APPLICATION FOR CERTIFICATE OF NEED

GENERAL HOSPICE PROGRAM IN BALTIMORE CITY

DECEMBER 9, 2016

SUBMITTED BY:

292 Stoner Avenue, Westminster, MD 21157

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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.)

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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: Marta D. Harting, Counsel, Venable LLP

Mailing Address:

750 E. Pratt Street	Baltimore	21202	MD
Street	City	Zip	State

Telephone: 410-244-7542

E-mail Address (required): mdharting@venable.com

Fax:4102447442

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

Applicant Response:

Carroll Hospice, a Medicare-certified, licensed general hospice program in the State of Maryland and an affiliate of Carroll Hospital, proposes to extend its existing outpatient program to serve adult residents of Baltimore City in response to the need projection published by the Maryland Health Care Commission ("MHCC"). Carroll Hospice intends to deliver outpatient services in the home, assisted living, and post-acute settings. As a member institution of LifeBridge Health System ("LifeBridge Health"), Carroll Hospice will leverage LifeBridge Health's identity and its relationships with the African American community in Baltimore City, particularly through the Faith Health Network, and will utilize culturally competent hospice teams. This will build broader acceptance of hospice care and engage community members in support of hospice services. Carroll Hospice will integrate its hospice expertise with LifeBridge Health's clinical programs, including its chronic disease management programs, its Aging in Place program, and its post-acute delivery system which extends across nursing homes in Baltimore City. Carroll Hospice will build referral relationships and working partnerships with other health systems and with Medicare Advantage plans. The hospice program is expected to empower patients with greater informed decision-making, provide the same compassionate care to patients and families for which it is known, reduce unnecessary hospital utilization and lower the total costs of care.

7. **Project Services (check applicable description):**

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

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: Baltimore City.

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

Applicant Response: This standard is not applicable.

A. Site Size _____ acres

B. Have all necessary State and Local land use approvals, including zoning, for the

project as proposed been obtained? YES_____ NO _____ (If NO, describe below the current status and timetable for receiving necessary approvals.)

_____

_____

_____

_____

_____

C. Site Control and utilities:

(1) Title held by: _____

(2) Options to purchase held by: _____

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

_____

_____

(iii) Cost of Option _____

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

_____

_____

(iii) Cost of Lease _____

(4) Option to lease held by: _____
(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.

_____

_____

(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.

_____

_____

(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 _____months from approval date.
B. Beginning Construction _____months from capital obligation.
C. Pre-Licensure/First Use _____months from capital obligation.
D. Full Utilization _____months from first use.

Applicant Response: This standard is not applicable.

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.

Applicant Response: This standard is not applicable.

12. For projects not involving capital expenditures.

Applicant Response:

Project Implementation Target Dates

A. Obligation or expenditure of 51% Project Budget __3___ months from CON approval date.
B. Pre-Licensure/First Use __6___ months from CON approval.
C. Full Utilization _____36_____ 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 – what the applicant proposes to do
(2) Rationale for the project – the need and/or business case for the proposed project
(3) Cost – the total cost of implementing the proposed project

Applicant Response:

(1) Brief Description of the Project – Carroll Hospice, a Medicare-certified, licensed general hospice program in the State of Maryland and an affiliate of Carroll Hospital, currently serves more than 900 hospice patients in Carroll, Baltimore and Frederick Counties. Carroll Hospice proposes to extend its outpatient program to serve adult residents of Baltimore City in response to the MHCC's published need projection. Carroll Hospice intends to deliver outpatient services in the home, assisted living, and post-acute settings. Carroll Hospice will provide community education and provider training to support advance care planning, encourage use of palliative care and promote use of hospice care, as appropriate. Carroll Hospice will accept hospice referrals from across the City, and expects to draw referrals from area hospitals, families and friends, physicians, Medicare Advantage plans, ACOs, MCOs, community-based organizations and religious groups.

Carroll Hospice has demonstrated superior performance, exceeding regional benchmarks for quality in all 11 dimensions of hospice care and reporting one of the highest county use rates for hospice care in Maryland. As a member institution of LifeBridge Health, which includes Sinai Hospital, Northwest Hospital and Carroll Hospital, as well as Levindale Geriatric Center and Hospital Carroll Hospice recognizes the tremendous opportunity to link its hospice program with LifeBridge Health and build broader acceptance of hospice care through LifeBridge Health's established and positive relationships with the African American community. Carroll Hospice's program will be identified with LifeBridge, and working together they will build community trust and involvement in hospice services through the Faith Health Network and through community-based programs that build relationships early on, during the healthier stages of life. Together, Carroll Hospice and LifeBridge Health will work to recruit culturally competent hospice team members, professionals and volunteers, educate providers, provide physical, emotional and spiritual support to patients and families, and yield reductions in the total costs of care.

Carroll Hospice also recognizes the potential to effectively integrate its hospice expertise with LifeBridge's clinical programs and growing post-acute delivery system. Hospice services, together with palliative care services, will be integrated into the Cancer Institute and chronic disease management programs at LifeBridge. Hospice services will also be linked with the Aging in Place program and the Complex and Chronic Care Improvement Program (CCIP) program to introduce palliative care and hospice care at an earlier stage along the care continuum. Hospice services will be delivered across LifeBridge Health's post-acute service settings, including its nursing homes. Hospice services will be offered in conjunction with PAPP (Post-Acute Physician Partners), a joint venture of LifeBridge Health that provides medical management services to nursing homes in Maryland. Stated simply, LifeBridge Health maintains more points of contact with patients and the community than any independent provider of hospice services can offer, and excels at building patient-provider relationships far earlier than at the end-of-life stage. In addition, Carroll Hospice will deliver education programs through its

physician residency and the 500+ physicians credentialed by LifeBridge to produce lasting change in practice patterns.

Finally, Carroll Hospice intends to serve the broader Baltimore City market through referrals from area hospitals, ACOs, Regional Collaboratives, Medicare Advantage plans and specialized programs through larger commercial insurers. Carroll Hospice's track record of demonstrating a 1% readmission rate and high quality measures will be compelling to hospitals and ACOs aiming to achieve their own performance targets under value-based models.

(2) Rationale for the Project - The MHCC has projected tremendous growth in the number of hospice patients in Baltimore City with the assumption that use rates in Baltimore City will become comparable to national use rates by 2019. Historically, this has been a challenge: Hospice use rates in Baltimore City are markedly low relative to other jurisdictions in Maryland and relative to national use rates. This pattern is understood to reflect a combination of factors including community culture, degree of acceptance of hospice services and service delivery models. At the community level, there has historically been a resistance to hospice care —particularly by the African American community but also subsets of the Jewish community— reflecting cultural mistrust and religious tradition. At the provider level, there continues to be a need for more provider education and a greater focus on building hospice care teams with the cultural competence to earn community respect and acceptance.

While eight (8) hospice providers are currently authorized to serve the Baltimore City population, use rates have remained relatively flat over the past three years. Therefore, the net need to serve 1,233 patients does not simply represent patient slots or manpower resources; **the "net need" is to effectively *reach* and earn the trust of 1,233 patients/families** who historically have not recognized the value of hospice care or been prepared to use existing hospice services, and to introduce the longer-range hospice option to patients earlier on in the care management relationship

In response, Carroll Hospice seeks to:

(1) integrate hospice services into LifeBridge Health's familiar, trusted continuum of care;

(2) build community support and engagement through the Faith Health Network and other community-based programs in the African American community;

(3) deliver culturally responsive home hospice services;

(4) offer education to providers and non-traditional referral sources;

(5) provide community education to demonstrate hospice to as an element of patient empowerment/informed decision-making; and

(6) engage community leadership/community members in the delivery of hospice services.

Carroll Hospice, positioned within LifeBridge Health, can provide the greatest opportunity for expanding hospice services in Baltimore City through its relationships with patients, faith networks, community organizations, physicians, other health systems and payers, as reflected in the following:

- Geographic reach
  - LifeBridge Health's service area incorporates more than 60% of the Baltimore City population, and LifeBridge is investing heavily in population health management activity across this region.
  - LifeBridge Health has established an identity and maintains strong community relationships with both the African American community and the Orthodox Jewish community, communities that have historically demonstrated the greatest reluctance to use hospice. LifeBridge Health will now have the opportunity to introduce outpatient hospice services as part of its affiliated and trusted continuum.

- Post-Acute Network
  - Levindale Hebrew Geriatric Center and Hospital and FutureCare Lochearn (partially owned by LifeBridge Health) together account for more than 600 nursing home admissions per year. Up to 10% of nursing home admissions may be expected to be candidates for hospice care. Levindale also provides adult day services and psychiatric day treatment, program settings that build patient-provider relationships long before end-of-life care requirements develop.
  - Post-Acute Physician Partners (PAPP), a LifeBridge Health joint venture, is a physician network that delivers medical management services to 20 area nursing homes; PAPP physicians emphasize the huge opportunity potential to improve quality of care through increased use of palliative care and hospice services, and are well-positioned to work with nursing home patients/families to facilitate informed decisions making and coordinate referrals.
- Clinical programs and care management models
  - Cancer care - The Lapidus Institute at Sinai Hospital treats more than 700 inpatients per year and is expected to be a major source of hospice referrals.
  - Palliative care – The palliative care program at Sinai Hospital provides more than 100 consults per month to Sinai's inpatient population; up to 30% of patients who receive a palliative care consultation may be expected to transition to hospice care.
  - Disease management programs – A clinic for congestive heart failure patients now operates at Sinai and Northwest Hospitals, serving approximately 200 severely ill patients, and plans are underway to expand disease management programs.
  - Home care services - HomeCare of Maryland, which is part-owned by LifeBridge, served more than 1,100 Baltimore City residents this past year. It will be a base for relationship-building and is anticipated to be a strong referral channel to hospice care.
  - Aging in Place – This program to support elderly patients living at home will be launched once funding is secured, and will be an important, supportive relationship-building initiative.
  - Value to the broader Baltimore City market - Every hospital, ACO, and Medicare Advantage plan in Baltimore City will benefit from a high-quality hospice provider. And, as enrollment grows in Medicare Advantage plans and ACOs for dual eligibles, Carroll Hospice will be particularly well-positioned to serve the City's enrollment. LifeBridge Health, itself, is an owner of the Hopkins Medicare Advantage plan, and LifeBridge

physicians will assume a stronger care management role for Medicare lives aligned with the plan.

(3) ***Costs and operating efficiencies*** - Carroll Hospice intends to serve nearly 500 patients in Baltimore City, or 25% of the outpatient hospice market projected for FY2019. This will include patients aligned with LifeBridge Health services as well as patients from across Baltimore City. The outpatient hospice program for Baltimore City residents will be integrated with Carroll Hospice's existing program permitting shared infrastructure and minimizing incremental costs. The total operating budget to serve the projected 482 Baltimore City patients is $2.5 million.

The MHCC has established expansion of hospice services as a priority, acknowledging the evidence that hospice can improve quality of care and reduce the total costs of care. Carroll Hospice expects its program will empower patients through informed decision-making, reduce avoidable hospital utilization, reduce hospital mortality rates, reduce patient and caregiver dissatisfaction with fragmented care and lower the total costs of care. The effect will be reflected in performance improvement under the Demonstration Model, ACOs, Medicare Advantage contracts, and other alternative payment models. In addition, published performance measures/ratings will improve on reports such as Nursing Home Compare and the upcoming CMS hospice quality reports.

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".

B. 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.

C. 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: This standard is not applicable.

15. FEATURES OF PROJECT CONSTRUCTION:

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.

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

_____

_____

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: This standard is not applicable.

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

Applicant Response: See Application Table 1 (Project Budget).

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.)

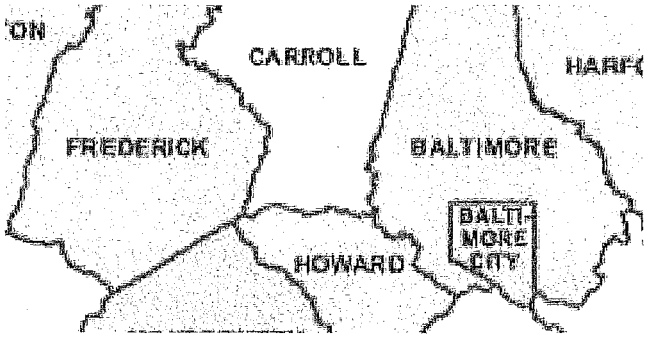
Please provide a direct and concise response explaining the project's consistency with each standard. Some standards require specific documentation (e.g., policies, certifications) which should be included within the application. Copies of the State Health Plan are available on the Commission's web site
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: The service area for this new program is defined to be all of Baltimore City. Carroll Hospice proposes to extend its existing hospice program - - that now serves Carroll County, Baltimore County, and Fredrick County - - to serve Baltimore City. This four-jurisdiction region is depicted in the map below to highlight that the new service area is a contiguous geography which will facilitate the integration of program operations and infrastructure.

Map of Current Service Area and Future Service Area
Carroll Hospice



Source: digital-topo-maps.com

The total population in Baltimore City is currently estimated at 624,000 residents, with the elderly population (age 65+ years) accounting for approximately 76,000 of these residents (see Section 10.24.01.08G(3)(b) Need, Table 5. More than 60% of this population resides in LifeBridge Health's service area.

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

Applicant Response:

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. Carroll Hospice's Admission Criteria are attached as **Exhibit 1**.

C. Minimum Services.

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

(a) Skilled nursing care:

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

(b) Medical social services:

Applicant Response: Initially, Carroll Hospice will provide medical social work services in numbers consistent with the NHPCO guidelines. Staffing

of social workers dedicated to Baltimore City patients and their families will be adjusted according to census and patient need.

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

Applicant Response: Carroll Hospice will provide comprehensive bereavement services through a designated bereavement counselor(s) for Baltimore City. Carroll Hospice will continually assess and adjust 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, will be performed by a qualified individual which may include a registered dietician, a nurse or other individual who are 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 will provide oversight for Baltimore City patients. Providing clinical leadership and guidance, the medical director will ensure every patient's unique medical needs are addressed through the development of individualized care plans. As the volumes build, medical oversight will be expanded proportionally.

(b) Hospice aide and homemaker services:

Applicant Response: Carroll Hospice will staff hospice aides in numbers and ratios consistent with NHPCO guidelines and provide services consistent for the assessed needs of patients.

(c) Spiritual services:

Applicant Response: Carroll Hospice will employ spiritual care providers who serve all faiths in numbers consistent with NHPCO guidelines. Working with the Maryland Health Faith Network we will recruit additional spiritual care providers from the established faith community throughout the city who can best serve our Baltimore City patients and their families.

(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: As a part of LifeBridge Health, Carroll Hospice is able to draw on the established inpatient hospice and respite options for patients at Sinai and Northwest hospitals as well as Levindale Hebrew Geriatric Center and Hospital.

(f) Personal care:

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

(g) Volunteer services:

Applicant Response: Again, Carroll Hospice plans to draw on the strength of LifeBridge Health to recruit volunteers from within our organizations to assist with patients in Baltimore City. Carroll Hospice currently has over 200 volunteers. Additionally, we plan to work with various faith-based organizations in Baltimore to educate community members about varied opportunities to support hospice and the patients and families we are privileged to serve.

(h) Bereavement services:

Applicant Response: As mentioned above, Carroll Hospice will provide comprehensive bereavement services in Baltimore City through a designated bereavement counselor. By drawing from LifeBridge Health, we will provide a robust program to assist families through the grieving process for up to 13 months following a loss. Our bereavement services will include on-on-one counseling, support groups and a unique and varied slate of existing programs offered throughout the health system, including those for veterans, a weekend grief camp for children ages seven to 15 and grief support after a substance abuse loss.

(i) Pharmacy services:

Applicant Response: With the support of Optum, Carroll Hospice's current Pharmacy Benefit Manager, we will provide patients with timely and safe pharmaceutical services utilizing pharmacies located throughout Baltimore City and a mail order option when preferred. This pharmacy partner provides 24/7 pharmacist consultations for optimal patient 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 will ensure patients have access to all palliative care

services consistent with the hospice care plan. Additionally, through LifeBridge Health, as needed, Carroll Hospice will be able to ensure patients receive the services they need to manage their symptoms and control their pain. And because our system has providers and services in and close to Baltimore City, we can fill any gaps in care that may exist for our patients ensuring they are able to obtain that care in the convenient, comfortable settings.

(k) Medical supplies and equipment:

Applicant Response: Through a contractual arrangement with an established, preferred vendor, Carroll Hospice will provide DME and medical 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 will ensure any special therapies included in a patient's plan of care are provided in a timely manner. We will have a contractual arrangement that will ensure we have professionals skilled at compassionately providing care and interventions consistent with patient and family goals and the hospice plan of care.

(3) 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: See response to Standard .05C(2)(h).

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 will deliver care in a combination of residential settings including private homes and 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 plans to draw on the strength of LifeBridge Health to recruit volunteers from within our organizations to assist with patients in Baltimore City. Additionally, we plan to work with various faith-based organizations in Baltimore to educate community members about opportunities to serve patients through hospice.

F. **Caregivers**

Applicant Response: Carroll Hospice will employ and provide professional and non-clinical staffing in ratios consistent with the National Hospice and Palliative Care Organization (NHPCO) guidelines and provide individualized care that meets the assessed needs of the patient and family.

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 prepared the impact analysis below to demonstrate that its new program in Baltimore City will not result in a decline in volume for existing providers; instead, the projected growth in the market will allow existing providers to increase volume even as an additional provider enters the market.

The MHCC's Maryland Hospice Need Projections for Target Year 2019 (as published in the Maryland Register on May 27, 2016) projects a total of 2,756 hospice deaths in Baltimore City in FY2019, an increase of more than 1,322 hospice patients relative to FY2014 volume. On this basis, the MHCC has projected a net need for hospice capacity to serve 1,233 patients.

Based on the MHCC Hospice Survey data and historical Baltimore City hospice utilization, Carroll applied a 70% factor to size the outpatient hospice market in Year 2019:

TABLE 1
Hospice Need Projection: Baltimore City

	2014 Actual	2019 Projected	# Growth	Net Need
# Hospice Deaths	1,433	2,756	+ 1,323	
# Net Need				1,233
Outpatient Estimate 70% of projected volume		1,929		863

Sources:
(1) 2014 Actual: MHCC Hospice Survey
(2) 2019 Projected Hospice Deaths: Federal Register, May 2016
(3) Outpatient Estimate: Carroll Hospice estimate @ 70% of total hospice volume, based on historical utilization

Currently, there are 7 providers delivering outpatient hospice services to Baltimore City residents, with Gilchrist Hospice and Seasons Hospice now serving 82% of the Baltimore City market:

Sources:
(1) 2014 Actual: MHCC Hospice Survey
(2) 2019 Projected Hospice Deaths: Federal Register, May 2016
(3) Outpatient Estimate: Carroll Hospice estimate @ 70% of total hospice volume, based on historical utilization

Table 2
2015 Hospice Market Share
Baltimore City Residents

	Actual FY 2015	
Provider	Hospice Deaths	Current Share
Gilchrist Hospice Care	748	52%
Seasons Hospice & Palliative Care of Maryland, Inc	424	30%
Stella Maris, Inc.	117	8%
Joseph Richey Hospice	84	6%
Heartland Hospice Services, LLC	43	3%
PHR of Baltimore Hospice	10	1%
Amedisys Hospice of Greater Chesapeake	7	0%
Total	1,433	100%

Source: MHCC Hospice Survey, 2015
Note: 8 providers are authorized to provide hospice services; the MHCC Survey documents only 7 providers with patient volume

Assuming that the total number of Year 2019 hospice cases in Baltimore City grows to 2,756 patients (as projected by the MHCC), existing hospice providers should expect to see a growth in overall hospice volume *even as Carroll Hospice enters the market*. This assessment is based on the analysis presented below. In Table 3 below, which presents the estimated impact on patient volume and market share with the entry of Carroll Hospice. The analysis demonstrates that even as Carroll Hospice enters the market, the projected growth in patient volume would permit each existing provider to increase its volume.

Table 3
2019 Projected Hospice Market Share
Baltimore City

	Actual FY 2015		Projected FY 2019		**Growth 2015-2019**
Provider	Hospice Deaths	Current Share	Hospice Deaths	Projected Share	**Incremental Volume**
7 existing hospice providers	1,433	100%	2,274	83%	**+841**
Carroll Hospice (new provider)	-	0%	482	17%	**+482**
Total	1,433	100%	2,756	100%	**+1,323**

Notes:
[1] FY 2015 Actual: MHCC Hospital Survey
[2] FY 2019 Projected Total: Federal Register, May 2016
[3] FY 2019 Projected Carroll volume: Based on 25% share of estimated outpatient volume, assumed to be 70% of total FY2019 volume

As Carroll Hospice expands its existing program to Baltimore City, there is likely to be an initial volume shift from the Seasons program to the Carroll Hospice program (as Seasons currently serves a portion of LifeBridge Health-aligned patients). However, as the market grows annually to the projected 2,756 cases, Seasons and other providers would be expected to regain and backfill this volume.

It is important to emphasize that Carroll Hospice will be investing heavily in patient education and activity with the Faith Health Network *across Baltimore City*. Therefore, all hospice providers serving Baltimore City should benefit from the broader education efforts and broader acceptance of hospice care; all Baltimore City providers would be expected to see volume increases. Indeed, Carroll Hospice's track record in Carroll County - - now showing one of the highest use rates in the State of Maryland - - provides evidence to indicate that volume across Baltimore City can be expected to grow, even beyond the LifeBridge Health referral base. Seasons Hospice and Gilchrist Services should see an increase in the number of patients from all current referral sources in Baltimore City as more patients opt for hospice care and initiate hospice care in the outpatient setting earlier along the care continuum. This will translate into incremental volume for existing providers, consistent with the State of Maryland's projections.

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 and 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 will provide 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 Baltimore City, (b) at least 5 physicians who practice in Baltimore City, (c) the Department of Aging and other senior services located in Baltimore City and (d) the general public in Baltimore City.

Carroll Hospice will communicate this information by publishing the information on its website, via public service announcements and written correspondence to hospitals, providers and agencies in Baltimore City. Additionally, this information will be included in materials disseminated through liaison activity and community education endeavors.

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

Applicant Response: Carroll Hospice will make its fees known to prospective patients and their families before services are begun.

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 will make 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 whether or not 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 any financial coverage, Carroll Hospice will work with each family on a case by case basis. In addition, Carroll Hospice will handle all of the billing of services and supplies as they relate to the terminal diagnosis.

See **Exhibit 2** for Carroll Hospice's complete Financial Assistance Policy and **Exhibit 3** 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. Carroll will add targeted media most likely to reach those in need in Baltimore City to its annual communication schedule. See **Exhibit 4** for Carroll's current advertisement.

(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 5**.

(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: As demonstrated with its current hospice program, Carroll Hospice provides charity care and will offer the same financial assistance programs to its patients in Baltimore City. We have increased provisions for charity care in Baltimore City, projecting that .9% of total revenue will be provided in charity care in that jurisdiction. See Application Table 4. In addition to providing Charity Care, Carroll Hospice also will offer free Medicaid enrollment assistance for patients. With the strong charity care commitment and record of LifeBridge Health in Baltimore City, Carroll Hospice is confident it will achieve its charity care goal through the community outreach and education efforts described in this Application along with the annual publication of its Charity Care notice (see **Exhibit 4)** and targeted media most likely to reach those in need in Baltimore City.

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. All surveys of Carroll Hospice have been deficiency free. Carroll Hospice is in good standing and holds deemed status with the Community Health Accreditation Program (CHAP). We submit 100% of the required Hospice Item Set (HIS) data to CMS and participate in the Hospice CAHPS survey to identify opportunity for improvement within our own program and to 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 lends itself to 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 6),** details the objectives, goals and performance measures that will guide our quality improvement work in fiscal year 2017.

(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 6** 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 and a solid foundation for excellence. Monthly direct supervisory visit expectations for each program leader provide regular opportunity to identify best practices, opportunities for improvement and acknowledge high performing team members.

Currently, through Deyta Analytics, Carroll Hospice participates in the Hospice CAHPS quality measures as required by CMS. In FY16 (July 2015 – June 2016) Carroll Hospice met or exceed the national benchmark in all 11 domains that includes global measures for, Rating of Patient Care; Recommending This Hospice; Support for Religious and Spiritual Beliefs; Information Continuity, Understanding Side Effects of Pain Medications; Hospice Team Communications; Getting Timely Care; Treating Family Members with Respect; Providing Emotional Support; Getting Help with Symptoms and Getting Hospice Care Training. See **Exhibit 7.**

In April of 2016, Carroll Hospice was awarded the 2016 Hospice Honors Award (based on 2015 data) by Deyta for exceeding the national benchmarks on 20 out of 24 quality indicators on the survey. 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 35% growth in its admissions (going from 676 to 910) between 2014 and 2016 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 Baltimore City.

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 will provide inpatient hospice care through contractual relationships with existing Baltimore City hospice providers and skilled nursing facilities. For LifeBridge Health patients, in particular, Carroll Hospice will be able to rely on the Seasons Program at Sinai and Northwest Hospitals to support the continuum of care and quality service.

(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: Prior to being authorized to serve Baltimore City residents, Carroll Hospice will document for the Commission its links to other 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 the City of Baltimore.

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 anticipates the majority of Baltimore City patients requiring or requesting respite care to be served at Levindale, also a component of LifeBridge Health. Additionally, FutureCare Lochearn as well as inpatient hospice settings at Sinai and Northwest Hospitals would be available options for the respite level of care.

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: The Carroll Hospice educational initiative has been fully budgeted for, is multi-pronged and includes, but is not limited to, providers,

facility partners, patients, families and communities. All education is rooted in respect for the individual and is personalized to meet specific needs of the patient and his or her family. The platform for education will be 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.

We also plan to use A.P.P.E.A.L. (A Progressive Palliative Care Educational Curriculum for the Care of African Americans at Life's End), to help educate healthcare professionals with essential clinical competencies and practical skills needed to provide culturally appropriate palliative and quality end of life services to African American patients and their families. A hospice rotation within the LifeBridge Health residency program also is highly anticipated and expected to help guide care planning earlier in the patient care experience.

Provider education will be conducted in cooperation with palliative care colleagues across LifeBridge Health entities as well as with other healthcare facilities throughout Baltimore City. Carroll Hospice has specialized teams of hospice professionals that work within facilities (assisted livings and skilled nursing facilities) and plans to apply the same model throughout Baltimore City. These team members value the relationships inherent to doing this work well and grasp both formal and informal opportunities to educate facility colleagues across disciplines

Working closely with hospitalist programs and private physician offices within Baltimore City are priorities for Carroll Hospice, as is building upon existing relationships with clinicians who manage care in assisted livings and skilled nursing facilities. By developing strong, trusting relationships with all providers, including nurses, case managers, physician liaisons and care navigators we plan to provide the support and guidance required to transition patients to palliative or hospice care. The important and expanding role of the nurse practitioner in facility care is heartily appreciated by Carroll Hospice. Education and support of these nursing colleagues through Hospice and Palliative Care Network conference and webinar offerings are made available to promote earlier patient identification, optimal patient management and care consistent with identified patient wishes.

Carroll Hospice presently has robust partnerships with numerous facility partners and plans to continue that type of relationship building with new facilities in Baltimore City. As is current practice, for new facilities, we plan to provide initial education and include a hospice in-service as part of every new hire orientation. By offering a variety of educational opportunities for staff, we have experienced a great deal of success in helping providers gain a better understanding of palliative and hospice care. As a result, patients and families are able to benefit from the support Carroll Hospice can provide. Courses are ongoing, designed to meet the unique needs of each facility and cover topics including the basics of hospice, advanced care planning, and symptom management strategies among others. By collaborating with practitioners in these facilities—many of whom never made the conscious choice to work in end of life care— Carroll Hospice

has been extremely successful at developing the relationships essential to ensuring a collective approach to developing care plans that provides patients with the most appropriate care, in the most appropriate setting.

Within facility settings, regular educational offerings to family members and resident councils are, 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 for care and the value added for the patient as well as those that love him or her and the legalities of advanced care planning, are all offered so that patients can advocate for themselves and designated decision makers can advocate for those they love who can no longer communicate on their own behalf.

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

To promote a higher level of acceptance for palliative and hospice care, Carroll Hospice plans to seek the assistance of non-traditional referral sources and respected community voices. Initially, working with the faith communities participating in the LifeBridge Health Faith Health Network, Carroll Hospice will provide community-based forums on end of life care training and care options. The ability to touch with determination the African American and other underserved populations, will be greatly enhanced by the support of our present faith community leaders. Carroll Hospice will embrace the opportunity to identify champions within each faith community to relate their personal stories, highlight their experiences sensitive to cultural preferences and speak to the depth of the care experience both prior to and after the death of a patient. By drawing on those deeply rooted in faith communities, we anticipate being able to identify barriers enabling us to address fears and misconceptions about hospice care.

Carroll Hospice also will become active in the Greater-Baltimore City community by collaborating on community-based health fair opportunities, working with the Baltimore City Department of Aging and the Baltimore City Health Department on programs that promote a better understanding of hospice services, and introducing Carroll Hospice services to Baltimore City residents.

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 in 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 8** 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;
(b) The source of inpatient hospice care currently used by the patients identified in subsection (1) (a); and
(c) The projected average length of stay for the hospice inpatients identified in subsection (1) (a).

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.

(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

(b) 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: This standard is not applicable.

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:

Carroll Hospice proposes to expand its current comprehensive hospice program to provide outpatient hospice services to Baltimore City, a jurisdiction that is contiguous to its current 3-county service area.

