for estimated self-insurance program claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. The estimates are based on historical trends, claims asserted, and reported incidents.

(l) Other Long-Term Liabilities

Other long-term liabilities consist of self-insurance liabilities, pension plan liabilities, asset retirement obligations, and deferred compensation plan liabilities.

(m) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Corporation are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date those promises become unconditional. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets

(Continued)

released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions.

(n) Net Assets

Net assets and revenues, expenses, gains and losses are classified based on the existence or absence of externally imposed stipulations. Accordingly, net assets of the Corporation and changes therein are classified and reported as follows:

Unrestricted net assets – Net assets that are not subject to externally imposed stipulations.

Temporarily restricted net assets – Net assets subject to externally imposed stipulations that may or will be met either by actions of the Corporation and/or the passage of time.

Permanently restricted net assets – Net assets subject to externally imposed stipulations that they be maintained by the Corporation in perpetuity.

Revenues are reported as increases in unrestricted net assets unless use of the related asset is limited by externally imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses are reported as increases or decreases in unrestricted net assets unless use of the related asset is limited by externally imposed restrictions or law. Expirations of temporary restrictions of net assets (i.e., the externally stipulated purpose has been fulfilled and/or the stipulated time period has elapsed) are reported as reclassifications between the applicable classes of net assets if used to acquire capital assets; otherwise, they are recorded as unrestricted operating revenue.

(o) Net Patient Service Revenue

Net patient service revenue for Sinai, Northwest, Carroll and the chronic hospital component of Levindale is recorded at rates established by the State of Maryland Health Services Cost Review Commission (HSCRC) and, accordingly, reflects actual charges to patients based on rates in effect during the period in which the services are rendered. On January 29, 2014, the Corporation and the Health Services Cost Review Commission (HSCRC) agreed to implement the Global Budget Revenue (GBR) methodology, effective July 1, 2013, for Sinai, Northwest and Levindale. The term of the Agreement continued through June 30, 2017 and will renew for a one-year period unless it is canceled by the HSCRC or by the applicable Hospital. The GBR model is a revenue constraint and quality improvement system, designed by the HSCRC to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in healthcare costs and improve healthcare delivery processes and outcomes. The GBR model is consistent with the Hospitals' mission to provide the highest value of care possible to their patients and the communities they serve.

The GBR agreement establishes a prospective, fixed revenue base (the GBR cap) for each fiscal year. This includes both inpatient and outpatient regulated services. Under GBR, the Corporation's revenue for all HSCRC-regulated services is predetermined for the upcoming year, regardless of changes in volume (subject to certain limits), service mix intensity, or mix of inpatient or outpatient services that occur during the year. The GBR agreement allows the Corporation to adjust unit rates, within certain limits, to achieve the overall revenue base for the Corporation at year-end. Any overcharge or

undercharge versus the GBR cap is prospectively added to the subsequent year's GBR cap. Beginning in fiscal year 2017, the GBR is adjusted for changes in market share. Effective with fiscal year 2017, market-shift adjustments will be made semi-annually, on January and July 1. The GBR cap is adjusted annually for inflation, changes in payor mix and uncompensated care, and changes in population within the Corporation's service area. A hospital's GBR cap may also be adjusted based on the hospital's performance on various quality and utilization metrics established from time to time by the HSCRC.

Prior to implementation of the GBR methodology, Carroll and the HSCRC agreed to a three year contract for Carroll to implement the Total Patient Revenue (TPR) methodology effective July 1, 2010, which was renewed for an additional three year period effective July 1, 2013. Similar to the GBR, the TPR agreement establishes a prospective, fixed revenue base, the "TPR cap," for the upcoming year. Effective in fiscal year 2017, all TPR agreements have been terminated and reinstituted as GBR agreements using the same parameters described above.

Contractual adjustments, which represent the difference between amounts billed as patient service revenue and amounts paid by third-party payors, are accrued in the period in which the related services are rendered. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue.

Medicare reimburses Northwest and Levindale for skilled nursing services under the Medicare skilled nursing Prospective Payment System (PPS). Under PPS, the payment rate is based on patient resource utilization as calculated by a patient classification system known as Resource Utilization Groups.

Medicaid reimburses Levindale for long-term care services based on Levindale's actual costs. However, beginning in January 2015, the cost data from the 2012 cost reports was used to set Resource Utilization Group (similar to Medicare) rates which are adjusted for changes in case mix. The case mix from two quarters prior is used to adjust the rates on a quarterly basis.

All other patient service revenue is recorded at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

During 2017, the Corporation changed its policy for recording pharmacy revenues to record them in net patient service revenues from other operating revenues. The Corporation determined that this change is appropriate as the majority of pharmacy revenues are derived from the Corporation's patients. Accordingly, the Corporation reclassified approximately $37,810 from other operating revenues to net patient service revenues during the year ended June 30, 2016. The change did not impact total operating revenues, operating income or the excess of revenues over expenses.

(p) Other Operating Revenue

Other operating revenue includes income of LifeBridge Health and Fitness LLC, revenue from other support services, and revenue generated from investments in joint ventures that offer health care services or services that support or complement the delivery of care.

(Continued)

(Dollars in thousands)

(q) Grants

Federal grants are accounted for either as an exchange transaction or as a contribution based on terms and conditions of the grant. If the grant is accounted for as an exchange transaction, revenue is recognized as other operating revenue when earned. If the grant is accounted for as a contribution, the revenues are recognized as either other operating revenue or temporarily restricted contributions depending on the restrictions within the grant.

(r) Charity Care and Bad Debt

Sinai, Northwest, Carroll, and Levindale provide care to patients who meet certain criteria under their charity care policies without charge or at amounts less than their established rates. Because the facilities do not pursue the collection of amounts determined to qualify as charity care, those amounts are not reported as revenue. The amount of charity care provided during the years ended June 30, 2017 and 2016, based on patient charges forgone, was $11,394 and $11,720, respectively. The total direct and indirect costs to provide the care amounted to approximately $9,274 and $10,044 for the years ended June 30, 2017 and 2016, respectively.

All patient accounts are handled consistently and appropriately to maximize cash flow and to identify bad debt accounts timely. Active accounts are considered bad debt accounts when they meet specific collection activity guidelines and/or are reviewed by the appropriate management and deemed to be uncollectible. Every effort is made to identify and pursue all account balance liquidation options, including but not limited to third party payor reimbursement, patient payment arrangements, Medicaid eligibility and financial assistance. Third party receivable management agencies provide extended business office services and insurance outsource services to ensure maximum effort is taken to recover insurance and self-pay dollars before transfer to bad debt. Contractual arrangements with third party collection agencies are used to assist in the recovery of bad debt after all internal collection efforts have been exhausted. In so doing, the collection agencies must operate consistently with the goal of maximum bad debt recovery and strict adherence with Fair Debt Collections Practices Act (FDCPA) rules and regulations, while maintaining positive patient relations.

		2017	2016
Beginning allowance	$	62,213	58,346
Plus provision for bad debt		47,341	56,982
Less bad debt write-offs, net of recoveries		(41,613)	(53,115)
Ending allowance	$	67,941	62,213

(s) Income Taxes

LifeBridge and its not-for-profit subsidiaries have been recognized by the Internal Revenue Service as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code.

(Continued)

LifeBridge's incorporated for-profit subsidiaries account for income taxes in accordance with Financial Accounting Standards Board (FASB) ASC Topic 740, *Income Taxes*. 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 the change. The Corporation accounts for uncertain tax positions in accordance with ASC Topic 740.

(t) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(u) Excess of Revenues over Expenses

The accompanying consolidated statements of operations include excess of revenue over expenses. Changes in unrestricted net assets that are excluded from excess of revenues over expenses, consistent with industry practice, include changes in the funded status of defined-benefit pension plans, permanent transfers of assets to and from affiliates for other than goods and services, and contributions received for additions of long-lived assets.

(v) Employee Pension Plan

Pension benefits are administered by the Corporation. The Corporation accounts for its defined-benefit pension plans within the framework of ASC Topic 958, *Not-for-Profit Entities, Section 715, Compensation-Retirement Benefits* (Topic 958, Section 715), which requires the recognition of the overfunded or underfunded status of a defined-benefit pension plan as an asset or liability. The plans are subject to annual actuarial evaluations, which involve various assumptions creating changes in elements of expense and liability measurement. Key assumptions include the discount rate, the expected rate of return on plan assets, retirement, mortality, and turnover. The Corporation evaluates these assumptions annually and modifies them as appropriate.

Additionally, Topic 958, Section 715 requires the measurement date for plan assets and liabilities to coincide with the employer's year-end and requires the disclosure in the notes to the consolidated financial statements of additional information about certain effects on net periodic benefit cost for the next fiscal year that arise from delayed recognition of the gains or losses, prior service costs or credits, and transition asset or obligation. During fiscal year 2017, LifeBridge adopted the RP-2014 Mortality Table with generational improvements. See note 11 for further discussion.

(Continued)

(w) Management's Assessment and Plans

The Corporation adopted Accounting Standards Update (ASU) 2014-15, *Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern*, (ASU 2014-15) during 2017. ASU 2014-15 requires management to evaluate an entity's ability to continue as a going concern within one year after the date that the financial statements are issued (or available to be issued, when applicable). Management determined that there were no conditions or events that raise substantial doubt about the Corporation's ability to continue as a going concern and the Corporation will continue to meet its obligations through October 18, 2018.

(x) New Accounting Pronouncements

In 2017, the Corporation adopted Accounting Standards Update (ASU) 2015-03, *Simplifying the Presentation of Debt Issuance Costs.* The presentation of debt issuance costs on the balance sheet has been changed from an asset to a direct reduction of debt, similar to the presentation of debt discounts. As a result of this change, $4,060 and $4,137 of deferred financing costs were classified as a direct reduction of debt at June 30, 2017 and 2016. The related consolidated statements of operations and changes in net assets for the periods were not affected by the adoption of ASU 2015-03.

In 2017, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2017-07, *Compensation – Retirement Benefits (Topic 715).* The ASU attempts to improve the presentation of net periodic pension and postretirement benefit costs. The ASU does not prescribe where the amount of net benefit cost should be presented in an employer's statement of operations, but it does require that the service cost component be presented in the same line item as other employee compensation costs and that the remaining components be presented separately from those line items and outside of operations. It also stipulates that only the service cost component is eligible for capitalization in assets, as applicable. The new standard is effective for fiscal years beginning after December 15, 2018. Early adoption is permitted. In fiscal 2017, the Corporation retrospectively adopted the standard, which resulted in no reclassification of net periodic benefit cost from salaries and employee benefits to pension costs other than service costs within other income (loss) for the years ended June 30, 2017 and 2016.

The Financial Accounting Standards Board (FASB) issued Accounting Standards update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606).* This ASU establishes principles for reporting useful information to users of financial statements about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. Particularly, that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. ASU 2014-09 is effective for fiscal year 2019. The Corporation expects to record a decrease in net patient service revenue related to self-pay patients and a corresponding decrease in bad debt expense upon the adoption of the standard.

The FASB issued ASU No. 2016-02, *Leases* (ASU 2016-02), which will require lessees to recognize most leases on-balance sheet, increasing their reported assets and liabilities – sometimes very significantly. This update was developed to provide financial statement users with more information

(Continued)

(Dollars in thousands)

about an entity's leasing activities, and will require changes in processes and internal controls. The adoption of ASU 2016-02 is effective fiscal year 2020, and will require application of the new guidance at the beginning of the earliest comparable period presented. Early adoption is permitted. The Corporation is currently assessing the impact of the adoption of ASU No. 2016-02 which is expected to have a material impact on its financial position.

The FASB issued ASU No. 2016-14, *Not-for-Profit Entities* (ASU 2016-14), which amends the requirements for financial statements and notes in Topic 958, Not-for-Profit Entities (NFP), require a NFP to the following:

- Reduces the number of net asset classes presented from three to two: with donor restrictions and without donor restrictions;
- Requires all NFPs to present expenses by their functional and their natural classifications in one location in the financial statements;
- Requires NFPs to provide quantitative and qualitative information about management of liquid resources and availability of financial assets to meet cash needs within one year of the balance sheet date; and
- Retains the option to present operating cash flows in the statement of cash flows using either the direct or indirect method.

The adoption of ASU 2016-14 is effective in fiscal year 2019, and is applied retrospectively in the year of adoption. The Corporation does not anticipate that the adoption of this ASU will have a material impact on its financial position and results of operations.

(3) Investments

Investments, which consist of assets limited as to use, board-designated investments, donor-restricted investments, and long-term investments in the accompanying consolidated balance sheets, are stated at fair value or under the equity method, as appropriate, as of June 30, 2017 and 2016, and consist of the following:

	2017	2016
Assets limited as to use:		
Self-insurance fund:		
Mutual funds	$ 19,163	22,060
Equity securities	9,411	9,210
U.S. Treasury	—	944
Fixed income	1,859	8,789
Alternative investments	2,606	2,598
Self-insurance fund	33,039	43,601

(Continued)

(Dollars in thousands)

	2017	2016
Debt service fund:		
Cash and cash equivalents	$ 7,374	12,376
Government securities	7,479	1,888
Debt service fund	14,853	14,264
Construction funds:		
Cash and cash equivalents	24,395	8,222
Government securities	29,248	45,174
	53,643	53,396
Total assets limited as to use	101,535	111,261
Less current portion	(68,496)	(67,660)
Assets limited as to use, net of current portion	$ 33,039	43,601
Donor-restricted investments:		
Cash and cash equivalents	$ 4,703	4,825
Mutual funds	5,963	5,649
Equity securities	2,464	2,585
U.S. Treasury	4,333	3,557
Government securities	2,533	3,016
Fixed income	984	566
Alternative investments	409	343
Donor-restricted investments	$ 21,389	20,541
Beneficial interest in split interest agreement	$ 4,757	4,477

(Continued)

(Dollars in thousands)

There are other investments restricted by donors other than pledges receivable, donor-restricted investments, and beneficial interest that are included in long-term investments as of June 30, 2017 and 2016. As of June 30, 2017 and 2016 current, long-term, and board-designated investments are as follows:

	2017	2016
Current, long-term, and board-designated investments:		
Cash and cash equivalents	$ 37,331	8,747
Mutual funds	162,576	177,303
Equity securities	186,741	159,173
Government securities	6,780	10,111
Fixed income	88,307	29,167
Alternative investments	96,845	135,897
Current, long-term and board-designated investments	578,580	520,398
Less current portion	(24,583)	(23,352)
Long-term and board-designated investments	$ 553,997	497,046

Investment income and gains and losses on long-term investments, board-designated investments, donor-restricted investments, and assets limited as to use are comprised of the following for the years ended June 30, 2017 and 2016:

	2017	2016
Investment income:		
Interest income and dividends	$ 7,366	9,516
Realized gains on sale of securities	23,542	6,512
Investment income	30,908	16,028
Unrealized gains (losses) on trading securities	36,654	(22,110)
Other changes in net assets:		
Changes in unrealized gains (losses) on temporarily and permanently restricted net assets	3,305	(1,847)
Total investment return	$ 70,867	(7,929)

(4) Pledges Receivable

Contributions and pledges to raise funds are recorded as temporarily restricted net assets until the donor-intended purpose is met and the cash is collected. Future pledges are discounted at the Treasury bill rate to reflect the time value of money, and an allowance for potentially uncollectible pledges has been established.

(Continued)

(Dollars in thousands)

Sinai, Northwest, Carroll, and Levindale have recorded total pledges as of June 30, 2017 and 2016 as follows:

	2017	2016
Gross pledges receivable	$ 9,259	9,051
Less:		
Discount for time value of money	(517)	(782)
Allowance for uncollectible accounts	(949)	(1,568)
	$ 7,793	6,701

Total anticipated future payments are as follows:

Less than one year	$ 3,341
One to five years	5,915
Five years and thereafter	3
	$ 9,259

(5) Property and Equipment

As described in note 13, Sinai and Levindale leases from an affiliate of AJCF all land, land improvements, buildings, and fixed equipment located at those entities' primary locations; LifeBridge entities own the movable equipment. Property and equipment are classified as follows at June 30:

	Estimated useful life	2017	2016
Land		$ 24,175	11,657
Land improvements	8 to 20 years	36,322	35,931
Building and improvements	10 to 40 years	927,766	863,963
Fixed equipment	8 to 20 years	107,785	101,411
Movable equipment	3 to 15 years	499,839	479,705
		1,595,887	1,492,667
Less accumulated depreciation		(995,195)	(926,430)
		600,692	566,237
Construction in progress		50,481	63,240
Property and equipment, net		$ 651,173	629,477

(Continued)

(Dollars in thousands)

Depreciation, amortization, and gain/loss on sale of assets were $77,214 and $75,699 for the years ended June 30, 2017 and 2016, respectively. Of this, depreciation expense was $76,815 and $75,546 for the years ended June 30, 2017 and 2016, respectively.

Included in property and equipment is building and equipment, net of accumulated amortization, of $16,452 and $18,774 for the years ended June 30, 2017 and 2016, respectively, financed with capital lease obligations. Accumulated amortization related to the building and equipment under capital leases was $14,128 and $11,806 at June 30, 2017 and 2016, respectively.

During 2017, the Corporation acquired a skilled nursing facility and two surgical centers for approximately $11,000. These acquisitions did not significantly impact the Corporation's total assets, liabilities, net assets, total operating revenues, operating income or the excess of revenues over expenses.

(6) Investments in Joint Ventures

Investments in joint ventures and partnerships, accounted for under the equity method, consist of the following at June 30, 2017 and 2016:

Joint Venture	Business purpose	2017 Percentage ownership	2017 Balance	2016 Percentage ownership	2016 Balance
MNR Industries, LLC	Urgent Care Centers	40 %	$ 24,587	40 %	$ 23,291
Baltimore County Radiology, LLC	Outpatient Radiology	25	7,148	25	5,724
Mt. Airy Med-Services, LLC	Real Estate	50	4,419	50	4,952
Future Care Old Court, LLC	Nursing Home	40	2,965	—	—
Lochearn Nursing Home, LLC	Nursing Home	10	2,000	10	1,997
Mt. Airy Plaza, LLC	Real Estate	50	1,594	50	1,628
LifeBridge Sports Medicine & Rehabilitation, LLC	Physical Therapy	50	1,173	50	1,303
Advanced Health Collaborative, LLC	Medicare Advantage Plan	25	1,266	—	—
Carroll Care Pharmacies, LLC	Pharmacies	49	944	49	1,037
Other Joint Ventures	Miscellaneous	5–50	4,786	5–50	4,108
Total			$ 50,882		$ 44,040

For those joint ventures and partnerships accounted for using the equity method, the Corporation recorded equity in earnings of joint ventures and partnerships. For those joint ventures and partnerships accounted for using the cost method, the Corporation recorded dividend income. Such amounts are included in other operating revenue in the consolidated statements of operations.

(Continued)

(Dollars in thousands)

(7) Other Assets

As of June 30, other assets are comprised of the following balances:

		2017	2016
Goodwill	$	16,902	2,108
Investment in Premier		12,496	10,264
Notes Receivable		11,442	12,249
Other Intangible Assets		11,510	12,150
Deferred compensation assets		9,181	8,896
Other		2,410	2,475
Other assets	$	63,941	48,142

(8) Long-Term Debt and Capital Lease Obligations

As of June 30, long-term debt and capital lease obligations consist of the following:

		2017	2016
Maryland Health and Higher Educational Facilities Authority (MHHEFA):			
Revenue Bonds Series 2008	$	155,380	237,590
Revenue Bonds Series 2011		5,015	47,465
Revenue Bonds Series 2012A		53,670	55,152
Revenue Bonds Series 2015		159,685	159,685
Revenue Bonds Series 2016		120,695	—
Other debt:			
M&T Bank taxable loan		41,345	45,905
Capital leases		16,545	18,501
Other		14,454	539
		566,789	564,837
Less current portion		(13,928)	(12,921)
Plus unamortized premium		22,380	12,685
Less deferred Financing Costs		(4,060)	(4,137)
Less unamortized discount		(3)	(42)
Long-term debt, net	$	571,178	560,422

(Continued)

A single obligated group (the Obligated Group), consisting of LifeBridge, Sinai, Northwest, Levindale, BJHF, CHSF, CCHS, Carroll, CCMS, CHG, CH, and CRCCP, has been formed with respect to certain bonds issued by the Maryland Health and Higher Educational Facilities Authority (MHHEFA) and certain other obligations. Members of the Obligated Group are jointly and severally liable for all of the outstanding bonds issued by MHHEFA on behalf of LifeBridge and CCHS and their respective affiliates, together with other obligations issued on parity with such bonds.

In January 2008, MHHEFA loaned $285,815 from the proceeds of bonds (Series 2008 Bonds) to LifeBridge and certain of its subsidiaries. Portions of the Series 2008 Bonds are payable on July 1 of each year through 2047. The Series 2008 Bonds bear interest at a weighted fixed rate of 5.35%. Approximately, $27,640 of the Series 2008 Bonds were repaid as part of the Series 2015 Bond offering, further discussed below. Approximately $74,655 of the Series 2008 Bonds were repaid as part of the Series 2016 Bond offering, further discussed below.