The MHCC's Maryland Hospice Need Projections for Target Year 2019 (as published in the Maryland Register on May 27, 2016) defines a net capacity need for 1,233 patients in Baltimore City by Year 2019. The MHCC projects hospice volume in Baltimore City to grow from 1,434 patients (Year 2014) to 2,756 patients (Year 2019), an increase 1,332 hospice patients during this period. Based on this analysis, the MHCC defined a net need for additional hospice capacity to serve 1,233 hospice patients by FY2019. Carroll Hospice adopted this projection to define unmet need in Baltimore City and to serve as the basis for sizing its program.

Carroll Hospice's response to this standard is organized below as follows:

1. The Underutilization of Hospice Services in Baltimore City and in the African-American Community in Particular.
2. The Expected Growth in Demand for Hospice Services as a Function of Care Delivery Models
3. Projected Growth in the Elderly Population in Baltimore City
4. Carroll Hospice Strategies for Meeting the Unmet Need in Baltimore City
5. Carroll Hospice Volume Projections

Data sources and technical notes accompanying the volume projections are found in **Exhibit 9** Data Sources and Technical Notes.

1. The Underutilization of Hospice Services in Baltimore City and in the African-American Community in Particular

Relative to other counties in the State of Maryland, hospice utilization in Baltimore City has remained markedly low, and FY2015 patient volume from Baltimore City residents was flat, as reflected in the following data:

County Use Rates for Hospice Care
Based on State Health Plan Methodology
2012-2014

County	Measure	2013	2014	2015
Allegany	# Hospice Deaths	163	195	174
	Hospice Use Rate	0.18	0.22	
Anne Arundel	# Hospice Deaths	1,996	1,926	1,707
	Hospice Use Rate	0.51	0.49	
Baltimore City	**# Hospice Deaths**	**1,848**	**1,434**	**1,433**
	Hospice Use Rate	**0.31**	**0.25**	
Baltimore County	# Hospice Deaths	4,024	4,321	4,554
	Hospice Use Rate	0.54	0.56	
Calvert	# Hospice Deaths	226	223	254
	Hospice Use Rate	0.37	0.37	
Caroline	# Hospice Deaths	66	89	92
	Hospice Use Rate	0.22	0.27	
Carroll	# Hospice Deaths	753	730	802
	Hospice Use Rate	0.52	0.50	
Cecil	# Hospice Deaths	395	379	367
	Hospice Use Rate	0.46	0.46	
Charles	# Hospice Deaths	287	265	268
	Hospice Use Rate	0.33	0.29	
Dorchester	# Hospice Deaths	77	75	82
	Hospice Use Rate	0.22	0.20	
Frederick	# Hospice Deaths	738	735	886
	Hospice Use Rate	0.47	0.46	
Garrett	# Hospice Deaths	75	63	73
	Hospice Use Rate	0.25	0.23	
Harford	# Hospice Deaths	850	966	991
	Hospice Use Rate	0.47	0.51	
Howard	# Hospice Deaths	730	766	789
	Hospice Use Rate	0.49	0.49	
Kent	# Hospice Deaths	81	111	65
	Hospice Use Rate	0.34	0.46	
Montgomery	# Hospice Deaths	2613	2601	2,836
	Hospice Use Rate	0.47	0.47	
Pr George's	# Hospice Deaths	1288	1430	1,400
	Hospice Use Rate	0.26	0.28	
Queen Anne's	# Hospice Deaths	151	200	173
	Hospice Use Rate	0.40	0.49	
Somerset	# Hospice Deaths	81	66	88
	Hospice Use Rate	0.32	0.25	
St. Mary's	# Hospice Deaths	310	338	316
	Hospice Use Rate	0.41	0.47	
Talbot	# Hospice Deaths	195	167	82
	Hospice Use Rate	0.46	0.37	
Washington	# Hospice Deaths	725	817	800
	Hospice Use Rate	0.48	0.57	
Wicomico	# Hospice Deaths	403	422	412
	Hospice Use Rate	0.45	0.46	
Worcester	# Hospice Deaths	246	235	296
	Hospice Use Rate	0.42	0.40	
Total, State of MD	# Hospice Deaths	18,321	18,554	18,940
	Hospice Use Rate	0.42	0.43	

Note: Hospice Use Rates = # Total Hospice Deaths / Deaths Age 35+ years

Sources: (1) Hospice Use Rates, 2012-2014: Maryland Health Care Commission
(2) Deaths, Age 35+, 2014: Maryland Vital Statistics Administration (2015 unavailable)
(3) Hospice Deaths, 2014-2015: MHCC Hospice Survey

The need for hospice care in Baltimore City was underscored in an analysis prepared by the MHCC that indicates an underutilization of hospice services by the African American population, as reflected in the following data:

Hospice Admissions: African Americans, as Percentage of Population, Age 35+
2014-2015

	African Americans: % of Deaths		African Americans: % of Deaths	
County	2014 % Hospice Admissions	2014 % of Population Deaths, Age 35+	2015 % Hospice Deaths	2015 % of Population Deaths
Baltimore City	57%	68%	55%	N/A
Prince Georges	60%	67%	60%	N/A
Charles	28%	32%	26%	N/A
Somerset	26%	25%	14%	N/A
Dorchester	14%	25%	21%	N/A
Wicomico	14%	20%	15%	N/A
Howard	12%	20%	16%	N/A
Baltimore	22%	17%	22%	N/A
Kent	12%	17%	9%	N/A
Montgomery	14%	16%	13%	N/A
St. Marys	13%	15%	14%	N/A
Calvert	11%	14%	10%	N/A
Worcester	11%	14%	11%	N/A
Talbot	7%	13%	6%	N/A
Anne Arundel	15%	13%	15%	N/A
Queen Annes	7%	12%	8%	N/A
Caroline	6%	12%	13%	N/A
Harford	7%	8%	7%	N/A
Frederick	5%	7%	5%	N/A
Cecil	5%	5%	5%	N/A
Washington	3%	4%	3%	N/A
Carroll	3%	2%	2%	N/A
Allegany	3%	1%	0%	N/A
Garrett	0%	0%	1%	N/A
Total, State of MD	**21%**	**27%**	**21%**	

Sources:

(1) Deaths, by Race and by Age Cohort: Maryland Administration of Vital Statistics

(2) Hospice admissions by race: MHCC Hospice Survey (number of deaths, by race, not available

Discussions with hospice providers, long-term care professionals, physicians, and case managers confirm that hospice could be utilized more valuably to improve care. Two major barriers are cited:

(a) Cultural and religious traditions that discourage hospice utilization – Health care professionals cite deep-rooted barriers that exist particularly among the African American community. The barriers include mistrust of hospice referrals, community culture, and possibly weaker home supports to permit home hospice arrangements. These barriers are consistent with patterns reported across the country; the literature on hospice care confirms that the disparities in hospice utilization for African American groups is significant across the nation, and that efforts to overcome these barriers require working relationships with community groups, cultural competent hospice teams, and responsiveness to religious traditions/cultural preferences.

(b) Need for provider education – Health care professionals emphasize that hospice care is not introduced early enough in chronic disease management to be most valuable to patients in Baltimore City, and that the need for greater provider education is critical to promoting effective use of hospice.

2. Expected Growth in Demand for Hospice Services as a Function of Care Delivery Models and Industry Dynamics

At the same time as these barriers are overcome, Carroll Hospice believes that hospice volume in Baltimore City will be further fueled by new care management models and a number of factors particularly relevant to the Maryland health care environment. These dynamics are described below.

(a) The growth of palliative care services is expected to increase the demand for hospice services

Clinicians anticipate major growth in the use of palliative care over the coming years, accompanied by a growth in hospice referrals. Clinicians project that 30% of patients who receive palliative care transition to hospice care. The growth in demand for palliative care is illustrated by the figures below, documenting the growth in the number of monthly palliative care consults for inpatients at Sinai Hospital and Northwest Hospitals. These figures represent only 2 of the 17 hospitals in Baltimore City, and only reflect inpatient demand for palliative care; clearly, the growth of palliative care extends across Baltimore City providers and across levels of care.

Table 4
Sinai Hospital and Northwest Hospital
Number of inpatient consults for palliative care

	FY 2015 Nov - June	FY 2016	FY 2017 Jul - Oct
# of Palliative Care Consults	225	596	301
# of Consults per Month	28	50	75
% Increase		78.6%	50.0%

Source: Sinai Hospital, Dept of Case Management (Oct 2016)

(b) Industry dynamics in Maryland will function to increase the demand for hospice care

The dynamics in Maryland that are expected to increase demand include the following:

- Total cost of care model – As Maryland advances to the next phase of the Demonstration Model, successful performance on the waiver test will depend on controlling the total costs of care. The demand for alternative service settings that can reduce spending (including post-acute spending) will become even more critical, and hospice services may play an increasingly valuable role by reducing hospital readmissions and mortality rates, reducing the costs per capita and improving quality of care. As ACOs and health systems formalize service networks and operationalize risk-sharing/incentive models across levels of care, hospice providers may be formally positioned within post-acute networks that take shape.

- Increased enrollment in Medicare ACOs - Enrollment is expected to increase considerably in Maryland, and the incentives for physicians to control spending and utilize the lowest cost setting will be stronger; hospice may function to support these goals.

- Coordinated care models and capitation for dual eligibles – Maryland expects to introduce ACO-like models for dual eligibles in Maryland, accompanied by greater care coordination and incentives to control the costs of care. This may lead to increased utilization of hospice services consistent with Medicare utilization patterns. Indeed, two MCO professionals interviewed confirmed that enrollment of dual eligibles is likely to generate increased demand for hospice services. Therefore, a high quality hospice provider in Baltimore City - -with home-based services, a low readmission rate and solid relationships with physicians - - may serve a valuable role as a "preferred provider" in the continuum of care.

- Medicare Choices – The new model, presently in demonstration, was introduced by CMS to allow patients to continue receiving some level of treatment as a hospice patient. It is expected to increase utilization of hospice services as patients become more comfortable opting for hospice under these more flexible terms.

- Public release of hospice performance data – CMS expects to make public the performance results from the Hospice Item Set (HIS) and Hospice CAHPS which will allow care

professionals and consumers to review cost and quality measures for individual hospice providers. If consumer satisfaction and quality of care ratings are high, one would expect that this consumer information will contribute to growing utilization of hospice services.

(c) Patient relationships and referral channels

Carroll Hospice expects to grow hospice volume at LifeBridge Health-affiliated institutions by integrating with the many levels of care at LifeBridge Health and by introducing palliative care and hospice services to patients earlier on in the course of care. The opportunity potential to grow hospice volume within the LifeBridge delivery system is substantial; specific program sites and referral channels are identified below.

3. Projected Growth in the Elderly Population in Baltimore City

Growth in hospice utilization in Baltimore City is also expected to result from the projected growth in the elderly population. The total population in Baltimore City, by age cohort, is presented below to highlight the projected growth of the elderly population. Between 2014 and 2020, the elderly population (age 65+ years) is projected to grow by 6%; by the Year 2020, there is projected to be nearly 5,000 additional residents over the age of 65 years old in Baltimore City.

Table 5
Population Growth Estimates and Projections: 2014 – 2020
Baltimore City

	2014	2015	2016	2017	2018	2019	2020
0-34	315,124	313,453	314,893	316,339	317,792	319,252	320,718
35-64	232,084	230,477	230,799	231,121	231,443	231,766	232,090
65-84	66,156	67,566	68,349	69,141	69,942	70,753	71,573
85+	10,347	10,353	10,221	10,091	9,963	9,836	9,711
Total	**623,711**	**621,849**	**624,262**	**626,692**	**629,141**	**631,607**	**634,092**
Total Growth YOY		*-0.30%*	*0.39%*	*0.39%*	*0.39%*	*0.39%*	*0.39%*
65+ Growth YOY		*1.85%*	*0.84%*	*0.84%*	*0.85%*	*0.86%*	*0.86%*
2014 - 2020 Total 65+ Growth							*6.25%*

Notes:
[1] Data retrieved from Maryland Department of Planning

4. Carroll Hospice's Strategies for Meeting the Unmet Need in Baltimore City

A successful hospice care provider in Baltimore City will need to:

- Build the care management relationships and earn the trust of patients before the very end-of-life stage, particularly in the minority and religious communities of Baltimore City;
- Engage community leaders to build greater acceptance of hospice;
- Educate/train providers and community health workers to introduce advance care planning and hospice care as part of chronic disease management programs; and
- Demonstrate high quality performance to earn a preferred position with payers and Regional Collaboratives.

As a LifeBridge Health program and one that is introduced through clinical programs, social services and interfaith work, Carroll Hospice's outpatient hospice program will earn the trust of community members and providers. Carroll Hospice's expertise and its readiness to support successful performance in Baltimore City is described below.

(a) Carroll Hospice's track record of successful strategies and high quality performance

Carroll Hospice provides comprehensive and compassionate hospice care to patients in their own homes, in health care settings such as nursing homes, and in Carroll's independent hospice facility (Dove House). Carroll Hospice has demonstrated an impressive track record for educating the community, promoting hospice use, building program volume, and maintaining high quality services. Performance reports are included in **Exhibit 7.** Key indicators presented below to highlight Carroll's outstanding performance:

(i) County Use Rates – In FY2013-14, Carroll County reported one of the highest county use rates in the State of Maryland. The significant volume growth in FY2015 strongly suggests that the use rate has increased further. In Carroll County, this growth may be largely attributable to the reputation and successful strategies of Carroll Hospice.

(ii) Program growth – Carroll reports a 41% growth in patient volume in the past three years, as measured by the number of unduplicated admissions. **Notably, volume growth reflects growth in each of the three jurisdictions served by Carroll Hospice.**

Table 6

Carroll Hospice: Existing Three-Jurisdiction Program
Unduplicated Admissions
FY2014-2017, Projected

	FY '13 thru Projected FY '17				
	FY '13	FY '14	FY '15	FY '16	FY '17 (Proj)
Service					
Home/Nursing Facility Based	440	417	570	622	695
Inpatient (Dove House)	260	259	252	288	260
Total Admissions (Undup)	**700**	**676**	**822**	**910**	**955**
County					
Carroll	596	572	695	745	782
Frederick	62	55	80	110	115
Baltimore	28	34	33	45	47
All Other	14	15	14	10	10
Total Admissions (Undup)	**700**	**676**	**822**	**910**	**955**

Source: Carroll Hospice Program, Oct 2016

(iii) Dove House – Dually licensed as a General Inpatient unit and a Hospice House, our inpatient facility is truly a home away from home. Since opening its doors to those who are experiencing symptoms and need a higher level of hospice care in 2007, our eight-bed, inpatient facility offers a warm and supportive environment for patients and those that love them. Staffed with an expert team of interdisciplinary professionals and volunteers, we consider it a privilege to care for our community and remain committed to highly personalized and individualized care.

(iv) Palliative care –Since 2008, Carroll Hospice has enjoyed a strong alignment with the palliative care professionals at Carroll Hospital. Early in 2016, palliative services were expanded to address the gaps in care within the community. This newest addition to the care continuum allows greater flexibility for the patient, and family to transition across care setting and programs and to receive the right care at the right time. Work to facilitate alignment with our colleagues at Sinai and Northwest Hospitals is already underway

(v) Responsiveness- Carroll Hospice considers every referral a call for our skills in pain and symptom management and our expertise in courageous conversations. We pride ourselves on responding within 24 hours of every call and most often within the same day. This level of commitment is shared by all team members and inherent to our work 24 hours per day each day of the year.

(vi) Tenure of hospice employees - The tenure and low turnover of hospice employees at Carroll Hospice attests to employee dedication and the high quality program leadership. Carroll's Hospice program is also supported by over 200 hospice volunteers who

dedicate their time and talent. In FY16, Carroll Hospice volunteers provided the equivalent of 12.6% of the total patient care hours of all paid hospice employees. This is well in excess of the 5% required by the CMS Hospice Conditions of Participation.

(vii) Quality indicators – Carroll Hospice has exceeded all regional benchmarks and has met or exceeded all national benchmarks in each of the 11 domains of the Hospice CAHPS for FY2016. See response to Standard 05(K).

(viii) Philanthropy - Carroll Hospice has enjoyed a 30-year history of community support. In fact, the Dove House General Inpatient Facility was funded 100% by private donations. Since that time an average of $750,000 - $1,000,000 is gifted each year.

(b) Carroll Hospice's opportunity potential to effectively reach and build positive relationships before the end-of-life stage

With this track record, Carroll Hospice is strongly positioned to reach, educate, engage and empower large numbers of the Baltimore community by identifying Carroll Hospice with LifeBridge Health, linking with its interfaith community work, leveraging LifeBridge Health's post-acute resources, and integrating the hospice program with chronic disease management programs and post-acute services. Carroll's hospice services will also be introduced to the community through LifeBridge Health's broader initiatives for population health management which builds positive relationships before sickness occurs through health education, wellness programs, visits by community health workers, housing support services, and volunteer programs.

LifeBridge Health will provide Carroll Hospice with broad geographic reach, a broad continuum of care, and deep, positive relationships with the local community upon which to build acceptance of hospice care:

- Geographic reach and market presence:
  - LifeBridge Health's service area incorporates more than 60% of the Baltimore City population, and LifeBridge Health is investing heavily in population health management activity across this region to continue building community relationships.
  - LifeBridge Health captures 54% of the age 65+ inpatient market in the Baltimore City communities of its Primary Service Area, and captures 15% market share in Baltimore City, overall. See **Exhibit 10.**
- Existing relationships with minority communities / religious communities:
  - *Patient base and market identity* – More than 60% of the discharges at Sinai and Northwest Hospital are African American patients. Historically, this has been the community that has demonstrated great reluctance to utilize hospice. By being linked to LifeBridge, Carroll Hospice, will be well-positioned to earn the trust of these communities; Carroll Hospice will have the opportunity to build trust and acceptance by identifying its hospice services with a familiar and trusted provider.

- *Orthodox Jewish community* - LifeBridge also maintains very positive community relationships with the Orthodox Jewish community, another community that has traditionally been reluctant to utilize hospice services. Sinai Hospital is closely identified by the Jewish community as particularly responsive to Jewish traditions. By way of illustration:

    - *Sinai Jewish Care Program* (hospice) - LifeBridge Health collaborated with leadership of the Jewish community to develop the "Sinai Jewish Care Program" as part of its inpatient hospice program so that end-of-life care was sensitive and responsive to Jewish religious practices. This effort translated into support for funeral planning and bereavement, and education to hospice unit team members around cultural traditions.

- Engaging religious leaderships and community members across communities

    - *Maryland Health Faith Network* - LifeBridge Health has established formal partnerships with 60 congregations/ministries and their congregants as part of the Maryland Faith Health Network, an important initiative that makes authentic the partnership between LifeBridge Health hospitals and local communities. In Baltimore City, the Network includes five large partner congregations representing more than 8,000 congregants/families. Currently, activity is focused on coordinating volunteer support services to patients who are hospitalized. Worshippers who enroll in the Network are issued a Network ID card and, in the event of a hospitalization, the card alerts a hospital navigator to notify the patient's faith liaison, a volunteer from the patient's congregation who is specially trained. The liaison from the congregation helps coordinate volunteer efforts with other congregation members who may provide assistance with transportation, prescription delivery, and meals and/or coordinate pastoral support. This represents only one activity than has been formalized through the Faith Health Network; the working relationship is ongoing, as LifeBridge and faith-based community groups continue to identify ways to jointly respond to community needs, continue to engage faith leadership, and deliver culturally-sensitive services.

(c) Patient relationships and referral channels

Carroll Hospice expects to grow volume at LifeBridge Health-affiliated institutions by integrating with the many levels of care at LifeBridge Health to introduce palliative care and hospice services to patients early on in the course of care. The opportunity potential to grow hospice volume within the LifeBridge Health delivery system is substantial; specific program sites and referral channels are identified below.

More broadly, Carroll Hospice will work across the City - - with providers, families, community

organizations and religious groups - - to effectively educate, build relationships, earn the trust and demonstrate the value of hospice care. Several Baltimore City hospitals refer to the "huge opportunity" to provide palliative care and hospice services to many more Baltimore City residents if hospice were discussed earlier with patients and understood as a care transition. Specific strategies and outreach activities are also described below.

(i) *Referral channels aligned with LifeBridge Health programs*

- Post-acute delivery system:
  - Levindale Hebrew Geriatric Center and Hospital and FutureCare, Lochearn together account for more than 600 nursing home admissions per year. Up to 10% of nursing home admissions are expected to be candidates for hospice care. Levindale also provides adult day services and psychiatric day treatment - - program settings that build patient-provider relationships long before end-of-life care requirements develop
  - Post-Acute Physician Partners (PAPP), a LifeBridge joint venture, PAPP is a network of 13 physicians and 13 midlevels that delivers care transition services to home-bound patients and provides medical management services to 20 nursing homes in Maryland, with plans to grow this activity to many more Maryland nursing homes. PAPP physicians will extend palliative care and hospice serves as appropriate to the patient base served in the facilities where PAPP physicians serve as medical managers. A review of hospice volumes at selected nursing homes in Baltimore City - - nursing homes with which LifeBridge has established working partnerships - - has suggested that there is substantial opportunity to increase volume and improve quality of care to patients through hospice services.
- Nursing home collaborative
  - LifeBridge Health leads an informal collaborative of area nursing homes to which it refers the majority of its patients. This collaborative is focused intently on quality of care measures that include readmission rates, use of palliative care, and use of hospice services; this activity is expected to further promote referrals to hospice care.
- Cancer care
  - The Lapidus Institute at Sinai Hospital treats more than 700 inpatients per year and is expected to be a considerable source of hospice referrals.
- Palliative care services
  - LifeBridge Health provides palliative care services to patients at each of its hospitals, and the most recent report from Sinai Hospital documents more than 100 inpatient consults per month for palliative care. The growth in palliative care is expected to be accompanied by a growth in hospice

utilization; industry benchmarks suggest that up to 30% of patients on palliative care may be expected to transition to hospice care. As discussed earlier, efforts are already underway to foster alignment between these services and Carroll Hospice.

- Disease management programs and senior care programs
    - LifeBridge Health operates a congestive heart failure clinic and expects to develop additional disease management programs in the coming year. These programs are supported by evidence-based protocols which can effectively incorporate protocols/guidelines for use of palliative care and hospice care at advanced stages of disease. These programs will provide an immense opportunity to introduce patient/family education and training, palliative care and advance care planning. The strong focus on self-management and empowerment will continue naturally to promote informed decision making and the election of hospice care.

- Aging in Place program
    - This program will incorporate an array of services including House Call services, Neighborhood Navigators, fall prevention and bedside visits. Fundamentally, it will promote relationship-building and provide care coordination, and may provide the platform for discussion of a comfort-oriented approach to care and of hospice services at a later stage.

- HomeCare
    - LifeBridge Health is part owner of HomeCare Maryland which served more than 1,100 Baltimore City residents this past year. Carroll Hospice is positioned to provide advance care planning and support to deliver seamless transitions to hospice services for patients from across the City through this agency.

- Physician referral base
    - LifeBridge Health represents a physician community of more than 700 employed providers, 137 residents, and several hundred additional providers credentialed throughout the health system. Additionally, more than 500 of our credentialed physicians have primary offices in Baltimore City. This provides a huge continuing education platform on the topics of patient decision-making/empowerment, advance care planning, palliative care, hospice care, and the cultural expectations of communities in Baltimore City.
    - Sinai Hospital expects to introduce a resident rotation in palliative care. This initiative is a critical component in achieving lasting change in practice patterns for end-of-life care.

Finally, post-acute services are a major business line for LifeBridge Health, and LifeBridge Health will continue to invest in this arena. Operating under Maryland's Demonstration Model, LifeBridge Health has particularly strong incentives to continue investing in this arena. This point is emphasized to contrast with private, for-profit companies that do not operate with this

incentive and historically have not invested in non-billable services to the same degree. Post-acute services will be one area for ongoing investment by LifeBridge Health to improve quality of care, lower readmission rates and reduce the total costs of care.

(ii) *Referral Channels: The broader Baltimore City market*

- Post-acute facilities – As noted above, PAPP physicians expect to expand their medical management services to additional nursing homes in Baltimore City, which will broaden the referral base for Carroll Hospice.

- Baltimore City hospitals – Case managers at St. Agnes Hospital and Bon Secours Hospital report that there is a considerable opportunity potential to deliver hospice services to a larger population; these individuals call for greater physician education and earlier introduction of palliative care and hospice services in patient-provider discussions. Carroll will work closely with these two hospitals and expects to increase hospice referral volume from these facilities.

- University of Maryland Medical System (UMMS) – Carroll Hospice has met with the leadership of post-acute services at UMMS, and this group has expressed interest in Carroll's proposed program.

- The Veterans Administration (VA) - The VA has enhanced the end of life services offered to those who have served our country. Carroll Hospice is a respected partner with the VA in this initiative and enjoys a long-standing collaborative relationship with the Baltimore VA Hospice Coordinator. Carroll Hospice is a proud Level 3 partner in the We Honor Veterans program, a joint initiative between the Veterans Administration and the National Hospice and Palliative Care Organization.

- Medicaid MCOs/ACOs for Dual Eligibles – While Medicaid referrals currently represent only 2% of hospice referrals in Maryland, the enrollment of dual eligibles in Maryland is likely to translate into additional hospice volume. Carroll Hospice hopes to establish itself as a recognized, high quality provider of hospice care for Medicaid networks.

(iii) *Program strategies to encourage hospice utilization*

Physician education – Case managers in Baltimore City hospitals identify physician education as a priority need to promote hospice utilization. In its current service area, Carroll Hospice is committed to providing physician education at facilities and will utilize identical strategies across Baltimore City.

- Hospital-based hospice nurse liaisons, are key to successful discharge planning for those approaching end of life. Colleagues in the acute care setting possess not the time nor the expertise to guide patients and families through the multitude of decisions and choices facing the seriously ill. The presence of liaison staff, working in conjunction with palliative care staff when available, serves to educate and role model for colleagues, as well as provide a confidence that the transition in care is being done thoroughly and seamlessly. Most importantly, nursing liaisons are able to help patients and families envision hospice care in their home or

residence of choice; service options available to them, the commitment of professionals and volunteers to physical, emotional and spiritual comfort and a full, understanding of the financial obligations that may accompany this care choice.

- Community health workers – Community health workers across disciplines and skill levels are increasingly being used to provide navigation and home-based support services. Carroll Hospice, consistent with the experience in our present service area, is prepared to equip community health workers with the information/guidance required to respond to patient/family inquiries about community based palliative care choices and hospice services.

- Family support/bereavement – Carroll Hospice has a rich history of providing support groups, grief education, celebrations of life etc. which are made available to families of those we have been privileged to serve, community members who have experienced a loss, as well as, facility based care colleagues

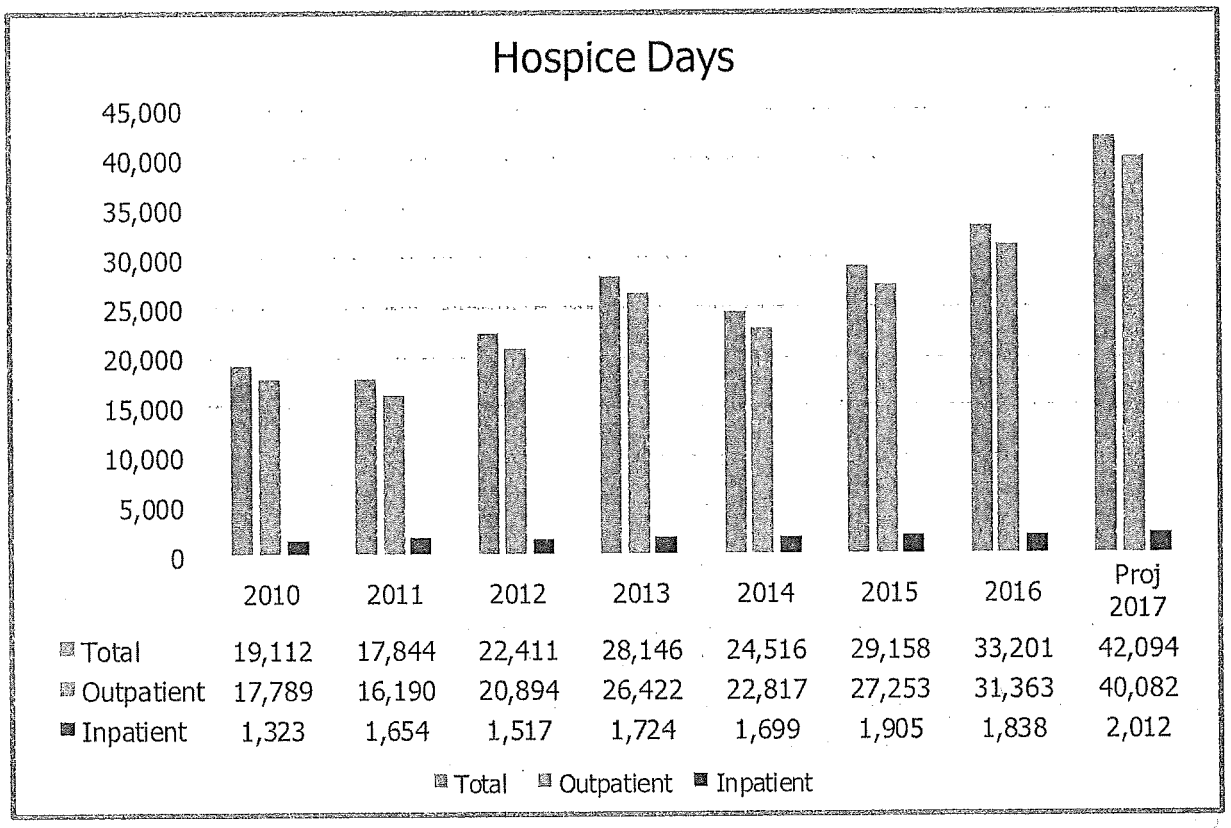
Evaluated together, these points of contact, the opportunities for relationship-building, the direct referral channels through LifeBridge Health and the broader referrals channels to be built across Baltimore City through education and professional support demonstrate Carroll's readiness for success. Together, this review served as the basis for reasonably establishing a 25% outpatient market share target for Carroll Hospice.

5. Volume Projections for Carroll Hospice

(a) Existing Carroll Hospice Program (3 jurisdictions)

Carroll Hospice has experienced 72% growth in patient days during the last three years at its existing program, reflecting growth in both inpatient and outpatient hospice services, and across all three jurisdictions.

TABLE 7
Carroll Hospice, Existing Program: Patient Days
FY2010-2017 Projected



	2010	2011	2012	2013	2014	2015	2016	Proj 2017
Total	19,112	17,844	22,411	28,146	24,516	29,158	33,201	42,094
Outpatient	17,789	16,190	20,894	26,422	22,817	27,253	31,363	40,082
Inpatient	1,323	1,654	1,517	1,724	1,699	1,905	1,838	2,012

Volume projections for Carroll's existing program were prepared based on the following assumption:

- Carroll's existing program from the three jurisdictions it serves will grow consistent with the demographic growth rate of the elderly population in its 3 County population base. This computes to a 3.5% average annual growth rate (or 12% volume growth by FY2020) for a projected census of 130 patients.

TABLE 8
Carroll Hospice Volume Projection: Existing Three-Jurisdiction Program
FY2015-2020 Projected

			Crnt Yr Proj	Projection Period		
	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Admissions (Unduplicated)						
Outpatient	570	622	694	723	752	782
Inpatient	252	288	260	265	271	276
Total	**822**	**910**	**954**	**988**	**1,023**	**1,058**
Annual % Chg.		*10.7%*	*4.8%*	*3.6%*	*3.5%*	*3.4%*
Admissions (Duplicated)						
Outpatient	667	712	818	852	886	921
Inpatient	411	439	468	477	487	497
Length of Stay						
Outpatient	40.9	44.0	49.0	49.0	49.0	49.0
Inpatient	4.6	4.2	4.3	4.3	4.3	4.3
Census Days						
Outpatient	27,253	31,363	40,082	41,734	43,404	45,140
Inpatient	1,905	1,838	2,012	2,053	2,094	2,136
Total	**29,158**	**33,201**	**42,094**	**43,787**	**45,498**	**47,276**
Annual % Chg.		*13.9%*	*26.8%*	*4.0%*	*3.9%*	*3.9%*
Average Daily Census						
Outpatient	74.7	85.9	109.8	114.3	118.9	123.7
Inpatient	5.2	5.0	5.5	5.6	5.7	5.9
Total	**79.9**	**91.0**	**115.3**	**120.0**	**124.7**	**129.5**
Annual % Chg.		*13.9%*	*26.8%*	*4.0%*	*3.9%*	*3.9%*

(b) Carroll's focus on outpatient hospice care for Baltimore City residents

Carroll Hospice and LifeBridge Health believe that Baltimore City residents are well-served by current providers of *inpatient* hospice care, and that capacity exists to meet the projected market growth. LifeBridge Health patients, in particular, are well-served: Under a partnership model with LifeBridge Health, Seasons operates inpatient hospice units at both Sinai Hospital and Northwest Hospital. Referrals to these hospice units have grown significantly, reflecting Seasons' quality program, the identification of the hospice program as a continuation of care with LifeBridge. However, the growth of *outpatient* hospice services has been more challenging for independent hospice providers. Carroll Hospice believes that to increase outpatient hospice utilization, it is necessary to build care management relationships with patients early on - - through disease management programs, aging services, and family support programs - - and to identify hospice care as part of a trusted continuum of care. Therefore, Carroll Hospice intends to focus exclusively on delivering outpatient hospice services for Baltimore City residents, working closely with LifeBridge Health and other health systems in Baltimore City to expand access and promote utilization of outpatient hospice services. As a provider of outpatient hospice currently, in a jurisdiction contiguous with Baltimore City, Carroll Hospice can expand capacity and leverage its infrastructure to operate these services in a highly cost-efficient delivery model.

(c) Volume projection for outpatient hospice services

The MHCC projects a total of 2,756 hospice deaths in Baltimore City by FY2019. Based on MHCC Hospice Survey data and industry benchmarks, Carroll Hospice applied a 70% factor to size the *outpatient* hospice market in Year 2019 (see Table 9 below).

Carroll Hospice projects a 25% market share for outpatient hospice services, equivalent to 482 patients by FY2019. This market share projection reflects the very broad base of referral channels outlined in Question 4(c), incorporating volume referred from LifeBridge Health-aligned programs as well as volume referred from across Baltimore City.

Table 9
Projected Volume for Carroll Hospice
FY2019

		FY2019
Total projected hospice deaths	State Health Plan projection ⇓	2,756 deaths ⇓
Total projected outpatient hospice deaths	Assume 70% of total volume	1,929
Carroll Hospice Program Serve 25% of outpatient volume deaths		**482**
Market share of the outpatient hospice market (482/1,929)		**25%**
Equivalent share of the total hospice market (482/2,756)		**17%**

The projected volume for Carroll Hospice (482 patients) represents 17% of the total projected hospice market, which approximates LifeBridge's current market share of elderly discharges from Baltimore City. As documented below, Sinai Hospital and Northwest Hospital currently serve 15% of elderly acute care discharges from Baltimore City. Market share for hospice services would be expected to be higher, given that there are a far more limited number of providers and given that LifeBridge Health itself provides many direct referral channels for hospice services.

Table 10
LifeBridge Health Hospitals
Current Market Share of Acute Hospital Discharges, Age 65+
FY2016

	Discharges	Market Share
Sinai	3,561	12.7%
Northwest	553	2.0%
Carroll	13	0.0%
LBH Total	4,127	14.8%
Balt. City Total	**27,948**	**100.0%**

For purposes of assessment, the projected volume of 482 cases was "translated" into the percentage of net need to be met by Carroll Hospice:

- The MHCC projects a net need to serve 1,233 patients in Baltimore City by FY2019.
- Assuming that 70% of the need is for outpatient hospice, the net *outpatient* need equates to 863 patients (1,233 x 70%).
- Carroll's volume target of 482 cases will meet more than half (56%) of the estimated outpatient need for Baltimore City residents (see Table 11 below).

This plan reflects the assumption that existing providers will continue serving the Baltimore City community and will expand capacity to meet the balance of the projected volume growth in Baltimore City. Existing providers will not be impacted negatively, but are instead expected to see program growth.

Table 11
Projected Volume for Carroll Hospice
FY2019

		FY2019
Total projected hospice deaths	State Health Plan projection	2,756 deaths
	⇓	⇓
Total projected outpatient hospice	Assume 70% of total	1,929 deaths

Carroll Hospice Program	**Serve 25% of outpatient volume**	**482 deaths**
	Net need defined by MHCC	**1,233**
	Net outpatient need estimated (70% x 1,233)	**863**
	Carroll projected volume	**482**
	Percentage of net outpatient need met by Carroll (482/863)	**56%**

Sources:
(1) 2019 Projected Hospice Deaths: Federal Register, May 2016
(2) 2019 Projected Need: Federal Register, May 2016
(3) Outpatient Estimate: @ 70% of total hospice volume based on historical utilization patterns

Length of stay – The projected length of stay for Carroll's Baltimore City outpatient hospice program is 35 days. This projection was based on a detailed analysis of length of stay patterns for both Baltimore City hospice patients and Carroll's existing hospice patients using two data sources:

- MHCC Hospice Survey: FY2015
- MedPAR files: Medicare data, only CY2014

These datasets provided the opportunity to examine length of stay of Baltimore City hospice patients by service setting and to examine the effect of outliers on length of stay (defined as 180+ days). A detailed review is provided in the Statement of Key Assumptions for Financial Projections in support of Hospice Application Tables 2A and 2B (Statistical Projections). The projected length of stay for the new program is 35 days.

Projected ramp up - The projected volume for the new program at Carroll Hospice is presented below:

Table 12
Carroll Hospice
Baltimore City Outpatients, only
FY2018-2020

	FY2018	FY2019	FY2020
# Admissions-unduplicated	123	290	482
ALOS	35.0	35.0	35.0
Census days	4,305	10,150	16,870
Average Daily Census	11.8	27.8	46.2

Operating costs - Operating costs are presented in Hospice Application Table 4 (Revenues and Expenses – Proposed Project) and incorporate the following factors for the new Baltimore City program:

- Wage rate differences
- Patient visit escort (25% of visits)
- Nurse/staff productivity (3-year ramp up period)
- Space costs
- Other administrative support
- Respite Services

Staffing requirements for the new Baltimore City program are presented in Hospice Application Table 5 (Manpower Information).

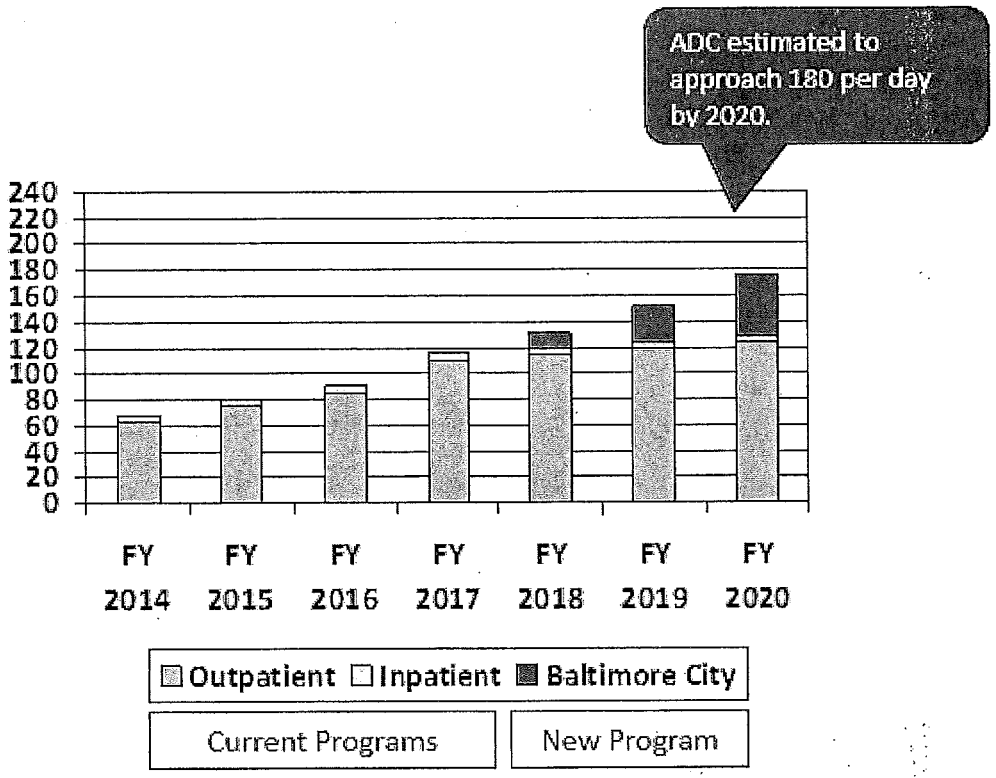
(d) Carroll Hospice: Integrated Program

The total volume for Carroll Hospice's integrated program is presented in the table below, accompanied by a chart to display program growth to a census of 180 patients.

Table 13
Carroll Hospice
Integrated Program
FY2018-2020

	FY2018	FY2019	FY2020
# Admissions - unduplicated	1,111	1,313	1,540
ALOS	43.3	42.4	41.7
Patient days	48,092	55,648	64,146
Average Daily Census	131.8	152.5	175.7

Carroll Hospice
Integrated Program: Average Daily Census
FY2018-2020



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 is well positioned to provide exceptional care to the residents of Baltimore City. Our program has the necessary experience and 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 this context, Carroll Hospice considered the following two alternatives to meet the unmet need, promote access to hospice care, overcome current barriers to utilization, strengthen care coordination, and lower the costs of care:

Option 1: Rely on high quality inpatient hospice services currently provided by Seasons at Northwest and Sinai Hospitals, and rely on existing providers for outpatient hospice care.

This option is not a more cost effective alternative due to the following considerations:

- Seasons provides high quality inpatient hospice services through direct transfers of LifeBridge Health's inpatients to its hospital-based units for end-of-life care. In general, patients are identified in the inpatient setting for referral to the inpatient hospice units. Therefore, this model does not provide the benefits of earlier introduction of hospice care, i.e. earlier-stage support services to patients and their families and the care planning to reduce unnecessary hospital utilization.

- Inpatients at Northwest and Sinai Hospitals and their families identify inpatient hospice services with both Seasons and LifeBridge Health. Indeed, LifeBridge Health has been able to respond to community-specific interests by designing hospital facilities and incorporating

program features to accommodate the religious traditions of subsets of the community and training hospice staff to be responsive to distinct cultural expectations. It is more challenging, however, to assure this responsiveness and this ongoing investment for outpatient hospice services, as these services are delivered off-site by another provider; moreover, it is more difficult to present hospice care to families as part of the LifeBridge Health continuum of care when an independent provider is utilized.

- Performance during the past two years has *not* demonstrated an appreciable change in hospice utilization by Baltimore City residents.
    - Data suggests that current providers of outpatient hospice have not effectively promoted hospice utilization among the underserved population. This may reflect under-investment or lack of resources to establish education programs and/or build working relationships that earns the trust and value recognition of hospice services
    - Current providers may not be staffed with the culturally competent hospice staff to provide a comfort level and sense of support that is needed during this very difficult stage
    - Current hospice providers may not be effectively linked to patients/families to introduce the hospice option until such time as they are hospitalized; independent hospice providers are not well-positioned in the care continuum or in the community to discuss advance care planning and future options.
    - Providers / institutions may not be promoting advance care planning and may not be referring patients to hospice to provide maximum access/maximum benefit to patients; practice patterns of referring providers/institutions may be producing disparities in care, and existing hospice providers may not be investing to change these referral patterns.
- The low utilization of hospice services results in relatively higher hospital utilization during the last 6 months of life
    - Under the Demonstration Model, Maryland must be concerned about reducing hospitalization costs, reducing the total costs of care, reducing readmissions, and lowering hospital mortality rates. Independent hospice providers are currently not incentivized to reduce the total costs of care, and therefore would not be as focused on hospital utilization pattern in spite of the performance targets under CMS.

Option 2: Leverage the expertise and the infrastructure of Carroll Hospice to deliver hospice services, and integrate these services with the LifeBridge market presence in the Baltimore City community.

This option was determined to be the most cost effective alternative based on the following considerations:

- The performance record of Carroll Hospice is outstanding, and provides evidence of successful strategies and investments:
    - Carroll Hospice demonstrates high quality performance along all dimensions, exceeding regional benchmarks on several measures
    - Carroll Hospice has increased patient volume by 40% over the course of the last 3 years, and Carroll County now reports one of the highest County hospice

utilization rates in the State of Maryland

- The leadership of Carroll Hospice, Regina Bodnar, Executive Director, brings more than 30 years of experience in hospice services and was the founding director of clinical services at Gilchrist Hospice Care. She is recognized nationally in the field, and is on the Board of Directors of the National Hospice and Palliative Care Organization, serves as the Chair of the NHPCO Quality and Standards Committee and is President of the Hospice and Palliative Care network of Maryland. Ms. Bodnar also was a content contributor to the NHPCO publication "Staffing Guidelines for Hospice Home Care Teams" and lectures widely on this topic.

- The commitment of Carroll Hospice is to promote effective utilization of hospice across Baltimore City through community education, physician education, positive relationships with community-based organizations and faith-based groups, and supportive relationships with nursing homes and assisted living facilities. Carroll Hospice can be introduced, described, promoted in community groups and faith-based organizations already tied to LifeBridge Health and trusted by the community. Carroll Hospice will work with a broader base of community groups/settings as well. The effect will be to increase hospice utilization across communities across the City.

- Carroll Hospice can be a particularly strong partner in post-acute services for LifeBridge Health through the following:

  - Identification of hospice services as a LifeBridge Health service and part of the continuum of care;

  - On-site nurse liaisons at LifeBridge Health hospitals;

  - Shared medical record for LifeBridge Health patients;

  - Alignment with the Post-Acute Physician Partners, a LifeBridge Health-owned medical management group dedicated to improving post-acute care for patients at home and in post-acute facilities

  - Provider education to LifeBridge Health's broad base of physicians to promote effective use of palliative care and hospice services. This will support success with chronic disease management under CCIP and MACRA targets and under

  - Integration with the larger post-acute business line and leveraging of LifeBridge Health's resources for ongoing growth/activity

- Finally, as an affiliate of LifeBridge Health, Carroll Hospice can be incentivized, longer-term, to achieve the GBR and total costs of care performance targets for the health system.

10.24.01.08G(3)(d). <u>Viability of the Proposal</u>.

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 11.**

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 are 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: The proposed project will not have any impact on charges for similar facilities. As stated above Hospice services are paid on a per diem rate based on fee schedules for Federal payers and existing contract for commercial payers. As outlined in section 10.24.13.05 G. there is an expectation that other hospice providers in the area will experience an increase in outpatient hospice cases. This incremental volume will result in an increase in costs for existing providers with a corresponding increase in revenue based on applicable per diem rate for Federal and commercial payers.

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

Applicant Response: Based on current experience for outpatient hospice services Carroll's per diem rate for outpatient hospice services will be $163 per day.

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 12**.

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.

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

Applicant Response:

As explained in Carroll Hospice's response to the Need standard (COMAR 10.24.08.08G(3)(b)) and in response to Standard .05G, the projected growth of hospice volume in Baltimore City will permit each existing provider to increase its volume even as 1-2 new providers enter the market. While market share figures decline, the overall growth of the market (i.e. case volume) allows each provider to increase its patient volume.

The new program at Carroll is not expected to have any impact on the costs/charges at existing hospice programs.

Additionally, approval of this project will has a positive impact on the health care system overall. The increase in hospice utilization is expected to be accompanied by:

- Performance improvement on quality indicators for Maryland hospitals defined by the Demonstration Model
  - Reduction in hospital mortality rates
  - Reduction in readmissions/re-visit rates/PAUs, particularly by nursing home patients
  - Improvement patient satisfaction

- Performance improvement on quality indicators for Maryland nursing homes
  - Improved satisfaction of nursing home patients and their caregivers

- Reduction in readmissions

These improvements will be reflected in new quality indicators at nursing homes and in published results on Nursing Home Compare.

- Performance improvement on ACO performance indicators and physician performance indicators under APMs.
  - This would include performance of the D-ACOs expected to be introduced for dual eligible.
  -
- Reductions in the total costs for care under the Demonstration Model
  - Under the GBR model, as hospice utilization increases, the total costs of care for this population may, in fact, increase in the near-term. Longer-term, however, as avoidable hospitalization is reduced and inpatient/ER resources can be reduced, Baltimore City hospitals would expect to see savings under the GBR model.

Research demonstrates that hospice care can reduce unnecessary hospitalizations, reduce the total costs per capita, and minimize the hardships associated with transfers of frail patients from nursing home and home. Under the GBR model, a modest reduction in admissions will not translate into hospital savings, and hospice utilization *will* initially constitute additional Medicare spending for the State of Maryland. However, under a total cost of care model, the use of hospice care can translate into measurable savings; the overall reductions in hospital spending during the final 6 months of life are expected to exceed the incremental costs of hospice care.

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. In addition, we will learn from the experience of our colleagues across the LifeBridge Health system and execute the recruitment strategies found to be most successful in their respective arenas including recruitment fairs, online applications via the Carroll Hospice website and incentivizing employee referrals. The Career Centers of the Hospice and Palliative Care Network of Maryland and the National Hospice and Palliative Care organization will also be utilized to broaden our recruitment reach. 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 program.

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, supporting and retaining staff. In FY16 Carroll Hospice's turnover rate was .11% and its vacancy rate was 1.59%. 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 13**.

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 13** for the health care facilities in the LifeBridge Health system.

3. 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 halth 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).

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 14** for this authorization.

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 halth 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).

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 14** 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.

Signature of Owner or Authorized Agent of the Applicant

Regina M. Bodnar

Regina Bodnar, Executive Director, Carroll Hospice

Date: 12·7·16

Hospice Application: Charts and Tables Supplement

TABLE 1 - PROJECT BUDGET

STATEMENT OF KEY ASSUMPTIONS FOR FINANCIAL PROJECTIONS

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

INSTRUCTIONS: All estimates for 1.a.-d., 2.a.-j., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

1. Capital Costs (if applicable):

a.	New Construction	$_____	
(1)	Building	_____	
(2)	Fixed Equipment (not included in construction)	_____	
(3)	Land Purchase	_____	
(4)	Site Preparation	_____	
(5)	Architect/Engineering Fees	_____	
(6)	Permits, (Building, Utilities, Etc)	_____	
SUBTOTAL			$_____
b.	Renovations		
(1)	Building	$_____	
(2)	Fixed Equipment (not included in construction)	_____	
(3)	Architect/Engineering Fees	_____	
(4)	Permits, (Building, Utilities, Etc.)	_____	
SUBTOTAL			$_____
c.	Other Capital Costs		
(1)	Major Movable Equipment	_____	
(2)	Minor Movable Equipment	_____	
(3)	Contingencies	_____	
(4)	Other (Specify)	_____	
TOTAL CURRENT CAPITAL COSTS (a - c)			$_____
d.	Non-Current Capital Cost		
(1)	Interest (Gross)	$_____	
(2)	Inflation (state all assumptions, Including time period and rate)	$_____	
TOTAL PROPOSED CAPITAL COSTS (a - d)			$_____

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	$_____
b.	Bond Discount	_____
c.	Legal Fees (CON Related)	_____
d.	Legal Fees (Other)	_____
e.	Printing	_____
f.	Consultant Fees	

	CON Application Assistance	$52,750	
	Other (Specify)	_____	
g.	Liquidation of Existing Debt	_____	
h.	Debt Service Reserve Fund	_____	
i.	Principal Amortization Reserve Fund	_____	
j.	Other (Specify)	_____	
	TOTAL (a - j)	$_____	
3.	Working Capital Startup Costs	$_____	
	TOTAL USES OF FUNDS (1 - 3)		$52,750

B. Sources of Funds for Project:

1.	Cash	$52,750	
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net	_____	
3.	Gifts, bequests	_____	
4.	Interest income (gross)	_____	
5.	Authorized Bonds	_____	
6.	Mortgage	_____	
7.	Working capital loans	_____	
8.	Grants or Appropriation		
	(a) Federal	_____	
	(b) State	_____	
	(c) Local	_____	
9.	Other (Specify)	_____	
TOTAL SOURCES OF FUNDS (1-9)			$52,750

Lease Costs:

a. Land	$_____	x _____	= $_____
b. Building	$_____	x _____	= $_____
c. Major Movable Equipment	$_____	x _____	= $_____
d. Minor Movable Equipment	$_____	x _____	= $_____
e. Other (Specify)	$_____	x _____	= $_____

Carroll Hospice
Statement of Key Assumptions
Financial Projections

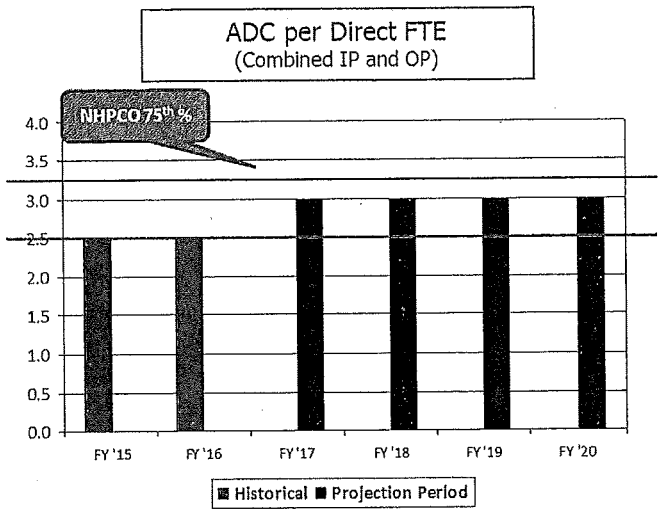
- **Current Program:** The following key financial assumptions were used to develop the financial outlook for Carroll Hospice current operations.

1. **Census Days / Average Daily Census:** Census days for the current program are projected to reach approximately 47,000 days (ADC of 130) by FY 2020. This represents annual average growth rate of 4% per year from current year (FY 2017) projected levels – and is consistent with projected population growth over this same time period for the elderly population demographic. Outpatient services account for 95% of Carroll Hospice total patient days. Length of stay has been projected to remain at current levels (Outpatient: 49 days, Inpatient: 4 days) throughout the projection period.

2. **Gross Revenue:** Gross revenues are projected to increase from $6.5 million currently to $7.3 million by FY 2020. 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 $163/day (outpatient) and $707/day (inpatient). Medicare accounts for over 93% of Carroll Hospice patient revenue stream.

3. **Deductions from Revenue:** Deductions from revenue are projected to total 3.9% of gross revenue throughout the projection period – consistent with prior experience. Deductions from revenue include: contractual allowances (3.2%), bad debt and other uncollectible (.5%), and charity care (.2%).

4. **Salaries and Benefits:** Salaries and benefits account for approximately 70% of total operating cost and are projected to total $5.4 million by FY 2020. Carroll Hospice existing program workforce is projected to total 69 FTE's by FY 2020 – an increase of approximately 7 FTE's from current levels. This FTE requirement assumes ADC per Direct FTE will remain at current levels (3.0) during the projection period as illustrated in the chart below. This productivity level is between the 50th and 75th % range as published by the NHPCO.



In addition, workforce requirements have been projected to maintain current mix of direct care FTE's (62%) to support FTE's (38%). The table below further illustrates Carroll Hospice current and projected workforce mix.

	Current State		Proj FY '20	
Direct FTE's				
Skilled Nursing	17.8		19.6	
Hospice Aides	12.3		14.2	
Social Work	4.6		5.0	
Chaplain Services / Phys	3.6		3.9	
Subtotal	38.3	62%	42.7	62%
Indirect FTE's	23.3	38%	26.1	38%
Total	61.6		68.8	
By Service				
Home/Facility	41.9	68%	46.9	68%
Inpatient (Dove House)	19.7	32%	21.9	32%
Total	61.6		68.8	

5. **Other Variable Expenses:** Other variable expenses include patient supplies, pharmaceuticals, DME rentals, care giver and patient travel expense, and other medical services. These costs are estimated to total approximately $32 per census day throughout the projection period – consistent with current levels. Based on 47,000 census days, these costs are projected to total $1.5 million by FY 2020 – accounting for approximately 19% of total operating costs.

6. **Other Expenses:** Other expenses represent fixed operating cost and include the following: utilities, insurance, maintenance contracts, linen processing, equipment

rentals, advertising, medical director and physician coverage, and other support functions (accounting, tax, human resources, recruitment, and information systems).

7. **Non-operating activities:** Non-operating activities include unrestricted annual fundraising proceeds (net of expense) and rental income. These activities are projected to support Hospice operating activities by $256k per year throughout the projection period. In addition, Carroll Hospice is projected to receive $425k in donor restricted contributions and $240k in endowment fund earnings during the projection period.

The table below illustrates the financial operating outlook for Carroll Hospice existing programs through FY 2020.

Carroll Hospice
Financial Outlook (Existing Programs)

	Results by Business Activity (000's Omitted)						
			Projection Period				
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	% '17-'20
Current Programs (IP and OP)							
Patient Revenues	$5,466	$6,106	$7,634	$7,914	$8,203	$8,504	11.4%
Expenses							
Salaries/Benes	$3,826	$4,547	$4,883	$5,054	$5,219	$5,391	10.4%
Supplies and Drugs	$471	$585	$727	$755	$782	$811	11.6%
DME/Mileage/Medical Services	$423	$488	$601	$625	$651	$676	12.5%
Services and Fees	$545	$709	$894	$900	$904	$909	1.7%
Subtotal	$5,265	$6,329	$7,105	$7,334	$7,556	$7,787	9.6%
EBIDA/Cash Flow	$201	($223)	$529	$580	$647	$717	
Depreciation	$158	$164	$164	$164	$164	$164	0.0%
Income from Current Programs	$43	($387)	$365	$416	$483	$553	
	0.8%	*-6.3%*	*4.8%*	*5.3%*	*5.9%*	*6.5%*	

The table below illustrates total sources of funds (including non-operating activity as described in #7 above.

	Results by Business Activity (000's Omitted)					
			Projection Period			
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020
Income from Current Programs	**$43**	**($387)**	**$365**	**$416**	**$483**	**$553**
Other Non-Operating Items						
Net Fundraising (Unrestricted)	$693	$569	$255	$255	$255	$255
Rental Income / Other	$1	$76	$48	$1	$1	$1
Subtotal	$694	$645	$303	$256	$256	$256
Net Income	**$737**	**$258**	**$668**	**$672**	**$739**	**$809**
Other Sources of Funds						
Restricted Gifts and Pledges	$343	$56	$425	$425	$425	$425
Endowment Fund Proceeds	$0	$0	$240	$240	$240	$240
Subtotal	$343	$56	$665	$665	$665	$665
Total	**$1,080**	**$314**	**$1,333**	**$1,337**	**$1,404**	**$1,474**

- **Baltimore City Outpatient Hospice:** The following key financial assumptions were used to develop the financial outlook for Carroll Hospice current operations.

1. **Patient Volume:** Carroll Hospice projects that it will provide outpatient hospice services to 482 Baltimore City residents by FY 2020 – representing 39% (482/1,233) of MHCC identified net incremental total need and an estimated 56% (482/863) of net incremental outpatient need. This level of Baltimore City admissions to Carroll Hospice represents 17% total hospice market share and 25% outpatient market share. Average daily census is projected to reach 46 patients per day by FY 2020 – based on average length of stay of 35 days.