In March 2011, MHHEFA loaned $50,695 from the proceeds of bonds (Series 2011 Bonds) to LifeBridge and certain of its subsidiaries. Portions of the Series 2011 Bonds are payable on July 1 of each year through 2041. The Series 2011 Bonds bear interest at a weighted fixed rate of 5.99%. Approximately $46,040 of the Series 2011 Bonds were repaid as part of the Series 2016 Bond offering, further discussed below.

In May 2012, MHHEFA loaned $59,780 from the proceeds of bonds (Series 2012A Bonds) to CCHS and certain of its subsidiaries (the Series 2012 Bonds). The Series 2012 Bonds were issued in three series: $26,995 of serial bonds maturing in 2013 through 2027 with interest rates ranging from 2% to 5%, $7,505 of term bonds maturing in 2030 with an interest rate of 4%, and $25,280 of term bonds maturing in 2037 (Series 2012A Bonds) with an interest rate of 5%.

On June 26, 2015, LifeBridge entered into a $50,000 direct bank placement with M&T Bank (2015 M&T Bank Taxable Loan). The interest rates range from 1.57% to 3.28%, with maturity dates ranging from July 1, 2016 to July 1, 2025. The 2015 M&T Loan is secured on parity with the bonds.

On July 30, 2015, MHHEFA issued $159,685 in bonds (Series 2015 Bonds) on behalf of LifeBridge. The proceeds of the Series 2015 Bonds have been and will be used to finance and refinance the cost of construction, renovation, and equipping of certain additional facilities for the Obligated Group, to refund a portion of the Series 2008 Bonds and the Authority's Carroll Issue, Series 2006 bonds, and refinance the portion of a line of credit from Bank of America that had been used to repay Carroll's loan from BB&T Bank. The remaining Bank of America line of credit was repaid by the Corporation. $33,130 of the bonds are serial bonds with maturity dates ranging from 2018 through 2030 and interest rates ranging from 2% to 5%. $14,260, $26,325, $35,970, and $50,000 of the bonds are term bonds that are due in 2035, 2040, 2047 and 2047, respectively, with interest rates of 4%, 5%, 4.1%, and 5%, respectively.

On October 25, 2016, MHHEFA issued $120,695 in bonds (Series 2016 Bonds) on behalf of LifeBridge Health. The proceeds of the Series 2016 Bonds were used to refinance the Series 2008 Bonds. $40,465 of the bonds are serial bonds with maturity dates ranging from 2017 through 2036 and interest rates ranging from 2% to 5%. $40,640 of the bonds are term bonds that are due in 2041 with an interest rate of 4%. The remaining $39,590 of the bonds are term bonds that are due in 2047 with an interest rate of 5%.

(Continued)

(Dollars in thousands)

The Series 2008, 2011, 2012A, 2015, and 2016 Bonds are governed by a Master Loan Agreement. Under the Master Loan Agreement, MHHEFA maintains a security interest in the revenue of the obligors. In addition, the Master Loan Agreement requires Obligated Group members to adhere to limitations on mergers, disposition of assets, and additional indebtedness and certain financial covenants. The financial covenants include a rate covenant, which requires the Obligated Group to achieve a debt service coverage ratio of 1.10; a liquidity covenant, which requires the Obligated Group to maintain 65 days cash on hand; and a debt-to-capitalization covenant, which requires the Obligated Group to maintain a debt-to-capitalization ratio of not more than 65%, all measured as of June 30 in each fiscal year.

In 2017, the Corporation acquired Springwell Partners, LLC (Springwell). Upon acquisition, the Corporation assumed the debt of Springwell. The debt consists of two term notes that were amended in February 2017. The first term note of $8,453 bears monthly interest of one month LIBOR plus 1.6% which approximates 2.7% as of June 30, 2017. The second term note of $5,614 bears monthly interest of 4.75%. Both term notes mature February 5, 2022 and one secured by certain property and equipment. The outstanding principal of the two notes as of June 30, 2017 was $13,978.

Deferred financing costs are amortized using the effective-interest method over the term of the related debt. Amortization expense was $1,168 and $513 for the years ended June 30, 2017 and 2016, respectively. Such amortization is included in interest expense in the consolidated financial statements.

The Corporation is obligated under several noncancelable capital leases for hospital equipment and office building space.

The total future principal payments on long-term debt and capital lease payments are as follows:

	MHHEFA and other debt	Capital lease obligations
Years ending June 30:		
2018	$ 12,689	2,240
2019	11,924	2,214
2020	12,455	2,258
2021	13,031	2,304
2022	25,507	2,351
Thereafter	474,638	7,973
	$ 550,244	19,340
Less interest portion		(2,795)
		$ 16,545

(9) M&T Bank Line of Credit

Sinai maintains a $5,000 line of credit with M&T Bank. As of June 30, 2017 and 2016, there were no balances outstanding on this line of credit.

(Continued)

(Dollars in thousands)

(10) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30:

	2017	2016
Healthcare services:		
Capital equipment/construction	$ 24,358	23,160
Other healthcare services:		
Service grants	415	496
Donor-specified healthcare services	14,216	14,452
Enrichment and research	15,543	15,277
	$ 54,532	53,385

Permanently restricted net assets of $16,191 and $15,887 at June 30, 2017 and 2016, respectively, are to investments to be held in perpetuity, the income from which is expendable to support healthcare services.

(11) Employee Benefit Plans

(a) LifeBridge Health Pension Plans (Sinai and Levindale)

The Corporation sponsors two noncontributory defined-benefit pension plans (the Sinai/Levindale Plans) covering full-time, nonunion and union employees of Sinai and Levindale. Annual contributions to the Sinai/Levindale Plans are made at a level equal to or greater than the funding requirement as determined by the Sinai/Levindale Plans' consulting actuary. Contributions are intended to provide not only for benefits attributed to service to date, but also for those expected to be earned in the future.

The following tables set forth the Sinai/Levindale Plans' funded status and amounts recognized in the accompanying consolidated financial statements as of June 30, 2017 and 2016:

	2017	2016
Measurement date	June 30, 2017	June 30, 2016
Change in projected benefit obligation:		
Benefit obligation at beginning of year	$ 214,725	185,808
Service cost	8,263	7,729
Interest cost	5,972	8,085
Actuarial loss	1,582	19,264
Benefits paid	(10,006)	(5,815)
Expenses paid from assets	(204)	(346)
Benefit obligation at end of year	220,332	214,725

(Continued)

(Dollars in thousands)

		2017	2016
Change in plan assets:			
Fair value of plan assets at beginning of year	$	157,577	158,657
Actual return on plan assets		22,425	(5,461)
Company contributions		16,721	10,542
Benefits paid		(10,006)	(5,815)
Expenses paid from assets		(204)	(346)
Fair value of plan assets at end of year		186,513	157,577
Funded status	$	(33,819)	(57,148)

Amounts recognized in the consolidated financial statements consist of the following at June 30:

		2017	2016
Amounts recognized in the consolidated balance sheets:			
Other long-term liabilities	$	33,819	57,148
Amounts recognized in unrestricted net assets:			
Net actuarial loss	$	58,991	74,421
Prior service cost		—	—
	$	58,991	74,421

The Corporation has estimated $11,423 for its defined-benefit contributions to the Sinai/Levindale Plans for the fiscal year ending June 30, 2018. The accumulated benefit obligation for the Sinai/Levindale Plans is $201,702 and $196,562 at June 30, 2017 and 2016, respectively.

Net periodic pension expense for the years ended June 30, 2017 and 2016 was as follows:

		2017	2016
Pension costs:			
Service cost	$	8,263	7,729
Interest cost		5,972	8,085
Expected return on plan assets		(10,969)	(10,963)
Amortization of net loss		5,555	2,353
Amortization of prior service cost		—	44
Net periodic benefit cost	$	8,821	7,248

The estimated net actuarial loss and prior service cost to be amortized from unrestricted net assets into net periodic pension benefit cost over the next fiscal year are $3,928 and $0, respectively.

(Continued)

(Dollars in thousands)

Actuarial assumptions used were as follows:

	2017	2016
Assumptions used to determine annual pension expense:		
Discount rate	3.68 %	4.47 %
Expected return on plan assets	7.00	7.00
Rate of compensation increase	2.50	2.50
Assumptions used to determine end-of-year liabilities:		
Discount rate	3.85 %	3.68 %
Expected return on plan assets	7.00	7.00
Rate of compensation increase	2.50	2.50
Plan asset allocation:		
Asset category:		
Cash and cash equivalents	— %	2.00 %
Fixed income/debt securities	26.00	26.00
Equity securities/mutual funds	56.00	47.00
Alternative investments	18.00	25.00
Total	100.00 %	100.00 %

In selecting the expected long-term rate of return on plan assets, Sinai and Levindale considered the average rate of earnings on the funds invested or to be invested to provide for the benefits of these plans. This included considering the Sinai/Levindale Plans' asset allocation and the expected returns likely to be earned over the life of the plans. Target asset allocation is as follows:

	Target
Target allocation on assets:	
Equity securities	52 %
Alternative investments	23
Fixed income/debt securities	25

(Continued)

(Dollars in thousands)

Following are the benefit payments expected to be disbursed from plan assets:

Years ending June 30:		
2018	$	11,668
2019		11,689
2020		12,215
2021		12,084
2022		12,346
Thereafter		68,857

The fair values of assets of the Sinai/Levindale Plans held by PNC Institutional Investments by level at June 30, 2017 were as follows:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 8,901	—	—	8,901
Mutual funds	73,860	—	—	73,860
Fixed income securities	—	7,017	—	7,017
Equity securities	79,158	—	—	79,158
Alternative investments	—	—	17,577	17,577
Total assets	$ 161,919	7,017	17,577	186,513

The fair values of assets of the Sinai/Levindale Plans held by PNC Institutional Investments by level at June 30, 2016 were as follows:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 4,860	—	—	4,860
Mutual funds	54,886	—	—	54,886
Fixed income securities	—	5,635	—	5,635
Equity securities	56,382	—	—	56,382
Alternative investments	—	—	35,814	35,814
Total assets	$ 116,128	5,635	35,814	157,577

(Continued)

(Dollars in thousands)

For the years ended June 30, 2017 and 2016, there were no significant transfers into or out of Levels 1, 2, or 3. Changes to the fair values based on the Level 3 inputs are summarized as follows:

	Total
Balance as of June 30, 2016	$ 35,814
Additions:	
Contributions/purchases	8,119
Disbursements:	
Withdrawals/sales	(19,730)
Net change in value	(6,626)
Balance as of June 30, 2017	$ 17,577

The following table summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2017:

	Fund 1	Fund 2	Fund 3
Redemption timing:			
Redemption frequency	Quarterly	Monthly	Annually
Required notice	65 days	30 days	90 days
Audit reserve:			
Percentage held back for audit reserve	10 %	— %	5 %

(b) Carroll Plan

CCHS sponsors a Defined Benefit Cash Balance Plan (the Carroll Plan) covering employees of Carroll, CCMS, and Carroll Foundation. CCHS's funding policy is to make contributions to the Carroll Plan based on actuarially determined amounts necessary to provide assets sufficient to meet benefits to be paid to plan participants and to meet the minimum funding requirements of the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code, plus such amounts as CCHS may determine to be appropriate from time to time. Under the cash balance plan structure, the benefits under the Carroll Plan are determined based on employee tenure rather than age. CCHS elected to freeze benefit accruals and participation in the Carroll Plan on December 31, 2006.

The information below describes certain actions of CCHS for the years ended June 30, 2017 and 2016.

(Continued)

(Dollars in thousands)

The following tables set forth the changes in the projected benefit obligation, the changes in the Carroll Plan's assets, the Carroll Plan's funded status, the amounts recognized in the consolidated financial statements, and the Carroll Plan's net periodic pension cost as of June 30, 2017 and 2016:

		2017	2016
Measurement date		June 30, 2017	June 30, 2016
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	76,619	68,498
Interest cost		2,345	3,004
Actuarial loss		(3,032)	7,514
Benefits paid		(2,301)	(2,397)
Benefit obligation at end of year		73,631	76,619
Change in plan assets:			
Fair value of plan assets at beginning of year		64,073	61,131
Actual return on plan assets		3,876	1,739
Employer contribution		2,070	3,600
Benefits paid		(2,301)	(2,397)
Fair value of plan assets at end of year		67,718	64,073
Funded status	$	(5,913)	(12,546)

The accumulated benefit obligation for the Carroll Plan was $73,631 and $76,619 at June 30, 2017 and 2016, respectively. The pension obligations of $5,913 and $12,546 as of June 30, 2017 and 2016, respectively, are included in other long-term liabilities in the consolidated balance sheets.

Net periodic pension expense for the years ended June 30, 2017 and 2016 was as follows:

		2017	2016
Pension expense:			
Components of net periodic pension expense:			
Interest cost	$	2,345	3,004
Expected return on plan assets		(4,464)	(4,315)
Amortization of actuarial loss		2,499	1,870
Net periodic pension expense	$	380	559

The estimated net actuarial loss and prior service cost to be amortized from unrestricted net assets into net periodic pension benefit cost over the next fiscal year is $2,111 and $0, respectively.

(Continued)

(Dollars in thousands)

Assumptions to determine the benefit obligation as of June 30, 2017 and 2016 were as follows:

	2017	2016
Discount rate	3.87 %	3.72 %

Assumptions used in the determination of net periodic pension expense for the year ended June 30, 2017 and 2016 were as follows:

	2017	2016
Discount rate	3.72 %	4.47 %
Expected long-term rate of return on plan assets	7.00	7.00

Deferred pension costs, which have not yet been recognized in periodic pension expense but are accrued in unrestricted net assets, are $28,019 and $32,962 at June 30, 2017 and 2016, respectively. Deferred pension costs represent unrecognized actuarial losses or unexpected changes in the projected benefit obligation and plan assets over time primarily due to changes in assumed discount rates and investment experience.

CCHS's weighted average asset allocations for the plan assets for the years ended June 30, 2017 and 2016 were as follows:

	2017	2016
Cash and cash equivalents	6.0 %	8.0 %
Fixed income/debt securities	18.0	22.0
Mutual funds and equity securities	49.0	53.0
Alternative investments	27.0	17.0
	100.0 %	100.0 %

Pension plan assets are invested in accordance with the CCHS's investment policy in an attempt to maximize return with reasonable and prudent levels of risk. This structure includes various assets classes, investment management styles, asset allocation, and acceptable ranges that, in total, are expected to produce a sufficient level of overall diversification and total investment return over the long term. CCHS periodically reviews performance to test progress toward attainment of longer term targets, to compare results with appropriate indices and peer groups, and to assess overall investment risk levels.

(Continued)

(Dollars in thousands)

The following table presents the Plan's assets measured at fair value at June 30, 2017:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 3,995	—	—	3,995
Mutual funds	32,988	—	—	32,988
Fixed income	—	12,437	—	12,437
Alternative investments	—	—	18,298	18,298
Total assets	$ 36,983	12,437	18,298	67,718

The following table presents the Plan's assets measured at fair value at June 30, 2016:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 5,366	—	—	5,366
Mutual funds	34,179	—	—	34,179
Fixed income	—	13,716	—	13,716
Alternative investments	—	—	10,812	10,812
Total assets	$ 39,545	13,716	10,812	64,073

During fiscal year 2017, Level 3 investments within the pension plan assets increased by $7,486. This increase was the result of purchases of $14,772, redemptions of $3,391 and losses in investments of $3,895. During fiscal year 2016, Level 3 investments within the pension plan assets increased by $7. This increase was the result of purchases of $3,391, redemptions of $2,828 and losses in investments of $556. There were no significant transfers between Levels 1, 2 and 3 during the years ended June 30, 2017 and 2016.

CCHS follows ASU No. 2009-12, and applied its provisions to its pension plan asset portfolio. The guidance amends ASC Topic 820 and permits, as a practical expedient, fair value of investments within its scope to be estimated using net asset value (NAV) or its equivalent. The alternative investments classified within Level 3 of the fair value hierarchy have been recorded using NAV.

The Carroll Plan invests in alternative investments which are primarily hedge fund of funds and real estate funds.

For the alternative investments, redemption requests can be made either quarterly or annually. The notice required in order to make a redemption is within a range of 65 to 100 days. The audit reserve requirements are 10% for each fund. There are generally no gate provisions with the exception of one fund which has a gate of 25% of net asset value (NAV).

(Continued)

(Dollars in thousands)

CCHS expects to contribute $3,580 to the Carroll Plan during the year-ending June 30, 2018.

The following benefit payments, which reflect future services, as appropriate, are expected to be paid from the Carroll Plan's assets during the years ending June 30 of the indicated year:

2018	$ 2,905
2019	3,047
2020	3,243
2021	3,426
2022	3,589
2023–2027	20,087
	$ 36,297

CCHS expensed total employer contributions of $1,280 and $1,291 for the years ended June 30, 2017 and 2016, respectively.

(c) Contributory Plans

Northwest has a qualified noncontributory defined-contribution pension plan (the NW Plan) covering substantially all employees who work at least 1,000 hours per year, who have completed two years of continuous service as of the beginning of the plan year, and who have attained the age of 21 as of the beginning of the plan year. Participants in the NW Plan are 100% vested. Northwest makes annual contributions to the NW Plan equivalent to 1.5% of the participants' salaries for employees who have been in the NW Plan from one to five years, 4.0% for those in the plan from six to 19 years, and 6.5% thereafter. It is Northwest's policy to fund plan costs as they accrue. Plan expense was approximately $2,181 and $2,849 for the years ended June 30, 2017 and 2016, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

Certain LifeBridge entities have supplemental 403(b) retirement plans for eligible employees. The entities may elect to match varying percentages of an employee's contribution up to a certain percentage of the employee's annual salary. The associated expense was approximately $4,810 and $4,710 for the years ended June 30, 2017 and 2016, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

Certain companies under Community Physicians and Investments maintain a defined-contribution plan for employees meeting certain eligibility requirements. Eligible employees can also make contributions. Under the plan, the employer may elect to match a percentage of eligible employees' contributions each year. The related expense was approximately $850 and $1,630 for the years ended June 30, 2017 and 2016, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

(Continued)

Certain LifeBridge entities maintain a nonqualified deferred compensation plan for key employees and physicians. The Corporation establishes a separate deferral account on its books for each participant for each plan year. In general, participants are entitled to receive the deferred funds upon their death, attainment of the specified vesting date, or involuntary termination of their employment without cause, whichever occurs first. The related expense was approximately $4,189 and $4,823 for the years ended June 30, 2017 and 2016, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

(d) Postretirement Plan Other than Pension

Carroll sponsors a postretirement plan other than pension for employees. Carroll employees retired from active employment at 65 years of age or older or at 55 years of age after earning at least 10 years of vesting service are eligible for health and prescription drug benefits under Carroll's self-insured health plan. Effective January 1, 2009, individuals are no longer permitted to participate in this Plan once they are Medicare eligible. Plan participants contribute premiums to the Plan in amounts determined by Carroll for pre-Medicare and post-Medicare age retirees. At June 30, 2017 and 2016, Carroll has accrued a liability of $425 related to this plan.

(12) Regulation and Reimbursement

The Corporation and other healthcare providers in Maryland are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the Federal Medicare and State Medicaid programs;
- Regulation of hospital rates by the State of Maryland Health Services Cost Review Commission (HSCRC);
- Government regulation, government budgetary constraints, and proposed legislative and regulatory changes; and
- Lawsuits alleging malpractice and related claims.

Such inherent risks require the use of certain management estimates in the preparation of the Corporation's consolidated financial statements, and it is reasonably possible that a change in such estimates may occur.

The Medicare and Medicaid programs represent a substantial portion of the Corporation's revenues, and the Corporation's operations are subject to a variety of other federal, state, and local regulatory requirements. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the Corporation. Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Corporation.

(Continued)

The current rate of reimbursement for hospital services to patients under the Medicare and Medicaid programs is based on an agreement between the Centers for Medicaid and Medicare Services (CMS) and the State of Maryland. This agreement is based upon a waiver from Medicare prospective payment system reimbursement principles granted to the State of Maryland by CMS.

In January 2014, CMS approved Maryland's new waiver for a five-year period beginning January 1, 2014 for inpatient and outpatient hospital services. The new waiver required Maryland to adopt a payment structure that incentivizes efficient utilization of hospital resources, limits hospital per capita growth in all-payer and Medicare spending, generate Medicare savings of $330 million over five years, limit growth in total cost of care per Medicare beneficiary, reduce hospital readmissions, and reduce certain hospital-acquired conditions.

(13) Related-Party Transactions

Land Leases

Sinai and Levindale are constituent agencies of AJCF, a charitable corporation.