   The table below illustrate ramp-up assumptions for admissions and average daily census for Carroll Hospice Baltimore City projected patient population.

Carroll Hospice
Key Volume Assumptions: Baltimore City

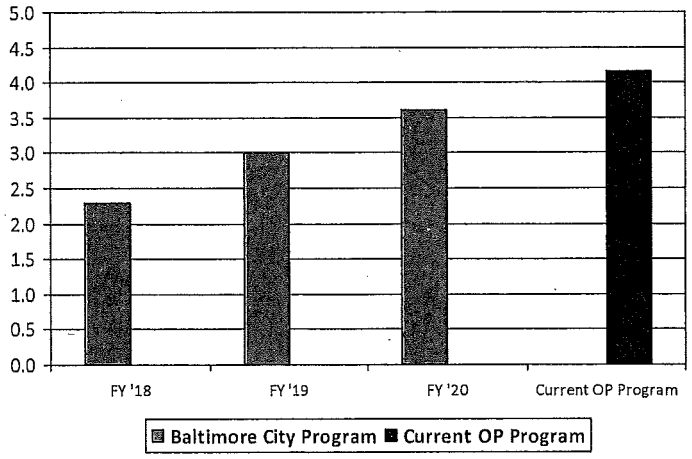
	Projection Period		
	FY 2018	FY 2019	FY 2020
Key Volume Indicators			
Admissions	123	290	482
LOS	35.0	35.0	35.0
Census Days	4,305	10,150	16,870
ADC	11.8	27.8	46.2

2. **Gross Revenue:** Gross revenues from the Baltimore City program are projected to total $2.6 million by FY 2020. Gross revenue per census day has been projected to remain consistent with current program levels of $163/day for outpatient hospice services. Medicare and Medicaid are projected to account for 95% of Carroll Hospice patient revenues attributable to Baltimore City patients.

3. **Deductions from Revenue:** Deductions from revenue are projected to total 5% of gross revenue throughout the projection period – somewhat higher than current program levels (3.9%). Increased provisions for charity care (.9%) and bad debt (.9%) have been provided for. Contractual allowances (3.2%) are projected to be consistent with current program levels.

4. **Salaries and Benefits:** Salaries and benefits account for approximately 63% of total operating cost associated with the Baltimore City program and are projected to total $1.6 million by FY 2020. Workforce requirements necessary to service this patient population are projected to total approximately 21 FTE's by year 3 of the program. In developing workforce size for Baltimore City, Carroll Hospice has assumed a three-year productivity ramp-up (as measured by ADC per direct FTE). By FY 2020, it is estimated that ADC per FTE will reach 3.6 – approximately 88% of current program experience. This anticipated gap is attributable to estimates that 70% of Baltimore City outpatient hospice census days will be attributed to hospice enrollees that reside in private residences (vs 40% for Carroll Hospice current program). ADC per FTE tends to be somewhat lower for home-based patients compared to patients that reside in skilled nursing and LTC facilities (based on current experience). Carroll Hospice has also assumed that workforce mix (Direct/Support) will remain consistent with current program experience. Wage rate differentials of 10% have also been assumed in projecting salary expense. The following charts further illustrate key assumptions used in developing workforce size and salary expense.

ADC Per FTE
Baltimore City Ramp-up vs Current OP Program



FTE Ramp-up and Mix
Baltimore City

	Projection Period		
	FY '18	FY '19	FY '20
Direct FTE's			
Skilled Nursing	2.0	3.8	6.2
Hospice Aides	1.3	2.8	3.7
Social Work	1.1	1.7	1.8
Chaplain Services / Phys	0.6	1.0	1.2
Subtotal	5.0	9.3	12.9
Indirect FTE's	3.3	5.8	7.8
Total	8.3	15.1	20.7
FTE Mix			
Direct	60%	62%	62%
Indirect	40%	38%	38%
Total	100%	100%	100%

5. **Other Variable Expenses:** Other variable expenses include patient supplies, pharmaceuticals, DME rentals, care giver and patient travel expense, and other medical services. These costs are estimated to total approximately $34 per census day throughout the projection period, somewhat higher than current program levels ($29 per outpatient census day). This difference is primarily attributable to estimated differences in residence status (home vs facility) from current program experience as discussed in developing workforce requirements. Based on 16,870 census days, these costs are projected to total $572,000 by FY 2020 – accounting for approximately 23% of total operating costs. In addition to items discussed above, projected expenses include a $13 per census day provision ($220k annually by 2020) for visit escort and patient respite services.

6. **Other Expenses:** Other expenses represent fixed operating cost and include the following: utilities, provision for rent, insurance, maintenance contracts, equipment rentals, and advertising.

The table below illustrates the incremental operating outlook for Carroll Hospice Baltimore City outpatient hospice program based on to the assumptions described above. By FY 2020, it is anticipated that these services with generate positive cash flow and an operating margin of approximately 4% on revenues of $2.6 million.

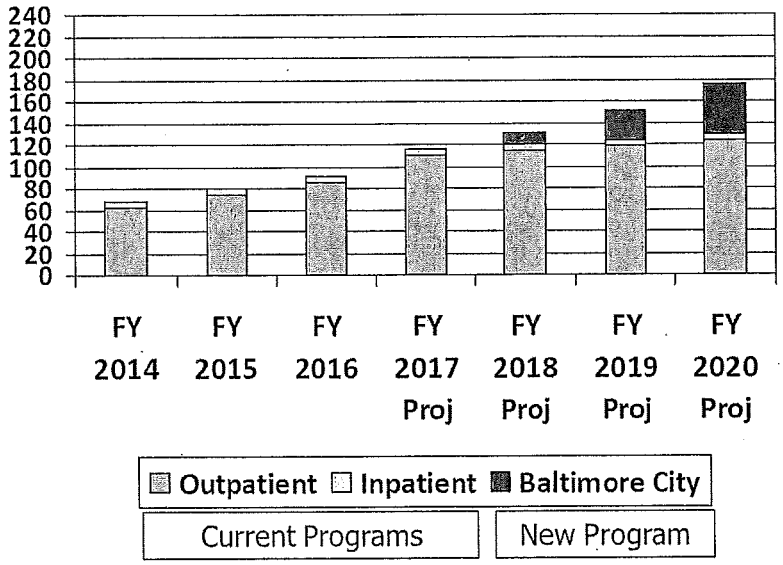
	Projection Period (000's)		
	FY2018	**FY2019**	**FY2020**
Key Volume Indicators			
Admissions	123	290	482
Census Days (All Outpatient)	4,305	10,150	16,870
ADC	11.8	27.8	46.2
Net Patient Revenues (000's)	**$662**	**$1,568**	**$2,604**
Per Day	*$154*	*$154*	*$154*
Expenses			
Salaries/Benes	$636	$1,131	$1,576
Supplies and Drugs	$69	$163	$270
DME/Mileage/Medical Services	$76	$183	$302
Security / Visit Escort	$20	$48	$79
Respite Services (Pass-thru)	$36	$85	$141
Subtotal	**$837**	**$1,610**	**$2,368**
Per Day	*$194*	*$159*	*$140*
Other Fixed Cost Provision (Rent,etc)	$116	$119	$127
Total Expenses	**$953**	**$1,729**	**$2,495**
Increm. Income from Balt. City	**($291)**	**($161)**	**$109**
	-44.0%	*-10.3%*	*4.2%*

- **Carroll Hospice – Including Baltimore City:** Based on the assumptions described earlier, the following tables illustrate Carroll Hospice anticipated volume levels and financial outlook when combining current program operations with projected results for patients served in Baltimore City.

1. **Patient Volume:** By FY 2020, Carroll Hospice projects that it will provide outpatient hospice services to over 1,500 to residents of Carroll, Frederick, and Baltimore counties, and Baltimore City. The tables below further illustrate historical and projected key volume indicators.

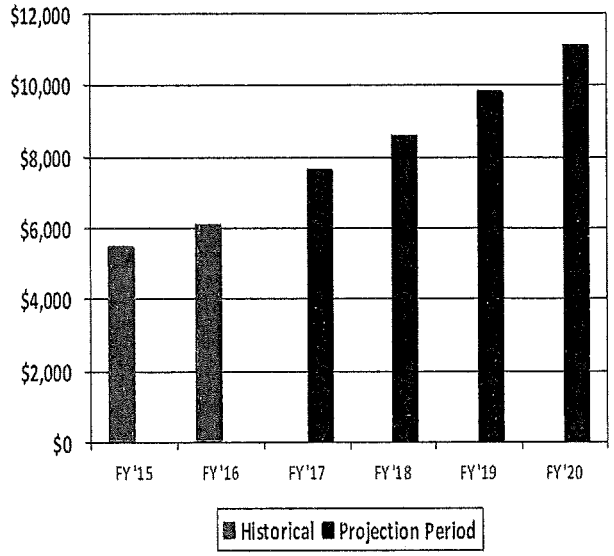
			Crnt Yr Proj	Projection Period			
	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	% Chg
Key Volume Indicators							(FY '17)
Admissions (Unduplictated)	822	910	954	1,111	1,313	1,540	61%
Census Days	29,158	33,201	42,094	48,092	55,648	64,146	52%
Length of Stay (Days/Adm)	35.5	36.5	44.1	43.3	42.4	41.7	-6%
Average Daily Census	79.9	91.0	115.3	131.8	152.5	175.7	52%

Carroll Hospice
Average Daily Census (All Programs Combined)



2. **Revenues and Program Operations.** By FY 2020, Carroll Hospice projects that net revenues will grow to $11.1 million and continue to demonstrate positive operating results and financial viability. Total program operating margins are projected to remain positive throughout the projection period while Baltimore City operations ramp-up over a three-year period.

Net Patient Revenue (000's)
All Programs (Current and Balt. City)



Program Operating Income (000's)
All Programs (Current and Balt. City

	Results by Business Activity (000's)			
		Projection Period		
	FY 2017	FY 2018	FY 2019	FY 2020
Baltimore City Program				
Patient Revenues		$662	$1,568	$2,604
Operating Expenses		$953	$1,729	$2,495
Income from Current Programs		($291)	($161)	$109
		-14.0%	*-10.3%*	*4.2%*
Current Programs (IP and OP)				
Patient Revenues	$7,634	$7,914	$8,203	$8,504
Operating Expenses	$7,269	$7,498	$7,720	$7,951
Income from New Program	$365	$416	$483	$553
	4.8%	*5.3%*	*5.9%*	*6.5%*
Combined Program Income				
Patient Revenues	$7,634	$8,576	$9,771	$11,108
Operating Expenses	$7,269	$8,451	$9,449	$10,446
Income from All Programs	$365	$125	$322	$662
	4.8%	*1.5%*	*3.3%*	*6.0%*

3. **Financial Outlook – All Activities.** Further demonstrating on-going financial viability, Carroll Hospice enjoys a history of strong community support to facilitate the delivery of high-quality, cost effective hospice care to its community. This community support is expected to continue as Carroll Hospice begins service to Baltimore City residents. The table below illustrates Carroll Hospice projected sources of funds available from all activities.

	Results by Business Activity (000's Omitted)					
			Projection Period			
	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Income from Current Programs	**$43**	**($387)**	**$365**	**$125**	**$322**	**$662**
Other Non-Operating Items						
Net Fundraising (Unrestricted)	$693	$569	$255	$255	$255	$255
Rental Income / Other	$1	$76	$48	$1	$1	$1
Subtotal	$694	$645	$303	$256	$256	$256
Net Income	**$737**	**$258**	**$668**	**$381**	**$578**	**$918**
Other Sources of Funds						
Restricted Gifts and Pledges	$343	$56	$425	$425	$425	$425
Endowment Fund Proceeds	$0	$0	$240	$240	$240	$240
Subtotal	$343	$56	$665	$665	$665	$665
Total	**$1,080**	**$314**	**$1,333**	**$1,046**	**$1,243**	**$1,583**

Instructions: Complete Table 2A for the Entire General Hospice Program, including the proposed project, and **Table 2B** for the proposed project only using the space provided on the following pages. **Only existing facility applicants should complete Table 2A. All Applicants should complete Table 2B. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY).**

TABLE 2A: STATISTICAL PROJECTIONS – ENTIRE Hospice Program

	Two Most Current Actual Years		**Projected years – ending with first year at full utilization**			
FISCAL YEAR	2015	2016	2017	2018	2019	2020
Admissions-unduplicated	822	910	954	1,111	1,313	1,540
Deaths	755	843	876	1,013	1,197	1,407
Non-death discharges	30	50	72	81	92	104
Patients served-unduplicated	880	1,005	1,067	1,231	1,449	1,702
Patient days	29,158	33,201	42,094	48,092	55,648	64,146
Average length of stay	35.5	36.5	44.1	43.3	42.4	41.7
Average daily hospice census	79.9	91.0	115.3	131.8	152.5	175.7
Visits by discipline						
Skilled nursing	14,268	15,051	17,629	19,675	22,260	25,151
Social work	3,805	3,968	4,441	4,768	5,171	5,618
Hospice aides	12,143	12,024	14,140	15,834	17,975	20,371
Physicians - paid	1,464	1,389	1,505	1,568	1,642	1,722
Physicians - volunteer	0	0	0	0	0	0
Chaplain	3,045	3,539	4,113	4,562	5,127	5,758
Other clinical-therapy	159	222	273	317	372	435
Licensed beds						
Number of licensed GIP beds	8	8	8	8	8	8
Number of licensed Hospice House beds	0	0	0	0	0	0
Occupancy %						
GIP(inpatient unit)	65%	63%	72%	74%	76%	78%
Hospice House	0%	0%	0%	0%	0%	0%

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

	Projected years – ending with first year at full utilization			
FISCAL YEAR	2017	2018	2019	2020
Admissions-unduplicated		123	290	482
Deaths		105	255	434
Non-death discharges		6	15	24
Patients served		123	302	515
Patient days		4,305	10,150	16,870
Average length of stay		35.0	35.0	35.0
Average daily hospice census		11.8	27.8	46.2
Visits by discipline				
Skilled nursing		1,446	3,426	5,690
Social work		203	481	799
Hospice aides		1,204	2,853	4,738
Physicians - paid		28	67	110
Physicians - volunteer		0	0	0
Chaplain		313	741	1,230
Other clinical-therapy		33	77	128
Licensed beds				
Number of licensed GIP beds		0	0	0
Number of licensed Hospice House beds		0	0	0
Occupancy %				
GIP(inpatient unit)		0%	0%	0%
Hospice House		0%	0%	0%

TABLE 3: **REVENUES AND EXPENSES - ENTIRE Hospice Program**

(INSTRUCTIONS: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

	Two Most Recent Years -- Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
FISCAL YEAR	2015	2016	2017	2018	2019	2020	
1. Revenue							
a. a. Inpatient services	1,338,187	1,286,020	1,421,961	1,450,400	1,479,408	1,508,996	
b. Hospice house services	0	0	0	0	0	0	
c. Home care services	4,325,490	5,103,475	6,522,241	7,479,917	8,704,935	10,077,954	
d. Gross Patient Service Revenue	5,663,677	6,389,495	7,944,202	8,930,317	10,184,343	11,586,950	
e. Allowance for Bad Debt	(28,786)	(32,165)	(39,991)	(47,719)	(57,814)	(69,201)	
f. Contractual Allowance	(159,012)	(240,295)	(257,255)	(287,844)	(326,751)	(370,051)	
g. Charity Care	(10,055)	(10,226)	(12,714)	(19,287)	(28,374)	(39,002)	
h. Net Patient Services Revenue	5,465,824	6,106,809	7,634,241	8,575,467	9,771,404	11,108,696	
i. Other Operating Revenues (Specify)	0	0	0	0	0	0	
j. Net Operating Revenue	5,465,824	6,106,809	7,634,241	8,575,467	9,771,404	11,108,696	
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	3,826,295	4,546,801	4,882,914	5,689,685	6,350,876	6,967,642	
b. Contractual Services	0	0	0	0	0	0	
c. Interest on Current Debt	0	0	0	0	0	0	
d. Interest on Project Debt	0	0	0	0	0	0	
e. Current Depreciation	158,377	164,370	164,370	164,370	164,370	164,370	

f. Project Depreciation	0	0	0	0	0	0	
g. Current Amortization	0	0	0	0	0	0	
h. Project Amortization	0	0	0	0	0	0	
i. Supplies	470,900	585,112	726,822	822,909	944,484	1,080,687	
j. Other Expenses (Specify)	966,706	1,197,827	1,495,551	1,773,655	1,990,041	2,234,072	
k. Total Operating Expenses	5,422,278	6,494,110	7,269,657	8,450,619	9,449,771	10,446,771	
3. Income							
a. Income from Operation	43,546	(387,301)	364,584	124,848	321,633	661,925	
b. Non-Operating Income	694,239	645,242	302,925	255,925	255,925	255,925	
c. Subtotal	737,785	257,941	667,509	380,773	577,558	917,850	
d. Income Taxes	0	0	0	0	0	0	
e. Net Income (Loss)	737,785	257,941	667,509	380,773	577,558	917,850	

Table 3 Cont.	**Two Most Actual Ended**	**Current Year**	**Projected Years (ending with first full year at**

	Recent Years		Projected	full utilization)			
FISCAL YEAR	2015	2016	2017	2018	2019	2020	
4. Patient Mix							
A. As Percent of Total Revenue							
1. Medicare	92%	93%	93%	92%	91%	90%	
2. Medicaid	1%	1%	1%	2%	3%	4%	
3. Blue Cross	3%	3%	3%	3%	3%	3%	
4. Other Commercial Insurance	4%	3%	3%	3%	3%	3%	
5. Self-Pay	0%	0%	0%	0%	0%	0%	
6. Other (Specify)	0%	0%	0%	0%	0%	0%	
7. TOTAL	100%	100%	100%	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)							
1. Medicare	92%	93%	92%	92%	91%	90%	
2. Medicaid	1%	1%	1%	2%	3%	4%	
3. Blue Cross	3%	3%	3%	3%	3%	3%	
4. Other Commercial Insurance	4%	3%	4%	3%	3%	3%	
5. Self-Pay	0%	0%	0%	0%	0%	0%	
6. Other (Specify)	0%	0%	0%	0%	0%	0%	
7. TOTAL	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTIONS: Each applicant should complete this table for the proposed project only)

	Projected Years (ending with first full year at full utilization)			
FISCAL YEAR	2017	2018	2019	2020
1. Revenue				
a. Inpatient services		0	0	0
b. Hospice House services		0	0	0
c. Home care services		696,789	1,650,479	2,741,319
d. Gross Patient Service Revenue		696,789	1,650,479	2,741,319
e. Allowance for Bad Debt		(6,271)	(14,854)	(24,672)
f. Contractual Allowance		(22,459)	(52,953)	(87,549)
g. Charity Care		(6,109)	(14,716)	(24,845)
h. Net Patient Services Revenue		661,947	1,567,955	2,604,253
i. Other Operating Revenues (Specify)		0	0	0
j. Net Operating Revenue		661,950	1,567,955	2,604,253
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)		635,917	1,131,272	1,576,487
b. Contractual Services				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation				
g. Current Amortization				
h. Project Amortization				
i. Supplies		68,648	162,607	270,078
j. Other Expenses (Specify)		248,646	435,193	648,560
k. Total Operating Expenses		953,211	1,729,072	2,495,125
3. Income				
a. Income from Operation		(291,265)	(161,117)	109,128

b. Non-Operating Income		0	0	0
c. Subtotal		(291,265)	(161,117)	109,128
d. Income Taxes		0	0	0
e. Net Income (Loss)		(291,265)	(161,117)	109,128

Table 4 Cont.	**Projected Years (ending with first full year at full utilization)**			
FISCAL YEAR	2017	2018	2019	2020_
4. Patient Mix				
A. As Percent of Total Revenue				
1. Medicare		90%	90%	90%
2. Medicaid		5%	5%	5%
3. Blue Cross		3%	3%	3%
4. Other Commercial Insurance		2%	2%	2%
6. Other (Specify)		0%	0%	0%
7. TOTAL	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)				
1. Medicare		90%	90%	90%
2. Medicaid		5%	5%	5%
3. Blue Cross		3%	3%	3%
4. Other Commercial Insurance		2%	2%	2%
5. Self-Pay		0%	0%	0%
6. Other (Specify)		0%	0%	0%
7. TOTAL	100%	100%	100%	100%

TABLE 5. MANPOWER INFORMATION

INSTRUCTIONS: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST-FY20
Administration					
Administration	0.0	3.25	68,861		223,048
Direct Care					
Nursing	0.0	6.20	79,350		491,968
Social work/services	0.0	1.75	73,713		128,998
Hospice aides	0.0	3.75	32,842		123,156
Physicians-paid	0.0	0.10	72,847		7,285
Physicians-volunteer	0.0	0.00			
Chaplains	0.0	1.15	47,750		54,912
Bereavement staff	0.0	1.50	59,861		89,791
Other clinical	0.0	0.00			
Support					
Other support	0.0	3.00	64,861		194,582
				Benefits*	262,748
				TOTAL	$1,576,487

* Indicate method of calculating benefits cost __Benefits calculated at 20% of salaries

Updated June 2016.

AFFIRMATIONS

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: December 9, 2016

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: December 9, 2016

Name: Teresa A. Fletcher
Title: Director, Business Dev.

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: December 9, 2016

Name: Chris Coleman
Title: AVP Finance, Carroll Health

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: December 9, 2016

Name: Jeanette Cross
Title: Managing Director, Berkeley Research Group

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: December 9, 2016

Name:
Title:

EXHIBITS

EXHIBIT 1

EXHIBIT 1

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

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 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 2

EXHIBIT 2

Title: Financial Assistance Policy	Effective Date: 02/04/2015
Document Owner: Lori Buxton	
Approver(s): Helen Whitehead, Kevin Kelbly, Leslie Simmons, Sharon McClernan (Sanders)	

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 2/3/2015.

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 requires prompt care and treatment, as defined by the Centers for Medicare and Medicaid Services (CMS) to occur within 12 hours.

C. Chronic Care: Care provide to patients in order to manage their disease and reduce their risk for hospitalization. These illnesses, characterized as ambulatory sensitive conditions, include conditions such as diabetes mellitus, CHF, COPD, angina, epilepsy, hypertension, and Asthma.

D. Elective Care: Care that can be postponed without harm to the patient or that is not medically necessary. An appropriate nursing or physician representative will be contacted for consultation in determining the patient status.

E. Medical Necessity: Any care that meets the definition of emergent, urgent, or chronic care.

F. Immediate family: A family unit is defined to include all individuals taken as exemptions on the income tax return for the individual completing the application, whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a family member is not obtainable, the family unit size will be assumed to be one. If a tax return has not been filed, then income from all members living in the household will be considered.

G. Liquid Assets: Cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, rental properties etc. The availability of liquid assets plus annual income will be considered in relation to the current poverty guidelines published in the Federal Register. The first $10,000 of monetary assets, and up to $150,000 in a primary residence is excluded.

H. Medical debt: Out of pocket expenses, excluding copayments, coinsurance and deductibles, for medical costs billed by a hospital as defined under Maryland Code, Title 10, Subtitle 37.10.26 – *Patient Rights and Obligations – Hospital Credit and Collection and Financial Assistance Policies*.

IV. Patient Education and Outreach:

A. Patients who qualify for financial assistance can be identified either before or after services are provided. A determination of probable eligibility will be made within two business days following a patient's completion of the financial assistance application.

B. CHC will clearly post signage in English and Spanish to advise patients of the availability of financial assistance. Staff members will communicate the contents of signs to people who do not appear able to read. Signage will be posted in conspicuous places throughout the hospital, including each registration area and the billing department, informing patients of their right to apply for financial assistance. Inquiries are directed to the financial counselor at (410) 871-6718.

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.

H. During open enrollment or the event of a major life change resulting in the loss of insurance coverage, the patient will be required to purchase coverage if eligible through the Maryland Health Connection. If it is determined that the patient cannot afford the insurance premium, the Hospital may pay the premium at the discretion of the Financial Assistance Committee.

I. Assessment forms shall identify all income sources on a monthly and annual basis (taking into consideration seasonal employment and temporary increases and/or decreases in income) for the patient/guarantor. If anyone in the family unit owns a business, the gross receipts and net income from the business will be considered. Additionally, current information must be submitted for business income and expenses. If current income and expenses are not available, the previous year's tax return 1040 and Schedule C must be submitted. Examples of income sources are:

    1. Income from wages
    2. Retirement/Pension Benefits
    3. Income from self-employment
    4. Alimony
    5. Child support
    6. Military family-allotments
    7. Public assistance
    8. Pension
    9. Social Security
    10. Strike benefits
    11. Unemployment compensation
    12. Workers Compensation
    13. Veterans Benefits
    14. Other sources, such as income and dividends, interest or rental property

J. All information obtained from patients and family members shall be treated as confidential. Assurances about confidentiality of patient information shall be provided to patients in both written and verbal communications.

K. Patients/guarantors shall be informed in writing of financial assistance determinations along with a brief explanation. Patients/guarantors shall be informed of the mechanism for them to request a reconsideration of the denial of free or reduced care. A copy of the letter shall be retained in the confidential central file, along with the patient/guarantor's application.

L. Financial assistance determinations shall remain in effect for future services provided for six months following approval.

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 sources such as physicians, community or religious groups, internal or external social services or financial counseling personnel.

Individuals shall be asked to provide proof of qualification or participation in programs that, by their nature, are operated to benefit individuals with limited financial resources. Patients receiving the following services shall be considered eligible for presumptive financial assistance.

a. Patient has received care from and/or has participated in Women's, Infants and Children's (WIC) programs.
b. Patient is homeless.
c. Patient's family is eligible for and is receiving Maryland food stamps.
d. Patient's family is eligible for and is participating in subsidized school lunch programs.
e. The patient's home address and documentation evidencing status in an affordable or subsidized housing development.
f. Patient/guarantor's wages are insufficient for garnishment, as defined by state law.
g. Patient is deceased, with no known estate.

VIII. Appeals

Patient/guarantors shall be informed of their right to appeal any decision regarding their eligibility for financial assistance. An appeal letter, including any additional information that may be applicable, will be reviewed by the Assistant Vice President of Revenue Cycle. After review, a final decision along with the criteria used to reach the decision will be mailed to the patient.

IX. Late Discovery of Eligibility

CHC shall provide a refund of amounts exceeding $25.00 collected from a patient or guarantor of a patient who, within a 2-year period after the date of service, was found to be eligible for free care on the date of service.

X. Reference Documents

1. *Carroll Hospital Center Service Area* – Exhibit A
2. *Income Scale for CHC Financial Assistance* (Based on Federal Poverty Guidelines (updated annually) in Federal Register) – Exhibit B
3. *Maryland State Uniform Financial Assistance Application* – Exhibit C

EXHIBIT 3

EXHIBIT 3

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	_____

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? _____

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 4

EXHIBIT 4

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 5

EXHIBIT 5

Income Scale for CHC Financial Assistance
Based on 2014* Federal Poverty Guidelines (A)

Financial Assistance %		100%	75%	50%	25%
Persons in Family/Household	**Income**	**Income Multiple**			
		300%	**325%**	**350%**	**375%**
1	$11,670	$35,010	$37,928	$40,845	$43,763
2	$15,730	$47,190	$51,123	$55,055	$58,988
3	$19,790	$59,370	$64,318	$69,265	$74,213
4	$23,850	$71,550	$77,513	$83,475	$89,438
5	$27,910	$83,730	$90,708	$97,685	$104,663
6	$31,970	$95,910	$103,903	$111,895	$119,888
7	$36,030	$108,090	$117,098	$126,105	$135,113
8	$40,090	$120,270	$130,293	$140,315	$150,338
For families/households with more than 8 persons, add $4,060 for each additional person.					

(A) SOURCE: *Federal Register*, Vol. 79, No. 14, January 22, 2014, pp. 3593-3594

Income Scale for CHC Medical Hardship Assistance
Based on 2014 Federal Poverty Guidelines

Financial Assistance %		75%	50%	25%	15%
Persons in Family/Household	**Income**	**Income Multiple**			
		350%	**400%**	**450%**	**500%**
1	$11,670	$40,845	$46,680	$52,515	$58,350
2	$15,730	$55,055	$62,920	$70,785	$78,650
3	$19,790	$69,265	$79,160	$89,055	$98,950
4	$23,850	$83,475	$95,400	$107,325	$119,250
5	$27,910	$97,685	$111,640	$125,595	$139,550
6	$31,970	$111,895	$127,880	$143,865	$159,850
7	$36,030	$126,105	$144,120	$162,135	$180,150
8	$40,090	$140,315	$160,360	$180,405	$200,450
For families/households with more than 8 persons, add $4,060 for each additional person.					

EXHIBIT 6

EXHIBIT 6

Quality Improvement and Patient Safety Plan
Carroll Hospice
FY 2017

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 100 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. 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 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.
- 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 anecdotal information from stakeholders, including staff, patients and families.

Objectives

The overarching quality strategy for FY2017 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 regarding falls and infections.
- Further integrate lean principles into daily practice.

1. **High Quality Outcomes**
    - Comply with regulatory requirements regarding quality reporting.
        - Reporting of Medicare HIS data
    - Improve CAHPS survey scores that fell below the national average scores in FY16 under the following domains.
        - Hospice Team Communications
        - Treating Family Member with Respect
        - Getting Help with Symptoms
    - Increase staff knowledge and compliance with CHAP deemed status accreditation standards, including preparedness for a deemed status survey, scheduled to occur in FY2017.
        - Prepare CHAP Leaders group
        - Perform mock survey
        - Educate staff
        - Renew deemed status accreditation
    - Create a Protocol Committee to develop standard work around clinical practice.
        - Review and edit existing protocols
        - Develop protocols as needed

2. **Support and Grow Staff Strengths**
    - Enhance staff skills by implementing supervisory visits and on-site competency assessment and coaching for 100% of staff who provide direct patient care, to include nurses, hospice aides, social workers, chaplains, bereavement counselors and volunteers.
        - Review and enrich supervisory visit content to determine competence and identify needs for education.
        - Design daily metrics to measure outcomes for supervisory visits and educational needs.
    - 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.

3. **Improve Patient Safety Data Collection**
    - Enhance the Hospice's Infection Prevention plan to include a focused list of surveillance data to track in the fiscal year and increased participation in activities of the Carroll Hospital Infectious Disease Committee.

- Identifying patient safety risks including patient falls and infections on daily huddle.
- Increase same-day reporting of falls and infections.

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.

Goals

1. **High Quality Outcomes**
    - Compliance with Regulatory Requirements
        - 90% reporting of Medicare HIS data
    - Improvement of CAHPS Survey Scores
        - Percent of top box scores for Survey Question 14 (Hospice team listened carefully about problems with care): 81.8% (FY16 score: 79.3%)
        - Percent of top box scores for Survey Question 11 (Patient was treated with dignity and respect): 94.9% (FY16 score: 91.8%)
        - Percent of top box scores for Survey Question 25 (Patient received help for constipation): 71.7% (FY16 score: 71.6%)
    - Compliance with CHAP Accreditation Standards
        - 0 CHAP survey findings related to patient safety

2. **Support and Grow Staff Strengths**

    - Supervisory visits and on-site competency assessment for staff who provide direct patient care
        - 100% supervisory visits for direct-care staff and volunteers
    - Redesign Utilization Review Committee and associated audits
        - 120 records audited
        - 100% participation by nursing staff

3. **Improve Patient Safety Data Collection**

    - Focused surveillance data collected daily
        - Increase reporting of UTIs to include 60% of identified infections
        - Increase reporting of C. diff infections to include 60% of identified infections
    - Increase same-day reporting of falls data
        - Increase reporting of falls to include 80% of identified falls

4. **Integrate Lean Principles into Daily Practice**

    - Lean events for FY2017:

- Transfers In and Out of the Dove House Inpatient Unit
- Bereavement
- Interdisciplinary Group (IDG)

Performance Measures for the FY17 Quality Improvement and Patient Safety Plan

Executive Summary

1. **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:** CMS produces submission reports to track successful data submission. **Method:** The Executive Assistant will pull the submission reports on a monthly basis and provide them to the Manager, PI for report out. **Frequency:** Quarterly reported through Hospice Corporate Compliance **Who:** Laura Welty, Manager of Performance Improvement
Assessment Frequency	The percentage of total HIS data submission will be reviewed by the QAPI Committee on a monthly basis. **GOAL: 90% of required HIS records will be submitted for FY2017.**

Name	**CAHPS Communications**
Definition	Question 14 on the CAHPS Hospice Survey asks the respondent whether the hospice team listened carefully about problems with care. The top box score will reflect the amount of respondents who chose "Always" on their survey responses.
Data Collection	**How:** DEYTA administers and produces reports for the CAHPS Hospice survey. **Method:** CAHPS survey results will be downloaded and distributed to the QAPI Committee at least monthly for review. Responses to question 14 will be isolated on a QI dashboard. **Frequency:** Monthly for the duration of the fiscal year. **Who:** Gail Forsyth, Accreditation and Quality Specialist
Assessment Frequency	All CAHPS hospice survey results will be reviewed by the QAPI Committee on a monthly basis. **GOAL: The top box score for CAHPS Q14 will increase to 81.8%, the national average top box score in FY16.**

Name	CAHPS Respect
Definition	Question 11 on the CAHPS Hospice Survey asks the respondent whether the patient was treated with dignity and respect. The top box score will reflect the amount of respondents who chose "Always" on their survey responses.
Data Collection	**How:** DEYTA administers and produces reports for the CAHPS Hospice survey. **Method:** CAHPS survey results will be downloaded and distributed to the QAPI Committee at least monthly for review. Responses to question 36 will be isolated on a QI dashboard. **Frequency:** Monthly for the duration of the fiscal year. **Who:** Gail Forsyth, Accreditation and Quality Specialist
Assessment Frequency	All CAHPS hospice survey results will be reviewed by the QAPI Committee on a monthly basis. **GOAL: The top box score for CAHPS Q11 will increase to 94.9%, the national average top box score in FY16.**

Name	CAHPS Symptoms
Definition	Question 25 on the CAHPS Hospice Survey asks the respondent whether the patient received help for constipation. The top box score will reflect the amount of respondents who chose "Always" on their survey responses.
Data Collection	**How:** DEYTA administers and produces reports for the CAHPS Hospice survey. **Method:** CAHPS survey results will be downloaded and distributed to the QAPI Committee at least monthly for review. Responses to question 36 will be isolated on a QI dashboard. **Frequency:** Monthly for the duration of the fiscal year. **Who:** Gail Forsyth, Accreditation and Quality Specialist
Assessment Frequency	All CAHPS hospice survey results will be reviewed by the QAPI Committee on a monthly basis. **GOAL: The top box score for CAHPS Q25 will increase to 71.7%, the national average top box score in FY16.**

2. **Support and Grow Staff Strengths**

Name	Supervisory Visits
Definition	All Carroll Hospice associates and volunteers who provide direct patient care will receive at least one supervisory visit during the fiscal year. This will include all nursing staff, hospice aides, social workers, chaplains and volunteers who provide direct patient care. During these visits, clinical competencies specific to each discipline will be assessed and documented.
Data Collection	**How:** Clinical Managers and other supervisory staff will perform supervisory visits and document the findings of those visits as annual competence assessments. **Method:** Each team manager will be responsible for completing at least one supervisory visit for each team member. The Volunteer Coordinator will perform the visits for volunteers. Other nurse managers will provide support to complete the visits as needed. **Frequency:** Supervisory visits will be completed as needed on a monthly basis. Completed supervisory visits will be reported to Gail Forsyth at the close of each month. **Who:** Gail Forsyth, Accreditation and Quality Specialist
Assessment Frequency	The number of completed supervisory visits will be assessed on a monthly basis. **GOAL: Supervisory visits complete for 100% of direct care staff and volunteers.**

Name	UR Audits
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	The number of completed UR audits will be reviewed on a monthly basis. Attendance at the UR Committee will be mandatory and tracked on a regular basis. **GOAL: Complete 120 UR audits.** **GOAL: 100% of nursing staff will participate in the UR Committee.**

3. **Improve Patient Safety Data Collection**

Name	**Surveillance Data**
Definition	Submission of surveillance data will be required for each confirmed UTI and C. diff infection. Surveillance data reported will be in addition to documentation of the infection in the electronic medical record (EMR).
Data Collection	**How:** Data will be submitted through triage and Infection Report forms. **Method:** Staff providing direct patient care will be educated to report confirmed infections in real time. Each reported case will be compared with the EMR to confirm that at least 60% of infections documented in the EMR are also reported as surveillance data. **Frequency:** Data will be collected on a daily basis and analyzed monthly at the QAPI meetings. **Who:** Gail Forsyth, Accreditation and Quality Specialist
Assessment Frequency	The percentage of total surveillance data submitted will be reviewed by the QAPI Committee on a monthly basis. **GOAL: Increase reporting of UTIs to include 60% of identified infections.** **GOAL: Increase reporting of C. diff infections to include 60% of identified infections.**

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 through triage and Patient Safety Report forms. **Method:** Staff providing direct patient care will be educated to report falls in real time. Each reported fall will be compared with the EMR to confirm that at least 90% of falls documented in the EMR are also reported as patient safety data. **Frequency:** Data will be collected on a daily basis and analyzed monthly at the QAPI meetings. **Who:** Gail Forsyth, Accreditation and Quality Specialist
Assessment Frequency	The falls data submitted will be reviewed by the QAPI Committee on a monthly basis. **GOAL: Increase reporting of falls to include 80% of identified falls.**

EXHIBIT 7

EXHIBIT 7

DEYTA

Quality Measure Dashboard
Hospice CAHPS
Carroll Hospice

Timeframe: Custom range (7/1/2015 - 6/30/2016) | **Surveys Included:** Only CMS Complete
Report by: Survey Return Date | **Report Level:** Carroll Hospice

GLOBAL MEASURES

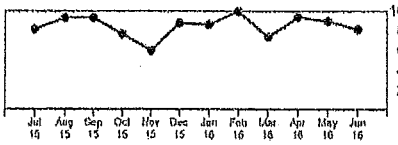
Interim results. CMS-published reports are official results.

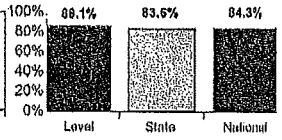
Report Level Results | Report Level Monthly Trends | Comparison Results

Rating of Patient Care (Survey Question: 39)

% Favorable: 86.1%

% Unfavorable: 13.9%

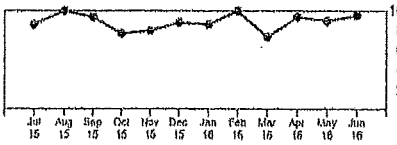


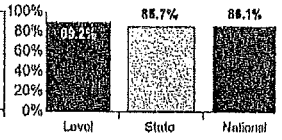


Would Recommend This Hospice (Survey Question: 40)

% Favorable: 89.2%

% Unfavorable: 10.8%



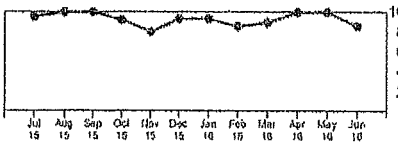


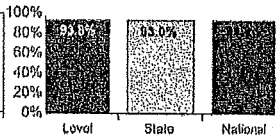
SINGLE ITEM MEASURES

Support for Religious and Spiritual Beliefs (Survey Question: 36)

% Favorable: 93.8%

% Unfavorable: 6.3%

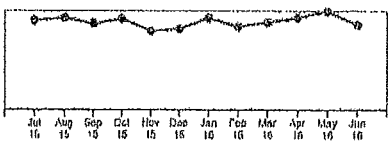


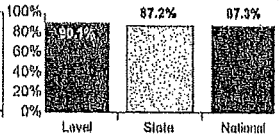


Information Continuity (Survey Question: 10)

% Favorable: 90.1%

% Unfavorable: 9.9%

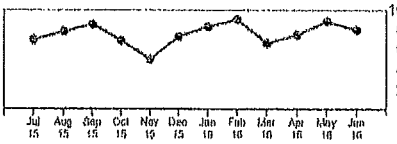


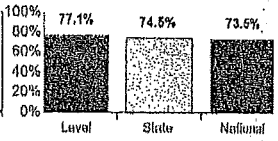


Understanding Side Effects of Pain Medications (Survey Question: 18)

% Favorable: 77.1%

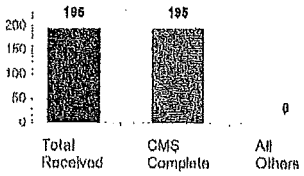
% Unfavorable: 22.9%





SURVEY PARTICIPATION

Records Submitted to Deyta	Surveys Sampled	Surveys Received
Not available by Survey Return Date	Not available by Survey Return Date	



DEYTA

Quality Measure Dashboard
Hospice CAHPS
Carroll Hospice

Timeframe: Custom range (7/1/2015 - 6/30/2016)
Report by: Survey Return Date

Surveys Included: Only CMS Complete
Report Level: Carroll Hospice

COMPOSITE MEASURES

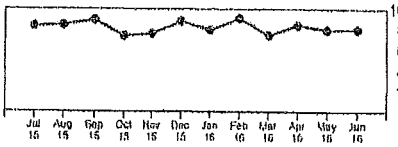
Interim results. CMS-published reports are official results.

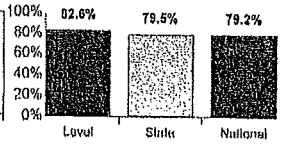
Report Level Results | Report Level Monthly Trends | Comparison Results

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

% Favorable: 82.6%

% Unfavorable: 17.4%

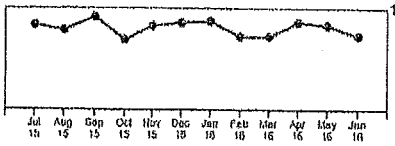


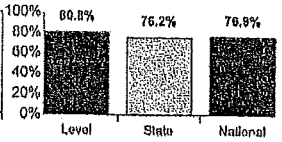


Getting Timely Care (Survey Questions: 5, 7)

% Favorable: 80.8%

% Unfavorable: 19.2%

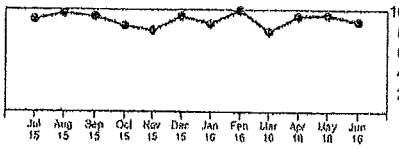


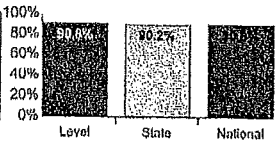


Treating Family Member with Respect (Survey Questions: 11, 12)

% Favorable: 90.8%

% Unfavorable: 9.2%

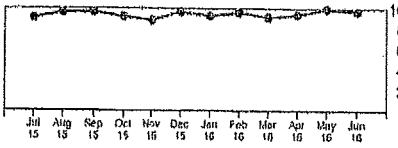


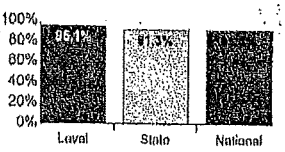


Providing Emotional Support (Survey Questions: 37, 38)

% Favorable: 95.1%

% Unfavorable: 4.9%

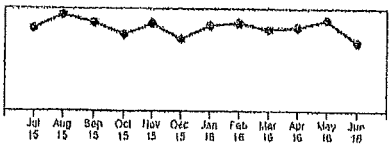


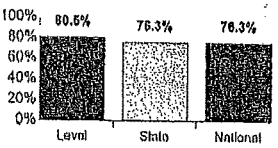


Getting Help with Symptoms (Survey Questions: 16, 22, 25, 27)

% Favorable: 80.5%

% Unfavorable: 19.5%

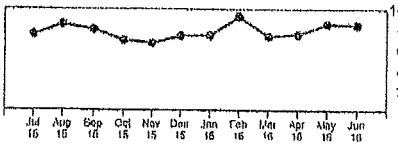




Getting Hospice Care Training (Survey Questions: 19, 20, 23, 29)

% Favorable: 78.6%

% Unfavorable: 21.4%



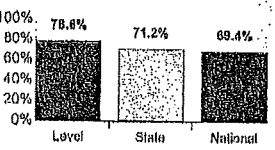


EXHIBIT 8

EXHIBIT 8

PATIENT RIGHTS AND RESPONSIBILITIES

A. 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. A 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, and you are not capable of decision making, Carroll Hospice will follow the State of Maryland's Health Care Decisions Act guidelines to determine who may make medical decisions on your behalf. You may also designate a legal representative at any time to exercise your rights and to 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.
    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 your 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. 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
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 have the right to be informed of short-term inpatient care options available for pain control, management and respite.
8. 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. REGARDING RESPECT, VOICING GRIEVENCES AND PROTECTION FROM MISTREATMENT, DISCRIMINATION AND REPRISAL

1. Carroll Hospice proudly states that no person shall, on the grounds of race, creed, color, religion, sex, national/ethnic origin, ancestry, sexual preference, age, mental or physical handicap, social status, political beliefs, or ability to pay, be excluded from participation in, be denied benefits of, or be subject to discrimination or harassment in the provision of any care or service. If you feel you have been the victim of discrimination, you have the right to file a grievance without retaliation for doing so.

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.

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. 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.
    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. 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.
6. You have the right to receive information addressing any beneficial relationship between Carroll Hospice and referring agencies.

F. IN ADDITION TO ALL OTHER RIGHTS AS A HOSPICE, THE PATIENT RESIDING IN A HOSPICE HOUSE HAS THE RIGHT TO:

1. Privacy, including the right to have a staff member knock on the resident's door before entering
2. Be free from mental, verbal, sexual and physical abuse, neglect, involuntary seclusion and exploitation
3. Be free from physical and chemical restraints
4. Manage personal financial affairs
5. Maintain legal council
6. Attend or not attend religious services as the patient chooses and receive visits from members of the clergy
7. Possess and use personal clothing and other personal effects to a reasonable extent, and to have reasonable security for those effects in accordance with the hospice house's security policy
8. Meet or visit privately with any individual the patient chooses in accordance with patient and facility safety
9. Have reasonable access to the private use of a telephone within the facility

10. Retain personal clothing and possessions as space permits with the understanding that the hospice house may limit the number of personal possessions retained at the facility for the health and safety of other patients

G. NOTICE OF PATIENTS RIGHTS - The hospice house shall place a copy of the patient's rights as set forth in this regulation, in a conspicuous location, plainly visible and easily read by patients, staff and visitors

EXHIBIT 9

EXHIBIT 9

Carroll Hospice
Certificate of Need Application: Outpatient Hospice Services to Baltimore City
Sources and Technical Notes

Data sources

Population data
- Maryland Department of Planning
  http://www.mdp.state.md.us/msdc/s3_projection.shtml

Hospital data
- Maryland hospitals: HSCRC Discharge Abstract Database, FY2016
  - HSCRC non-confidential revisit file (abstract data)
- LifeBridge Hospitals: Patient volume, internal reports

Data	Source
Palliative care consultations, inpatient	Department of Case Management
Hospice referrals from LifeBridge	Department of Case Management
Hospice admissions to Seasons	Seasons data provided to LifeBridge Planning Dept

Nursing home volumes
- MHCC Public Use Files

Hospice use rate
- Deaths, age 35+: Maryland Vital Statistics Administration
- Hospice deaths: MHCC Hospice Survey

Hospice needs projection
- Federal Register, Volume 43, Issue 11 (May 27, 2016)

Hospice length of stay, Baltimore City residents
- MHCC Hospice Survey, FY2015
- MedPAR, CY2014

Chronic conditions: Definitions
- CMS Chronic Conditions Data Warehouse (ICD-9/CPT4/HCPS Codes)

Technical Notes
Hospice use rate: Number of total hospice deaths divided by number of deaths, age 35+

"Outpatient hospice" defined to include the following settings in the MHCC Hospice Survey
- Home
- Assisted living
- Skilled nursing/Long term care
- Residential hospice

Outpatient hospice volume

- Estimated to be 70% of total hospice volume projected by the MHCC based on historical experience in Maryland and national benchmarks

Chronic conditions: Candidates for hospice care, hospital spending (High level analysis)

- The high level analysis selected the following diagnostic groupings and age cohorts:
  - Any one of CMS-defined cancer diagnoses, patients age 20+ years
  - Any of the of the following chronic condition diagnoses, patients age 65+ years
    - Heart failure
    - Ischemic heart disease
    - Chronic obstructive pulmonary disease (COPD)
    - Chronic kidney disease
    - Alzheimer's disease and related disorders
- Hospital spending for patients with discharge disposition = death
  - Documented spending for the 6-month period prior to death obtained using the HSCRC non-confidential revisit files

EXHIBIT 10

EXHIBIT 10

LifeBridge Health service area
Zip code definitions

Zip Code	PSA/SSA
21048	PSA
21074	PSA
21102	PSA
21117	PSA
21133	PSA
21136	PSA
21157	PSA
21158	PSA
21207	PSA
21208	PSA
21209	PSA
21215	PSA
21216	PSA
21244	PSA
21784	PSA
21787	PSA
21093	SSA
21206	SSA
21211	SSA
21212	SSA
21217	SSA
21218	SSA
21228	SSA
21229	SSA
21234	SSA
21239	SSA
21771	SSA
21776	SSA
21791	SSA
21797	SSA

EXHIBIT 11

Carroll Hospice
Reconciliation of Audited Financials to Table 3 Application
FY 2015 and FY 2016

	Audit Results	Hospice Expenses Subsidized by Hospital (Note 2)	Adj Hospice Results (Table 3)
FY 2015			
July - March 2015 (Pre-Merger with LBH)	$ 1,076,645		
Apr - June 2015 (Post Merger) - Note 1	$ 222,043		
FY 2015 Total	$ 1,298,688	$ (560,903)	$ 737,785
FY 2016			
July - June 2016 (Post Merger)	$ 875,541	$ (617,600)	$ 257,941

Note 1: Carroll merged with LifeBridge Health effective April 1, 2016

Note 2: Hospice related expenses subsidized by Carroll Hospital include: Finance, Audit, Tax, IT, HR, Benefit Administration, Benefits

FY 2015
9 MONTHS JULY - MARCH '15
(PRE-MERGER)

KPMG LLP
1 East Pratt Street
Baltimore, MD 21201-1128

- APPLICABLE PAGES ONLY

July 8, 2015

LifeBridge Health, Inc.
2401 W. Belvedere Ave.
Baltimore, Maryland 21215

Maryland Health and Higher Educational Facilities Authority
401 E. Pratt Street
Suite 1224
Baltimore, Maryland 21202

Merrill Lynch, Pierce, Fenner & Smith Incorporated
One Bryant Park, 12th Floor
New York, New York 10036

Ladies and Gentlemen:

We have audited the consolidated balance sheets of LifeBridge Health, Inc. and Subsidiaries (LifeBridge) and Carroll County Health Services Corporation (Carroll), (together, the Corporation), as of June 30, 2014 and 2013, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended which are included separately in Appendix B-1 and B-2 to the Preliminary Official Statement, dated July 8, 2015, for the $163,625,000 Maryland Health and Higher Educational Facilities Authority Revenue Bonds, Series 2015.

In connection with the Preliminary Official Statement:

1. We are independent certified public accountants with respect to the Corporation under Rule 101 of the American Institute of Certified Public Accountants' Code of Professional Conduct, and its interpretations and rulings.

2. We have not audited any financial statements of LifeBridge and Carroll as of any date or any period subsequent to June 30, 2014. Although we have conducted an audit for the year ended June 30, 2014, the purpose (and therefore the scope) of the audit was to enable us to express our opinion on the consolidated financial statements of LifeBridge and Carroll, separately, as of June 30, 2014 and for the year then ended, but not on the consolidated financial statements of the Corporation for any interim period within that year or any period thereafter. Therefore, we are unable to and do not express any opinion on the unaudited consolidated balance sheets as of March 31, 2015 and 2014, and the unaudited consolidated statements of operations and changes in net assets and cash flows for the nine-month periods ended March 31, 2015 and 2014, included in the Preliminary Official Statement, or on the financial position, results of

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity

CARROLL COUNTY HEALTH SERVICES CORPORATION AND SUBSIDIARIES

Consolidated Statements of Operations

Nine months ended March 31, 2015 and 2014

(In thousands)

	2015 (unaudited)	2014 (unaudited)
Unrestricted revenues, gains, and other support:		
Patient service revenue (net of contractuals)	$ 211,618	205,643
Less provision for bad debts	5,486	7,461
Net patient service revenue	206,132	198,182
Other operating revenues	15,942	16,860
Net assets released from restrictions used for operations	—	—
Total unrestricted revenues, gains, and other support	222,074	215,042
Expenses:		
Salaries and wages	95,570	91,157
Employee benefits	16,768	15,768
Departmental supplies and expenses	38,794	37,280
Professional fees	20,808	17,527
Purchased services	30,223	29,972
Depreciation and amortization	14,447	13,980
Interest	4,452	4,518
Total expenses	221,062	210,202
Operating income	1,012	4,840
Other income (expense):		
Investment income	1,725	7,413
Unrestricted gifts	1,250	741
Change in fair value of interest rate hedge, including settlement payments	(6,364)	(486)
Other, net	(699)	(698)
Excess of revenues over expenses	$ (3,076)	11,810

See accompanying notes to condensed consolidated financial statements.

See Page 3 for Entity Breakout

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CONSOLIDATING
FOR THE 9 MONTHS ENDED March 31, 2015

July to March	Health Services	Carroll Hospital Center	Dixon Imaging Center	Carroll Hospice, Inc	Carroll Hospital Center Foundation, Inc	Ote-Mar	Eliminations	TOTAL CHC and Subs	Carroll County MedServices, Inc	Eliminations	Consolidated
GROSS REVENUE											
Inpatient Revenue	$0	$103,864,624		$980,374	$0	$0	$0	$104,853,998	$0	$0	$104,853,998
Outpatient Revenue	0	93,196,341	43,493,489	3,135,887	0	0	(5712,205)	139,113,432	40,109,239	0	179,222,671
TOTAL PATIENT REVENUE	$0	$197,060,965	$43,493,489	$4,125,181	$0	$0	($712,205)	$243,967,430	$40,109,239	$0	$284,076,669
Allowances & Uncollectible's	0	(29,746,236)	(27,406,934)	(139,122)	0	0	0	(57,292,292)	(20,653,560)	0	(77,945,852)
NET PATIENT REVENUE	$0	$167,314,729	$16,086,555	$3,986,059	$0	$0	($712,205)	$186,675,138	$19,455,679	$0	$206,130,817
Other Operating Revenue	87,116	3,524,142	0	0	2,756	2,232,333	(2,232,333)	3,553,898	14,888,522	(1,767,844)	15,952,576
TOTAL OPERATING REVENUE	$87,116	$170,838,871	$16,086,555	$3,986,059	$2,756	$2,232,333	($2,944,538)	$190,209,036	$34,344,202	($2,367,644)	$222,083,010
OPERATING EXPENSES											
Salaries		$66,534,472	$3,453,623	$2,574,085	$0	$0		$72,558,179	$23,241,446		$95,799,625
Benefits		13,163,204	438,044	272,316	0	0		13,873,518	2,894,303		16,767,821
Professional Fees		16,756,816	5,072,410	37,740	0	0		21,866,967	870,164	(1,929,067)	20,808,058
Supplies		28,232,458	784,719	217,400	0	0		29,534,528	9,268,814		38,794,342
Purchased Services	54,837	23,435,660	2,524,245	564,241	0	969,253	(13,755,726)	12,792,877	7,436,498	(1,437,940)	18,791,435
Operating Cash Flow	32,279	22,296,435	3,817,434	573,783	9,756	1,262,980	789,188	28,949,576	(9,661,260)	589,312	19,909,908
Depreciation/Amortization		11,875,198	1,022,521	148,522	0	0	297,068	13,342,901	913,569	221,815	13,447,235
Interest	29,802	5,545,308	0	0	0	0	282,128	4,937,530	16,678	367,488	4,451,904
TOTAL OPERATING EXPENSES	$84,639	$163,763,042	$13,291,442	$3,530,598	$0	$969,353	($2,944,538)	$178,609,896	$44,734,949	($2,367,644)	$221,063,840
INCOME FROM OPERATIONS	$2,477	$7,075,829	$2,795,113	$455,462	$9,756	$1,262,980	$0	$11,599,140	($10,390,447)	$0	$1,011,170
Contributions		0		251,521	417,942	0		1,249,763			1,249,763
Fundraising Expenses		(316,772)		(251,513)	(170,765)	0		(699,048)			(699,048)
Non-Operating Income	191,641	240,862		835	313,518	146,258		661,265	872,572		1,725,416
SA AP Interest		(979,474)			0	0		(979,474)			(979,474)
Interest Rate Derivative		(5,383,841)			0	0		(5,383,841)			(5,383,841)
NON-OPERATING REVENUES / EXPENSES	$191,641	($6,439,495)	$0	$621,184	$560,657	$146,258	$0	($5,151,396)	$872,572	$0	($4,007,183)
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	$194,118	$596,334	$2,795,113	$1,076,645	$570,413	$1,409,238	$0	$6,447,744	($9,717,875)	$0	($3,076,014)

FY 2015
3 MONTHS APR.-JUNE '15
(POST-MERGER)
- APPROPRIATE PAGES ONLY

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Financial Statements and
Supplementary Financial Information

June 30, 2015 and 2014

(With Independent Auditors' Report Thereon)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended June 30, 2015 and 2014

(Dollars in thousands)

	2015	2014
Unrestricted revenues, gains and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 1,201,545	1,073,738
Provision for bad debts	54,845	56,245
Net patient service revenue	1,146,700	1,017,493
Net assets released from restrictions used for operations	3,665	3,935
Other operating revenue	62,764	56,357
Total operating revenues	1,213,129	1,077,785
Expenses:		
Salaries and employee benefits	662,338	598,683
Supplies	195,387	174,446
Purchased services	201,240	173,441
Depreciation, amortization and gain/loss on sale of assets	62,957	62,053
Repairs and maintenance	19,774	18,912
Interest	20,687	18,997
Total expenses	1,162,383	1,046,532
Operating income	50,746	31,253
Other income, net:		
Investment income	21,161	22,460
Unrealized (losses) gains on trading investments	(10,978)	31,232
Other	4,563	9
Total other income, net	14,746	53,701
Excess of revenues over expenses before inherent contribution	65,492	84,954
Inherent contribution – CCHS	134,032	—
Excess of revenues over expenses	$ 199,524 (2)	84,954

See accompanying notes to consolidated financial statements.