The legal title to substantially all land, land improvements, buildings, and fixed equipment included in Sinai's and Levindale's operating property is held by an affiliate of AJCF. Sinai and Levindale have entered into leases with the AJCF affiliate with respect to these assets. The leases allow Sinai and Levindale to conduct their business on the property as currently conducted. Rent under each lease is $1.00 per year. The leases may not be terminated before December 31, 2050.

Other

In addition to its arrangement with AJCF, Sinai receives services from certain other constituent agencies of AJCF.

(14) Income Taxes

At June 30, 2017, Investments has approximately $60,226 in net operating loss carryforwards for income tax purposes. The net operating loss carryforwards for tax purposes are available to reduce future taxable income and expire in varying periods through 2037.

The net operating loss carryforwards created a federal net deferred tax asset of approximately $20,477 and $21,087 as of June 30, 2017 and 2016, respectively, and a state deferred tax asset of approximately $3,340 and $3,358 as of June 30, 2017 and 2016, respectively. Management has determined that it is more likely than not that Investments will not be able to utilize the deferred tax assets; therefore, a full valuation allowance was recorded against the net deferred assets as of June 30, 2017 and 2016.

At June 30, 2017, Carroll has approximately $75,656 in net operating loss carryforwards for income tax purposes. The net operating loss carryforwards for tax purposes are available to reduce future taxable income and expire in varying periods through 2037.

(Continued)

(Dollars in thousands)

The net operating loss carryforwards created a federal net deferred tax asset of approximately $25,723 and $21,621 as of June 30, 2017 and 2016, respectively, and a state deferred tax asset of approximately $4,120 and $3,463 as of June 30, 2017 and 2016, respectively. Management has determined that it is more likely than not that Carroll will not be able to utilize the deferred tax assets; therefore, a full valuation allowance was recorded against the net deferred assets as of June 30, 2017 and 2016.

(15) Other Long-Term Liabilities

Other long-term liabilities at June 30, 2017 and 2016 are as follows:

	2017	2016
Professional/general liability (note 16(a))	$ 46,598	52,174
Pension liability	40,157	70,119
Medical office building	31,924	33,128
Asset retirement obligation	3,260	3,260
Deferred compensation	8,208	6,967
Other	5,557	1,361
	$ 135,704	167,009

At June 30, 2017 and 2016, there was $16,303 and $13,023 included in other current liabilities related to professional liabilities, respectively.

(16) Self-Insurance Programs

(a) Professional/General Liability

The Corporation is self-insured, through LifeBridge Insurance (and Cen-Mar prior to June 30, 2016), for most medical malpractice and general liability claims arising out of the operations of LifeBridge and its subsidiaries. Estimated liabilities have been recorded for both reported and incurred but not reported claims.

LifeBridge Insurance and Cen-Mar purchase reinsurance coverage from other highly rated insurance carriers to cover their liabilities in excess of various retentions. The amounts that LifeBridge subsidiaries must transfer to LifeBridge Insurance and Cen-Mar to fund medical malpractice and general liability claims are actuarially determined and are sufficient to cover expected liabilities. Management's estimate of the liability for medical malpractice and general liability claims, including incurred but not reported claims, is principally based on actuarial estimates performed by an independent third-party actuary. Professional liability coverage for certain employed physicians is provided by commercial insurance carriers. The receivable for the expected reinsurance receivable is recorded within other assets on the consolidated balance sheets. Amounts in excess of the self-insured limits are insured by highly rated commercial insurance companies.

(Continued)

(Dollars in thousands)

(b) Workers' Compensation

Sinai, Northwest, Levindale, LAA, and CCMS and its subsidiaries are insured for workers' compensation liability through a combination of self-insurance and excess insurance. Losses for asserted and unasserted claims are accrued based on estimates derived from past experiences, as well as other considerations including the nature of each claim or incident, relevant trend factors, and estimates of incurred but not reported amounts.

LifeBridge has accrued a liability for known and incurred but not reported claims of $8,032 and $7,005 at June 30, 2017 and 2016, respectively. These amounts are included in accounts payable and accrued liabilities in the accompanying consolidated balance sheets. Management believes these accruals are adequate to provide for all workers' compensation claims that have been incurred through June 30, 2017.

All other entities have occurrence-based commercial insurance coverage. There are no material insurance recoveries related to workers' compensation as of June 30, 2017.

LifeBridge maintains stop-loss policies on workers' compensation claims. The Corporation is insured for individual claims exceeding $450.

(c) Health Insurance

LifeBridge is self-insured for employee health claims. LifeBridge has accrued a liability of $3,721 and $3,655 at June 30, 2017 and 2016, respectively, for known claims and incurred but not reported claims. These amounts are included in accounts payable and accrued liabilities in the accompanying consolidated balance sheets.

(17) Concentration of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2017 and 2016 is as follows:

	2017	2016
Medicare	31 %	30 %
Medicaid	8	9
BlueCross	10	12
Commercial and other	41	40
Self-pay	10	9
	100 %	100 %

(Continued)

(Dollars in thousands)

The mix of net patient service revenue for the Corporation for the years ended June 30, 2017 and 2016 is as follows:

	2017	2016
Medicare	42 %	42 %
Medicaid	6	7
BlueCross	12	14
Commercial and other	37	33
Self-pay	3	4
	100 %	100 %

(18) Commitments and Contingencies

(a) Litigation

The Corporation is subject to numerous laws and regulations of federal, state, and local governments. The Corporation's compliance with these laws and regulations can be subject to periodic governmental review and interpretation, which can result in regulatory action unknown or unasserted at this time. Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the ordinary course of business. After consultation with legal counsel, it is management's opinion that the ultimate resolution of these claims will not have a material adverse effect on the Corporation's financial position.

(b) Letters of Credit

M&T Bank has established an open letter of credit for Sinai of $211 (which has not been drawn upon) to guarantee Sinai's obligation for liabilities assumed as a member of a risk retention group during the period 1988 to 1994. Additionally, M&T Bank has established a standby letter of credit of $2,399 to serve as collateral as required by the Maryland Office of Unemployment Insurance. M&T Bank has established a standby letter of credit for Levindale of $421 as required by the State of Maryland Department of Labor, Licensing, and Regulation. M&T Bank has established a standby letter of credit for LifeBridge Health & Fitness of $200 as required by the State of Maryland Office of the Attorney General. M&T Bank has established standby letters of credit of $52 and of $84 to serve as collateral as required by the City of Baltimore for the completion of certain construction work at Sinai. M&T has established standby letters of credit of $94, $76, $42 and $4 to serve as collateral as required by Baltimore County for the completion of certain construction work at Northwest.

(Continued)

(Dollars in thousands)

(c) Operating Leases

The Corporation has entered into operating lease agreements for hospital equipment and office space, which expire on various dates through year 2026. Total rental expense for the years ended June 30, 2017 and 2016 for all operating leases was approximately $27,342 and $24,135, respectively. Future minimum lease payments under all noncancelable operating leases are as follows:

Years ending June 30:	
2018	$ 17,663
2019	17,307
2020	16,052
2021	14,545
2022	13,198
Thereafter	17,657
	$ 96,422

(19) Noncontrolling Interest

The reconciliation of a noncontrolling interest reported in unrestricted net assets is as follows:

	LifeBridge Health, Inc.	Noncontrolling interest	Unrestricted net assets
Balance at June 30, 2015	$ 844,907	3,922	848,829
Operating income	48,533	1,177	49,710
Nonoperating loss	(9,023)	—	(9,023)
Excess of revenues over expenses	39,510	1,177	40,687
Change in funded status of pension plan	(41,513)	—	(41,513)
Net assets released for purchase of property and equipment	7,613	—	7,613
Other	(841)	—	(841)
Change in net assets	4,769	1,177	5,946
Balance at June 30, 2016	849,676	5,099	854,775

(Continued)

(Dollars in thousands)

	LifeBridge Health, Inc.	Noncontrolling interest	Unrestricted net assets
Operating income	$ 52,081	2,173	54,254
Nonoperating income	56,750	—	56,750
Excess of revenues over expenses	108,831	2,173	111,004
Change in funded status of pension plan	20,341	—	20,341
Net assets released for purchase of property and equipment	4,147	—	4,147
Fair value of noncontrolling interests of acquisitions	—	9,754	9,754
Other	915	(2,400)	(1,485)
Change in net assets	134,234	9,527	143,761
Balance at June 30, 2017	$ 983,910	14,626	998,536

(20) Functional Expenses

The Corporation provides general healthcare services to patients. Expenses for the years ended June 30, 2017 and 2016 related to providing these services are as follows:

	2017	2016
Healthcare services	$ 1,098,642	1,069,047
General and administrative	374,158	358,668
	$ 1,472,800	1,427,715

(21) Fair Value of Financial Instruments

The following methods and assumptions were used by the Corporation in estimating the fair value of its financial instruments:

(a) Assets and Liabilities

Cash and cash equivalents, patient service receivables, other receivables, inventory, prepaid expenses, pledges receivable, accounts payable and accrued liabilities, advances to third-party payors, and other current liabilities – The carrying amounts reported in the consolidated balance sheet approximate the related fair values.

Investments (donor-restricted, assets limited as to use, and long-term), and beneficial interest in split interest agreements – Fair values are based on quoted market prices of individual securities or investments if available, or are estimated using quoted market prices for similar securities or investment managers' best estimate of underlying fair value.

(Continued)

(Dollars in thousands)

Investment in unconsolidated affiliates – Investments in unconsolidated affiliates are not readily marketable. Therefore, it is not practicable to estimate their fair value and such investments are recorded in accordance with the equity method or at cost.

(b) Long-Term Debt

The Series 2008 MHHEFA Bonds bear interest at fixed rates and had a fair value of $155,736 and $244,684 at June 30, 2017 and 2016, respectively. The fair market value of the fixed rate Series 2011 MHHEFA Bonds was $5,358 and $56,556 as of June 30, 2017 and 2016, respectively. The fair market value of the fixed rate Series 2012A MHHEFA Bonds was $58,933 and $62,742 as of June 30, 2017 and 2016, respectively. The fair market value of the variable rate Series 2015 MHHEFA Bonds was $175,838 and $185,798 as of June 30, 2017 and 2016, respectively. The fair market value of the variable rate Series 2016 MHHEFA Bonds was $131,581 as of June 30, 2017.

The fair value of other long-term debt, and bank loans payable approximates its carrying value.

The fair value of the Corporation's long-term MHHEFA debt is measured using quoted offered-side prices when quoted market prices are available. If quoted market prices are not available, the fair value is determined by discounting the future cash flows of each instrument at rates that reflect, among other things, market interest rates and the Corporation's credit standing. In determining an appropriate spread to reflect its credit standing, the Corporation considers credit default swap spreads, bond yields of other long-term debt, and interest rates currently offered for similar debt instruments of comparable maturities by the Corporation's bankers as well as other banks that regularly compete to provide financing to the Corporation.

(c) Fair Value Hierarchy

The following table presents assets that are measured at fair value on a recurring basis as of June 30, 2017:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 73,803	—	—	73,803
Equity securities and mutual funds	386,318	—	—	386,318
Treasury securities	4,333	—	—	4,333
Government securities	—	46,040	—	46,040
Fixed income	—	91,150	—	91,150
Beneficial interest in split-interest agreement	—	4,757	—	4,757
Total assets	$ 464,454	141,947	—	606,401

(Continued)

(Dollars in thousands)

The following table presents assets that are measured at fair value on a recurring basis as of June 30, 2016:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 34,170	—	—	34,170
Equity securities and mutual funds	375,980	—	—	375,980
Treasury securities	4,501	—	—	4,501
Government securities	—	60,189	—	60,189
Fixed income	—	38,522	—	38,522
Beneficial interest in split-interest agreement	—	4,477	—	4,477
Total assets	$ 414,651	103,188	—	517,839

See note 2(e) for information on investments of the Corporation that are treated under the equity method and are not reported above.

For the years ended June 30, 2017 and 2016, there were no significant transfers into or out of Levels 1, 2, or 3.

During the year ended June 30 2017, in connection with business combinations during the year the Corporation recorded the fair value of equipment of $24,715, debt of $14,961 and noncontrolling interests of $9,754. The Corporation determined that the fair values were based on Level 3 inputs. The Corporation used a market multiple analysis approach, a widely accepted valuation technique, to develop the fair values.

(22) Subsequent Events

Management evaluated all events and transactions that occurred after June 30, 2017 and through October 18, 2017. The Corporation did not have any subsequent events during this period that were required to be recognized or disclosed.

Schedule 1

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2017

(Dollars in thousands)

Assets	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Current assets:							
Cash and cash equivalents	$ 66,953	55,684	38,630	20,087	175,011	—	356,365
Investments	13,265	3,407	7,043	276	592	—	24,583
Assets limited as to use, current portion	44,802	12,830	5,137	283	5,444	—	68,496
Patient service receivables, net of allowance for doubtful accounts	73,885	23,434	20,741	8,300	19,279	—	145,639
Other receivables	75,552	5,321	12,363	674	33,779	(110,678)	17,011
Inventory	22,308	5,088	2,728	211	180	—	30,515
Prepaid expenses	2,536	782	3,585	133	8,149	—	15,185
Pledges receivable, current portion	859	180	1,525	107	—	—	2,671
Total current assets	300,160	106,726	91,752	30,071	242,434	(110,678)	660,465
Board-designated investments	92,852	57,180	—	17,683	70,962	—	238,677
Long-term investments	59,517	36,653	145,005	11,334	62,811	—	315,320
Donor-restricted investments	13,265	3,407	4,952	276	(511)	—	21,389
Reinsurance recovery receivable	—	—	—	—	15,548	—	15,548
Assets limited as to use, net of current portion	—	—	—	—	33,039	—	33,039
Pledges receivable, net of current portion	1,372	148	1,270	173	2,159	—	5,122
Property and equipment, net	230,406	106,812	118,089	40,461	155,405	—	651,173
Beneficial interest in split interest agreement	4,757	—	—	—	—	—	4,757
Investment in unconsolidated affiliates	—	—	1,230	—	195,537	(145,885)	50,882
Other assets, net of accumulated amortization	13,853	2,709	18,559	60	28,760	—	63,941
Total assets	$ 716,182	313,635	380,857	100,058	806,144	(256,563)	2,060,313

(Continued)

Schedule 1

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2017

(Dollars in thousands)

Liabilities and Net Assets	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Current liabilities:							
Accounts payable and accrued liabilities	$ 64,065	23,432	30,942	8,640	112,329	(110,678)	128,730
Accrued salaries, wages, and benefits	34,846	9,785	10,124	3,302	21,387	—	79,444
Advances from third-party payors	26,493	6,742	5,340	3,360	—	—	41,935
Current portion of long-term debt and capital lease, net obligations	3,848	1,271	1,625	221	6,963	—	13,928
Other current liabilities	1,645	327	157	—	18,006	—	20,135
Total current liabilities	130,897	41,557	48,188	15,523	158,685	(110,678)	284,172
Other long-term liabilities	51,212	10,587	20,811	5,043	48,051	—	135,704
Long-term debt and capital lease obligations, net	274,111	89,999	131,494	10,364	65,210	—	571,178
Total liabilities	456,220	142,143	200,493	30,930	271,946	(110,678)	991,054
Net assets:							
Unrestricted net assets	212,435	163,631	118,887	68,317	520,962	(100,322)	983,910
Noncontrolling interest in consolidated subsidiaries	—	—	4,134	—	6,055	4,437	14,626
Total unrestricted net assets	212,435	163,631	123,021	68,317	527,017	(95,885)	998,536
Temporarily restricted	36,732	7,861	56,170	811	2,958	(50,000)	54,532
Permanently restricted	10,795	—	1,173	—	4,223	—	16,191
	259,962	171,492	180,364	69,128	534,198	(145,885)	1,069,259
Total liabilities and net assets	$ 716,182	313,635	380,857	100,058	806,144	(256,563)	2,060,313

See accompanying independent auditors' report.

Schedule 2

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Statement of Operations Information

Year ended June 30, 2017

(Dollars in thousands)

	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Unrestricted revenues, gains, and other support:							
Patient service revenue (net of contractual allowances and discounts)	$ 763,077	266,417	241,640	78,701	159,113	—	1,508,948
Provision for bad debts	(22,204)	(12,962)	(4,237)	(2,588)	(5,350)	—	(47,341)
Net patient service revenue	740,873	253,455	237,403	76,113	153,763	—	1,461,607
Net assets released from restrictions used for operations	3,473	—	40	108	258	—	3,879
Other operating revenue	24,810	2,990	12,030	2,209	43,888	(24,359)	61,568
Total operating revenues	769,156	256,445	249,473	78,430	197,909	(24,359)	1,527,054
Expenses:							
Salaries and employee benefits	375,539	132,274	120,665	48,172	131,841	531	809,022
Supplies	161,411	49,687	26,051	6,111	18,674	(3,320)	258,614
Purchased services	136,459	39,543	54,623	15,441	53,581	(21,570)	278,077
Depreciation, amortization, and gain/loss on sale of assets	32,580	11,337	14,908	2,790	15,599	—	77,214
Repairs and maintenance	13,429	4,446	1,445	977	1,009	—	21,306
Interest	8,450	3,261	5,492	269	11,095	—	28,567
Total expenses	727,868	240,548	223,184	73,760	231,799	(24,359)	1,472,800
Operating income (loss)	41,288	15,897	26,289	4,670	(33,890)	—	54,254
Other income (loss), net:							
Investment income	14,912	7,984	2,220	855	4,937	—	30,908
Unrealized gains on trading investments	13,761	7,226	12,493	2,968	206	—	36,654
Other	419	—	11	—	(440)	—	(10)
Loss on refinancing of debt	(7,302)	(2,091)	—	(1,409)	—	—	(10,802)
Total other income, net	21,790	13,119	14,724	2,414	4,703	—	56,750
Excess (deficit) of revenues over expenses	$ 63,078	29,016	41,013	7,084	(29,187)	—	111,004

See accompanying independent auditors' report.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Financial Statements and
Supplementary Financial Information

June 30, 2016 and 2015

(With Independent Auditors' Report Thereon)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Table of Contents

KPMG LLP
1 East Pratt Street
Baltimore, MD 21202-1128

Independent Auditors' Report

The Board of Directors
LifeBridge Health, Inc. and Subsidiaries:

We have audited the accompanying consolidated financial statements of LifeBridge Health, Inc. and Subsidiaries (the Corporation), which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this responsibility includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly in all material respects, the financial position of LifeBridge Health, Inc. and Subsidiaries as of June 30, 2016 and 2015, and the results of their operations, changes in their net assets and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Emphasis of Matter

As discussed in note 3 to the consolidated financial statements, the Corporation acquired Carroll County Health Services Corporation. Our opinion is not modified with respect to this matter.

Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in Schedules 1 and 2 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

October 12, 2016

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2016 and 2015

(Dollars in thousands)

Assets		2016	2015
Current assets:			
Cash and cash equivalents	$	322,937	356,973
Investments		23,352	23,761
Assets limited as to use, current portion		67,660	30,565
Patient service receivables, net of allowance for doubtful accounts of $62,213 in 2016 and $58,346 in 2015		141,651	142,212
Other receivables		11,508	10,164
Inventory		31,514	29,482
Prepaid expenses		18,761	19,079
Pledges receivable, current portion		3,296	6,693
Total current assets		620,679	618,929
Board-designated investments		243,289	250,000
Long-term investments		253,757	258,685
Donor-restricted investments		20,541	21,644
Reinsurance recovery receivable		15,694	15,935
Assets limited as to use, net of current portion		43,601	33,187
Pledges receivable, net of current portion		3,405	5,477
Property and equipment, net		629,477	595,143
Deferred financing costs, net of accumulated amortization of $1,077 in 2016 and $767 in 2015		4,137	4,073
Beneficial interest in split interest agreement		4,477	4,628
Investment in unconsolidated affiliates		44,040	33,865
Other assets, net		48,142	43,082
Total assets	$	1,931,239	1,884,648

(Continued)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2016 and 2015

(Dollars in thousands)

Liabilities and Net Assets	2016	2015
Current liabilities:		
Accounts payable and accrued liabilities	$ 119,225	117,874
Accrued salaries, wages and benefits	80,361	80,534
Advances from third-party payors	46,246	41,780
Current portion of long-term debt and capital lease obligations	12,921	14,711
Other current liabilities	16,871	14,418
Total current liabilities	275,624	269,317
Other long-term liabilities	167,009	130,856
Long-term debt and capital lease obligations, net of current portion	564,559	558,170
Total liabilities	1,007,192	958,343
Net assets:		
Unrestricted	849,676	844,907
Noncontrolling interest in consolidated subsidiaries	5,099	3,922
Total unrestricted net assets	854,775	848,829
Temporarily restricted	53,385	61,660
Permanently restricted	15,887	15,816
	924,047	926,305
Total liabilities and net assets	$ 1,931,239	1,884,648

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended June 30, 2016 and 2015

(Dollars in thousands)

	2016	2015
Unrestricted revenues, gains and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 1,435,810	1,201,545
Provision for bad debts	56,982	54,845
Net patient service revenue	1,378,828	1,146,700
Net assets released from restrictions used for operations	3,537	3,665
Other operating revenue	95,060	62,764
Total operating revenues	1,477,425	1,213,129
Expenses:		
Salaries and employee benefits	795,094	662,338
Supplies	253,599	195,387
Purchased services	254,211	201,240
Depreciation, amortization and gain/loss on sale of assets	75,699	62,957
Repairs and maintenance	20,538	19,774
Interest	28,574	20,687
Total expenses	1,427,715	1,162,383
Operating income	49,710	50,746
Other income, net:		
Investment income	16,028	21,161
Unrealized losses on trading investments	(22,110)	(10,978)
Other	779	4,563
Total other (expense) income, net	(5,303)	14,746
Excess of revenues over expenses before loss on refinancing of debt and inherent contribution	44,407	65,492
Loss on refinancing of debt	(3,720)	—
Excess of revenues over expenses before inherent contribution	40,687	65,492
Inherent contribution – CCHS	—	134,032
Excess of revenues over expenses	$ 40,687	199,524

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2016 and 2015

(Dollars in thousands)

	Unrestricted	Temporarily restricted	Permanently restricted	Total net assets
Net assets at June 30, 2014	$ 660,778	49,703	14,647	725,128
Excess of revenues over expenses	199,524	—	—	199,524
Inherent contribution – CCHS	—	10,733	1,173	11,906
Unrealized loss on investments	—	(370)	(3)	(373)
Net assets released from restrictions used for the purchase of property and equipment	5,347	(5,347)	—	—
Restricted gifts and bequests	—	10,789	3	10,792
Net assets released from restrictions used for operations	—	(3,661)	(4)	(3,665)
Net change in value of beneficial interest in split interest agreement	—	5	—	5
Adjustment to pension liability	(16,548)	—	—	(16,548)
Other	(272)	(192)	—	(464)
Change in net assets	188,051	11,957	1,169	201,177
Net assets at June 30, 2015	848,829	61,660	15,816	926,305
Excess of revenues over expenses	40,687	—	—	40,687
Unrealized loss on investments	—	(1,842)	(5)	(1,847)
Net assets released from restrictions used for the purchase of property and equipment	7,613	(7,613)	—	—
Restricted gifts and bequests	—	4,908	76	4,984
Net assets released from restrictions used for operations	—	(3,537)	—	(3,537)
Net change in value of beneficial interest in split interest agreement	—	(151)	—	(151)
Adjustment to pension liability	(41,513)	—	—	(41,513)
Other	(841)	(40)	—	(881)
Change in net assets	5,946	(8,275)	71	(2,258)
Net assets at June 30, 2016	$ 854,775	53,385	15,887	924,047

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2016 and 2015

(Dollars in thousands)

	2016	2015
Cash flows from operating activities:		
Change in net assets	$ (2,258)	201,177
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	76,059	62,697
Loss (gain) on disposal of equipment	(360)	260
Gain on sale of Courtland Gardens	—	(3,409)
Change in pension liability	41,513	16,548
Provision for bad debts	56,982	54,845
Realized and unrealized gains on investments, net	17,593	(2,412)
Inherent contribution – CCHS	—	(145,938)
Restricted gifts and bequests	(4,984)	(10,789)
Change in beneficial interest of split interest agreement	151	5
Earnings on investments in unconsolidated affiliates	(3,277)	(5,342)
Loss on refinancing of debt	3,720	—
Change in operating assets and liabilities:		
Increase in patient service receivables, net	(56,421)	(41,962)
Increase in other receivables	(1,344)	(1,021)
Decrease (increase) in pledges receivable	5,469	(4,438)
Increase in inventory	(2,032)	(2,136)
Decrease in prepaid expenses	318	115
Decrease (increase) in reinsurance recovery receivable	241	(2,570)
(Increase) decrease in other assets	(5,637)	5,877
Decrease in accounts payable and accrued liabilities, and accrued salaries, wages, and benefits	(7,481)	(10,462)
Increase (decrease) in advances from third-party payors	4,466	(944)
(Decrease) increase in other current and long-term liabilities	(2,907)	1,121
Net cash provided by operating activities	119,811	111,222
Cash flows from investing activities:		
Change in donor-restricted investments	1,103	(8,968)
Addition of cash from CCHS acquisition	—	15,719
Change in current and long-term investments	(3,698)	(49,422)
Change in assets limited as to use	(49,356)	28,098
Investment in/distributions from unconsolidated affiliates, net	(6,898)	(6,543)
Additions to operating property	(101,221)	(44,462)
Proceeds from the sale of property	360	31
Settlement of swap	—	(13,998)
Acquisition of physician practices	—	(1,404)
Net cash used in investing activities	(159,710)	(80,949)
Cash flows from financing activities:		
Payment on debt and capital lease obligations	(182,127)	(53,800)
Proceeds from issuance of debt	183,006	150,000
Restricted gifts and bequests	4,984	10,789
Net cash provided by financing activities	5,863	106,989
Net (decrease) increase in cash and cash equivalents	(34,036)	137,262
Cash and cash equivalents:		
Beginning of year	356,973	219,711
End of year	$ 322,937	356,973
Supplemental cash flow disclosures:		
Cash paid during the year for interest	$ 24,444	19,412
Cash paid during the year for income taxes	52	44
Accounts payable related to purchase of operating property	8,659	11,210

See accompanying notes to consolidated financial statements.

(1) Organization

On October 1, 1998, Sinai Health System, Inc. merged with Northwest Health System, Inc. to form LifeBridge Health, Inc. (LifeBridge). LifeBridge is a not-for-profit, nonstock Maryland corporation.

LifeBridge's subsidiaries include Sinai Hospital of Baltimore, Inc. (Sinai); Northwest Hospital Center, Inc. (Northwest); Levindale Hebrew Geriatric Center and Hospital, Inc. (Levindale); Children's Hospital of Baltimore City, Inc.; The Baltimore Jewish Health Foundation, Inc. (BJHF); The Baltimore Jewish Eldercare Foundation, Inc. (BJEF); Children's Hospital at Sinai Foundation, Inc. (CHSF); LifeBridge Anesthesia Associates, LLC (LAA); LifeBridge Insurance Company, Ltd. (LifeBridge Insurance); LifeBridge Investments, Inc. (Investments); LifeBridge Health ACO, LLC; LifeBridge Physician Network, LLC; 8600 Liberty Road, LLC; and LifeBridge 23 Crossroads Drive Medical Office Building, LLC. This group will be referred to as Legacy LifeBridge. Except for LifeBridge Insurance and Investments, all of the entities named above are not-for-profit and tax-exempt. Sinai and Levindale are constituent agencies of THE ASSOCIATED: Jewish Community Federation of Baltimore, Inc. (AJCF), a charitable corporation.

Effective April 1, 2015, Carroll County Health Services Corporation (CCHS), the parent of Carroll Hospital Center, Inc. (Carroll) and other related entities, became a subsidiary of LifeBridge. CCHS is further discussed below and the acquisition of CCHS by LifeBridge is further discussed in note 3.

Investments is a for-profit corporation that holds, directly and indirectly, interests in a variety of for-profit businesses. Investments' wholly owned subsidiaries include:

- *Practice Dynamics, Inc.*
- *LifeBridge Health and Fitness, LLC*
- *Sinai Eldersburg Real Estate, LLC*
- *General Surgery Specialists, LLC*
- *BW Primary Care, LLC*
- *LifeBridge Community Practices, LLC*
- *The Center for Urologic Specialties, LLC*
- *LifeBridge Community Physicians, LLC (Community Physicians)*

Investments also holds interests in numerous other health-related businesses.

Community Physicians is a for-profit corporation that provides physician and related services through numerous subsidiaries.

Courtland Gardens Nursing and Rehabilitation Center, Inc. is a wholly owned subsidiary of Levindale. On September 1, 2014, Levindale sold substantially all of the assets of Courtland, except for cash and accounts receivable, for $8,215.

(Continued)

CCHS is a not-for-profit, nonstock Maryland Corporation. The accompanying consolidated financial statements include the accounts of CCHS and it's wholly or partially owned subsidiaries.

Wholly owned direct and indirect subsidiaries of CCHS include:

Carroll Hospital Center, Inc (Carroll); Carroll Hospital Center Foundation, Inc. (Carroll Foundation); Carroll Hospice, Inc. (CH); Carroll Regional Cancer Center Physicians, LLC (CRCCP); and Carroll Hospital Center MOB Investment, LLC. Carroll also holds interests in various health-related companies.

Prior to June 30, 2016, Carroll owned Cen-Mar Assurance Company (Cen-Mar). Cen-Mar was merged into LifeBridge Insuracne on June 30, 2016.

Carroll County Med-Services, Inc. (CCMS) is a wholly owned, for-profit subsidiary of CCHS that is involved in real estate holdings, physician services, and other activities, and also maintains ownership interests in various joint ventures. Wholly owned direct and indirect subsidiaries of CCMS include: Carroll Health Group, LLC; Carroll County CMO, LLC; Carroll PHO, LLC; and Carroll ACO, LLC.

(2) Significant Accounting Policies

(a) Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. All controlled and direct member entities are consolidated. The accompanying consolidated financial statements include the accounts of LifeBridge Health, Inc. and Subsidiaries (the Corporation). All entities where the Corporation exercises significant influence, but does not have control, are accounted for under the equity method. All other unconsolidated entities are accounted for under the cost method. All significant intercompany accounts and transactions have been eliminated.

(b) Cash and Cash Equivalents

Cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less at the date of purchase.

(c) Assets Limited as to Use

Assets limited as to use primarily consists of assets held by trustees under bond indenture agreements, a self-insured workers' compensation reserve fund, and designated assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion subsequently use for other purposes. A portion of the designated assets set aside by the Board of Directors are contractually designated.

(d) Inventory

Inventories, which consist primarily of medical supplies and pharmaceuticals, are stated at the lower of cost (using the moving average cost method of valuation) or market.

(Continued)

(e) Investments, Long-Term Investments and Donor-Restricted Investments

The Corporation's investment portfolio is considered a trading portfolio and is classified as current or noncurrent assets based on management's intention as to use. All debt and equity securities are reported in the consolidated balance sheets at fair value, principally based on quoted market prices.

The Corporation has investments in alternative investments, primarily funds of hedge funds, totaling $138,838 and $146,923 at June 30, 2016 and 2015, respectively. These funds utilize various types of debt and equity securities and derivative instruments in their investment strategies. Also included in alternative investments are BJEF's and BJHF's funds that are invested on their behalf by the Associated Jewish Charities (AJC), an affiliate of AJCF. The underlying investments for these funds include cash of $241, equities of $23,368, private equity of $2,987, fixed income of $4,013, inflation hedging funds of $2,460, and alternative investments of $15,606. Alternative investments are recorded based on the Net Asset Value (NAV) of the shares in each investment company or partnership.

Investments in unconsolidated affiliates are accounted for under the cost or equity method of accounting as appropriate and are included in other assets and investment in unconsolidated affiliates, respectively, in the consolidated balance sheets. The Corporation's equity income or loss is recognized in other operating revenue within the excess of revenue over expenses in the accompanying consolidated statements of operations.

Investments also include assets restricted by donor, and assets designated by the Board of Directors for future capital improvements and other purposes over which it retains control and may, at its discretion, use for other purposes. Purchases and sales of securities are recorded on a trade-date basis.

Investment income (interest and dividends) including realized gains and losses on investment sales is reported as other income (expense) within the excess of revenues over expenses in the accompanying consolidated statements of operations and changes in net assets unless the income or loss is restricted by the donor or law. Investment income on funds held in trust for self-insurance purposes is included in other operating revenue. Investment income and net gains (losses) that are restricted by the donor are recorded as a component of changes in temporarily or permanently restricted net assets, in accordance with donor-imposed restrictions. Realized gains and losses are determined based on the specific security's original purchase price. Unrealized gains and losses are included in other income, net within the excess of revenue over expenses.

Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and lowest priority to measurements involving significant unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are as follows:

- Level 1 Inputs – Unadjusted quoted prices in active markets for identical assets or liabilities accessible to the reporting entity at the measurement date.

(Continued)

- Level 2 Inputs – Other than quoted prices included in Level 1 inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the asset or liability.
- Level 3 Inputs – Unobservable inputs for the asset or liability used to measure fair value to the extent that observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at measurement date.

The hierarchy requires the use of observable market data when available. Assets and liabilities are classified in their entirety based on the lowest level input that is significant to the fair value measurements.

(f) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter of the period of the lease term or the estimated useful life of the equipment. Maintenance and repair costs are expensed as incurred. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(g) Deferred Financing Costs and Other Assets

Deferred financing costs and other assets consist primarily of deferred financing costs, intangibles related to practice acquisitions, notes receivable, and the cash surrender value of split dollar life insurance. The deferred financing costs are amortized using the effective-interest method over the term of the related debt. Amortization expense was $513 and $2,430 for the years ended June 30, 2016 and 2015, respectively. Such amortization is included in depreciation and amortization in the consolidated financial statements.

(h) Beneficial Interest in Split Interest Agreement

CHSF holds a 25% interest in a trust, of which management has estimated the present value of the future income stream. CHSF will receive 25% of the net annual income until 2024, when at the end the trust will terminate, and 25% of the principal will be distributed to CHSF. Management has reported the beneficial interest at fair value based on the fair value of the underlying trust investments.

(Continued)

(i) Advances from Third-Party Payors

Advances from third-party payors are comprised of advance funding from CareFirst BlueCross BlueShield, Medicaid, Aetna, United/MAMSI, and other insurance providers.

(j) Self-Insurance Programs

The Corporation maintains self-insurance programs for professional and general liability, workers' compensation, and employee health benefits. The provision for estimated self-insurance program claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. The estimates are based on historical trends, claims asserted, and reported incidents.

(k) Other Long-Term Liabilities

Other long-term liabilities consist of self-insurance liabilities, pension plan liabilities, asset retirement obligations, and deferred compensation plan liabilities.

(l) Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Corporation are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date those promises become unconditional. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions.

(m) Net Assets

Net assets and revenues, expenses, gains and losses are classified based on the existence or absence of externally imposed stipulations. Accordingly, net assets of the Corporation and changes therein are classified and reported as follows:

Unrestricted net assets – Net assets that are not subject to externally imposed stipulations.

Temporarily restricted net assets – Net assets subject to externally imposed stipulations that may or will be met either by actions of the Corporation and/or the passage of time.

Permanently restricted net assets – Net assets subject to externally imposed stipulations that they be maintained by the Corporation in perpetuity.

Revenues are reported as increases in unrestricted net assets unless use of the related asset is limited by externally imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses are reported as increases or decreases in unrestricted net assets unless use of the related asset is limited by externally imposed restrictions or law. Expirations of temporary restrictions of net assets (i.e., the externally stipulated purpose has been fulfilled and/or the stipulated time period has

elapsed) are reported as reclassifications between the applicable classes of net assets if used to acquire capital assets; otherwise, they are recorded as unrestricted operating revenue.

(n) Net Patient Service Revenue

Net patient service revenue for Sinai, Northwest, Carroll and the chronic hospital component of Levindale is recorded at rates established by the State of Maryland Health Services Cost Review Commission (HSCRC) and, accordingly, reflects actual charges to patients based on rates in effect during the period in which the services are rendered. On January 29, 2014, the Corporation and the Health Services Cost Review Commission (HSCRC) agreed to implement the Global Budget Revenue (GBR) methodology, effective July 1, 2013, for Sinai, Northwest and Levindale. The term of the Agreement will continue through June 30, 2016 and will renew for a one-year period unless it is canceled by the HSCRC or by the applicable Hospital. The GBR model is a revenue constraint and quality improvement system, designed by the HSCRC to provide hospitals with strong financial incentives to manage their resources efficiently and effectively in order to slow the rate of increase in healthcare costs and improve healthcare delivery processes and outcomes. The GBR model is consistent with the Hospitals' mission to provide the highest value of care possible to their patients and the communities they serve.

The GBR agreement establishes a prospective, fixed revenue base (the GBR cap) for each fiscal year. This includes both inpatient and outpatient regulated services. Under GBR, the Corporation's revenue for all HSCRC-regulated services is predetermined for the upcoming year, regardless of changes in volume, service mix intensity, or mix of inpatient or outpatient services that occur during the year. The GBR agreement allows the Corporation to adjust unit rates, within certain limits, to achieve the overall revenue base for the Corporation at year-end. Any overcharge or undercharge versus the GBR cap is prospectively added to the subsequent year's GBR cap. Beginning in fiscal year 2016, the GBR is adjusted for changes in market share. Effective with fiscal year 2017, market-shift adjustments will be made semi-annually, on January and July 1. The GBR cap is adjusted annually for inflation, and for changes in payor mix and uncompensated care, and changes in population within the Corporation's service area. A hospital's GBR cap may also be adjusted based on the hospital's performance on various quality and utilization metrics established from time to time by the HSCRC.

Prior to implementation of the GBR methodology, Carroll and the HSCRC agreed to a three year contract for Carroll to implement the Total Patient Revenue (TPR) methodology effective July 1, 2010, which was renewed for an additional three year period effective July 1, 2013. Similar to the GBR, the TPR agreement establishes a prospective, fixed revenue base, the "TPR cap," for the upcoming year. Effective with fiscal year 2017, all TPR agreements have been terminated and reinstituted as GBR agreements using the same parameters described above.

Contractual adjustments, which represent the difference between amounts billed as patient service revenue and amounts paid by third-party payors, are accrued in the period in which the related services are rendered. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue.

Medicare reimburses Northwest and Levindale for skilled nursing services under the Medicare skilled nursing Prospective Payment System (PPS). Under PPS, the payment rate is based on patient resource utilization as calculated by a patient classification system known as Resource Utilization Groups.

Medicaid reimburses Levindale for long-term care services facilities based on Levindale's actual costs. However, beginning in January 2015, the cost data from the 2012 cost reports was used to set Resource Utilization Group (similar to Medicare) rates which are adjusted for changes in case mix. The case mix from two quarters prior is used to adjust the rates on a quarterly basis.

All other patient service revenue is recorded at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

(o) Other Operating Revenue

Other operating revenue includes income of LifeBridge Health and Fitness LLC, revenue from retail pharmacy and other support services, and revenue generated from investments in joint ventures that offer health care services or services that support or complement the delivery of care.

(p) Grants

Federal grants are accounted for either as an exchange transaction or as a contribution based on terms and conditions of the grant. If the grant is accounted for as an exchange transaction, revenue is recognized as other operating revenue when earned. If the grant is accounted for as a contribution, the revenues are recognized as either other operating revenue or temporarily restricted contributions depending on the restrictions within the grant.

(q) Meaningful Use Incentives

Under certain provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), federal incentive payments are available to hospitals, physicians, and certain other professionals when they adopt, implement, or upgrade certified electronic health record (EHR) technology or become "meaningful users," as defined under ARRA, of EHR technology in ways that demonstrate improved quality, safety, and effectiveness of care. Incentive payments will be paid out over varying transitional schedules depending on the type of incentive (Medicare and Medicaid) and recipient (hospital or other eligible provider). Eligible hospitals can attest for both Medicare and Medicaid incentives, while physicians must select to attest for either Medicare or Medicaid incentives. For Medicare incentives, eligible hospitals receive payments over four years while eligible physicians receive payments over five years. For Medicaid incentives, eligible Maryland hospitals receive payments over four years and physicians receive payments over six years.

The Corporation recognizes EHR incentives when the payment is received. During the years ended June 30, 2016 and 2015, certain hospitals and physicians satisfied the meaningful use criteria. As a result, the Corporation recognized $3,349 and $3,728 of EHR incentives during fiscal years 2016 and 2015, respectively, in other operating revenue.

(Continued)

(Dollars in thousands)

(r) Charity Care and Bad Debt

Sinai, Northwest, Carroll, Levindale and Courtland provide care to patients who meet certain criteria under their charity care policies without charge or at amounts less than their established rates. Because the facilities do not pursue the collection of amounts determined to qualify as charity care, those amounts are not reported as revenue. The amount of charity care provided during the years ended June 30, 2016 and 2015, based on patient charges forgone, was $11,720 and $9,179, respectively. The total direct and indirect costs to provide the care amounted to approximately $10,044 and $7,548 for the years ended June 30, 2016 and 2015, respectively.

All patient accounts are handled consistently and appropriately to maximize cash flow and to identify bad debt accounts timely. Active accounts are considered bad debt accounts when they meet specific collection activity guidelines and/or are reviewed by the appropriate management and deemed to be uncollectible. Every effort is made to identify and pursue all account balance liquidation options, including but not limited to third party payor reimbursement, patient payment arrangements, Medicaid eligibility and financial assistance. Third party receivable management agencies provide extended business office services and insurance outsource services to ensure maximum effort is taken to recover insurance and self-pay dollars before transfer to bad debt. Contractual arrangements with third party collection agencies are used to assist in the recovery of bad debt after all internal collection efforts have been exhausted. In so doing, the collection agencies must operate consistently with the goal of maximum bad debt recovery and strict adherence with Fair Debt Collections Practices Act (FDCPA) rules and regulations, while maintaining positive patient relations.