See Page 6 For Breakdown

Schedule 2

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Statement of Operations Information

Year ended June 30, 2015

(Dollars in thousands)

	Sinai Hospital Consolidated	Northwest Hospital	* Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Courtland Gardens	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Unrestricted revenues, gains, and other support								
Patient service revenue (net of contractual allowances and discounts)	$ 708,803	242,622	63,809	76,730	2,159	107,422	—	1,201,545
Provision for bad debts	31,010	16,247	605	3,338	186	3,459	—	54,845
Net patient service revenue	677,793	226,375	63,204	73,392	1,973	103,963	—	1,146,700
Net assets released from restrictions used for operations	3,179	—	7	35	—	444	—	3,665
Other operating revenue	46,983	7,232	1,233	860	29	58,487	(52,060)	62,764
Total operating revenues	727,955	233,607	64,444	74,287	2,002	162,894	(52,060)	1,213,129
Expenses								
Salaries and employee benefits	362,346	122,469	29,740	47,727	1,694	97,831	531	662,338
Supplies	129,199	36,038	11,177	6,735	152	12,086	—	195,387
Purchased services	139,568	38,355	13,896	13,212	865	47,935	(52,591)	201,240
Depreciation, amortization, and gain/loss on sale of assets	33,340	11,509	3,821	3,296	81	10,910	—	62,957
Repairs and maintenance	13,819	4,323	—	987	41	604	—	19,774
Interest	12,210	4,459	1,489	529	—	2,000	—	20,687
Total expenses	690,482	217,153	60,123	72,486	2,833	171,366	(52,060)	1,162,383
Operating income (loss)	37,473	16,454	4,321	1,801	(831)	(8,472)	—	50,746
Other income (loss), net								
Investment income	9,490	8,384	545	742	—	2,000	—	21,161
Unrealized gains on trading investments	(1,762)	(6,046)	17	(1,762)	—	(1,425)	—	(10,978)
Other	—	—	661	—	3,409	493	—	4,563
Total other income (loss), net	7,728	2,338	1,223	(1,020)	3,409	1,068	—	14,746
Excess (deficiency) of revenues over expenses before inherent contributions	45,201	18,792	5,544	781	2,578	(7,404)	—	65,492
Inherent contribution – CCHS	—	—	—	—	—	134,032	—	134,032
Excess of revenues over expenses	$ 45,201	18,792	5,544	781	2,578	126,628	—	199,524

(3) (2)

SEE PAGE 7

See accompanying independent auditors' report

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CONSOLIDATING
FOR THE 3 MONTHS ENDED June 30, 2015

April to June	Health Services	Carroll Hospital Center	Dixon Imaging Center	Carroll Hospice, Inc	Carroll Hospital Center Foundation, Inc	Cen-Mar	Eliminations	TOTAL CHC and Subs	Carroll County MedServices, Inc	Eliminations	Consolidated
GROSS REVENUE											
Inpatient Revenue	$0	$34,602,140	$0	$348,812	$0	$0	$0	$34,951,952	$0	$0	$34,951,952
Outpatient Revenue	0	31,838,595	12,667,734	1,189,683	0	0	(310,730)	47,385,282	13,683,946	0	61,189,228
TOTAL PATIENT REVENUE	$0	$66,441,735	$14,683,734	$1,538,495	$0	$0	($310,730)	$82,337,234	$13,683,946	$0	$96,141,180
Allowances & Uncollectibles	0	(9,757,502)	(9,437,024)	(58,731)	0	0	0	(19,253,257)	(6,779,372)	0	(26,232,629)
NET PATIENT REVENUE	$0	$56,684,233	$5,250,710	$1,479,764	$0	$0	($310,730)	$63,203,977	$6,904,574	$0	$69,988,551
Other Operating Revenue	27,347	914,989	0	171,524	153,877	744,110	(744,110)	1,240,399	1,602,361	(742,774)	2,127,324
TOTAL OPERATING REVENUE	$27,347	$57,599,222	$5,250,710	$1,651,288	$153,877	$744,110	($954,840)	$64,444,367	$8,506,935	($742,774)	$72,035,875
OPERATING EXPENSES											
Salaries	$0	$25,295,050	$1,171,448	$521,277	$0	$0	$0	$25,246,378	$7,624,710	$0	$32,871,088
Benefits	0	4,169,395	219,394	104,344	0	0	0	4,493,333	935,195	0	5,428,528
Professional Fees	0	4,375,127	1,659,204	11,995	0	0	0	6,246,526	381,243	(656,248)	5,971,131
Supplies	0	10,707,261	311,718	157,240	0	0	0	11,176,918	401,374	0	11,578,292
Purchased Services	24,234	8,202,426	556,753	292,585	60,525	177,792	(1,255,330)	7,649,986	2,591,715	(497,094)	9,764,160
Operating Cash Flow	7,013	6,991,341	1,351,733	262,871	103,349	821,902	401,030	9,631,396	(2,517,402)	311,660	6,432,675
Depreciation/Amortization	0	3,325,538	256,747	40,955	0	0	98,513	3,631,354	1,862,961	37,147	5,761,932
Interest	19,528	1,186,178	0	0	0	0	302,527	1,488,705	(720)	234,482	1,722,468
TOTAL OPERATING EXPENSES	$30,862	$55,419,937	$4,355,935	$1,429,272	$60,525	($77,792)	($954,840)	$60,123,038	$13,686,578	($742,774)	$73,097,696
INCOME FROM OPERATIONS	($3,515)	$2,179,285	$994,786	$222,016	$103,349	$821,902	$0	$4,321,337	($5,179,643)	$0	($1,061,821)
Contributions	0	0	0	0	0	0	0	0	0	0	0
Fundraising Expenses	0	0	0	0	0	0	0	(0)	0	0	(0)
Non-Operating Revenue	0	0	0	50	44,463	(621,554)	0	592,824	84,540	0	677,028
SW AP Interest	24,664	539,887	0	38	0	0	0	(105,948)	0	0	(105,948)
Interest Rate Derivatives	0	(105,948)	0	0	0	0	0	769,653	0	0	769,653
	0	769,653	0	0	0	0	0	0	0	0	0
NON-OPERATING REVENUES / EXPENSES	$24,664	$1,200,592	$0	$88	$44,463	($621,554)	$0	$1,255,529	$84,540	$0	$1,332,733
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	$21,149	$3,379,877	$994,786	$222,045	$147,812	$800,348	$0	$5,544,866	($5,095,103)	$0	$270,912

All of FY 2015

CONSOLIDATING
FY 2015 FINANCIALS BEFORE RECLASSES

	Health Services	Carroll Hospital Center	Dixon Imaging Center	Carroll Hospice, Inc.	Carroll Hospital Center Foundation, Inc.	Cen-Mar	Eliminations	TOTAL CHC and Subs	Carroll County MedServices, Inc	Eliminations	Consolidated
FY 2015											
GROSS REVENUE											
Inpatient Revenue	$0	$139,805,951	$0	$1,358,187	$0	$0	$0	$139,805,951	$0	$0	$139,805,951
Outpatient Revenue	0	123,104,556	58,181,223	4,305,489	0	0	(927,935)	186,618,714	53,793,185	0	241,411,899
TOTAL PATIENT REVENUE	$0	$263,502,710	$58,181,223	$5,663,676	$0	$0	($927,935)	$326,424,664	$53,793,185	$0	$380,217,849
Allowances & Uncollectibles	0	(39,503,738)	(36,843,958)	(197,653)	0	0	0	(76,545,349)	(27,633,532)	0	(104,178,881)
NET PATIENT REVENUE	$0	$223,998,962	$21,337,265	$5,465,023	$0	$0	($927,935)	$249,879,315	$26,160,253	$0	$276,039,368
Other Operating Revenue	114,463	4,429,131	0	171,924	163,633	2,976,443	(2,971,443)	4,774,288	16,291,184	(2,116,438)	18,949,512
TOTAL OPERATING REVENUE	$114,463	$228,428,093	$21,337,265	$5,637,347	$163,633	$2,976,443	($3,899,378)	$254,653,603	$42,451,437	($3,116,438)	$294,108,885
OPERATING EXPENSES											
Salaries	$0	$89,467,377	$4,625,071	$3,003,562	$0	$0	$0	$97,474,957	$30,965,256	$0	$128,440,213
Benefits	0	17,532,659	653,638	735,355	0	0	0	18,366,852	3,819,406	0	22,186,258
Professional Fees	0	21,731,953	6,731,905	49,643	0	0	0	28,113,499	1,151,447	(2,486,251)	26,779,195
Supplies	0	[illegible]	1,096,428	470,990	0	0	0	40,707,446	9,665,185	0	50,372,631
Purchased Services	75,171	[illegible]	3,057,036	361,830	491,561	(5,189,667)	5,189,667	31,489,684	10,028,216	(1,525,049)	39,987,815
Operating Cash Flow	39,292	29,165,738	5,169,167	335,954	2,084,982	1,190,226	1,190,226	38,580,972	(13,178,662)	900,985	26,342,284
Depreciation/Amortization	0	[illegible]	1,576,268	158,377	0	0	393,573	17,134,254	2,775,470	[illegible]	20,209,166
Interest	40,936	4,371,366	0	0	0	0	204,655	5,536,241	15,958	[illegible]	6,184,069
TOTAL OPERATING EXPENSES	$115,501	$219,182,939	$17,547,365	$4,959,870	$50,538	$891,561	($3,899,378)	$238,732,926	$55,421,527	($3,116,438)	$294,159,536
INCOME FROM OPERATIONS	($1,038)	$9,255,114	$3,789,899	$677,477	$113,105	$2,084,882	$0	$15,920,477	($13,970,090)	$0	($550,651)
Contributions	0	0	0	351,861	417,913	0	0	1,249,762	0	0	1,249,763
Fundraising Expenses	0	(349,772)	0	121,314	(129,763)	0	0	(699,049)	0	0	(699,049)
Non-Operating Revenue	216,305	749,479	0	563	357,981	124,704	0	1,224,027	957,112	0	2,397,244
SWAP Interest	0	(1,088,422)	0	0	0	0	0	(1,088,422)	0	0	(1,088,422)
Interest Rate Derivatives	0	(4,614,188)	0	0	0	0	0	(4,614,188)	0	0	(4,614,188)
NON-OPERATING REVENUES / EXPENSES	$216,305	($5,278,903)	$0	$473,737	$646,130	$124,704	$0	($5,927,868)	$957,112	$0	($2,754,451)
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	$215,266	$3,976,211	$3,789,899	$1,298,688	$759,235	$2,209,586	$0	$11,992,609	($13,012,978)	$0	($2,805,102)

FY 2016
12 MONTHS July-June 2016
(Post Merger)

· Applicable Pages Only

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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

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.

See Page 11

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 (4)	3,926	(15,663)	—	40,687

See accompanying independent auditors' report

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CARROLL HOSPITAL CENTER INC & SUBSIDIARIES

Consolidated Statements of Operations

Year ended June 30, 2016

(Dollars in thousands)

	Carroll Hospital Center & Subsidiaries	Carroll County Radiology, LLC	Carroll Hospice Inc	Carroll Hospital Center Foundation Inc	Cen-Mar	Eliminations	Total
Unrestricted revenues, gains and other support:							
Patient service revenue (net of contractual allowances and discounts)	$ 229,165	23,175	6,107	0		(940)	257,505
Provision for bad debts	6,269	1,142		0			7,411
Net patient service revenue	222,896	22,031	6,107	0	0	(940)	250,094
Net assets released from restrictions used for operations							
Other operating revenue	3,320	0	945	1,094			5,359
Total operating revenues	226,217	22,031	7,052	1,094	0	(940)	255,453
Expenses:							
Salaries and employee benefits	108,697	5,531	4,312				118,540
Supplies	41,403	1,131	590				43,124
Purchased services	46,155	9,471	1,110	152		(2,133)	54,754
Depreciation, amortization and gain/loss on sale of assets	13,818	1,518	164	19		385	15,904
Repairs and maintenance	1,273						1,273
Interest	4,718					807	5,525
Total expenses	216,063	17,650	6,176	172	0	(941)	239,120
Operating income	10,154	4,381	876	922	0	0	16,333
Other income, net:							
Investment income	3,072			4,707			7,778
Unrealized gains on trading investments	(3,560)			(2,570)			(6,130)
Other	252						252
Total other income, net	(236)	0	0	2,137	0	0	1,901
Excess of revenues over expenses	$ 9,918	4,381	876	3,059	0	0	18,233
Loss on Refinancing of Debt	(1,592)	0	0	0	0	0	(1,592)
Net Income/(Loss) After Loss on Refinancing of Debt	$ 8,326	4,381	876	3,059	0	0	16,641

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Financial Statements and
Supplementary Financial Information

June 30, 2015 and 2014

(With Independent Auditors' Report Thereon)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

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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, 2015 and 2014, 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, 2015 and 2014, 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 LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

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 26, 2015

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2015 and 2014

(Dollars in thousands)

Assets	2015	2014
Current assets:		
Cash and cash equivalents	$ 356,973	219,711
Investments	23,761	12,675
Assets limited as to use, current portion	30,565	11,873
Patient service receivables, net of allowance for doubtful accounts of $58,346 in 2015 and $35,085 in 2014	142,212	121,324
Other receivables	10,164	6,559
Inventory	29,482	22,665
Prepaid expenses	19,079	10,719
Pledges receivable, current portion	6,693	4,298
Total current assets	618,929	409,824
Board-designated investments	250,000	—
Long-term investments	258,685	374,695
Donor-restricted investments	21,644	12,676
Reinsurance recovery receivable	15,935	13,365
Assets limited as to use, net of current portion	33,187	34,157
Pledges receivable, net of current portion	5,477	3,434
Property and equipment, net	595,143	459,638
Deferred financing costs, net of accumulated amortization of $767 in 2015 and $633 in 2014	4,073	2,319
Beneficial interest in split interest agreement	4,628	4,633
Investment in unconsolidated affiliates	33,865	18,720
Other assets, net	43,082	16,939
Total assets	$ 1,884,648	1,350,400

(Continued)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

June 30, 2015 and 2014

(Dollars in thousands)

Liabilities and Net Assets		2015	2014
Current liabilities:			
Accounts payable and accrued liabilities	$	117,874	86,384
Accrued salaries, wages and benefits		80,534	63,781
Advances from third-party payors		41,780	35,966
Current portion of long-term debt and capital lease obligations		14,711	6,198
Other current liabilities		14,418	9,382
Total current liabilities		269,317	201,711
Other long-term liabilities		130,856	100,147
Long-term debt and capital lease obligations, net of current portion		558,170	323,414
Total liabilities		958,343	625,272
Net assets:			
Unrestricted		844,907	660,970
Noncontrolling interest in consolidated subsidiaries		3,922	(192)
Total unrestricted net assets		848,829	660,778
Temporarily restricted		61,660	49,703
Permanently restricted		15,816	14,647
		926,305	725,128
Total liabilities and net assets	$	1,884,648	1,350,400

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended June 30, 2015 and 2014

(Dollars in thousands)

	2015	2014
Unrestricted revenues, gains and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 1,201,545	1,073,738
Provision for bad debts	54,845	56,245
Net patient service revenue	1,146,700	1,017,493
Net assets released from restrictions used for operations	3,665	3,935
Other operating revenue	62,764	56,357
Total operating revenues	1,213,129	1,077,785
Expenses:		
Salaries and employee benefits	662,338	598,683
Supplies	195,387	174,446
Purchased services	201,240	173,441
Depreciation, amortization and gain/loss on sale of assets	62,957	62,053
Repairs and maintenance	19,774	18,912
Interest	20,687	18,997
Total expenses	1,162,383	1,046,532
Operating income	50,746	31,253
Other income, net:		
Investment income	21,161	22,460
Unrealized (losses) gains on trading investments	(10,978)	31,232
Other	4,563	9
Total other income, net	14,746	53,701
Excess of revenues over expenses before inherent contribution	65,492	84,954
Inherent contribution – CCHS	134,032	—
Excess of revenues over expenses	$ 199,524	84,954

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2015 and 2014

(Dollars in thousands)

	Unrestricted	Temporarily restricted	Permanently restricted	Total net assets
Net assets at June 30, 2013	$ 562,818	47,190	14,540	624,548
Excess of revenues over expenses	84,954	—	—	84,954
Unrealized gain on investments	—	4,051	8	4,059
Net assets released from restrictions used for the purchase of property and equipment	5,202	(5,202)	—	—
Restricted gifts and bequests	—	7,051	102	7,153
Net assets released from restrictions used for operations	—	(3,932)	(3)	(3,935)
Net change in value of beneficial interest in split interest agreement	—	545	—	545
Adjustment to pension liability	7,623	—	—	7,623
Other	181	—	—	181
Change in net assets	97,960	2,513	107	100,580
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

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended June 30, 2015 and 2014

(Dollars in thousands)

	2015	2014
Cash flows from operating activities:		
Change in net assets	$ 201,177	100,580
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	62,697	62,076
Loss (gain) on disposal of equipment	260	(23)
Gain on sale of Courtland Gardens	(3,409)	—
Change in pension liability	16,548	(7,623)
Provision for bad debts	54,845	56,245
Realized and unrealized gains on investments, net	(2,412)	(51,925)
Inherent contribution – CCHS	(145,938)	—
Restricted gifts and bequests	(10,789)	(7,153)
Change in beneficial interest of split interest agreement	5	(545)
Earnings on investments in unconsolidated affiliates	(5,342)	(3,229)
Change in operating assets and liabilities:		
Increase in patient service receivables, net	(41,962)	(55,576)
Increase in other receivables	(1,021)	(1,336)
(Increase) decrease in pledges receivable	(4,438)	1,316
(Increase) decrease in inventory	(2,136)	728
Decrease in prepaid expenses	115	196
(Increase) decrease in reinsurance recovery receivable	(2,570)	10,549
Decrease (increase) in other assets	5,877	(10,159)
(Decrease) increase in accounts payable and accrued liabilities, and accrued salaries, wages, and benefits	(10,462)	7,390
(Decrease) increase in advances from third-party payors	(944)	1,210
Increase (decrease) in other current and long-term liabilities	1,121	(14,351)
Net cash provided by operating activities	111,222	88,370
Cash flows from investing activities:		
Change in donor-restricted investments	(8,968)	2,024
Addition of cash from CCHS acquisition	15,719	—
Change in long-term investments	(49,422)	1,874
Change in assets limited as to use	28,098	4,912
Investment in/distributions from unconsolidated affiliates, net	(6,543)	(10,561)
Additions to operating property	(44,462)	(47,128)
Proceeds from the sale of property	31	17
Settlement of swap	(13,998)	—
Acquisition of physician practices	(1,404)	(2,482)
Net cash used in investing activities	(80,949)	(51,344)
Cash flows from financing activities:		
Payment on debt and capital lease obligations	(53,800)	(5,997)
Proceeds from issuance of debt	150,000	—
Restricted gifts and bequests	10,789	7,153
Net cash provided by financing activities	106,989	1,156
Net increase in cash and cash equivalents	137,262	38,182
Cash and cash equivalents:		
Beginning of year	219,711	181,529
End of year	$ 356,973	219,711
Supplemental cash flow disclosures:		
Cash paid during the year for interest	$ 19,412	19,060
Cash paid during the year for income taxes	44	86
Accounts payable related to purchase of operating property	11,210	5,487

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; and 8600 Liberty Road, 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*
- *David L. Zisow M.D., LLC*
- *General Surgery Specialists, LLC*
- *BW Primary Care, LLC*
- *LifeBridge Community Practices, LLC*
- *The Center for Urologic Specialties, LLC*
- *LifeBridge Roundwood Practices, 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.

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 since April 1, 2015, as described below.

Wholly owned subsidiaries of CCHS include:

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

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 County CMO, LLC; and Carroll PHO, 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.

(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 $146,923 and $125,198 at June 30, 2015 and 2014, 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 $1,052, equities of $25,672, private equity of $2,945, fixed income of $4,351, inflation hedging funds of $2,820, and alternative investments of $17,427. 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 $2,430 and $3,780 for the years ended June 30, 2015 and 2014, 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 over the next 10 years. At the end of this period in 2024, 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.

(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

(Continued)

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 Agreement will continue through June 30, 2015 and on July 1, 2014, and each year thereafter, the Agreement will renew for a one-year period unless it is canceled by the HSCRC or by the Hospital (the Agreement was not cancelled for the period ending June 30, 2016). 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 "GBR cap" for the upcoming 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 occurred 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. The market share adjustment adjusts revenue and volumes at a 50% variable cost factor and is designed to be revenue-neutral on a statewide basis. The GBR cap continues to be adjusted annually for inflation, and for changes in payor mix and uncompensated care. Beginning on July 1, 2014 and each year thereafter, the Corporation will receive an annual adjustment to its cap for the change in population in the Corporation's service area.

Effective July 1, 2010, Carroll and the HSCRC agreed to a three year contract for Carroll to implement the Total Patient Revenue (TPR) methodology, which was renewed for an additional three year period effective July 1, 2013. The TPR agreement establishes a prospective, fixed revenue base, the "TPR cap," for the upcoming year. This includes both inpatient and outpatient regulated services. Under TPR, Carroll'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 occurred during the year. The TPR agreement allows Carroll to adjust unit rates, within certain limits, to achieve the overall revenue base for Carroll at year end. Any overcharge or undercharge versus the TPR cap is prospectively added to the subsequent year's TPR cap. Beginning in Fiscal Year 2016, the TPR is adjusted for changes in market share. The market share adjustment is a revenue neutral adjustment which adjusts revenue and volumes at a 50% variable cost factor. The TPR cap continues to be adjusted annually for inflation, and for changes in payor mix and uncompensated care. Beginning

in year three of the three-year contract, Carroll will receive an annual adjustment to its cap for the change in population in Carroll's service area. TPR is designed to encourage hospitals to operate efficiently by reducing utilization and managing patients in the appropriate care delivery setting.

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, Levindale and Courtland 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 and Courtland for services rendered in their long-term care facilities based on their actual costs, however, beginning in January 2015, the cost 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, 2015 and 2014, certain hospitals and physicians satisfied the meaningful use criteria. As a result, the Corporation recognized $3,728 and $4,494 of EHR incentives during fiscal years 2015 and 2014, respectively, in other operating revenue.

(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, 2015 and 2014, based on patient charges forgone, was $9,179 and $20,368, respectively. The total direct and indirect costs to provide the care amounted to approximately $7,548 and $16,918 for the years ended June 30, 2015 and 2014, 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.

		2015	2014
Beginning allowance	$	35,085	25,280
Plus provision for bad debt		54,845	56,245
Less bad debt write-offs, net of recoveries		(31,584)	(46,440)
Ending allowance	$	58,346	35,085

(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, 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 2015, LifeBridge adopted the RP-2014 Mortality Table with generational improvements. See footnote 11 for further discussion.

(Continued)

(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 other charitable CCHS Affiliates (the Foundation Contribution), 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 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.

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

(Continued)

The following table summarizes the Corporation's pro forma consolidated results as though the acquisition occurred at July 1:

		2015	2014
Total operating revenues	$	1,435,203	1,364,206
Operating income		51,757	38,293
Other income, net		144,690	61,366
Changes in net assets:			
Unrestricted	$	184,931	112,668
Temporarily restricted		12,488	2,290
Permanently restricted		1,169	107
Total changes in net assets	$	198,588	115,065

(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, 2015 and 2014, and consist of the following:

		2015	2014
Assets limited as to use:			
Self-insurance fund:			
Cash and cash equivalents	$	3,128	—
Mutual funds		2,197	—
Equity securities		7,106	8,346
U.S. Treasury		11,389	10,273
Government securities		1,705	2,006
Fixed income		11,350	9,160
Alternative investments		4,364	4,372
Self-insurance fund		41,239	34,157
Debt service fund:			
Cash and cash equivalents		11,501	10,221
Government securities		7,328	1,652
Debt Service Fund		18,829	11,873
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		(30,565)	(11,873)
Assets limited as to use, net of current portion	$	33,187	34,157
Donor-restricted investments:			
Cash and cash equivalents	$	5,418	3,617
Mutual funds		6,082	3,055
Equity securities		2,091	969
U.S. Treasury		3,238	2,057
Government securities		3,324	2,282
Fixed income		1,205	696
Alternative investments		286	—
Donor-restricted investments	$	21,644	12,676
Beneficial interest in split interest agreement	$	4,628	4,633

(Continued)

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, 2015 and 2014. As of June 30, 2015 and 2014 current, long-term, and board-designated investments are as follows:

		2015	2014
Current, long-term, and board-designated investments:			
Cash and cash equivalents	$	56,619	4,249
Mutual funds		165,392	110,780
Equity securities		132,483	136,221
Government securities		8,849	2,097
Fixed income		26,830	13,197
Alternative investments		142,273	120,826
Current, long-term and board-designated investments		532,446	387,370
Less current portion		(23,761)	(12,675)
Long-term and board-designated investments	$	508,685	374,695

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, 2015 and 2014:

		2015	2014
Investment income:			
Interest income and dividends	$	7,398	9,259
Realized gains on sale of securities		13,763	13,201
Investment income		21,161	22,460
Unrealized (losses) gains on trading securities		(10,978)	31,232
Other changes in net assets:			
Changes in unrealized gains on temporarily and permanently restricted net assets		(373)	4,059
Total investment return	$	9,810	57,751

(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.

Sinai, Northwest, Carroll, and Levindale have recorded total pledges as of June 30, 2015 and 2014 as follows:

		2015	2014
Gross pledges receivable	$	15,878	11,128
Less:			
Discount for time value of money		(1,232)	(1,261)
Allowance for uncollectible accounts		(2,476)	(2,135)
	$	12,170	7,732

Total future payments are as follows:

Less than one year	$	8,492
One to five years		6,657
Five years and thereafter		729
	$	15,878

(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		2015	2014
Land		$	7,302	2,838
Land improvements	8 to 20 years		35,913	11,964
Building and improvements	10 to 40 years		829,588	663,248
Fixed equipment	8 to 20 years		88,710	52,702
Movable equipment	3 to 15 years		453,896	305,244
			1,415,409	1,035,996
Less accumulated depreciation			(867,451)	(619,292)
			547,958	416,704
Construction in progress			47,185	42,934
Property and equipment, net		$	595,143	459,638

Depreciation, amortization, and gain/loss on sale of assets were $62,957 and $62,053 for the years ended June 30, 2015 and 2014, respectively. Of this, depreciation expense was $60,267 and $58,296 for the years ended June 30, 2015 and 2014, respectively.

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Included in property and equipment is building and equipment, net of accumulated amortization, of $9,258 and $9,849 for the years ended June 30, 2015 and 2014, respectively, financed with capital lease obligations. Accumulated amortization related to the building and equipment under capital leases was $21,222 and $16,583 at June 30, 2015 and 2014, 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, 2015 and 2014:

		2015		2014	
Joint Venture	Business purpose	Percentage ownership	Balance	Percentage ownership	Balance
MNR Industries, LLC	Urgent Care Centers	40%	$ 23,123	40%	$ 12,873
Riverside Health of Maryland, Inc.	Medicaid Managed Care Plan	20	2,736	20	2,314
Mt. Airy Plaza, LLC	Real Estate	50	1,649	—	—
LifeBridge Sports Medicine & Rehabilitation, LLC	Physical Therapy	50	1,165	50	1,217
Carroll Care Pharmacies, LLC	Pharmacies	49	1,018	—	—
Other Joint Ventures	Miscellaneous	0.12–50	4,174	25–50	2,316
	Total		$ 33,865		$ 18,720

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)

(8) Long-Term Debt and Capital Lease Obligations

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

	2015	2014
Maryland Health and Higher Educational Facilities Authority (MHHEFA):		
Revenue Bonds Series 2006	$ 35,000	—
Revenue Bonds Series 2008	266,285	269,405
Revenue Bonds Series 2011	48,315	49,130
Revenue Bonds Series 2012A	56,620	—
Other debt:		
Bank of America line of credit	100,000	—
M&T Bank taxable loan	50,000	—
Mortgage Payable line of credit	2,351	—
Capital leases	7,206	8,299
Other	343	343
	566,120	327,177
Less current portion	(14,711)	(6,198)
Unamortized premium	6,805	2,482
Unamortized discount	(44)	(47)
Long-term debt, net	$ 558,170	323,414

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 included $3,165 of term bonds maturing in 2026, $7,420 of term bonds maturing in 2036, and $24,415 of term bonds maturing in 2040, bearing interest at fixed rates of 4.5%, 5.0%, and 5.0%, respectively.

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%.

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

(Continued)

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).

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 (1.07% at June 30, 2015). 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.

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.

The Series 2006, 2008, 2011, and 2012A 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, 2015, the Obligated Group met all of its covenants.

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.

CCHS has a $3,500 line of credit with BB&T for property acquisition. The line of credit is interest only, payable at 30-day LIBOR plus 1.7%. The line matures on February 24, 2016. Currently, the line of credit has an outstanding balance of $2,300 and CCHS has pledged securities of $3,700 against the line.

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.

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:		
2016	$ 12,354	3,730
2017	110,792	2,344
2018	10,750	1,070
2019	11,140	1,022
2020	11,605	1,022
Thereafter	402,273	936
	$ 558,914	10,124
Less interest portion		(2,918)
		$ 7,206

(9) M&T Bank Line of Credit

Sinai maintains a $5,000 line of credit with M&T Bank. As of June 30, 2015 and 2014, 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:

	2015	2014
Healthcare services:		
Capital equipment/construction	$ 24,824	24,790
Other healthcare services:		
Service grants	215	149
Donor-specified healthcare services	20,491	11,939
Enrichment and research	16,130	12,825
	$ 61,660	49,703

Permanently restricted net assets of $15,816 and $14,647 at June 30, 2015 and 2014, respectively, are restricted 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 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, 2015 and 2014:

		2015	2014
Measurement date		June 30, 2015	June 30, 2014
Change in projected benefit obligation:			
Benefit obligation at beginning of year	$	174,787	159,218
Service cost		7,490	6,769
Interest cost		7,369	7,138
Actuarial loss		6,933	7,531
Benefits paid		(10,321)	(5,462)
Expenses paid from assets		(450)	(407)
Benefit obligation at end of year		185,808	174,787
Change in plan assets:			
Fair value of plan assets at beginning of year		157,068	130,332
Actual return on plan assets		3,666	22,519
Company contributions		8,694	10,086
Benefits paid		(10,321)	(5,462)
Expenses paid from assets		(450)	(407)
Fair value of plan assets at end of year		158,657	157,068
Funded status	$	(27,151)	(17,719)

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

		2015	2014
Amounts recognized in the consolidated balance sheets:			
Other long-term liabilities	$	27,151	17,719
Amounts recognized in unrestricted net assets:			
Net actuarial loss	$	41,086	27,984
Prior service cost		43	132
	$	41,129	28,116

The Corporation has estimated $10,523 for its defined-benefit contributions to the Sinai/Levindale Plans for the fiscal year ending June 30, 2016. The accumulated benefit obligation is $169,323 and $158,145 at June 30, 2015 and 2014, respectively.