		2016	2015
Beginning allowance	$	58,346	35,085
Plus provision for bad debt		56,982	54,845
Less bad debt write-offs, net of recoveries		(53,115)	(31,584)
Ending allowance	$	62,213	58,346

(s) Income Taxes

LifeBridge and its not-for-profit subsidiaries have been recognized by the Internal Revenue Service as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code.

LifeBridge's incorporated for-profit subsidiaries account for income taxes in accordance with Financial Accounting Standards Board (FASB) ASC Topic 740, *Income Taxes*. 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

(Continued)

asset are reflected in the year of the change. The Corporation accounts for uncertain tax positions in accordance with ASC Topic 740.

(t) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(u) Excess of Revenues over Expenses

The accompanying consolidated statements of operations include excess of revenue over expenses. Changes in unrestricted net assets that are excluded from excess of revenues over expenses, consistent with industry practice, include changes in the funded status of defined-benefit pension plans, permanent transfers of assets to and from affiliates for other than goods and services, the cumulative effect of a change in accounting principles, and contributions received for additions of long-lived assets.

(v) Employee Pension Plan

Pension benefits are administered by the Corporation. The Corporation accounts for its defined-benefit pension plans within the framework of ASC Topic 958, *Not-for-Profit Entities, Section 715, Compensation-Retirement Benefits* (Topic 958, Section 715), which requires the recognition of the overfunded or underfunded status of a defined-benefit pension plan as an asset or liability. The plans are subject to annual actuarial evaluations, which involve various assumptions creating changes in elements of expense and liability measurement. Key assumptions include the discount rate, the expected rate of return on plan assets, retirement, mortality, and turnover. The Corporation evaluates these assumptions annually and modifies them as appropriate.

Additionally, Topic 958, Section 715 requires the measurement date for plan assets and liabilities to coincide with the employer's year-end and requires the disclosure in the notes to the consolidated financial statements of additional information about certain effects on net periodic benefit cost for the next fiscal year that arise from delayed recognition of the gains or losses, prior service costs or credits, and transition asset or obligation. During fiscal year 2016, LifeBridge adopted the RP-2014 Mortality Table with generational improvements. See footnote 11 for further discussion.

(3) Carroll County Health Services Corporation

The Corporation became the sole corporate member of CCHS and all of its subsidiaries on April 1, 2015. Beginning on that date the financial position and results of operations of CCHS were consolidated. As part of the transaction, LifeBridge contributed $50,000 to Carroll Foundation to be used solely in furtherance of the Foundation's charitable purposes of supporting the missions of CCHS and LifeBridge committed to provide $250,000 to meet the strategic needs of CCHS and its affiliates. LifeBridge established a $250,000 board-designated fund containing the funds required to meet the commitment. The affiliation was accounted

(Continued)

(Dollars in thousands)

for under the purchase accounting method for business combinations. As a result, the Corporation recorded an inherent contribution related to the transaction of $145,938 in fiscal year 2015.

The following table summarizes the estimated fair value of assets acquired and liabilities assumed at April 1, 2015 (the acquisition date prior to the Foundation Contribution):

Assets:		
Current assets	$	91,236
Property and equipment		144,403
Other long-term assets		144,079
Total assets	$	379,718
Liabilities:		
Current liabilities	$	58,769
Long-term liabilities		175,011
Total liabilities		233,780
Net assets:		
Unrestricted		134,032
Temporarily restricted		10,733
Permanently restricted		1,173
Total net assets		145,938
Total liabilities and net assets	$	379,718

The following table summarizes the Corporation's pro forma consolidated results as though the acquisition occurred at July 1, 2014:

		2015
Total operating revenues	$	1,435,203
Operating income		51,757
Other income, net		144,690
Changes in net assets:		
Unrestricted	$	184,931
Temporarily restricted		12,488
Permanently restricted		1,169
Total changes in net assets	$	198,588

(Continued)

(Dollars in thousands)

(4) Investments

Investments, which consist of assets limited as to use, board-designated investments, donor-restricted investments, and long-term investments in the accompanying consolidated balance sheets, are stated at fair value or under the equity method, as appropriate, as of June 30, 2016 and 2015, and consist of the following:

	2016	2015
Assets limited as to use:		
Self-insurance fund:		
Cash and cash equivalents	$ —	3,128
Mutual funds	22,060	2,197
Equity securities	9,210	7,106
U.S. Treasury	944	11,389
Government securities	—	1,705
Fixed income	8,789	11,350
Alternative investments	2,598	4,364
Self-insurance fund	43,601	41,239
Debt service fund:		
Cash and cash equivalents	20,598	11,501
Government securities	47,062	7,328
Debt Service Fund	67,660	18,829
Collateral held for lines of credit and other:		
Cash and cash equivalents	—	89
Mutual funds	—	1,230
Equity securities	—	2,297
Fixed income	—	68
Collateral held for lines of credit	—	3,684
Less current portion	(67,660)	(30,565)
Assets limited as to use, net of current portion	$ 43,601	33,187
Donor-restricted investments:		
Cash and cash equivalents	$ 4,825	5,418
Mutual funds	5,649	6,082
Equity securities	2,585	2,091
U.S. Treasury	3,557	3,238
Government securities	3,016	3,324
Fixed income	566	1,205
Alternative investments	343	286
Donor-restricted investments	$ 20,541	21,644
Beneficial interest in split interest agreement	$ 4,477	4,628

(Continued)

(Dollars in thousands)

There are other investments restricted by donors other than pledges receivable, donor-restricted investments, and beneficial interest that are included in long-term investments as of June 30, 2016 and 2015. As of June 30, 2016 and 2015 current, long-term, and board-designated investments are as follows:

	2016	2015
Current, long-term, and board-designated investments:		
Cash and cash equivalents	$ 8,747	56,619
Mutual funds	177,303	165,392
Equity securities	159,173	132,483
Government securities	10,111	8,849
Fixed income	29,167	26,830
Alternative investments	135,897	142,273
Current, long-term and board-designated investments	520,398	532,446
Less current portion	(23,352)	(23,761)
Long-term and board-designated investments	$ 497,046	508,685

Investment income and gains and losses on long-term investments, board-designated investments, donor-restricted investments, and assets limited as to use are comprised of the following for the years ended June 30, 2016 and 2015:

	2016	2015
Investment income:		
Interest income and dividends	$ 9,516	7,398
Realized gains on sale of securities	6,512	13,763
Investment income	16,028	21,161
Unrealized (losses) gains on trading securities	(22,110)	(10,978)
Other changes in net assets:		
Changes in unrealized gains on temporarily and permanently restricted net assets	(1,847)	(373)
Total investment return	$ (7,929)	9,810

(5) Pledges Receivable

Contributions and pledges to raise funds are recorded as temporarily restricted net assets until the donor-intended purpose is met and the cash is collected. Future pledges are discounted at the treasury bill rate to reflect the time value of money, and an allowance for potentially uncollectible pledges has been established.

(Continued)

(Dollars in thousands)

Sinai, Northwest, Carroll, and Levindale have recorded total pledges as of June 30, 2016 and 2015 as follows:

	2016	2015
Gross pledges receivable	$ 9,051	15,878
Less:		
Discount for time value of money	(782)	(1,232)
Allowance for uncollectible accounts	(1,568)	(2,476)
	$ 6,701	12,170

Total anticipated future payments are as follows:

Less than one year	$ 3,550
One to five years	5,288
Five years and thereafter	213
	$ 9,051

(6) Property and Equipment

As described in note 13, Sinai and Levindale leases from an affiliate of AJCF lease all land, land improvements, buildings, and fixed equipment located at those entities' primary locations; LifeBridge entities own the movable equipment. Property and equipment are classified as follows at June 30:

	Estimated useful life	2016	2015
Land		$ 11,657	7,302
Land improvements	8 to 20 years	35,931	35,913
Building and improvements	10 to 40 years	863,963	829,588
Fixed equipment	8 to 20 years	101,411	88,710
Movable equipment	3 to 15 years	479,705	453,896
		1,492,667	1,415,409
Less accumulated depreciation		(926,430)	(867,451)
		566,237	547,958
Construction in progress		63,240	47,185
Property and equipment, net		$ 629,477	595,143

Depreciation, amortization, and gain/loss on sale of assets were $75,699 and $62,957 for the years ended June 30, 2016 and 2015, respectively. Of this, depreciation expense was $75,546 and $60,267 for the years ended June 30, 2016 and 2015, respectively.

(Continued)

(Dollars in thousands)

Included in property and equipment is building and equipment, net of accumulated amortization, of $18,774 and $9,258 for the years ended June 30, 2016 and 2015, respectively, financed with capital lease obligations. Accumulated amortization related to the building and equipment under capital leases was $11,806 and $21,222 at June 30, 2016 and 2015, respectively.

(7) Investments in Joint Ventures

Investments in joint ventures and partnerships, accounted for under the equity method, consist of the following at June 30, 2016 and 2015:

Joint Venture	Business purpose	2016 Percentage ownership	2016 Balance	2015 Percentage ownership	2015 Balance
MNR Industries, LLC	Urgent Care Centers	40%	$ 23,291	40%	$ 23,123
Baltimore County Radiology, LLC	Outpatient Radiology	25	5,724	—	—
Riverside Health of Maryland, Inc.	Medicaid Managed Care Plan	—	—	20	2,736
Mt. Airy Med-Services, LLC	Real Estate	50	4,952	50	375
Lochearn Nursing Home, LLC	Nursing Home	10	1,997	—	—
Mt. Airy Plaza, LLC	Real Estate	50	1,628	50	1,649
LifeBridge Sports Medicine & Rehabilitation, LLC	Physical Therapy	50	1,303	50	1,165
Carroll Care Pharmacies, LLC	Pharmacies	49	1,037	49	1,018
Other Joint Ventures	Miscellaneous	5–50	4,108	5–50	3,799
	Total		$ 44,040		$ 33,865

For those joint ventures and partnerships accounted for using the equity method, LifeBridge recorded equity in earnings of joint ventures and partnerships. For those joint ventures and partnerships accounted for using the cost method, LifeBridge recorded dividend income. Such amounts are included in other operating revenue in the consolidated statements of operations.

(Continued)

(Dollars in thousands)

(8) Long-Term Debt and Capital Lease Obligations

As of June 30, long-term debt and capital lease obligations consist of the following:

	2016	2015
Maryland Health and Higher Educational Facilities Authority (MHHEFA):		
Revenue Bonds Series 2006	$ —	35,000
Revenue Bonds Series 2008	237,590	266,285
Revenue Bonds Series 2011	47,465	48,315
Revenue Bonds Series 2012A	55,152	56,620
Revenue Bonds Series 2015	159,685	—
Other debt:		
Bank of America line of credit	—	100,000
M&T Bank taxable loan	45,905	50,000
BB&T line of credit	—	2,351
Capital leases	18,501	7,206
Other	539	343
	564,837	566,120
Less current portion	(12,921)	(14,711)
Unamortized premium	12,685	6,805
Unamortized discount	(42)	(44)
Long-term debt, net	$ 564,559	558,170

In November 2006, the Maryland Health and Higher Educational Facilities Authority (MHHEFA or the Authority) loaned $35,000 from the proceeds of bonds (Series 2006 Bonds) to CCHS and certain of its subsidiaries, resulting in proceeds of $35,000. The Series 2006 Bonds were repaid as part of the Series 2015 Bond offering, further discussed below.

In January 2008, MHHEFA loaned $285,815 from the proceeds of bonds (Series 2008 Bonds) to LifeBridge and certain of its subsidiaries. Portions of the Series 2008 Bonds are payable on July 1 of each year through 2047. The Series 2008 Bonds bear interest at a weighted fixed rate of 5.35%. Approximately, $27,640 of the Series 2008 Bonds were repaid as part of the Series 2015 Bond offering, further discussed below.

In March 2011, the Authority loaned $50,695 from the proceeds of bonds (Series 2011 Bonds) to LifeBridge and certain of its subsidiaries. Portions of the Series 2011 Bonds are payable on July 1 of each year through 2041. The Series 2011 Bonds bear interest at a weighted fixed rate of 5.99%.

In May 2012, MHHEFA loaned $89,790 from the proceeds of bonds (Series 2012A Bonds) to CCHS and certain of its subsidiaries (the Series 2012 Bonds). The Series 2012 Bonds were issued in three series: $26,995 of serial bonds maturing in 2013 through 2027, $7,505 of term bonds maturing in 2030, and $25,280 of term bonds maturing in 2037 (Series 2012A Bonds); $15,010 of term bonds maturing in 2037 (Series 2012B Bonds); and $15,000 of term bonds maturing in 2042 (Series 2012C Bonds).

(Continued)

On April 1, 2015, LifeBridge established a two-year loan facility with Bank of America in the amount of $250,000 (2015 Line of Credit) that matures on March 31, 2017, with a variable rate of interest on amounts drawn of 30-day LIBOR plus 88 basis points. The 2015 Line of Credit is secured on parity with the Series 2008 and 2011 Bonds. On April 1, 2015, LifeBridge drew $100,000 on the 2015 Line of Credit, of which $50,000 was transferred to Carroll Foundation for the Foundation Contribution and $39,800 was used to pay off the Series 2012B and 2012C Bonds Bank. The Line of Credit was repaid during the year ended June 30, 2016. The outstanding obligation was $0 and $100,000 for the years ended June 30, 2016 and 2015, respectively.

On May 1, 2015, a single obligated group (the Obligated Group) was formed, consisting of LifeBridge, Sinai, Northwest, Levindale, BJHF, CHSF, CCHS, Carroll, CCMS, CHG, CH, and CRCCP. Members of the Obligated Group are jointly and severally liable for all of the outstanding bonds issued by the Authority on behalf of LifeBridge and CCHS and their respective affiliates, together with the other obligations on parity with such bonds.

On June 26, 2015, LifeBridge entered into a $50,000 direct bank placement with M&T Bank (2015 M&T Loan). The interest rates range from 1.57% to 3.28%, with maturity dates ranging from July 1, 2016 to July 1, 2025. The 2015 M&T Loan is secured on parity with the bonds.

On July 30, 2015, the Authority issued $159,685 in bonds (Series 2015 Bonds) on behalf of LifeBridge Health. The proceeds of the Series 2015 Bonds have been and will be used to finance and refinance the cost of construction, renovation, and equipping of certain additional facilities for the Obligated Group, to refund a portion of the Series 2008 Bonds and the Authority's Carroll Issue, Series 2006 bonds, and refinance the portion of the Bank of America Line of Credit that had been used to repay Carroll's loan from BB&T Bank. The remaining Bank of America line of credit was repaid by the Corporation in July.

The Series 2008, 2011, 2012A, and 2015 Bonds are governed by a Master Loan Agreement. Under the Master Loan Agreement, the Authority maintains a security interest in the revenue of the obligors. In addition, the Master Loan Agreement requires Obligated Group members to adhere to limitations on mergers, disposition of assets, and additional indebtedness and certain financial covenants. The financial covenants include a rate covenant, which requires the Obligated Group to achieve a debt service coverage ratio of 1.10; a liquidity covenant, which requires the Obligated Group to maintain 65 days cash on hand; and a debt-to-capitalization covenant, which requires the Obligated Group to maintain a debt-to-capitalization ratio of not more than 65%, all measured as of June 30 in each fiscal year. In the fiscal year ended June 30, 2016, the Obligated Group met all of its covenants.

On April 28, 2015, Carroll entered into a termination agreement related to its floating-to-fixed interest rate swap agreement with Bank of America. Carroll paid Bank of America $13,998 to terminate the swap agreement. The Corporation recognized a realized gain on settlement of approximately $600. This amount was recognized within other income, net within the consolidated statements of operations.

The Corporation is obligated under several noncancelable capital leases for hospital equipment and office building space.

(Continued)

(Dollars in thousands)

The total future principal payments on long-term debt and capital lease payments are as follows:

	MHHEFA and other debt	Capital lease obligations
Years ending June 30:		
2017	$ 11,329	2,517
2018	10,750	2,196
2019	11,270	2,231
2020	11,795	2,269
2021	12,345	2,304
Thereafter	488,847	10,324
	$ 546,336	21,841
Less interest portion		(3,340)
		$ 18,501

(9) M&T Bank Line of Credit

Sinai maintains a $5,000 line of credit with M&T Bank. As of June 30, 2016 and 2015, there were no balances outstanding on this line of credit.

(10) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30:

	2016	2015
Healthcare services:		
Capital equipment/construction	$ 23,160	24,824
Other healthcare services:		
Service grants	496	215
Donor-specified healthcare services	14,452	20,491
Enrichment and research	15,277	16,130
	$ 53,385	61,660

Permanently restricted net assets of $15,887 and $15,816 at June 30, 2016 and 2015, respectively, are to investments to be held in perpetuity, the income from which is expendable to support healthcare services.

(Continued)

(Dollars in thousands)

(11) Employee Benefit Plans

(a) LifeBridge Health Pension Plans (Sinai and Levindale)

The Corporation sponsors noncontributory defined-benefit pension plans (the Sinai/Levindale Plans) covering full-time, nonunion and union employees of Sinai and Levindale. Annual contributions to the Sinai/Levindale Plans are made at a level equal to or greater than the funding requirement as determined by the Sinai/Levindale Plans' consulting actuary. Contributions are intended to provide not only for benefits attributed to service to date, but also for those expected to be earned in the future.

The following tables set forth the Sinai/Levindale Plans' funded status and amounts recognized in the accompanying consolidated financial statements as of June 30, 2016 and 2015:

		2016	2015
Measurement date		June 30, 2016	June 30, 2015
Change in projected benefit obligation:			
Benefit obligation at beginning of year	$	185,808	174,787
Service cost		7,729	7,490
Interest cost		8,085	7,369
Actuarial loss		19,264	6,933
Benefits paid		(5,815)	(10,321)
Expenses paid from assets		(346)	(450)
Benefit obligation at end of year		214,725	185,808
Change in plan assets:			
Fair value of plan assets at beginning of year		158,657	157,068
Actual return on plan assets		(5,461)	3,666
Company contributions		10,542	8,694
Benefits paid		(5,815)	(10,321)
Expenses paid from assets		(346)	(450)
Fair value of plan assets at end of year		157,577	158,657
Funded status	$	(57,148)	(27,151)

(Continued)

(Dollars in thousands)

Amounts recognized in the consolidated financial statements consist of the following at June 30:

		2016	2015
Amounts recognized in the consolidated balance sheets:			
Other long-term liabilities	$	57,148	27,151
Amounts recognized in unrestricted net assets:			
Net actuarial loss	$	74,421	41,086
Prior service cost		—	43
	$	74,421	41,129

The Corporation has estimated $16,721 for its defined-benefit contributions to the Sinai/Levindale Plans for the fiscal year ending June 30, 2017. The accumulated benefit obligation is $196,562 and $169,323 at June 30, 2016 and 2015, respectively.

Net periodic pension expense for the years ended June 30, 2016 and 2015 was as follows:

		2016	2015
Service cost	$	7,730	7,490
Interest cost		8,085	7,369
Expected return on plan assets		(10,963)	(10,982)
Amortization of net loss		2,353	1,149
Amortization of prior service cost		43	89
Net periodic benefit cost	$	7,248	5,115

The estimated net actuarial loss and prior service cost to be amortized from unrestricted net assets into net periodic pension benefit cost over the next fiscal year are $5,555 and $0, respectively.

(Continued)

(Dollars in thousands)

Actuarial assumptions used were as follows:

	2016	2015
Assumptions used to determine annual pension expense:		
Discount rate	4.47%	4.40%
Expected return on plan assets	7.00	7.25
Rate of compensation increase	2.50	2.50
Assumptions used to determine end-of-year liabilities:		
Discount rate	3.68%	4.47%
Expected return on plan assets	7.00	7.00
Rate of compensation increase	2.50	2.50
Plan asset allocation:		
Asset category:		
Cash and cash equivalents	2.00%	2.00%
Fixed income/debt securities	26.00	25.00
Equity securities	47.00	48.00
Alternative investments	25.00	25.00
Total	100.00%	100.00%

In selecting the expected long-term rate on asset, Sinai and Levindale considered the average rate of earnings on the funds invested or to be invested to provide for the benefits of these plans. This included considering the Sinai/Levindale Plans' asset allocation and the expected returns likely to be earned over the life of the plans. Target asset allocation is as follows:

	Target
Target allocation on assets:	
Equity securities	45%
Alternative investments	30
Fixed income/debt securities	25

Following are the benefit payments expected to be disbursed from plan assets:

Years ending June 30:	
2017	$ 11,125
2018	11,204
2019	11,363
2020	12,068
2021	11,839
Thereafter	65,242

(Continued)

(Dollars in thousands)

The fair values of assets of the Sinai/Levindale Plans held by PNC Institutional Investments by level at June 30, 2016 were as follows:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 4,860	—	—	4,860
Mutual funds	54,886	—	—	54,886
Fixed income	—	5,635	—	5,635
Equity securities	56,382	—	—	56,382
Alternative investments	—	—	35,814	35,814
Total assets	$ 116,128	5,635	35,814	157,577

The fair values of assets of the Sinai/Levindale Plans held by PNC Institutional Investments by level at June 30, 2015 were as follows:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 5,411	—	—	5,411
Mutual funds	53,314	—	—	53,314
Fixed income	—	6,140	—	6,140
Equity securities	57,330	—	—	57,330
Alternative investments	—	—	36,462	36,462
Total assets	$ 116,055	6,140	36,462	158,657

For the years ended June 30, 2016 and 2015, there were no significant transfers into or out of Levels 1, 2, or 3.