Net periodic pension expense for the years ended June 30, 2015 and 2014 was as follows:

		2015	2014
Service cost	$	7,490	6,769
Interest cost		7,369	7,138
Expected return on plan assets		(10,982)	(9,413)
Amortization of net loss		1,149	2,042
Amortization of prior service cost		89	89
Net periodic benefit cost	$	5,115	6,625

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 $2,383 and $43, respectively.

Actuarial assumptions used were as follows:

	2015	2014
Assumptions used to determine annual pension expense:		
Discount rate	4.40%	4.70%
Expected return on plan assets	7.25	7.50
Rate of compensation increase	2.50	2.50
Assumptions used to determine end-of-year liabilities:		
Discount rate	4.47%	4.40%
Expected return on plan assets	7.00	7.25
Rate of compensation increase	2.50	2.50
Plan asset allocation:		
Asset category:		
Cash and cash equivalents	2.00%	1.00%
Fixed income/debt securities	25.00	24.00
Equity securities	48.00	50.00
Alternative investments	25.00	25.00
Total	100.00%	100.00%

In selecting the expected long-term rate on asset assumption, 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
Target allocation on assets:	
Equity securities	45%
Alternative investments	30
Fixed income/debt securities	25

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

Years ending June 30:		
2016	$	9,360
2017		10,997
2018		11,168
2019		11,418
2020		11,820
Thereafter		63,114

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

The fair values of assets of the Sinai/Levindale Plans held by PNC Institutional Investments by level at June 30, 2014 were as follows:

	Pension benefits – plan assets			
	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 5,146	—	—	5,146
Mutual funds	56,073	—	—	56,073
Fixed income	—	5,157	—	5,157
Equity securities	56,677	—	—	56,677
Alternative investments	—	—	34,015	34,015
Total assets	$ 117,896	5,157	34,015	157,068

For the years ended June 30, 2015 and 2014, 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, 2014	$ 34,015
Additions:	
Contributions/purchases	1,171
Disbursements:	
Withdrawals/sales	(1,063)
Net change in value	2,339
Balance as of June 30, 2015	$ 36,462

The following table summarizes redemption terms for the hedge fund-of-funds vehicles held as of June 30, 2015:

	Fund 1	Fund 2	Fund 3	Fund 4	Fund 5
Redemption timing:					
Redemption frequency	Quarterly	Quarterly	Quarterly	Annually	Monthly
Required notice	33 days	65 days	65 days	45 days	30 days
Audit reserve:					
Percentage held back for audit reserve	10%	5%	10%	—%	—%

(Continued)

(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 includes the activity of CCHS for the year ended June 30, 2015. As discussed in footnote 3, the statements of operations only includes the CCHS activity for the period April 1, 2015 to June 30, 2015.

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, 2015:

Measurement date		June 30, 2015
Change in projected benefit obligation:		
Projected benefit obligation at July 1, 2014	$	66,031
Interest cost		2,755
Actuarial loss		1,919
Benefits paid		(2,207)
Projected benefit obligation at end of year		68,498
Change in plan assets:		
Fair value of plan assets at beginning of year		58,548
Actual return on plan assets		1,190
Employer contribution		3,600
Benefits paid		(2,207)
Fair value of plan assets at end of year		61,131
Funded status	$	(7,367)

The accumulated benefit obligation for the Plan was $68,498 at June 30, 2015.

Net periodic pension expense for the year ended June 30, 2015 was as follows:

Components of net periodic pension expense:		
Interest cost	$	2,755
Expected return on plan assets		(4,140)
Amortization of actuarial loss		1,484
Net periodic pension expense	$	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 $1,869.

Assumptions to determine the benefit obligation as of June 30, 2015 (the measurement date) were as follows:

Discount rate	4.47%

Assumptions used in the determination of net periodic pension expense for the year ended June 30, 2015 were as follows:

Discount rate	4.25%
Expected long-term rate of return on plan assets	7.00

Deferred pension costs, which have not yet been recognized in periodic pension expense but are accrued in unrestricted net assets, are $24,742 at June 30, 2015. 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, 2016 is $559.

CCHS's weighted average asset allocations for the plan assets as of June 30, 2015 were as follows:

Mutual funds and equity securities	30.0%
Government and corporate bonds	45.0
Alternative investments	18.0
Cash and cash equivalents	7.0
	100.0%

Pension plan assets are invested in accordance with the CCHS's investment policy statement objectives in an attempt to maximize return with reasonable and prudent levels of risk. This structure

(Continued)

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.

The following table presents the Plan's assets measured at fair value at June 30, 2015:

	Pension benefits – plan assets			
Assets:				
Cash and cash equivalents	$ 4,205	—	—	4,205
Mutual funds	34,102	—	—	34,102
Fixed income	—	12,199	—	12,199
Equity Securities	—	—	—	—
Alternative investments	—	—	10,625	10,625
Total assets	$ 38,307	12,199	10,625	61,131

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, 2015 and 2014.

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).

CCHS expects to contribute $3,600 to the Carroll Plan in 2016.

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:

2016	$	2,587
2017		2,684
2018		2,817
2019		2,992
2020		3,212
2021–2025		18,660
	$	32,952

CCHS expensed total employee contributions of $290 for the three months April-June 2015.

(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 1 to 5 years, 4.0% for those in the plan from 6 to 19 years, and 6.5% thereafter. It is Northwest's policy to fund plan costs as they accrue. Plan expense was approximately $2,794 and $2,236 for the years ended June 30, 2015 and 2014, 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 $4,774 and $4,687 for the years ended June 30, 2015 and 2014, 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 $1,668 and $1,205 for the years ended June 30, 2015 and 2014, 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, whichever occurs first. The related expense was approximately $3,469 and $2,836 for the years ended

(Continued)

June 30, 2015 and 2014, 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, 2015, Carroll has accrued a liability of $376 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 under Section 1814(b) of the Social Security Act.

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 ties hospital per capita revenue growth to the state's historic economic growth rate of 3.58% per annum and requires that Medicare spending per capita in

(Continued)

Maryland not exceed the national average by more than 1%. It also requires Maryland to generate Medicare savings of $330 million over five years. The new waiver also imposes quality measures and encourages population health management.

(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, 2015, Investments has approximately $54,912 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 2035.

The net operating loss carryforwards created a federal net deferred tax asset of approximately $18,670 and $20,915 as of June 30, 2015 and 2014, respectively, and a state deferred tax asset of approximately $2,996 and $3,349 as of June 30, 2015 and 2014, 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, 2015 and 2014.

At June 30, 2015, CCHS has approximately $56,534 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 $24,801 and $19,042 as of June 30, 2015 and 2014, 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, 2015 and 2014. It has not yet been determined if the CCHS operating losses are subject to usage limitations under certain Internal Revenue Code provisions.

(Continued)

(15) Other Long-Term Liabilities

Other long-term liabilities at June 30, 2015 and 2014 are as follows:

		2015	2014
Professional/general liability (note 16(a))	$	51,924	51,959
Pension liability		34,894	17,719
Medical office building		34,256	21,257
Asset retirement obligation		3,260	3,260
Deferred compensation		4,864	4,959
Other		1,658	993
	$	130,856	100,147

At June 30, 2015, there was $12,121 included in other current liabilities related to professional liabilities.

(16) Self-Insurance Programs

(a) Professional/General Liability

The Corporation is self-insured, through LifeBridge Insurance and Cen-Mar, 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.

Legacy LifeBridge has accrued a liability for known and incurred but not reported claims of $5,905 and $6,439 at June 30, 2015 and 2014, respectively, and CCHS has accrued a liability for known and incurred but not reported claims of $994 as of June 30, 2015. These amounts are included in accounts payable and accrued liabilities in the accompanying consolidated balance sheets. Management believes

(Continued)

these accruals are is adequate to provide for all workers' compensation claims that have been incurred through June 30, 2015.

All other entities have occurrence-based commercial insurance coverage. There are no material insurance recoveries related to workers' compensation as of June 30, 2015.

Legacy LifeBridge and CCHS maintain 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***

Legacy LifeBridge and CCHS are self-insured for employee health claims. Legacy LifeBridge has accrued a liability of $2,167 and $2,178 at June 30, 2015 and 2014, respectively, for known claims and incurred but not reported claims, and CCHS has accrued a liability of $1,350 at June 30, 2015 for known and incurred but not reported claims. These amounts are included in accounts payable and accrued liabilities in the accompanying consolidated balance sheets.

CCHS maintains a stop-loss policy on health insurance claims. CCHS is insured for individual claims exceeding $350.

(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, 2015 and 2014 is as follows:

	2015	2014
Medicare	27%	29%
Medicaid	10	10
BlueCross	13	12
Commercial and other	40	40
Self-pay	10	9
	100%	100%

(Continued)

The mix of net patient service revenue for the Corporation for the years ended June 30, 2015 and 2014 is as follows:

	2015	2014
Medicare	41%	41%
Medicaid	5	6
BlueCross	14	15
Commercial and other	36	34
Self-pay	4	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 $2,384 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 $441 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 letter of credit of $52 to serve as collateral as required by the City of Baltimore for the completion of certain construction work at Sinai.

(c) Contract Commitments

There are no material contract commitments outstanding at June 30, 2015.

(d) Operating Leases

The Corporation has entered into operating lease agreements for hospital equipment and office space, which expire on various dates through year 2020. Total rental expense for the years ended June 30,

(Continued)

2015 and 2014 for all operating leases was approximately $21,540 and $14,761, respectively. Future minimum lease payments under all noncancelable operating leases are as follows:

Years ending June 30:		
2016	$	18,467
2017		16,698
2018		15,185
2019		14,439
2020		13,436
Thereafter		13,937
	$	92,162

(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, 2013	$ 563,128	(310)	562,818
Operating income	31,135	118	31,253
Nonoperating income	53,701	—	53,701
Excess of revenues over expenses	84,836	118	84,954
Change in funded status of pension plan	7,623	—	7,623
Net assets released for purchase of property and equipment	5,202	—	5,202
Other	181	—	181
Change in net assets	97,842	118	97,960
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

(20) Functional Expenses

The Corporation provides general healthcare services to patients. Expenses for the years ended June 30, 2015 and 2014 related to providing these services are as follows:

	2015	2014
Healthcare services	$ 875,650	793,874
General and administrative	286,733	252,658
	$ 1,162,383	1,046,532

(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 $273,529 and $276,718 at June 30, 2015 and 2014, respectively. The fair market value of the fixed rate Series 2011 MHHEFA Bonds was $55,110 and $55,387 as of June 30, 2015 and 2014, respectively. The fair market value of the variable rate Series 2006 MHHEFA Bonds was $35,582 as of June 30, 2015. The fair market value of the fixed rate Series 2012A MHHEFA Bonds was $60,244 as of June 30, 2015.

The fair value of other long-term debt, mortgage payable, 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, 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

The following table presents assets that are measured at fair value on a recurring basis as of June 30, 2014:

	Level 1	Level 2	Level 3	Total
Assets:				
Cash and cash equivalents	$ 18,087	—	—	18,087
Equity securities and mutual funds	259,371	—	—	259,371
Treasury securities	12,330	—	—	12,330
Government securities	—	8,037	—	8,037
Fixed income	—	23,053	—	23,053
Beneficial interest in split-interest agreement	—	4,633	—	4,633
Total assets	$ 289,788	35,723	—	325,511

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, 2015 and 2014, there were no significant transfers into or out of Levels 1, 2, or 3.

(Continued)

(22) Subsequent Events

Management evaluated all events and transactions that occurred after June 30, 2015 and through October 26, 2015. The Corporation did not have any subsequent events during this period that were required to be recognized or disclosed other than those disclosed below.

On July 1, 2015, LifeBridge purchased the building that houses the fitness center occupied by LifeBridge Health and Fitness LLC, a subsidiary of Investments, and entered into an agreement to purchase a medical office building in its service area. The cost of these acquisitions is approximately $24,000 in the aggregate.

On July 30, 2015, the Authority issued approximately $159,685 in bonds (Series 2015 Bonds) on behalf of LifeBridge Health. The proceeds of the Series 2015 Bonds 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.

Schedule 1

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2015

(Dollars in thousands)

Assets	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Courtland Gardens	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Current assets:								
Cash and cash equivalents	$ 143,163	84,460	15,834	15,385	256	97,875	—	356,973
Investments	13,194	3,383	6,908	276	—	—	—	23,761
Assets limited as to use, current portion	8,675	2,879	14,907	420	—	3,684	—	30,565
Patient service receivables, net of allowance for doubtful accounts	72,711	24,829	22,301	7,311	6	15,054	—	142,212
Other receivables	43,438	2,838	2,437	1,990	8,370	52,791	(101,700)	10,164
Inventory	20,996	5,191	3,035	181	—	79	—	29,482
Prepaid expenses	4,379	1,548	6,072	366	—	6,714	—	19,079
Pledges receivable, current portion	2,949	663	2,893	188	—	—	—	6,693
Total current assets	309,505	125,791	74,387	26,117	8,632	176,197	(101,700)	618,929
Board-designated investments	96,124	57,763	—	17,013	—	79,100	—	250,000
Long-term investments	48,432	29,104	132,722	8,572	—	39,855	—	258,685
Donor-restricted investments	13,194	3,383	4,791	276	—	—	—	21,644
Reinsurance recovery receivable	—	—	7,169	—	—	8,766	—	15,935
Assets limited as to use, net of current portion	—	—	3,225	—	—	29,962	—	33,187
Pledges receivable, net of current portion	2,738	261	2,125	353	—	—	—	5,477
Property and equipment, net	247,220	114,041	126,828	42,330	—	64,724	—	595,143
Deferred financing costs, net of accumulated amortization	1,571	506	1,813	127	—	56	—	4,073
Beneficial interest in split interest agreement	4,628	—	—	—	—	—	—	4,628
Investment in unconsolidated affiliates	—	—	726	—	—	149,676	(116,537)	33,865
Other assets, net of accumulated amortization	10,675	1,599	14,791	60	—	15,957	—	43,082
Total assets	$ 734,087	332,448	368,577	94,848	8,632	564,293	(218,237)	1,884,648

(Continued)

Schedule 1

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Balance Sheet Information

June 30, 2015

(Dollars in thousands)

Liabilities and Net Assets	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Courtland Gardens	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Current liabilities:								
Accounts payable and accrued liabilities	$ 72,749	17,628	52,884	7,338	352	68,623	(101,700)	117,874
Accrued salaries, wages, and benefits	30,675	11,745	9,361	3,026	—	25,727	—	80,534
Advances from third-party payors	24,613	6,821	6,732	3,604	10	—	—	41,780
Current portion of long-term debt and capital lease obligations	2,983	990	1,888	157	—	8,693	—	14,711
Other current liabilities	991	278	12,333	13	—	803	—	14,418
Total current liabilities	132,011	37,462	83,198	14,138	362	103,846	(101,700)	269,317
Other long-term liabilities	43,077	10,607	23,178	4,162	34	49,798	—	130,856
Long-term debt and capital lease obligations, net of current portion	227,156	76,152	94,916	9,450	—	150,496	—	558,170
Total liabilities	402,244	124,221	201,292	27,750	396	304,140	(101,700)	958,343
Net assets:								
Unrestricted net assets	279,892	200,801	103,621	66,180	8,236	252,714	(66,537)	844,907
Noncontrolling interest in consolidated subsidiaries	—	—	3,868	—	—	54	—	3,922
Total unrestricted net assets	279,892	200,801	107,489	66,180	8,236	252,768	(66,537)	848,829
Temporarily restricted	41,531	7,426	58,625	918	—	3,160	(50,000)	61,660
Permanently restricted	10,420	—	1,173	—	—	4,223	—	15,816
	331,843	208,227	167,287	67,098	8,236	260,151	(116,537)	926,305
Total liabilities and net assets	$ 734,087	332,448	368,579	94,848	8,632	564,291	(218,237)	1,884,648

See accompanying independent auditors' report.

Schedule 2

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidating Statement of Operations Information

Year ended June 30, 2015

(Dollars in thousands)

	Sinai Hospital Consolidated	Northwest Hospital	Carroll Hospital	Levindale Hebrew Geriatric Ctr & Hospital	Courtland Gardens	Other LifeBridge Entities	Eliminations	LifeBridge Health Consolidated
Unrestricted revenues, gains, and other support:								
Patient service revenue (net of contractual allowances and discounts)	$ 708,803	242,622	63,809	76,730	2,159	107,422	—	1,201,545
Provision for bad debts	31,010	16,247	605	3,338	186	3,459	—	54,845
Net patient service revenue	677,793	226,375	63,204	73,392	1,973	103,963	—	1,146,700
Net assets released from restrictions used for operations	3,179	—	7	35	—	444	—	3,665
Other operating revenue	46,983	7,232	1,233	860	29	58,487	(52,060)	62,764
Total operating revenues	727,955	233,607	64,444	74,287	2,002	162,894	(52,060)	1,213,129
Expenses:								
Salaries and employee benefits	362,346	122,469	29,740	47,727	1,694	97,831	531	662,338
Supplies	129,199	36,038	11,177	6,735	152	12,086	—	195,387
Purchased services	139,568	38,355	13,896	13,212	865	47,935	(52,591)	201,240
Depreciation, amortization, and gain/loss on sale of assets	33,340	11,509	3,821	3,296	81	10,910	—	62,957
Repairs and maintenance	13,819	4,323	—	987	41	604	—	19,774
Interest	12,210	4,459	1,489	529	—	2,000	—	20,687
Total expenses	690,482	217,153	60,123	72,486	2,833	171,366	(52,060)	1,162,383
Operating income (loss)	37,473	16,454	4,321	1,801	(831)	(8,472)	—	50,746
Other income (loss), net:								
Investment income	9,490	8,384	545	742	—	2,000	—	21,161
Unrealized gains on trading investments	(1,762)	(6,046)	17	(1,762)	—	(1,425)	—	(10,978)
Other	—	—	661	—	3,409	493	—	4,563
Total other income (loss), net	7,728	2,338	1,223	(1,020)	3,409	1,068	—	14,746
Excess (deficiency) of revenues over expenses before inherent contributions	45,201	18,792	5,544	781	2,578	(7,404)	—	65,492
Inherent contribution – CCHS	—	—	—	—	—	134,032	—	134,032
Excess of revenues over expenses	$ 45,201	18,792	5,544	781	2,578	126,628	—	199,524

See accompanying independent auditors' report.

KPMG LLP
1 East Pratt Street
Baltimore, MD 21201-1128

July 8, 2015

LifeBridge Health, Inc.
2401 W. Belvedere Ave.
Baltimore, Maryland 21215

Maryland Health and Higher Educational Facilities Authority
401 E. Pratt Street
Suite 1224
Baltimore, Maryland 21202

Merrill Lynch, Pierce, Fenner & Smith Incorporated
One Bryant Park, 12th Floor
New York, New York 10036

Ladies and Gentlemen:

We have audited the consolidated balance sheets of LifeBridge Health, Inc. and Subsidiaries (LifeBridge) and Carroll County Health Services Corporation (Carroll), (together, the Corporation), as of June 30, 2014 and 2013, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended which are included separately in Appendix B-1 and B-2 to the Preliminary Official Statement, dated July 8, 2015, for the $163,625,000 Maryland Health and Higher Educational Facilities Authority Revenue Bonds, Series 2015.

In connection with the Preliminary Official Statement:

1. We are independent certified public accountants with respect to the Corporation under Rule 101 of the American Institute of Certified Public Accountants' Code of Professional Conduct, and its interpretations and rulings.

2. We have not audited any financial statements of LifeBridge and Carroll as of any date or any period subsequent to June 30, 2014. Although we have conducted an audit for the year ended June 30, 2014, the purpose (and therefore the scope) of the audit was to enable us to express our opinion on the consolidated financial statements of LifeBridge and Carroll, separately, as of June 30, 2014 and for the year then ended, but not on the consolidated financial statements of the Corporation for any interim period within that year or any period thereafter. Therefore, we are unable to and do not express any opinion on the unaudited consolidated balance sheets as of March 31, 2015 and 2014, and the unaudited consolidated statements of operations and changes in net assets and cash flows for the nine-month periods ended March 31, 2015 and 2014, included in the Preliminary Official Statement, or on the financial position, results of

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operations, or cash flows of LifeBridge and Carroll as of any date or for any period subsequent to June 30, 2014.

3. At your request, we have read the available minutes of meetings of the Board of Directors, Budget and Finance Committee, Risk, Audit and Compliance Committee, Health Investment Committee, and the Finance and Treasury Committee as set forth in the minute books from July 1, 2014 through July 8, 2015, officials of the Corporation having advised us that the minutes of all such meetings were set forth therein.

4. With respect to the nine-month periods ended March 31, 2015 and 2014, we have:

   (i) Read the unaudited condensed consolidated financial statements of LifeBridge and Carroll (condensed in that the consolidated financial statements omit certain required footnote disclosures as required by U.S. generally accepted accounting principles) as of March 31, 2015 and 2014 and for the nine-month periods ended March 31, 2015 and 2014, furnished to us by the Corporation and included in Appendix A-1 of the Preliminary Official Statement and agreed the amounts contained therein with the corresponding Corporation's accounting records as of March 31, 2015 and 2014, and for the nine-month periods then ended. We inquired of certain officials of LifeBridge and Carroll who have responsibility for financial and accounting matters whether the unaudited consolidated financial statements are in conformity with U.S. generally accepted accounting principles and applied on a basis substantially consistent with that of the audited consolidated financial statements of LifeBridge and Carroll included in the Preliminary Official Statement. Those officials stated that the unaudited condensed consolidated financial statements are in conformity with U.S. generally accepted accounting principles and applied on a basis substantially consistent with that of the audited consolidated financial statements of LifeBridge and Carroll included in the Preliminary Official Statement aside from the exclusion of certain required disclosures.

5. With respect to the period from April 1, 2015 to May 31, 2015, we have:

   (i) Read the unaudited condensed consolidated financial statements of the Corporation (condensed in that the consolidated financial statements omit the statement of cash flows, statement of changes in net assets and all required footnote disclosures as required by U.S. generally accepted accounting principles) as of May 31, 2015 and 2014 and for the period from April 1, 2015 to May 31, 2015 and 2014, furnished to us by the Corporation. Officials of the Corporation have advised us that no such financial statements as of any date or for any period subsequent to May 31, 2015 were available and approved by the Finance Committee.

(ii) Inquired of certain officials of the Corporation who have responsibility for financial and accounting matters whether (1) the unaudited condensed consolidated financial statements referred to in paragraph 5(i) above are in conformity with U.S. generally accepted accounting principles and applied on a basis substantially consistent with that of the audited consolidated financial statements of the Corporation included in the Preliminary Official Statement (2) at May 31, 2015, there was an increase in total debt or decrease in total assets or net assets of the Corporation, as compared with amounts shown on the March 31, 2015 unaudited condensed consolidated balance sheet of LifeBridge included in the Preliminary Official Statement, or (3) for the period from April 1 to May 31, 2015, there was any decreases, as compared with the corresponding period in the preceding year of LifeBridge, in consolidated net operating revenues or excess of revenues over expenses.

(iii) Those officials stated that (1) the unaudited condensed consolidated financial statements referred to in paragraph 5(i) above are in conformity with U.S. generally accepted accounting principles and applied on a basis substantially consistent with that of the audited consolidated financial statements of the Corporation included in the Preliminary Official Statement. Additionally, effective April 1, 2015, the results of LifeBridge and Carroll became consolidated. The fluctuations below compare May 31, 2015 and the activity for the period of April 1 to May 31 of the Corporation in 2015 to LifeBridge during the same period of 2014, which is prior to the inclusion of Carroll's assets and liabilities, and results from operations. (2) at May 31, 2015, related to the Corporation there was an increase in total debt of approximately $206.6 million, which management of LifeBridge states is related to the inclusion of Carroll and the $100 million line of credit. There was not a decrease in total assets or net assets as compared with the respective amounts shown on the March 31, 2015 unaudited condensed consolidated balance sheet of LifeBridge included in Appendix A-1 to the Preliminary Official Statement; (3) for the period from April 1 to May 31, 2015, there was not a decrease, as compared with the corresponding period in the preceding year, in consolidated net operating revenues, or in excess of revenues over expenses.

6. As mentioned in 5(i), officials of the Corporation have advised us that no financial statements as of any period subsequent to May 31, 2015 are available and has been presented to the Finance Committee; accordingly, the procedures carried out by us with respect to changes in financial statement line items after May 31, 2015 have, of necessity, been even more limited than those with respect to the period referred to in 5(i) through 5(iii) above. We have inquired of certain officials of the Corporation who have responsibility for financial and accounting matters whether (1) at July 8, 2015, there was an increase in total debt or decrease in total assets or net assets of the Corporation, as compared with amounts shown on the March 31, 2015 unaudited condensed consolidated balance sheets of LifeBridge included in the Preliminary Official Statement, or (2) for the period from June 1, 2015 to July 8, 2015, there

was any decreases, as compared with the corresponding period in the preceding year, in consolidated net operating revenues or excess of revenues over expenses.

(i) Those officials stated that based upon the information available (1) at July 8, 2015, there was an increase in total debt of approximately $256.6 million, however, there was not a decrease in total assets or net assets as compared with the respective amounts shown on the March 31, 2015 unaudited condensed consolidated balance sheets of LifeBridge; (2) for the period of June 1, 2015 through July 8, 2015, there was not a decrease, as compared with the corresponding period in the preceding year, in consolidated net operating revenues or excess of revenues over expenses for LifeBridge.

7. Our audits of the consolidated financial statements of the LifeBridge and Carroll for the periods referred to in the introductory paragraph of this letter comprised audit tests and procedures deemed necessary for the purpose of expressing an opinion on such financial statements of LifeBridge and Carroll, separately, taken as a whole. For none of the periods referred to therein, nor for any other period, did we perform audit tests for the purpose of expressing an opinion on individual balances of accounts such as those enumerated above or attached, and, accordingly, we express no opinion therein.

8. For purposes of this letter, we have also read the items identified by the Corporation on the attached selected pages of the Preliminary Official Statement and have performed the following procedures, which were applied as indicated with respect to the symbols explained below. For the purposes of reporting our findings, in those instances in which one or both of the compared amounts and percentages were rounded to some degree, we have nevertheless stated that we found the compared amounts and percentage to be in agreement. With respect to the items identified, we make no comment as to the appropriateness of the Corporation's determination to select those amounts to appear under the captions so presented, and we make no comment as to the Corporation's determination as to what constitutes the appropriate presentation, disclosure, or explanation of such items, or their completeness or appropriateness for purposes of the Preliminary Official Statement. Also, we make no comment as to the appropriateness or completeness of the Corporation's determination of the causes of the increases or decreases in amounts discussed in the Preliminary Official Statement.

(✓) Compared the dollar amount to the corresponding amount or combinations of amounts in Carroll and/or LifeBridge's audited consolidated financial statements as of and for the years ended June 30, 2014 and 2013, and found such amounts to be in agreement.

(R) Recalculated based on amounts in Carroll and/or LifeBridge's audited consolidated financial statements as of and for the years ended June 30, 2014 and 2013, and noted no mathematical errors.

(✓x) Agreed the amount to a schedule prepared by LifeBridge and/or Carroll, which was derived from LifeBridge or Carroll's general ledger or other accounting records and found them to be in agreement.

(Rx) Recalculated based on amounts in a schedule prepared by LifeBridge and/or Carroll, which was derived from LifeBridge or Carroll's general ledger or other accounting records, and noted no mathematical errors.

(✓✓) Compared the dollar amount to the corresponding amount in LifeBridge and Carroll's unaudited condensed consolidated financial statements as of March 31, 2015 and for the nine month periods ended March 31, 2015 and 2014, which was derived from the corresponding general ledger or other accounting records of LifeBridge and Carroll, and found such amounts to be in agreement.

(Rxx) Recalculated based on amounts in the LifeBridge and Carroll unaudited condensed consolidated financial statements as of March 31, 2015 and for the nine month periods ended March 31, 2015 and 2014, which were derived from the corresponding general ledger or other accounting records of LifeBridge and Carroll, and noted no mathematical errors.

(✓✓) Agreed the amount to a schedule prepared by the Corporation, and found them to be in agreement. However, we make no comment as to the reasonableness of the planned debt transaction or whether such transaction will take place.

(^) Footed

9. It should be understood that we have no responsibility for establishing (and did not establish) the scope and nature of the procedures enumerated in paragraphs 3 through 8 above; rather, the procedures enumerated therein are those that the requesting party has asked us to perform. Accordingly, we make no representations regarding questions of legal interpretation or regarding the sufficiency for your purposes of the procedures enumerated in the preceding paragraphs. Also, such procedures would not necessarily reveal any material misstatement of the amounts listed above as set forth in the Preliminary Official Statement. Further, we have addressed ourselves solely to the foregoing data and make no representations regarding the adequacy of disclosures or whether any material facts have been omitted. This letter relates to the financial statement items specified above and does not extend to any financial statements of the Corporation taken as a whole.

10. The foregoing procedures do not constitute an audit conducted in accordance with auditing standards generally accepted in the United States of America. Had we performed additional procedures or had we conducted an audit or review in accordance with standards established

by the American Institute of Certified Public Accountants, other matters might have come to our attention that would have been reported to you.

11. These procedures should not be taken to supplant any additional inquiries or procedures that you would undertake in your consideration of the proposed offering.