Changes to the fair values based on the Level 3 inputs are summarized as follows:

	Total
Balance as of June 30, 2015	$ 36,462
Additions:	
Contributions/purchases	36,392
Disbursements:	
Withdrawals/sales	(35,744)
Net change in value	(1,296)
Balance as of June 30, 2016	$ 35,814

(Continued)

(Dollars in thousands)

The following table summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2016:

	Fund 1	Fund 2	Fund 3	Fund 4	Fund 5	Fund 6
Redemption timing:						
Redemption frequency	Quarterly	Quarterly	Quarterly	Annually	Monthly	Annually
Required notice	33 days	65 days	65 days	45 days	30 days	90 days
Audit reserve:						
Percentage held back for audit reserve	10%	5%	10%	—%	—%	5%

(b) Carroll Plan

CCHS sponsors a Defined Benefit Cash Balance Plan (the Carroll Plan) covering employees of Carroll, CCMS, and Carroll Foundation. CCHS's funding policy is to make contributions to the Carroll Plan based on actuarially determined amounts necessary to provide assets sufficient to meet benefits to be paid to plan participants and to meet the minimum funding requirements of the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code, plus such amounts as CCHS may determine to be appropriate from time to time. Under the cash balance plan structure, the benefits under the Carroll Plan are determined based on employee tenure rather than age. CCHS elected to freeze benefit accruals and participation in the Carroll Plan on December 31, 2006.

The information below describes certain actions of CCHS for the years ended June 30, 2016 and 2015. As discussed in footnote 3, the fiscal year 2015 statements of operations of the Corporations includes CCHS activity for the period April 1, 2015 through June 30, 2015.

(Continued)

(Dollars in thousands)

The following tables set forth the changes in the projected benefit obligation, the changes in the Carroll Plan's assets, the Carroll Plan's funded status, the amounts recognized in the consolidated financial statements, and the Carroll Plan's net periodic pension cost as of June 30, 2016 and 2015:

		2016	2015
Measurement date		June 30, 2016	June 30, 2015
Change in projected benefit obligation:			
Projected benefit obligation at beginning of year	$	68,498	66,031
Interest cost		3,004	2,755
Actuarial loss		7,514	1,919
Benefits paid		(2,397)	(2,207)
Benefit obligation at end of year		76,619	68,498
Change in plan assets:			
Fair value of plan assets at beginning of year		61,131	58,548
Actual return on plan assets		1,739	1,190
Employer contribution		3,600	3,600
Benefits paid		(2,397)	(2,207)
Fair value of plan assets at end of year		64,073	61,131
Funded status	$	(12,546)	(7,367)

The accumulated benefit obligation for the Plan was $76,619 and $68,498 at June 30, 2016 and 2015, respectively.

Net periodic pension expense for the year ended June 30, 2016 was as follows:

		2016	2015
Components of net periodic pension expense:			
Interest cost	$	3,004	2,755
Expected return on plan assets		(4,315)	(4,140)
Amortization of actuarial loss		1,870	1,484
Net periodic pension expense	$	559	99

The estimated net actuarial loss and prior service cost to be amortized from unrestricted net assets into net periodic pension benefit cost over the next fiscal year is $2,499 and $0, respectively.

(Continued)

(Dollars in thousands)

Assumptions to determine the benefit obligation as of June 30, 2016 and 2015 were as follows:

	2016	2015
Discount rate	3.72%	4.47%

Assumptions used in the determination of net periodic pension expense for the year ended June 30, 2016 and 2015 were as follows:

	2016	2015
Discount rate	4.47%	4.25%
Expected long-term rate of return on plan assets	7.00	7.00

Deferred pension costs, which have not yet been recognized in periodic pension expense but are accrued in unrestricted net assets, are $32,962 and $24,742 at June 30, 2016 and 2015, respectively. Deferred pension costs represent unrecognized actuarial losses or unexpected changes in the projected benefit obligation and plan assets over time primarily due to changes in assumed discount rates and investment experience. The amount of deferred pension costs expected to be recognized as a component of net periodic pension costs during the year ended June 30, 2017 is $380.

CCHS's weighted average asset allocations for the plan assets as of June 30, 2016 and 2015 were as follows:

	2016	2015
Cash and cash equivalents	8.0%	7.0%
Fixed income/debt securities	22.0	19.0
Mutual funds and equity securities	53.0	56.0
Alternative investments	17.0	18.0
	100.0%	100.0%

Pension plan assets are invested in accordance with the CCHS's investment policy in an attempt to maximize return with reasonable and prudent levels of risk. This structure includes various assets classes, investment management styles, asset allocation, and acceptable ranges that, in total, are expected to produce a sufficient level of overall diversification and total investment return over the long term. CCHS periodically reviews performance to test progress toward attainment of longer term targets, to compare results with appropriate indices and peer groups, and to assess overall investment risk levels.

(Continued)

(Dollars in thousands)

The following table presents the Plan's assets measured at fair value at June 30, 2016:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 5,366	—	—	5,366
Mutual funds	34,179	—	—	34,179
Fixed income	—	13,716	—	13,716
Alternative investments	—	—	10,812	10,812
Total assets	$ 39,545	13,716	10,812	64,073

The following table presents the Plan's assets measured at fair value at June 30, 2015:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 4,205	—	—	4,205
Mutual funds	34,102	—	—	34,102
Fixed income	—	12,199	—	12,199
Alternative investments	—	—	10,625	10,625
Total assets	$ 38,307	12,199	10,625	61,131

During fiscal year 2016, Level 3 investments within the pension plan assets increased by $7. This increase was the result of purchases of $3,391, redemptions of $2,828 and losses in investments of $556. During fiscal year 2015, Level 3 investments within the pension plan assets decreased by $78. This decrease was the result of purchases of $0, redemptions of $447 and gain on earnings in investments of $369. There were no significant transfers between Levels 1, 2 and 3 during the years ended June 30, 2016 and 2015.

CCHS follows ASU No. 2009-12, and applied its provisions to its pension plan asset portfolio. The guidance amends ASC Topic 820 and permits, as a practical expedient, fair value of investments within its scope to be estimated using net asset value (NAV) or its equivalent. The alternative investments classified within Level 3 of the fair value hierarchy have been recorded using NAV.

The Carroll Plan invests in alternative investments which are primarily hedge fund of funds and real estate funds.

For the alternative investments, redemption requests can be made either quarterly or annually. The notice required in order to make a redemption is within a range of 65 to 100 days. The audit reserve requirements are 10% for each fund. There are generally no gate provisions with the exception of one fund which has a gate of 25% of net asset value (NAV).

(Continued)

(Dollars in thousands)

CCHS expects to contribute $2,070 to the Carroll Plan during the year-ending June 30, 2017.

The following benefit payments, which reflect future services, as appropriate, are expected to be paid from the Plan's assets during the years ending June 30 of the indicated year:

2017	$	2,677
2018		2,802
2019		2,920
2020		3,123
2021		3,337
2022–2026		19,075
	$	33,934

CCHS expensed total employer contributions of $1,291 and $290 for the year ended June 30, 2016 and 2015, respectively.

*(c) **Contributory Plans***

Northwest has a qualified noncontributory defined-contribution pension plan (the NW Plan) covering substantially all employees who work at least 1,000 hours per year, who have completed two years of continuous service as of the beginning of the plan year, and who have attained the age of 21 as of the beginning of the plan year. Participants in the NW Plan are 100% vested. Northwest makes annual contributions to the NW Plan equivalent to 1.5% of the participants' salaries for employees who have been in the NW Plan from one to five years, 4.0% for those in the plan from six to 19 years, and 6.5% thereafter. It is Northwest's policy to fund plan costs as they accrue. Plan expense was approximately $2,849 and $2,794 for the years ended June 30, 2016 and 2015, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

Certain LifeBridge entities have supplemental 403(b) retirement plans for eligible employees. The entities may elect to match varying percentages of an employee's contribution up to a certain percentage of the employee's annual salary. The associated expense was approximately $4,710 and $4,774 for the years ended June 30, 2016 and 2015, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

Certain companies under Community Physicians and Investments maintain a defined-contribution plan for employees meeting certain eligibility requirements. Eligible employees can also make contributions. Under the plan, the employer may elect to match a percentage of eligible employees' contributions each year. The related expense was approximately $1,627 and $1,668 for the years ended June 30, 2016 and 2015, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

Certain LifeBridge entities maintain a nonqualified deferred compensation plan for key employees and physicians. The Corporation establishes a separate deferral account on its books for each participant for each plan year. In general, participants are entitled to receive the deferred funds upon their death, attainment of the specified vesting date, or involuntary termination of their employment without cause,

(Continued)

whichever occurs first. The related expense was approximately $4,823 and $3,469 for the years ended June 30, 2016 and 2015, respectively, and is included in salaries and employee benefits in the accompanying consolidated statements of operations.

(d) Postretirement Plan Other than Pension

Carroll sponsors a postretirement plan other than pension for employees. Carroll employees retired from active employment at 65 years of age or older or at 55 years of age after earning at least 10 years of vesting service are eligible for health and prescription drug benefits under Carroll's self-insured health plan. Effective January 1, 2009, individuals are no longer permitted to participate in this Plan once they are Medicare eligible. Plan participants contribute premiums to the Plan in amounts determined by Carroll for Pre-Medicare and post-Medicare age retirees. At June 30, 2016 and 2015, Carroll has accrued a liability of $425 and $376, respectively, related to this Plan.

(12) Regulation and Reimbursement

The Corporation and other healthcare providers in Maryland are subject to certain inherent risks, including the following:

- Dependence on revenues derived from reimbursement by the Federal Medicare and State Medicaid programs;
- Regulation of hospital rates by the State of Maryland Health Services Cost Review Commission (HSCRC);
- Government regulation, government budgetary constraints, and proposed legislative and regulatory changes; and
- Lawsuits alleging malpractice and related claims.

Such inherent risks require the use of certain management estimates in the preparation of the Corporation's consolidated financial statements, and it is reasonably possible that a change in such estimates may occur.

The Medicare and Medicaid programs represent a substantial portion of the Corporation's revenues, and the Corporation's operations are subject to a variety of other federal, state, and local regulatory requirements. Failure to maintain required regulatory approvals and licenses and/or changes in such regulatory requirements could have a significant adverse effect on the Corporation. Changes in federal and state reimbursement funding mechanisms and related government budgetary constraints could have a significant adverse effect on the Corporation.

The current rate of reimbursement for hospital services to patients under the Medicare and Medicaid programs is based on an agreement between the Center for Medicaid and Medicare Services (CMS) and the State of Maryland. This agreement is based upon a waiver from Medicare prospective payment system reimbursement principles granted to the State of Maryland by CMS.

In January 2014, CMS approved Maryland's new waiver for a five-year period beginning January 1, 2014 for inpatient and outpatient hospital services. The new waiver requires Maryland to adopt a payment structure

that incentivizes efficient utilization of hospital resources, limits hospital per capita growth in all-payer and Medicare spending, generate Medicare savings of $330 million over five years, limit growth in total cost of care per Medicare beneficiary, reduce hospital readmissions, and reduce certain hospital-acquired conditions.

(13) Related-Party Transactions

Land Leases

Sinai and Levindale are constituent agencies of AJCF, a charitable corporation.

The legal title to substantially all land, land improvements, buildings, and fixed equipment included in Sinai's and Levindale's operating property is held by an affiliate of AJCF. Sinai and Levindale have entered into leases with the AJCF affiliate with respect to these assets. The leases allow Sinai and Levindale to conduct their business on the property as currently conducted. Rent under each lease is $1.00 per year. The leases may not be terminated before December 31, 2050.

Other

In addition to its arrangement with AJCF, Sinai receives services from certain other constituent agencies of AJCF.

(14) Income Taxes

At June 30, 2016, Investments has approximately $62,019 in net operating loss carryforwards for income tax purposes. The net operating loss carryforwards for tax purposes are available to reduce future taxable income and expire in varying periods through 2036.

The net operating loss carryforwards created a federal net deferred tax asset of approximately $21,087 and $18,670 as of June 30, 2016 and 2015, respectively, and a state deferred tax asset of approximately $3,358 and $2,996 as of June 30, 2016 and 2015, respectively. Management has determined that it is more likely than not that Investments will not be able to utilize the deferred tax assets; therefore, a full valuation allowance was recorded against the net deferred assets as of June 30, 2016 and 2015.

At June 30, 2016, CCHS has approximately $65,243 of net operating loss carryforwards, primarily at CCMS, that will expire through 2033. The net operating loss carryforwards created a net deferred tax asset of approximately $28,928 and $24,801 as of June 30, 2016 and 2015, respectively. Management has determined that it is more likely than not that CCHS will not be able to utilize the deferred tax assets; therefore, a full valuation allowance has been recorded against the deferred tax asset as of June 30, 2016 and 2015.

(Continued)

(Dollars in thousands)

(15) Other Long-Term Liabilities

Other long-term liabilities at June 30, 2016 and 2015 are as follows:

	2016	2015
Professional/general liability (note 16(a))	$ 52,174	51,924
Pension liability	70,119	34,894
Medical office building	33,128	34,256
Asset retirement obligation	3,260	3,260
Deferred compensation	6,967	4,864
Other	1,361	1,658
	$ 167,009	130,856

At June 30, 2016 and 2015, there was $13,023 and $12,121 included in other current liabilities related to professional liabilities, respectively.

(16) Self-Insurance Programs

(a) Professional/General Liability

The Corporation is self-insured, through LifeBridge Insurance (and Cen-Mar prior to June 30, 2016), for most medical malpractice and general liability claims arising out of the operations of LifeBridge and its subsidiaries. Estimated liabilities have been recorded for both reported and incurred but not reported claims.

LifeBridge Insurance and Cen-Mar purchase reinsurance coverage from other carriers to cover their liabilities in excess of various retentions. The amounts that LifeBridge subsidiaries must transfer to LifeBridge Insurance and Cen-Mar to fund medical malpractice and general liability claims are actuarially determined and are sufficient to cover expected liabilities. Management's estimate of the liability for medical malpractice and general liability claims, including incurred but not reported claims, is principally based on actuarial estimates performed by an independent third-party actuary. Professional liability coverage for certain employed physicians is provided by commercial insurance carriers.

(b) Workers' Compensation

Sinai, Northwest, Levindale, LAA, and CCMS and its subsidiaries are insured for workers' compensation liability through a combination of self-insurance and excess insurance. Losses for asserted and unasserted claims are accrued based on estimates derived from past experiences, as well as other considerations including the nature of each claim or incident, relevant trend factors, and estimates of incurred but not reported amounts.

LifeBridge has accrued a liability for known and incurred but not reported claims of $7,005 and $6,899 at June 30, 2016 and 2015, respectively. These amounts are included in accounts payable and accrued liabilities in the accompanying consolidated balance sheets. Management believes these accruals are

(Continued)

(Dollars in thousands)

is adequate to provide for all workers' compensation claims that have been incurred through June 30, 2016.

All other entities have occurrence-based commercial insurance coverage. There are no material insurance recoveries related to workers' compensation as of June 30, 2016.

LifeBridge maintains stop-loss policies on workers' compensation claims. Legacy LifeBridge is insured for individual claims exceeding $450. CCHS is insured for individual claims exceeding $500.

(c) Health Insurance

LifeBridge is self-insured for employee health claims. LifeBridge has accrued a liability of $3,655 and $3,517 at June 30, 2016 and 2015, respectively, for known claims and incurred but not reported claims. These amounts are included in accounts payable and accrued liabilities in the accompanying consolidated balance sheets.

(17) Concentration of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2016 and 2015 is as follows:

	2016	2015
Medicare	30%	27%
Medicaid	9	10
BlueCross	12	13
Commercial and other	40	40
Self-pay	9	10
	100%	100%

The mix of net patient service revenue for the Corporation for the years ended June 30, 2016 and 2015 is as follows:

	2016	2015
Medicare	42%	41%
Medicaid	7	5
BlueCross	14	14
Commercial and other	33	36
Self-pay	4	4
	100%	100%

(Continued)

(Dollars in thousands)

(18) Commitments and Contingencies

(a) Litigation

The Corporation is subject to numerous laws and regulations of federal, state, and local governments. The Corporation's compliance with these laws and regulations can be subject to periodic governmental review and interpretation, which can result in regulatory action unknown or unasserted at this time. Management is aware of certain asserted and unasserted legal claims and regulatory matters arising in the ordinary course of business. After consultation with legal counsel, it is management's opinion that the ultimate resolution of these claims will not have a material adverse effect on the Corporation's financial position.

(b) Letters of Credit

M&T Bank has established an open letter of credit for Sinai of $211 (which has not been drawn upon) to guarantee Sinai's obligation for liabilities assumed as a member of a risk retention group during the period 1988 to 1994. Additionally, M&T Bank has established a standby letter of credit of $2,407 to serve as collateral as required by the Maryland Office of Unemployment Insurance. M&T Bank has established a standby letter of credit for Levindale of $411 as required by the State of Maryland Department of Labor, Licensing, and Regulation. M&T Bank has established a standby letter of credit for LifeBridge Health & Fitness of $200 as required by the State of Maryland Office of the Attorney General. M&T Bank has established a standby letters of credit of $52 and of $84 to serve as collateral as required by the City of Baltimore for the completion of certain construction work at Sinai.

(c) Operating Leases

The Corporation has entered into operating lease agreements for hospital equipment and office space, which expire on various dates through year 2026. Total rental expense for the years ended June 30, 2016 and 2015 for all operating leases was approximately $24,135 and $21,540, respectively. Future minimum lease payments under all noncancelable operating leases are as follows:

ars ending June 30:	
2017	$ 18,079
2018	15,757
2019	14,957
2020	14,090
2021	12,915
Thereafter	17,894
	$ 93,692

(Continued)

(Dollars in thousands)

(19) Noncontrolling Interest

The reconciliation of a noncontrolling interest reported in unrestricted net assets is as follows:

	LifeBridge Health, Inc.	Noncontrolling interest	Unrestricted net assets
Balance at June 30, 2014	$ 660,970	(192)	660,778
Operating income	50,276	470	50,746
Nonoperating income	14,746	—	14,746
Excess of revenues over expenses	65,022	470	65,492
CCHS acquisition	130,388	3,644	134,032
Change in funded status of pension plan	(16,548)	—	(16,548)
Net assets released for purchase of property and equipment	5,347	—	5,347
Other	(272)	—	(272)
Change in net assets	183,937	4,114	188,051
Balance at June 30, 2015	844,907	3,922	848,829
Operating income	48,533	1,177	49,710
Nonoperating income	(5,303)	—	(5,303)
Loss on refinancing of debt	(3,720)	—	(3,720)
Excess of revenues over expenses	39,510	1,177	40,687
Change in funded status of pension plan	(41,513)	—	(41,513)
Net assets released for purchase of property and equipment	7,613	—	7,613
Other	(841)	—	(841)
Change in net assets	4,769	1,177	5,946
Balance at June 30, 2016	$ 849,676	5,099	854,775

(20) Functional Expenses

The Corporation provides general healthcare services to patients. Expenses for the years ended June 30, 2016 and 2015 related to providing these services are as follows:

	2016	2015
Healthcare services	$ 1,069,047	875,650
General and administrative	358,668	286,733
	$ 1,427,715	1,162,383

(Continued)

(21) Fair Value of Financial Instruments

The following methods and assumptions were used by the Corporation in estimating the fair value of its financial instruments:

(a) Assets and Liabilities

Cash and cash equivalents, patient service receivables, other receivables, inventory, prepaid expenses, pledges receivable, accounts payable and accrued liabilities, advances to third-party payors, and other current liabilities – The carrying amounts reported in the consolidated balance sheet approximate the related fair values.

Investments (donor-restricted, assets limited as to use, and long-term), and beneficial interest in split interest agreements – Fair values are based on quoted market prices of individual securities or investments if available, or are estimated using quoted market prices for similar securities or investment managers' best estimate of underlying fair value.

Investment in unconsolidated affiliates – Investments in unconsolidated affiliates are not readily marketable. Therefore, it is not practicable to estimate their fair value and such investments are recorded in accordance with the equity method or at cost.

(b) Long-Term Debt

The Series 2008 MHHEFA Bonds bear interest at fixed rates and had a fair value of $244,684 and $273,529 at June 30, 2016 and 2015, respectively. The fair market value of the fixed rate Series 2011 MHHEFA Bonds was $56,556 and $55,110 as of June 30, 2016 and 2015, respectively. The fair market value of the variable rate Series 2006 MHHEFA Bonds was $0 and $35,582 as of June 30, 2016 and 2015, respectively. The fair market value of the fixed rate Series 2012A MHHEFA Bonds was $62,742 and $60,244 as of June 30, 2016 and 2015, respectively. The fair market value of the variable rate Series 2015 MHHEFA Bonds was $185,798 as of June 30, 2016.

The fair value of other long-term debt, and bank loans payable approximates its carrying value.

The fair value of the Corporation's long-term MHHEFA debt is measured using quoted offered-side prices when quoted market prices are available. If quoted market prices are not available, the fair value is determined by discounting the future cash flows of each instrument at rates that reflect, among other things, market interest rates and the Corporation's credit standing. In determining an appropriate spread to reflect its credit standing, the Corporation considers credit default swap spreads, bond yields of other long-term debt, and interest rates currently offered for similar debt instruments of comparable maturities by the Corporation's bankers as well as other banks that regularly compete to provide financing to the Corporation.

(Continued)

(Dollars in thousands)

(c) Fair Value Hierarchy

The following table presents assets that are measured at fair value on a recurring basis as of June 30, 2016:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 34,170	—	—	34,170
Equity securities and mutual funds	375,980	—	—	375,980
Treasury securities	4,501	—	—	4,501
Government securities	—	60,189	—	60,189
Fixed income	—	38,522	—	38,522
Beneficial interest in split-interest agreement	—	4,477	—	4,477
Total assets	$ 414,651	103,188	—	517,839

The following table presents assets that are measured at fair value on a recurring basis as of June 30, 2015:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 76,755	—	—	76,755
Equity securities and mutual funds	318,878	—	—	318,878
Treasury securities	14,627	—	—	14,627
Government securities	—	21,206	—	21,206
Fixed income	—	39,453	—	39,453
Beneficial interest in split-interest agreement	—	4,628	—	4,628
Total assets	$ 410,260	65,287	—	475,547

See note 2(e) for information on investments of the Corporation that are treated under the equity method and are not reported above.

For the years ended June 30, 2016 and 2015, there were no significant transfers into or out of Levels 1, 2, or 3.

(22) Subsequent Events

Management evaluated all events and transactions that occurred after June 30, 2016 and through October 12, 2016. The Corporation did not have any subsequent events during this period that were required to be recognized or disclosed.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2016

(Dollars in thousands)

Assets	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Current assets:							
Cash and cash equivalents	$ 121,957	104,929	23,238	20,248	52,565	—	322,937
Investments	12,695	3,395	6,987	276	(1)	—	23,352
Assets limited as to use, current portion	46,082	13,262	4,260	418	3,638	—	67,660
Patient service receivables, net of allowance for doubtful accounts	74,694	22,527	20,646	7,944	15,840	—	141,651
Other receivables	61,719	4,191	4,455	536	25,984	(85,377)	11,508
Inventory	22,572	5,081	3,600	183	78	—	31,514
Prepaid expenses	5,165	1,003	5,327	350	6,916	—	18,761
Pledges receivable, current portion	1,602	216	1,365	113	—	—	3,296
Total current assets	346,486	154,604	69,878	30,068	105,020	(85,377)	620,679
Board-designated investments	92,770	55,966	—	17,046	77,507	—	243,289
Long-term investments	43,563	26,280	132,460	8,005	43,449	—	253,757
Donor-restricted investments	12,695	3,395	4,175	276	—	—	20,541
Reinsurance recovery receivable	—	—	—	—	15,694	—	15,694
Assets limited as to use, net of current portion	—	—	—	—	43,601	—	43,601
Pledges receivable, net of current portion	1,747	295	1,100	263	—	—	3,405
Property and equipment, net	238,342	112,208	120,471	40,491	117,965	—	629,477
Deferred financing costs, net of accumulated amortization	2,004	647	1,365	121	—	—	4,137
Beneficial interest in split interest agreement	4,477	—	—	—	—	—	4,477
Investment in unconsolidated affiliates	—	—	3,000	—	158,076	(117,036)	44,040
Other assets, net of accumulated amortization	13,070	2,277	14,939	65	17,791	—	48,142
Total assets	$ 755,154	355,672	347,388	96,335	579,103	(202,413)	1,931,239

(Continued)

Schedule 1

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2016

(Dollars in thousands)

Liabilities and Net Assets	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Current liabilities:							
Accounts payable and accrued liabilities	$ 66,718	18,759	19,029	4,571	95,525	(85,377)	119,225
Accrued salaries, wages, and benefits	35,094	9,479	9,470	3,091	23,227	—	80,361
Advances from third-party payors	28,077	7,773	6,962	3,434	—	—	46,246
Current portion of long-term debt and capital lease obligations	3,128	1,039	1,850	163	6,741	—	12,921
Other current liabilities	1,373	320	532	13	14,633	—	16,871
Total current liabilities	134,390	37,370	37,843	11,272	140,126	(85,377)	275,624
Other long-term liabilities	72,758	10,756	28,014	5,747	49,734	—	167,009
Long-term debt and capital lease obligations, net of current portion	272,976	89,913	134,497	9,305	57,868	—	564,559
Total liabilities	480,124	138,039	200,354	26,324	247,728	(85,377)	1,007,192
Net assets:							
Unrestricted net assets	227,852	209,936	85,847	68,852	324,225	(67,036)	849,676
Noncontrolling interest in consolidated subsidiaries	—	—	4,793	—	306	—	5,099
Total unrestricted net assets	227,852	209,936	90,640	68,852	324,531	(67,036)	854,775
Temporarily restricted	36,687	7,697	55,221	1,159	2,621	(50,000)	53,385
Permanently restricted	10,491	—	1,173	—	4,223	—	15,887
	275,030	217,633	147,034	70,011	331,375	(117,036)	924,047
Total liabilities and net assets	$ 755,154	355,672	347,388	96,335	579,103	(202,413)	1,931,239

See accompanying independent auditors' report.

Schedule 2

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Statement of Operations Information

Year ended June 30, 2016

(Dollars in thousands)

	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Unrestricted revenues, gains, and other support:							
Patient service revenue (net of contractual allowances and discounts)	$ 717,728	243,716	257,505	77,946	138,915	—	1,435,810
Provision for bad debts	28,141	13,365	7,411	3,297	4,768	—	56,982
Net patient service revenue	689,587	230,351	250,094	74,649	134,147	—	1,378,828
Net assets released from restrictions used for operations	3,191	—	—	111	235	—	3,537
Other operating revenue	53,043	16,847	5,359	2,036	60,506	(42,731)	95,060
Total operating revenues	745,821	247,198	255,453	76,796	194,888	(42,731)	1,477,425
Expenses:							
Salaries and employee benefits	375,433	127,658	118,540	46,803	126,199	461	795,094
Supplies	143,312	44,306	43,124	6,296	16,561	—	253,599
Purchased services	138,430	40,956	54,755	14,869	48,393	(43,192)	254,211
Depreciation, amortization, and gain/loss on sale of assets	33,370	11,725	15,904	3,056	11,644	—	75,699
Repairs and maintenance	13,249	4,537	1,273	880	599	—	20,538
Interest	11,132	4,104	5,525	509	7,304	—	28,574
Total expenses	714,926	233,286	239,121	72,413	210,700	(42,731)	1,427,715
Operating income (loss)	30,895	13,912	16,332	4,383	(15,812)	—	49,710
Other income (loss), net:							
Investment income	6,383	561	7,779	(221)	1,526	—	16,028
Unrealized gains on trading investments	(9,063)	(4,796)	(6,130)	(217)	(1,904)	—	(22,110)
Other	—	—	252	—	527	—	779
Total other income (loss), net	(2,680)	(4,235)	1,901	(438)	149	—	(5,303)
Excess (deficiency) of revenues over expenses before inherent contributions	28,215	9,677	18,233	3,945	(15,663)	—	44,407
Loss on refinancing of debt	(1,568)	(541)	(1,592)	(19)	—	—	(3,720)
Excess of revenues over expenses	$ 26,647	9,136	16,641	3,926	(15,663)	—	40,687

See accompanying independent auditors' report.

EXHIBIT 15

Exhibit 15

Rec'd 5/19/03

STATE OF MARYLAND

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

August 18, 2003

Ms. Marie Bossie, Director
Carroll Hospice, Inc.
95 Carroll Street
Westminster, MD 21157

Dear Ms. Bossie:

Effective July 1, 2003, the Maryland law (Health General 19-906) limits hospices to providing services to only those counties where the hospice, or entity acquired by the hospice, provided services during the twelve month period prior to December 31, 2001. The law requires the Secretary to use data provided by the Maryland Health Care Commission (MHCC) from the annual hospice survey submitted by your hospice to the Maryland Hospice Network for the 2001 reporting period. The MHCC data indicate that Carroll Hospice, Inc. provided hospice services in the following jurisdictions: **BALTIMORE CO., CARROLL, FREDERICK.**

Therefore, this letter amends your license to show that you are authorized to provide hospice services only in the above jurisdictions.

If you disagree with the findings in this letter, you may be entitled to an appeal by requesting a hearing. A request for a hearing shall be filed in writing with the Office of Administrative Hearings, with a copy to the Office of Health Care Quality, no later than 30 days after receipt of this letter. The request shall include a copy of this letter. The hearing shall be conducted in accordance with State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland and the Code of Maryland Regulations COMAR 28.02.01 and 10.01.03. The Office of Administrative Hearings is located at 11101 Gilroy Road, Hunt Valley, Maryland 21031.

The law also provides that a hospital-based hospice or a hospice with an affiliation agreement with a health care facility or health care system prior to April 5, 2003 may serve patients immediately upon discharge from that hospital, health care facility, or health care system regardless of the jurisdiction where the patient resides.

Ms. Marie Bossie, Director
August 18, 2003

In consultation with the MHCC, the Department will be developing regulations to fully implement the provisions of the new law. If you have any questions, please call Michelle Woodson at 410-402-8041.

Sincerely yours,

Carol Benner

Carol Benner, Director
Office of Health Care Quality

EXHIBIT 16

Exhibit 16

LifeBridge Health, Inc.

Organizational Chart

July 24, 2018

Notes

Ownership is 100% unless otherwise noted

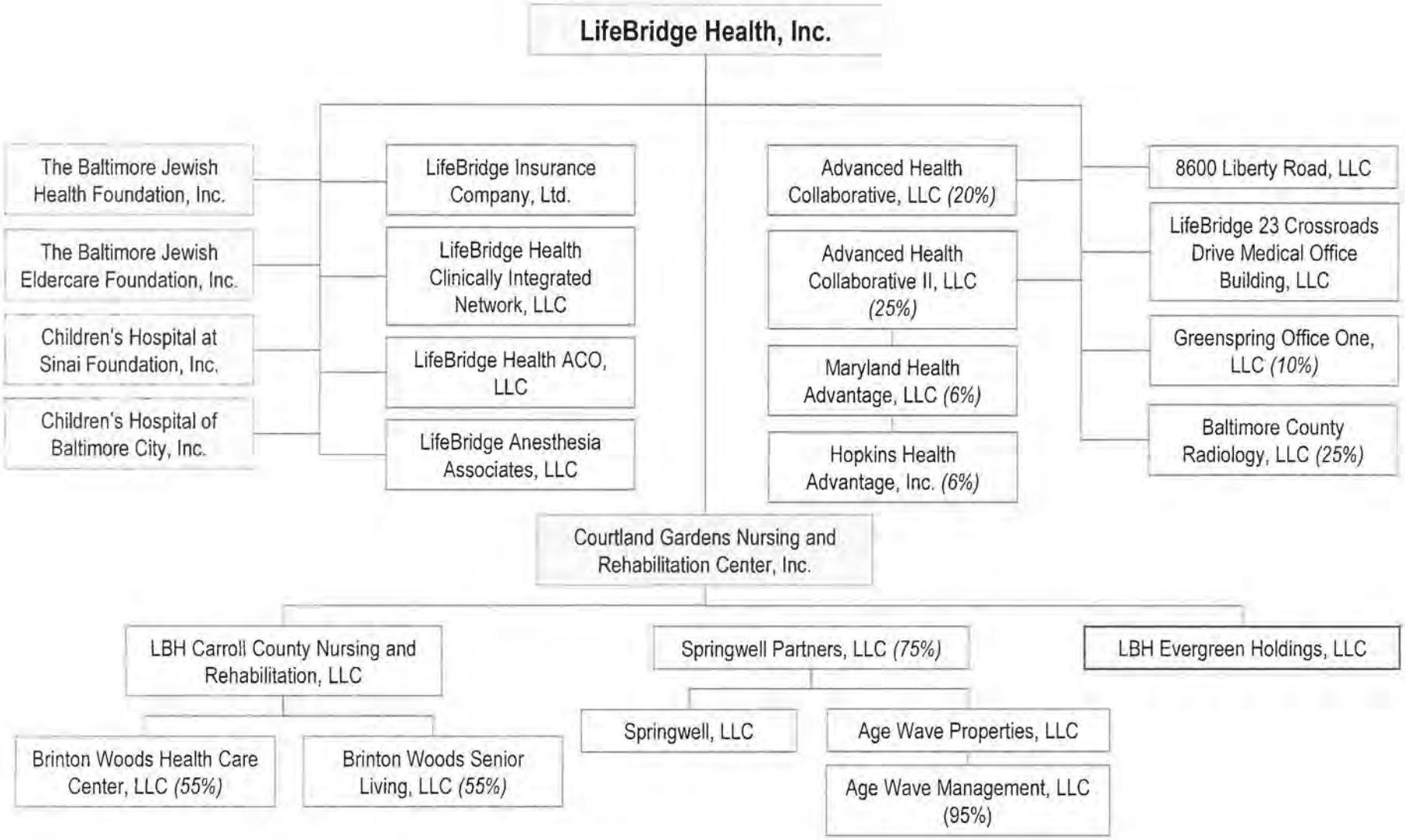
501(c)(3) entity

Inactive (no employees or business activity)

LifeBridge Health, Inc.

Organizational Chart

July 24, 2018



LifeBridge Health, Inc.

Organizational Chart

July 24, 2018

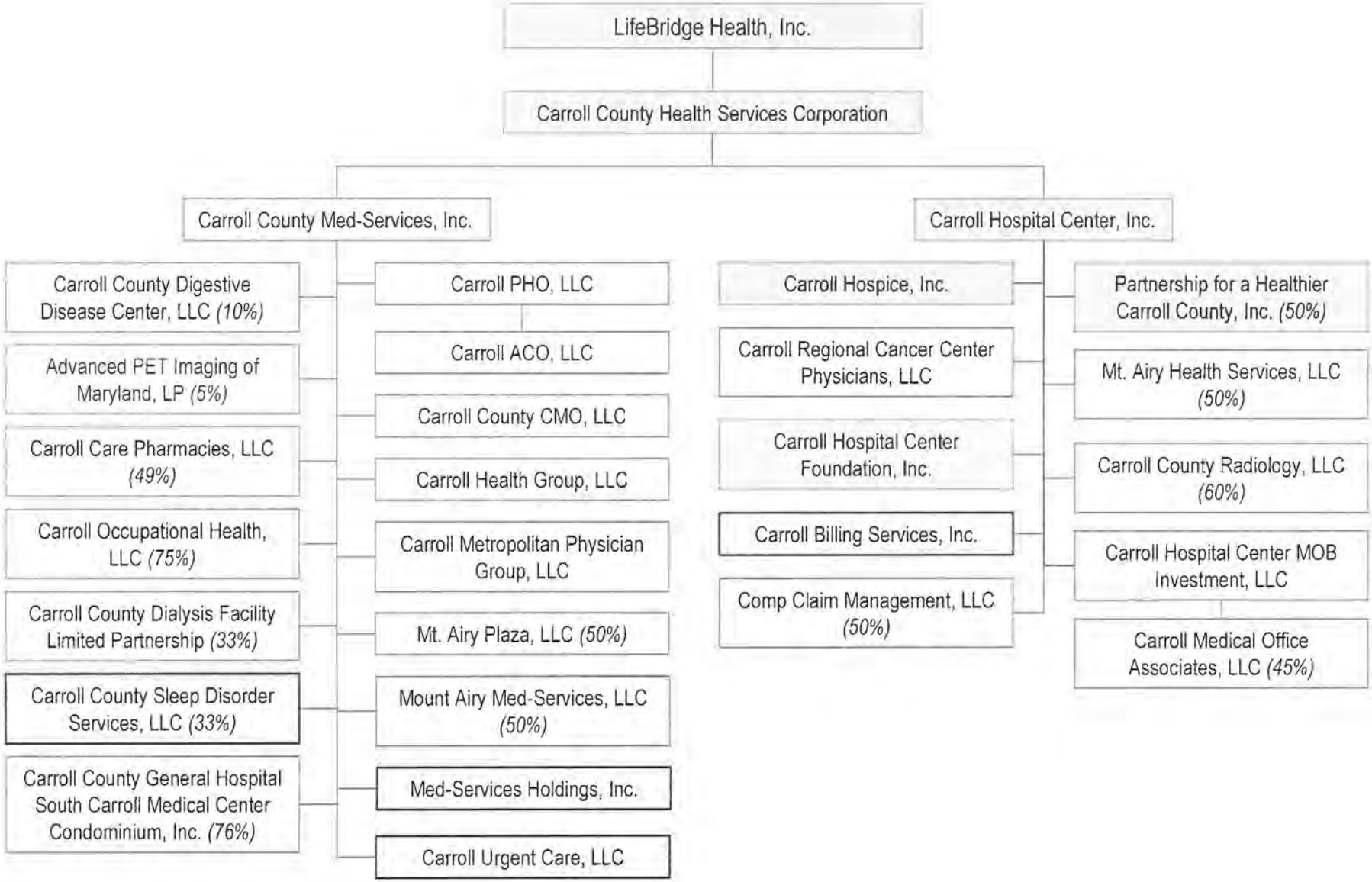


EXHIBIT 17

Exhibit 17

CARROLL HOSPICE, INC.

AMENDED AND RESTATED BYLAWS

26th DAY OF MARCH 2018

ARTICLE I

NAME

The name of this organization is Carroll Hospice, Inc. ("Corporation").

ARTICLE II

OFFICES

The principal office of the Corporation shall be located in the City of Westminster, Carroll County, State of Maryland.

ARTICLE III

MISSON

Carroll Hospice, a voluntary nonprofit, community-based organization provides palliative care, support and pain and symptom management for persons needing end of life care and support for their families. Care is provided without regard to race, religion, nationality, are or sex.

ARTICLE IV

MEMBERS

SECTION 1. Sole Member. The Sole Member of the Corporation shall be Carroll Hospital Center, Inc., a Maryland non-stock, non-profit corporation which is recognized as exempt under Section 501(c)(3) of the Internal Revenue code of 1986, as amended.

SECTION 2. Rights of the Sole Member. The Sole Member of the Corporation shall have the right to elect and remove trustees, the right to approve amendments to these Bylaws and such other rights as may be conferred by law on the members of a corporation organized under the laws of the State of Maryland.

SECTION 3. Annual Meeting. The Corporation shall hold an annual meeting of its Sole Member to elect trustees and to transact any other business within its powers on the date set and at the place for the annual meeting of the Board of Trustees ("Board ") set in accordance with Article VI, Section 1 of these Bylaws and at a time immediately preceding such annual meeting of the Board. Unless statute or the Charter provide otherwise, any business may be considered at an annual meeting without the purpose of the meeting having been specified in the notice.

Failure to hold an annual meeting does not invalidate the Corporation's existence or affect any otherwise valid corporate acts.

SECTION 4. Special Meeting. At any time in the interval between annual meetings, a special meeting of the Sole Member may be called by the Sole Member, the Chairperson of the Board or by a majority of the Board by vote at a meeting or in writing (addressed to the Secretary of the Corporation) with or without a meeting.

SECTION 5. Place of Meetings. Meetings of the Sole Member shall be held at such place in the United States as is set from time to time by the Board.

SECTION 6. Notice of meetings; Waiver of Notice. Not less than 10 nor more than 90 days before each meeting of the Sole Member, the Secretary shall give written notice of the meeting to the Sole Member. The notice shall state the time and place of the meeting and, if the meeting is a special meeting or notice of the purpose is required by statute, the purpose of the meeting. Notice is given when it is communicated by telephone to the President of the Sole Member, personally delivered, mailed, sent by e-mail or facsimile to the Sole Member at such mailing address or facsimile number appearing on the records of the Corporation. Notwithstanding the foregoing provisions, the Sole Member waives notice if before or after the meeting an authorized officer of the Sole Member signs a waiver of notice which is filed with the records of the Sole Member's meetings, or the Sole Member is present at the meeting in person or by proxy. Any meeting of the Sole Member, annual or special, may adjourn from time to time to reconvene at the same or some other place, and no notice need be given of any such adjourned meeting other than by announcement.

SECTION 7. Proxies. The Sole Member may vote either in person through an authorized officer or by written proxy signed by an authorized officer. Unless a proxy provides otherwise, it is not valid more than 11 months after its date.

SECTION 8. Informal Action by Sole Member. Any action required or permitted to be taken at a meeting of the Sole Member may be taken without a meeting if there is filed with the records of the Sole Member's meetings a written consent of the Sole Member which sets forth the action and which is signed by an authorized officer of the Sole Member.

ARTICLE V

BOARD OF TRUSTEES

SECTION 1. Function of Trustees. The business and affairs of the Corporation shall be managed under the direction of its Board. With a principal focus on fundraising, support and advocacy for persons in need of end of life care, the Board shall determine and make policy relating to the management of the business, property and affairs of the Corporation. The Board may exercise all powers of the Corporation, and delegate any and all such powers as it sees fit, subject only to the restrictions imposed by statute, the Corporation's Charter and these Bylaws.

SECTION 2. Number of Trustees. The Corporation shall have no more than 19 trustees, or such lesser number as may be fixed from time to time by the Board, provided it shall never have less than seven trustees. The maximum and minimum number of trustees may be changed by an amendment to these Bylaws, but any such amendment may not affect the tenure of office of any trustee then serving. Two of the trustees shall serve in *ex-officio* positions with full voting power. The *ex-officio* positions shall be occupied by (1) the President of the Sole Member, or his/her designee (2) the Executive Director of Carroll Hospice, Inc. The remaining trustees shall be elected by the Sole Member as provided in Article IV Sections 3.

SECTION 3. Election and Tenure of Trustees. Each of the elected trustees shall serve a term of two (2) years or until his or her earlier removal, resignation, permanent disability or death and until his or her respective successor is elected and qualified; provided, that a trustee may be elected for a term shorter than two years if (i) the term limit applicable to such trustee prevents such trustee from serving a two-year term or (ii) if the Board of Trustees approves such shortened term pursuant to a resolution in advance of such trustee's election for such shortened term. No individual who is an elected trustee may serve for more than five consecutive terms of two years (or such shorter period of time established by the Board of Trustees pursuant to a resolution of the Board of Trustees); provided, that the foregoing term limits shall not apply to any trustee who is then serving as Chairman of the Board of Trustees in order to allow such trustee to continue serving his or her remaining term as Chairman. An elected trustee may serve any number of nonconsecutive terms; provided that for any such elected trustee who has served five consecutive terms (other than any trustee who is not subject to term limits pursuant to the immediately preceding sentence), a period of not less than one year has elapsed between the time such trustee last served and such trustee's re-election to the Board of Trustees.

SECTION 4. Removal of Trustee. The Sole Member may remove any elected trustee at any time, with or without cause. Ex-officio trustees shall be deemed to be removed as of the time they cease to hold the office on which their ex-officio status is based.

SECTION 5. Vacancy on Board. If the office of any member of the Board becomes vacant, the remaining members of the Board, by a majority vote of the entire Board, may elect a successor who shall hold office until the next annual meeting of the Sole Member of the Corporation. The Sole Member may, at the next annual meeting, ratify the election of the trustee to serve for the remainder of the term of office of the trustee whose office was vacated, or may instead elect another trustee in his or her place. A vacancy in an ex-officio position shall be filled by the individual appointed to the underlying office.

SECTION 6. Resignations. Resignations shall be submitted in writing to the Board. Vacancies resulting from resignations shall be filled in accordance with Section 5 of this Article.

SECTION 7. Compensation. A trustee may not receive any compensation or reimbursement for expenses (except for travel expenses) for attendance at any annual, regular, or special meeting of the Board or any committee thereof. A trustee who serves the Corporation in any other capacity may receive compensation for such other services, pursuant to a resolution of the Board.

ARTICLE VI

MEETINGS OF THE BOARD OF TRUSTEES

SECTION 1. Annual and Regular Meetings. The annual meeting of the Board shall be held each year in May or at such other time as is determined by the Board. In addition to the annual meeting, the Board shall hold regular meetings during the year on a schedule established from time to time by the Board. Annual and regular meetings shall be held on such date and at such place as shall be designated in the notice. Failure to hold an annual meeting or any regular meeting does not invalidate the Corporation's existence or affect any otherwise valid corporate acts.

SECTION 2. Special Meetings. Special meetings may be called at any time by the Chairperson, the President, or by any group of three trustees upon request to the Chairperson.

SECTION 3. Notice. The President (or a designee) shall give notice to each trustee of each annual, regular and special meeting of the Board. The notice shall state the time and place of the meeting. For any meeting of the Board, notice is given to a trustee when it is delivered personally to him or her, left at his or her residence or usual place of business, communicated by telephone, or sent by e-mail or facsimile at least two business days prior to the date of the meeting, or when it is deposited with an overnight courier, at least three business days prior to the date of the meeting, or when it is deposited in the U.S. Mail at least five business days prior to the date of the meeting. The notice for any meeting of the Board need not state the business to be transacted at such meeting. No notice of meeting of the Board need be given to any trustee who attends, or to any trustee who, in writing executed and filed with the records of the meeting either before or after the holding thereof, waives such notice. Any meeting of the Board, annual, regular or special, may adjourn from time to time to reconvene at the same or some other place, and no notice need be given of any such adjourned meeting other than by general announcement.

SECTION 4. Quorum. A majority of the voting members of the Board shall constitute a quorum at all meetings. In the absence of a quorum, the trustees present by majority vote and without notice other than by announcement may adjourn the meeting from time to time until a quorum shall attend. At any such adjourned meeting at which a quorum shall be present, any business may be transacted which might have been transacted at the meeting as originally notified.

SECTION 5. Voting. Unless otherwise specifically provided in these Bylaws, when a quorum is present at any meeting, the vote of a majority of those present and voting shall decide any questions or matter brought before such meeting.

SECTION 6. Minutes. The Secretary shall take, or cause to be taken, minutes of all Board meetings and shall distribute such minutes to the members of the Board prior to the next regular or annual meeting. The minutes shall be available in the principal office of the Corporation.

SECTION 7. Action Without Meeting. Any action required or permitted to be taken at a meeting of the Board may be taken without a meeting, if a unanimous written consent which sets forth the action is signed by each member of the Board and filed with the minutes of proceedings of the Board.

SECTION 8. Meeting by Conference Telephone. Trustees may participate in a meeting by means of a conference telephone or similar communications equipment if all persons participating in the meeting can hear each other at the same time. Participation in a meeting by these means constitutes presence in person at a meeting.

SECTION 9. Attendance at Meetings. In the event that any trustee shall be absent, both excused and unexcused, from three (3) consecutive meetings annually, the Board may, in its discretion, deem such absences to constitute a resignation from the Board by such trustee.

ARTICLE VII

OFFICERS

SECTION 1. Executive and Other Officers. The Corporation shall have a Chairperson, a President, a Vice Chairperson, a Secretary, and a Treasurer who shall be the executive officers of the Corporation. The Board, in conjunction with the Sole Member, shall appoint the Executive Director, who shall serve ex-officio as President, having general supervision of the business and affairs of the Corporation. The individual serving as the Chief Financial Officer of the Sole Member shall serve, ex-officio, as Treasurer of the Corporation. The Corporation may also have one or more Vice Presidents, assistant officers, and subordinate officers as may be established by the Board.

SECTION 2. Multiple Positions. A trustee may not hold more than one office at time.

SECTION 3. Election. No later than the Board meeting prior to the annual meeting, the Board Development Committee shall present to the Board for election as officers a slate of candidates who have consented to such a nomination. Additional nominees may be nominated from the floor provided that the nominator has obtained the candidate's consent to such a nomination. If there are nominations from the floor, election shall be by written ballot. A trustee may cast only one vote per position that is subject to election and, provided that there is a quorum, the highest number of votes of the trustees present and voting in favor of a candidate shall constitute election of that candidate to office. In case of a tie for an officer position, a run-off election will be held between or among those candidates involved in the tie.

SECTION 4. Term of Office. The Board shall appoint the Chairman every three (3) years and all other officers of the Corporation every two (2) years. The Board may from time to time authorize the President to appoint assistant and subordinate officers. All officers shall serve until the expiration of their terms or their earlier removal, resignation, permanent disability or death. The Board may remove any officer at any time. The President may remove and assistant or subordinate officer at any time. The removal of an officer does not prejudice any of such

officer's contract rights under any employment agreement. The Board (or the President, in the case of assistant and subordinate officers) may fill a vacancy which occurs in any office.

SECTION 5. Duties of the Officers. The officers of the Corporation shall possess such powers as are required to perform the functions assigned to them by the Board and shall perform such other duties and have such other powers as may be conferred upon or assigned to them by the Board.

(a) The Chairperson of the Board shall:

1. Preside at all meetings of the Board and of the Executive Committee;

2. Perform such other duties incident to the office of a chairperson, or as directed by the Board;

3. Serve as a voting ex-officio member of all committees except the Nominating Committee;

4. Nominate all committees members and committee chairpersons; and

5. Represent the Board to the public.

6. Act as liaison with hospital and foundation boards. Lead and focus discussion during meeting.

(b) The Vice Chairperson of the Board shall:

1. Support the Chairperson in providing leadership for the Corporation;

2. Perform such specific duties as the Chairperson or the Board may direct; and

3. In the absence of the Chairperson, perform the duties of the Chairperson.

(c) The President shall:

1. Sign and execute, in the name of the Corporation, all authorized deeds, mortgages, bonds, contracts or other instruments, except as otherwise provided;

2. Perform all duties usually performed by a president of a corporation and such other duties as are from time to time assigned by the Board;

3. Serve as the Executive Director of the Corporation;

4. Manage and oversee the day-to-day activities of the Corporation; and

5. Serve as a non-voting ex-officio member of the Board and all committees thereof.

(d) **The Secretary shall:**

1. Send and receive communications relative to the Board's work;

2. Send notices and keep the minutes of all meetings of the Board and the Executive Committee;

3. Conduct the general correspondence of the Board;

4. Maintain official records of Board action; and

5. Perform such other duties incident to the office of a secretary and as may be required by the Board or Chairperson.

(e) The Treasurer shall:

1. Oversee the accurate reporting and maintenance of adequate financial records of all transactions of the Corporation. The Treasurer shall perform all duties usually performed by a treasurer or a corporation, and such other duties as are from time to time assigned by the Board of Trustees;

2. Act as liaison with hospital and foundation boards.

(f) Assistant and Subordinate Officers (below the office of Vice President, Secretary or Treasurer) shall have such duties as are from time to time assigned to them by the Board, the Chairperson, or the President.

SECTION 6. Vacancies. Vacancies in the position of Chairperson will be filled by the following line of succession: the Vice Chairperson, the Secretary and the Treasurer. The Vice Chairperson may permanently fill a vacancy in the office of the Chairperson for the remainder of the Chairperson's term. Any further resort to the line of succession will only be for the reasonable time period necessary to elect a new Chairperson. All vacancies in officer positions except Chairperson will be allowed to stand pending election of a new officer.

SECTION 7. Tenure and Removal. All officers shall serve until the expiration of their terms or their earlier removal, resignation, permanent disability or death. The Board may remove any officer at any time. The removal of an officer does not prejudice any of such officer's contract rights under any employment agreement.

SECTION 8. Compensation. The Sole Member, in consultation with the Executive Committee of the Board shall have the power to fix the salary and other compensation and remuneration of the President.

ARTICLE VIII

COMMITTEES

SECTION 1. Committees in General. Committees advise the Board on issues germane to the committee charge, recommend courses of action to the Board, and serve as a resource of knowledge, expertise, and experience for the President. The Board shall establish those committees which it deems necessary to carry forth the mission and purpose of the Corporation. Committees may be composed of one or more trustees and non-trustees, in each case upon nomination by the Chairperson. All committees must have at least one trustee. A member of the Board shall serve as the chairperson of each committee. Subject to the voting restrictions on non-trustees set forth in this Section 1, the Board may delegate to these committees any of the powers of the Board, except the power to remove trustees pursuant to Article VI, Section 9 and the power to submit proposed amendments to these Bylaws to the Sole Member pursuant to Article XI, Section 2. For any committee that is authorized to act on behalf of the Board, such committee must have at least three trustees and only the votes of trustees may be counted in deciding upon a course of action. All other committee votes and assignments shall be advisory in nature. The Chairperson shall be an ex-officio voting member of all committees except the Nominating Committee. The President shall be an ex-officio non-voting member of all committees.

SECTION 2. Standing Committees. The standing committees of the Board shall include the following committees and such other committees as the Board may authorize at the discretion of Chair and Board:

(a) Executive Committee. The Executive Committee shall consist of the Chairperson of the Board, the Vice Chairperson of the Board, the President of the Corporation in his or her capacity as an ex-officio member of the Board, the Secretary of the Corporation and the Treasurer of the Corporation. The Executive Committee shall assist the Board in overseeing the executive functions of the Corporation and act as a liaison with the sole member. The Executive Committee shall have the authority to act on behalf of the Board between meetings of the Board.

(b) Board Development Committee. The Board Development Committee, shall be Chaired by the Vice Chair of the Board and consist of the President of the Sole Member or his/her designee and at least 3 other Board members. Non board members may also serve on this Committee. The Board Development Committee shall be responsible for the periodic review of the Bylaws and nominating individuals to serve on the Board. The Board Development Committee shall present any recommended slate of trustees to the Board at least 60 days prior to the date of the annual meeting of the Sole Member and shall present the recommended slate to the Sole Member at the annual meeting. It shall be the responsibility of the Board Development Committee to nominate replacements for vacancies in the Board and officers. The committee will also be responsible for mentoring new members and be responsive to the education needs of the board.

SECTION 3. Ad Hoc Committees. The Board may appoint one or more ad hoc committees composed of one or more trustees and non-trustees, in each case upon nomination by the Chairperson, for such specific tasks as circumstances warrant. All ad hoc committees must have at least one trustee. Such ad hoc committees shall limit their activities to the accomplishment of the task for which they are created and appointed, and shall have no power to act except as is

specifically conferred by action of the Board. Upon completing the task for which appointed, such ad hoc committees shall stand discharged.

ARTICLE IX

FINANCE

SECTION 1. Checks, Drafts, Etc. All checks, drafts and orders for the payment of money, notes and other evidences of indebtedness, issued in the name of the Corporation, shall, unless otherwise provided by resolution of the Board of Trustees, be signed by the Sole Member.

SECTION 2. Annual Statement of Affairs. An executive officer, as designated by the Board, shall prepare annually a full and correct statement of the affairs of the Corporation, to include a balance sheet and a financial statement of operations for the preceding fiscal year. The statement of affairs shall be submitted at the annual meetings of the Sole Member and the Board and, within 20 days after such meetings, placed on file at the Corporation's principal office. The President shall prepare or cause to be prepared the annual statement if no other officer is designated by the Board.

SECTION 3. Books and Records. The Corporation shall keep correct and complete books and records of its accounts and transactions and minutes of the proceedings of its Sole Member, its Board and of any executive or other committee when exercising any of the powers of the Board. The books and records of the Corporation may be in written form or in any other form which can be converted within a reasonable time into written form for visual inspection. Minutes shall be recorded in written form but may be maintained in the form of a reproduction. The original or a certified copy of these Bylaws shall be kept at the principal office of the Corporation.

SECTION 4. Budget. The President shall act as a liaison with the Sole Member. Together the President with the AVP of Finance or delegated representative from Carroll Hospital Center and the Board shall be responsible for assisting the Board of Trustees in fulfilling its responsibility to oversee: (i) the preparation of the annual budget for the Corporation and the monitoring of financial performance relative to the budget; (ii) the preparation of updates to capital plans for the Corporation and the monitoring of financial performance relative to any such capital plan; (iii) the preparation of key capital investment and financing recommendations for the Corporation; (iv) the Corporation's asset and liability structure; (v) the management and investment of the investment assets of the Corporation, including operating cash reserves, excess cash reserves, and the endowment fund; and (vi) such other matters identified in its committee charter or as requested by the Board of Trustees from time to time.

SECTION 5. Fiscal Year. The fiscal year of the Corporation shall be from July 1 through June 30 of the following year.

ARTICLE X

NON-PROFIT CHARACTER

No trustee, officer, agent or employee of the Corporation shall at any time receive or be entitled to receive any compensation or any pecuniary profit from the operation of the Corporation or upon its liquidation or dissolution, except for reasonable compensation for services actually rendered to the Corporation.

ARTICLE XI

AMENDMENTS

SECTION 1. Periodic Review. The Bylaws of the Corporation shall be reviewed for appropriateness to current Corporation policies and practices at least once every three years. The review is to be conducted by the Board or a committee of the Board.

SECTION 2. Amendments. Any amendment to these Bylaws must first be proposed and approved by the Board, but no such amendment shall be effective unless and until approved by the Sole Member.

ARTICLE XII

INDEMNIFICATION

The Corporation may, by resolution of the Board, provide for indemnification by the Corporation of any and all of its trustees or officers or former trustees or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit or proceeding, in which they or any of them are made parties, or a party, by reason of having been trustees or officers of the Corporation, except in relation to matters as to which such trustee or officer or former trustee or officer shall be adjudged in such action, suit or proceeding to be liable for negligence or misconduct in the performance of duty and to such matters as shall be settled in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for negligence or misconduct.

ARTICLE XIII

LIQUIDATION OR DISSOLUTION

In the event of the liquidation or dissolution of the Corporation, all financial obligations must be satisfied; any remaining assets shall be distributed at the discretion of the Board in accordance with these Bylaws.

ARTICLE XIV

MISCELLANEOUS

SECTION 1. Maintenance of Tax Exempt Status. The Corporation shall not carry on any activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986 (or the corresponding provisions of any future United States Internal Revenue Law) or (b) by a corporation, contributions to which are deductible under Sections 170(c)(2), 2055(a)(2) and 2522(a)(2) of the Internal Revenue. Code of 1986 (or the corresponding provisions of any future United States Internal Revenue Law).

SECTION 2. Corporate Seal. The Board shall provide a suitable seal, bearing the name of the Corporation, which shall be in the charge of the Secretary. The Board may authorize one or more duplicate seals and provide for the custody thereof. If the Corporation is required to place its corporate seal to a document, it is sufficient to meet the requirement of any law, rule or regulation relating to a corporate seal to place the word "Seal" adjacent to the signature of the person authorized to sign the document on behalf of the Corporation.

SECTION 3. Conflict of Interest. In the event any trustee or officer of the Corporation is or may be an officer, trustee, stockholder, employee, or have a financial interest in a corporation or other organization with which the Corporation shall enter into contract or other transaction, or shall directly or indirectly be a party to or have an interest in any contract or transaction of the Corporation, such person shall fully disclose such interest to the Board. The Board has adopted and shall maintain a specific conflict of interest policy which shall be followed whenever a conflict is found to exist. Subject to compliance with these requirements of disclosure and adherence to the Board's conflict of interest policy then in effect, no contract or other transaction between the Corporation and any other corporation, partnership or individual, shall be affected by the fact that the trustee or officer of the Corporation is interested in or is a trustee or officer of such other corporation, provided that such contract is negotiated on an arm's length basis and is fair and reasonable to the Corporation.

SECTION 4. Membership. In the event that membership in the Corporation is expanded, then all references to Sole Member shall automatically mean the full membership or members, as the case may be.

REVISED AND APPROVED BY RESOLUTION OF THE BOARD OF TRUSTEES AS SOLE MEMBER OF CARROLL HOSPICE, INC.
THIS 26 DAY OF MARCH 2018

EXHIBIT 18

Exhibit 18

Carroll Hospice

Certificate of Need Application: Inpatient Bed Expansion

Data Sources

Population Data

- Maryland Department of Planning, Projections and State Data Center
  "2017 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender (January 2018)"

Hospice Use Rate

- Deaths- Maryland Vital Statistics Annual Report 2016

Data

- Palliative Care information- Carroll Hospital Department of Case Management
- National hospice numbers- National Hospice and Palliative Care Organization,
  "Proposed FY 2017 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements"

  "Facts and Figures- Hospice Care in America-2017 Edition"

Hospice Volumes

- MHCC Public Use Files- Hospice Survey

EXHIBIT 19

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need: Hospice Services filed by Carroll Hospice, Inc. are true and correct to the best of my knowledge, information and belief.

Dated: September, 14 2018

Regina M. Bodnar

Name: Regina M. Bodnar

Title: Executive Director

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need: Hospice Services filed by Carroll Hospice, Inc. are true and correct to the best of my knowledge, information and belief.

Dated: September, 14 2018

Name: Chris Coleman

Title: AVP Finances CBH

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need: Hospice Services filed by Carroll Hospice, Inc. are true and correct to the best of my knowledge, information and belief.

Dated: September, 14 2018

Patrick F. McMahon

Name: Patrick F. McMahon

Title: Manager of Business Development

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need: Hospice Services filed by Carroll Hospice, Inc. are true and correct to the best of my knowledge, information and belief.

Dated: September, 14 2018

Maurice Spielman

Name: Maurice Spielman

Title: Corporate Dir. Design & Construction