12. This letter is solely for your information and to assist you in your inquiries in connection with the offering of the bonds covered by the Preliminary Official Statement, and is not to be used, circulated, quoted, or otherwise referred to for any other purpose, including but not limited to the registration, purchase or sale of securities, nor is it to be filed with or referred to in whole or in part in the Preliminary Official Statement and it may be included in the closing document or any other document, except that reference may be made to it in any list of closing documents pertaining to the offering covered by the Preliminary Official Statement.

13. We have no responsibility to update this letter for events and circumstances occurring after July 8, 2015.

Very truly yours,

KPMG LLP

FINANCIAL PERFORMANCE

The following tables present summary combined statements of operations and balance sheets for LifeBridge Health and its subsidiaries (including the results of entities which are not members of the Obligated Group; see "OTHER AFFILIATES AND RELATED ORGANIZATIONS NOT MEMBERS OF THE OBLIGATED GROUP" above) for the fiscal years ended June 30, 2012, 2013 and 2014 (derived from the audited financial statements of LifeBridge Health and its subsidiaries, including the audited financial statements for Carroll Health Services and its subsidiaries) and for the nine months ended March 31, 2014 and 2015 (derived from the unaudited financial statements of LifeBridge Health and its subsidiaries, which were prepared using generally accepted accounting principles and include all adjustments management considers necessary for a fair presentation of operations of LifeBridge Health). This unaudited financial information for the nine-month period ended March 31, 2015 should not be regarded as indicative of results for the fiscal year ended June 30, 2015. These tables should be read in conjunction with the unaudited consolidated financial statements of LifeBridge Health and its subsidiaries (including unaudited consolidated financial statements of Carroll Health Services and its subsidiaries) for the nine-month period ending March 31, 2015 appearing in Appendix A-1 to this Official Statement and the audited consolidated financial statements of LifeBridge Health and its subsidiaries for the fiscal years ending June 30, 2013 and 2014 (including the audited financial statements for Carroll Health Services and its subsidiaries) appearing in Appendices B-1 and B-2 to this Official Statement. The audits of LifeBridge Health and its subsidiaries and of Carroll Health Services and its subsidiaries for the fiscal year ended June 30, 2014 have been filed with the Nationally Recognized Municipal Securities Information Repositories.

Combined Statement of Operations and Change in Net Assets
(Dollars in thousands)

	Years Ended June 30,			Nine Months Ended March 31, (Unaudited)	
	2012	2013	2014	2014	2015
Operating Revenues					
Net patient service revenue	$1,201,760	$1,242,950	$1,281,196	$951,884	$1,009,988
Net assets released from restrictions used for operations	4,036	3,559	3,951	2,838	2,399
Other operating revenue	73,066	72,989	79,059	57,580	58,331
Total operating revenues	1,278,862	1,319,498	1,364,206	1,012,302	1,070,718
Expenses					
Salaries and employee benefits	701,093	727,569	741,160	553,876	576,601
Supplies	211,215	217,338	224,165	167,088	175,803
Purchased services	213,950	220,396	236,497	169,335	185,168
Depreciation and amortization	74,724	77,945	80,178	59,784	56,898
Repairs and maintenance	18,426	19,274	18,912	14,466	14,937
Interest	28,365	26,099	25,001	18,742	18,537
Total operating expenses	1,247,773	1,288,621	1,325,913	983,291	1,027,945
Operating gain (loss)	31,089	30,877	38,293	29,012	42,773
Other Income					
Investment income	17,249	19,612	27,153	17,895	19,478
Unrealized gains (losses) on trading investments	(11,322)	20,146	36,271	26,647	(11,426)
Other	(12,444)	5,454	(2,058)	(437)	(2,117)
Total other income	(6,517)	45,212	61,366	44,105	5,935
Excess of Revenue over Expenses	$24,572	$76,089	$99,659	$73,117	$48,709

Combined Balance Sheet
(Dollars in thousands)

	Years Ended June 30,			Nine Months Ended March 31, (Unaudited)	
	2012	2013	2014	2014	2015
Assets					
Current assets					
Cash and cash equivalents	$194,720	$222,705	$247,855	$215,736	$268,206
Temporarily restricted investments	23,253	25,256	27,475	27,841	20,975
Assets whose use is limited, current portion	29,316	23,151	29,187	22,065	23,733
Patient service receivables, net of allowance for doubtful accounts	138,252	149,474	151,764	164,141	160,126
Other receivables	8,586	8,193	9,101	8,681	10,862
Inventory	27,447	27,330	26,693	27,697	29,781
Prepaid expenses	12,881	17,624	17,097	21,594	20,448
Pledges receivable, current portion	5,828	6,303	7,148	6,303	6,736
Total current assets	440,283	480,036	516,320	494,059	540,867
Long-term investments	381,250	412,451	461,898	450,281	460,979
Temporarily restricted assets	2,499	13,957	16,650	18,704	20,680
Reinsurance Recovery Receivable	25,374	30,163	19,770	33,490	20,853
Assets whose use is limited, net of current portion	58,028	54,199	46,642	51,541	47,633
Pledges receivable, net of current portion	15,266	11,113	8,227	9,439	5,100
Operating property, net	622,218	636,561	630,503	628,702	631,372
Other assets					
Deferred financing costs and other assets, net of amortization	4,564	4,399	4,207	4,465	4,064
Beneficial interest in split interest agreement	3,930	4,088	4,633	3,953	4,489
Investments in affiliates	6,750	8,937	22,416	19,550	24,056
Other assets	20,171	15,210	23,383	17,044	35,813
Total assets	$1,580,333	$1,671,114	$1,754,649	$1,731,227	$1,795,907
Liabilities and net assets					
Current liabilities					
Accounts payable and accrued liabilities	$109,815	$129,131	$117,804	$104,559	$104,740
Accrued salaries, wages and benefits	61,860	65,840	76,438	73,564	80,623
Advances from third-party payors	50,804	41,472	42,471	41,140	41,830
Current portion of long-term debt and capital lease obligations	10,558	10,441	12,470	10,495	13,042
Other current liabilities	1,142	1,263	9,535	3,356	2,329
Total current liabilities	234,179	248,147	258,718	233,114	242,565
Other long-term liabilities	201,252	167,395	132,919	168,036	141,474
Long-term debt and capital lease obligations, net of current portion	473,003	467,600	459,975	459,157	458,177
Net assets					
Unrestricted	599,827	714,644	827,312	791,232	877,247
Temporarily restricted	56,419	57,615	59,905	63,871	60,627
Permanently restricted	15,653	15,713	15,820	15,818	15,816
Total liabilities and net assets	$1,580,333	$1,671,114	$1,754,649	$1,731,228	$1,795,906

MANAGEMENT'S DISCUSSION AND ANALYSIS OF OPERATIONS

Financial Performance

Financial Results for Fiscal Years 2012, 2013 and 2014.

Total operating revenues for LifeBridge Health in fiscal year 2014 were $1,364 million, an increase of 3.4% from the prior year's revenues and an increase of 6.7% from 2012 revenues. The majority of gains were due to increased net physician revenue ($30.8 million), sub-acute revenue ($6.0 million) and retail pharmacy ($4.7 million).

Net cash provided by operating activities for LifeBridge Health was $105 million in 2014, compared to $114 million in 2013. The decrease in cash provided by operating activities from 2013 to 2014 was primarily due to timing of payment of accounts payable. Debt service coverage for the Obligated Group in fiscal years 2012, 2013 and 2014 was 4.3x, 4.4x and 4.8x respectively and the debt service coverage for LifeBridge Health in fiscal years 2012, 2013 and 2014 was 4.4x, 4.5x and 4.9x, respectively. Operating gains for LifeBridge Health were $38 million in 2014, $31 million in 2013 and $31 million in 2012. The increase in operating gains in 2014 was primarily due to the new Maryland reimbursement system which resulted in fixed regulated revenue ("Global Budget") and initiatives to reduce avoidable utilization.

Non-operating revenues, consisting primarily of investment results from LifeBridge Health's investment portfolios, were $61 million in 2014, compared to $45 million in 2013 and a loss of $7 million in 2012. The loss in 2012 was primarily due to changes in fair value of an interest rate hedge during that period by CHC. As of April 28, 2015, CHC is no longer a party to any interest rate hedging arrangements.

Capital expenditures for LifeBridge Health were $69 million in 2014, $88 million in 2013 and $101 million in 2012, and were funded by cash generated from operating activities, philanthropy and borrowings.

Financial Results for the Nine Months Ended March 31, 2014 and 2015.

Total operating revenues for LifeBridge Health were $1,071 million for the nine-month period ended March 31, 2015, a 5.8% increase from the nine-month period ended March 31, 2014. The increase in revenue was primarily due to the full year impact of the Global Budget in fiscal year 2015 and reductions in bad debts.

Earnings from operations for LifeBridge Health were $43 million for the nine-month period ended March 31, 2015, compared to $29 million for the nine-month period ended March 31, 2014. Total operating expenses increased by $45 million driven primarily by the Population Health initiative and physician alignment initiatives. This increase in expenses was more than offset by the increase in operating revenue.

Net cash provided by operating activities for LifeBridge Health was $67.1 million for the nine-month period ended March 31, 2015, compared to $58.6 million for the nine-month period ended March 31, 2014. The increase in cash was primarily due to an increase in operating income of $10.9 million. Debt service coverage for the first nine months of fiscal year 2015 was 5.56x.

Critical Accounting Policies

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires the management of LifeBridge Health to make estimates and assumptions that affect the amounts reported in its consolidated financial statements and the accompanying notes. LifeBridge Health considers its critical accounting policies to be those that require

Approximately 500 service and maintenance employees of Sinai are represented by Service Employees International Union 1199, SEIU Healthcare ("SEIU"). Sinai has reached agreement with SEIU on a contract that extends through September 30, 2018. Management considers the relations with the employees of Sinai to be satisfactory.

Approximately 230 service and maintenance employees of Levindale are represented by SEIU. Levindale's current contract with SEIU is effective through September 2016. Management considers the relations with the employees of Levindale to be satisfactory.

No employees of Northwest or CHC are represented by a labor union. Management considers the relations with the employees of Northwest and CHC to be satisfactory.

PENSION PLAN

Northwest has a qualified noncontributory defined contribution pension plan covering a majority of the employees of Northwest. Sinai and Levindale have noncontributory defined benefit pension plans covering a majority of the employees of Sinai and Levindale. Annual contributions to the pension plans are made at a level equal to the funding requirements as determined by the consulting actuary for the pension plans. As of June 30, 2014, the Sinai and Levindale pension plans were underfunded by approximately $17.7 million and as of June 30, 2013, the Sinai and Levindale pension plans were underfunded by approximately $28.9 million. LifeBridge Health monitors the returns for the pension assets regularly in consultation with actuaries and remains committed to funding its pension obligations. For additional information regarding LifeBridge Health's pension plans, see Note titled "Employee Benefit Plans" in the audited consolidated financial statements of LifeBridge Health in Appendix B-1.

CHC sponsors a 403(b) defined contribution supplemental retirement plan, which has served as CHC's primary retirement program since January 1, 2007. CHC also maintains a defined benefit pension plan, which has been frozen since January 1, 2007. This plan formerly covered substantially all of the employees of CHC, Med-Services and the CHC Foundation. As of June 30, 2014, the funding status for the defined benefit plan (market value of assets divided by present value of plan liabilities) was 89% based on a discount rate of 4.25%. CHC's funding policy is to make the minimum annual contribution that is required by applicable regulations, plus such amounts as CHC may determine from time to time. CHC made contributions of $2.6 million, $3.6 million and $3.6 million respectively, in the fiscal years ended June 30, 2012, 2013 and 2014.

CHC also offers employees a post-retirement benefit plan providing certain health and prescription drug benefits. Since January 1, 2009, retirees may only participate in this plan until they are Medicare-eligible. In addition, certain key employees are eligible for a supplemental retirement plan. See the notes to the consolidated financial statements of Carroll Health Services and subsidiaries included in Appendix B-2.

LICENSES AND ACCREDITATIONS

Sinai Hospital, Northwest Hospital, Carroll Hospital and Levindale Hospital are licensed by the Department of Health and Mental Hygiene of the State of Maryland. The rehabilitation units at Sinai Hospital and Levindale Hospital also hold accreditations from CARF. The Joint Commission surveyed Sinai Hospital and found it to meet the requirements for an acute care general hospital as of January 17, 2015. The Joint Commission surveyed Northwest Hospital and found it to meet the requirements for an acute care general hospital as of February 23, 2013. The Joint Commission surveyed Carroll Hospital and found it to meet the requirements for an acute care general hospital as of June 22, 2013. The Joint Commission surveyed Levindale Hospital and found it to meet the requirements for the Hospital Accreditation Program, Long Term Care Accreditation Program and Behavioral Health Care Accreditation Program as of February 1, 2013. The Joint Commission accreditations and certifications customarily are valid for a period of 36 months. CARF surveyed the Sinai Rehabilitation Center at Sinai Hospital on April 11-12, 2013 and awarded accreditation to Sinai Hospital's inpatient brain injury, outpatient brain injury and inpatient rehabilitation programs. The CARF accreditation for the rehabilitation center at Sinai

Hospital expires in April 2016. CARF awarded accreditation to Levindale Hospital's inpatient rehabilitation, stroke specialty and brain injury program as of March 28, 2014. The CARF accreditation for the inpatient rehabilitation, stroke specialty and brain injury programs at Levindale Hospital expires in March 2017.

In addition to the licenses applicable to their hospital operations, Levindale Hospital is currently licensed through October 10, 2016 to operate 210 nursing home (comprehensive care) beds, and Northwest Hospital's subacute unit is licensed through July 12, 2016 to operate 39 comprehensive care beds.

INSURANCE

LifeBridge Health, Sinai, Northwest, Levindale, various other LifeBridge Health subsidiaries and certain of LifeBridge Health's employed and contracted physicians are covered for professional and liability claims through LifeBridge Insurance. LifeBridge Insurance has full responsibility for claims up to a specified limit. For professional liability claims, the limit is $5 million per claim for claims arising in Baltimore City (other than on the Levindale campus) and $3 million per claim for claims arising elsewhere, with a maximum of $30 million per policy year. For general liability claims, the limit is $2 million per claim. LifeBridge Insurance purchases reinsurance for claims above the specified limits. Certain other physicians and entities are insured through policies purchased directly from commercial carriers.

Carroll Health Services, CHC and other Carroll Health Services subsidiaries are insured for medical professional liability and general liability through Cen-Mar. Cen-Mar retains the first $1 million of exposure per claim, up to a maximum of $3 million per year. Cen-Mar purchases reinsurance for claims above these limits.

The premiums charged by LifeBridge Insurance and Cen-Mar are set so that those entities have adequate resources to pay insured claims, as determined by an independent actuary. The adequacy of the companies' reserves is reviewed twice annually. Management believes that LifeBridge Health and its subsidiaries are appropriately insured for general and professional liability claims.

LifeBridge Health carries property insurance covering the properties owned or leased by LifeBridge Health and its subsidiaries. The current property and casualty insurance coverage limit for the policies covering the hospital facilities is $750 million. LifeBridge Health purchases all other lines of traditional commercial insurance including crime, director and officer, fiduciary, auto, helipad and pollution. It also purchases "cyber" liability insurance, covering losses and liabilities associated with loss or theft of electronic data, including protected health information. Limits and coverage on all lines of insurance are reviewed and updated annually.

Sinai, Northwest, Levindale and CHC are partially self-insured for workers' compensation claims and maintain excess liability policies for losses in excess of the self-insured component.

LITIGATION

The nature of LifeBridge Health's businesses generates claims and litigation against LifeBridge Health and its affiliates arising in the ordinary course of their activities. At any given time, LifeBridge Health and its affiliates may have lawsuits pending against them based on alleged medical malpractice or other business activities.

In the opinion of management and counsel to LifeBridge Health for the particular matter, there is no litigation pending or threatened against LifeBridge Health or its affiliates, other than claims for malpractice and general liability against which they are insured, that would materially affect the ability of the members of the Obligated Group to meet their obligations with respect to the Series 2015 Bonds in the event of an adverse result.

CARROLL COUNTY HEALTH SERVICES CORPORATION AND SUBSIDIARIES

Consolidated Balance Sheets

March 31, 2015 and June 30, 2014

(In thousands)

Assets		2015 (unaudited)	2014
Current assets:			
Cash and cash equivalents	$	15,719	28,144
Short-term investments		6,904	14,800
Current portion of assets limited as to use		19,102	20,164
Patient receivables, net of allowance for uncollectible of $10,424 in 2015 and $9,468 in 2014		33,771	30,440
Other receivables		2,584	2,542
Inventory		4,681	4,028
Prepaid expenses		8,475	6,378
Total current assets		91,236	106,496
Property and equipment, net		182,926	170,865
Long-term investments		66,046	66,458
Long-term investments – other		19,919	20,745
Investments in joint ventures		3,260	3,696
Assets limited as to use, less current portion		27,091	21,252
Other assets		17,763	14,737
Total assets	$	408,241	404,249
Liabilities and Net Assets			
Current liabilities:			
Current portion of long-term debt	$	5,682	5,717
Current obligation under capital lease		997	555
Accounts payable and accrued expenses		28,962	31,420
Accrued payroll and related taxes		14,887	12,657
Deferred revenue		624	153
Advances from third-party payors		6,758	6,505
Total current liabilities		57,910	57,007
Long-term debt, less current portion		132,708	135,963
Long-term obligation under capital lease, less current portion		7,682	598
Other liabilities		29,401	24,964
Accrued pension and postretirement benefits		5,220	7,808
Total liabilities		232,921	226,340
Net assets:			
Unrestricted:			
Unrestricted net assets		158,535	162,023
Noncontrolling interest in consolidated subsidiaries		4,879	4,511
Total unrestricted net assets		163,414	166,534
Restricted:			
Temporarily restricted		10,733	10,202
Permanently restricted		1,173	1,173
Total restricted net assets		11,906	11,375
Total net assets		175,320	177,909
Total liabilities and net assets	$	408,241	404,249

See accompanying notes to condensed consolidated financial statements.

CARROLL COUNTY HEALTH SERVICES CORPORATION AND SUBSIDIARIES

Consolidated Statements of Operations

Nine months ended March 31, 2015 and 2014

(In thousands)

	2015 (unaudited)	2014 (unaudited)
Unrestricted revenues, gains, and other support:		
Patient service revenue (net of contractuals)	$ 211,618	205,643
Less provision for bad debts	5,486	7,461
Net patient service revenue	206,132	198,182
Other operating revenues	15,942	16,860
Net assets released from restrictions used for operations	—	—
Total unrestricted revenues, gains, and other support	222,074	215,042
Expenses:		
Salaries and wages	95,570	91,157
Employee benefits	16,768	15,768
Departmental supplies and expenses	38,794	37,280
Professional fees	20,808	17,527
Purchased services	30,223	29,972
Depreciation and amortization	14,447	13,980
Interest	4,452	4,518
Total expenses	221,062	210,202
Operating income	1,012	4,840
Other income (expense):		
Investment income	1,725	7,413
Unrestricted gifts	1,250	741
Change in fair value of interest rate hedge, including settlement payments	(6,364)	(486)
Other, net	(699)	(698)
Excess of revenues over expenses	$ (3,076)	11,810

See accompanying notes to condensed consolidated financial statements.

CARROLL COUNTY HEALTH SERVICES CORPORATION AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Nine month ended March 31, 2015 and year ended June 30, 2014

(In thousands)

(unaudited)

	Unrestricted net assets	Temporarily restricted net assets	Permanently restricted net assets	Total net assets
Balance at June 30, 2013	$ 151,826	10,425	1,173	163,424
Excess of revenues over expenses	14,705	—	—	14,705
Restricted gifts, bequests, and contributions	—	2,615	—	2,615
Change in unrealized gains/losses other than trading securities	—	192	—	192
Net assets released from restrictions used for capital expenditures	3,014	(3,014)	—	—
Net assets released from restrictions used for operations	—	(16)	—	(16)
Distributions to noncontrolling owners	(1,730)	—	—	(1,730)
Contributions from noncontrolling owners	30	—	—	30
Change in funded status of pension plan and postretirement	(1,311)	—	—	(1,311)
Changes in net assets	14,708	(223)	—	14,485
Balance at June 30, 2014	166,534	10,202	1,173	177,909
Excess of revenues over expenses	(3,076)	—	—	(3,076)
Restricted gifts, bequests, and contributions	—	1,227	—	1,227
Change in unrealized gains/losses other than trading securities	—	63	—	63
Net assets released from restrictions used for capital expenditures	759	(759)	—	—
Net assets released from restrictions used for operations	—	—	—	—
Distributions to noncontrolling owners	(925)	—	—	(925)
Contributions from noncontrolling owners	122	—	—	122
Change in funded status of pension plan and postretirement	—	—	—	—
Changes in net assets	(3,120)	531	—	(2,589)
Balance at March 31, 2015	$ 163,414	10,733	1,173	175,320

See accompanying notes to condensed consolidated financial statements.

CARROLL COUNTY HEALTH SERVICES CORPORATION AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Nine months ended March 31, 2015 and 2014

(In thousands)

(unaudited)

	2015	2014
Cash flows from operating activities:		
Change in net assets	$ (2,589)	12,818
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	14,447	13,980
Provision for bad debts	5,486	7,461
Change in funded status of pension plan and postretirement	—	—
Equity in earnings of joint ventures and alternative investments	(488)	(1,784)
Loss (gain) on disposition of property and equipment	—	—
Distributions to noncontrolling interest holder	925	1,130
Contributions from non controlling interest holder	(122)	(30)
Restricted gifts, bequests, and contributions	(1,227)	(1,953)
Change in net unrealized gains on investments	(987)	(2,648)
Realized gains on sales of investments	(838)	(265)
Change in unrealized and realized losses (gains) on derivative instruments	6,363	486
Changes in assets and liabilities:		
Patient and other receivables	(8,859)	(20,402)
Inventory	(653)	(152)
Prepaid expenses	(2,097)	(382)
Other assets	(3,495)	(1,426)
Accounts payable, accrued expenses, accrued payroll and related taxes, and other liabilities	(3,763)	(2,835)
Deferred revenue	471	1,002
Advances from third-party payors	253	(727)
Net cash provided by operating activities	2,827	4,273
Cash flows from investing activities:		
Purchases of property and equipment, net	(17,846)	(23,783)
Proceeds from sale of property and equipment	—	7
Investment in joint ventures	(367)	(158)
Net purchases of investments	10,646	(60)
Net purchases (sales) of assets limited as to use, net	(4,714)	(1,482)
Distributions from joint ventures	1,219	747
Payment on derivative instrument	(979)	(976)
Net cash used in investing activities	(12,041)	(25,705)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	—	196
Payments on long-term debt	(3,290)	(3,175)
Payments on capital lease obligation	(350)	(385)
Distributions to noncontrolling interest holder	(925)	(1,130)
Contributions from noncontrolling interest holder	127	30
Proceeds from restricted gifts, bequests, and contributions	1,227	1,953
Net cash provided by financing activities	(3,211)	(2,511)
Net decrease in cash and cash equivalents	(12,425)	(23,943)
Cash and cash equivalents, beginning of year	28,144	41,176
Cash and cash equivalents, end of year	$ 15,719	17,233
Supplemental cash flow information:		
Interest paid	$ 5,575	5,640
Medical office building	519	521
Additions to property and equipment for capital leases and other obligations	7,876	196

See accompanying notes to condensed consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

March 31, 2015 and June 30, 2014

(Dollars in thousands)

Assets	2015	2014
Current assets:		
Cash and cash equivalents	$ 252,487	219,711
Investments	14,071	12,675
Assets limited as to use, current portion	7,021	11,873
Patient service receivables, net of allowance for doubtful accounts of $50,563 in 2015 and $35,085 in 2014	126,355	121,324
Other receivables	8,278	6,559
Inventory	25,100	22,665
Prepaid expenses	11,973	10,719
Pledges receivable, current portion	4,346	4,298
Total current assets	449,631	409,824
Long-term investments	375,013	374,695
Donor-restricted investments	14,071	12,676
Reinsurance recovery receivable	13,184	13,365
Assets limited as to use, net of current portion	30,048	34,157
Pledges receivable, net of current portion	2,203	3,434
Property and equipment, net	448,446	459,638
Deferred financing costs, net of accumulated amortization of $721 in 2015 and $633 in 2014	2,233	2,319
Beneficial interest in split interest agreement	4,489	4,633
Investment in unconsolidated affiliates	20,796	18,720
Other assets	27,551	16,939
Total assets	$ 1,387,665	1,350,400

(Continued)

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

March 31, 2015 and June 30, 2014

(Dollars in thousands)

Liabilities and Net Assets		2015	2014
Current liabilities:			
Accounts payable and accrued liabilities	$	75,804	86,384
Accrued salaries, wages and benefits		65,736	63,781
Advances from third-party payors		35,072	35,966
Current portion of long-term debt and capital lease obligations		6,364	6,198
Other current liabilities		1,679	9,382
Total current liabilities		184,655	201,711
Other long-term liabilities		106,853	100,147
Long-term debt and capital lease obligations, net of current portion		317,787	323,414
Total liabilities		609,295	625,272
Net assets:			
Unrestricted		713,890	660,970
Noncontrolling interest in consolidated subsidiaries		(57)	(192)
Total unrestricted net assets		713,833	660,778
Temporarily restricted		49,894	49,703
Permanently restricted		14,643	14,647
		778,370	725,128
Total liabilities and net assets	$	1,387,665	1,350,400

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended March 31, 2015 and 2014

(Dollars in thousands)

	2015	2014
Unrestricted revenues, gains and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 842,162	796,411
Provision for bad debts	38,306	42,709
Net patient service revenue	803,856	753,702
Net assets released from restrictions used for operations	2,399	2,838
Other operating revenue	42,389	40,720
Total operating revenues	848,644	797,260
Expenses:		
Salaries and employee benefits	464,264	446,951
Supplies	137,009	129,808
Purchased services	134,137	121,835
Depreciation, amortization and gain/loss on sale of assets	42,451	45,804
Repairs and maintenance	14,937	14,466
Interest	14,085	14,224
Total expenses	806,883	773,088
Operating income	41,761	24,172
Other income, net:		
Investment income	17,715	14,965
Unrealized gains on trading investments	(11,389)	22,164
Other	3,696	6
Total other income, net	10,022	37,135
Excess of revenues over expenses	$ 51,783	61,307

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended June 30, 2015 and 2014

(Dollars in thousands)

	Unrestricted	Temporarily restricted	Permanently restricted	Total net assets
Net assets at June 30, 2013	$ 562,818	47,190	14,540	624,548
Excess of revenues over expenses	84,954	—	—	84,954
Unrealized gain on investments	—	4,051	8	4,059
Net assets released from restrictions used for the purchase of property and equipment	5,202	(5,202)	—	—
Restricted gifts and bequests	—	7,051	102	7,153
Net assets released from restrictions used for operations	—	(3,932)	(3)	(3,935)
Net change in value of beneficial interest in split interest agreement	—	545	—	545
Adjustment to pension liability	7,623	—	—	7,623
Other	181	—	—	181
Change in net assets	97,960	2,513	107	100,580
Net assets at June 30, 2014	660,778	49,703	14,647	725,128
Excess of revenues over expenses	51,783	—	—	51,783
Unrealized gain on investments	—	(638)	(3)	(641)
Net assets released from restrictions used for the purchase of property and equipment	1,128	(1,128)	—	—
Restricted gifts and bequests	—	4,520	1	4,521
Net assets released from restrictions used for operations	—	(2,472)	(2)	(2,474)
Net change in value of beneficial interest in split interest agreement	—	—	—	—
Other	144	(91)	—	53
Change in net assets	53,055	191	(4)	53,242
Net assets at March 31, 2015	$ 713,833	49,894	14,643	778,370

See accompanying notes to consolidated financial statements.

LIFEBRIDGE HEALTH, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended March 31, 2015 and 2014

(Dollars in thousands)

	2015	2014
Cash flows from operating activities:		
Change in net assets	$ 53,242	70,131
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	42,517	45,808
Gain on disposal of equipment	(66)	(4)
Gain on sale of Courtland Gardens	(3,409)	—
Provision for bad debts	38,306	42,709
Realized and unrealized gains on investments	86	(34,956)
Restricted gifts and bequests	(4,521)	(6,829)
Change in beneficial interest of split interest agreement	144	135
Earnings on investments in unconsolidated affiliates	(2,856)	(1,028)
Change in operating assets and liabilities:		
Increase in patient service receivables, net	(43,337)	(43,821)
(Increase) decrease in other receivables	(1,719)	(1,102)
Decrease in pledges receivable	1,183	654
Increase in inventory	(2,435)	(216)
Increase in prepaid expenses	(1,254)	(3,588)
Decrease (increase) in reinsurance recovery receivable	181	(1,896)
Increase in other assets	(3,420)	(2,416)
Decrease in accounts payable and accrued liabilities, and accrued salaries, wages, and benefits	(6,437)	(14,454)
(Decrease) increase in advances from third-party payors	(894)	395
(Decrease) increase in other current and long-term liabilities	(997)	4,776
Net cash provided by operating activities	64,314	54,298
Cash flows from investing activities:		
Change in donor-restricted investments	(2,036)	277
Change in long-term investments	(1,159)	(3,670)
Change in assets limited as to use	8,961	4,108
Investment in/distributions from unconsolidated affiliates, net	780	(10,313)
Additions to operating property	(37,231)	(26,565)
Proceeds from the sale of property	—	4
Acquisition of physician practices	—	(2,482)
Net cash used in investing activities	(30,685)	(38,641)
Cash flows from financing activities:		
Payment on debt and capital lease obligations	(5,485)	(5,512)
Proceeds from issuance of debt	111	—
Restricted gifts and bequests	4,521	6,829
Net cash provided by financing activities	(853)	1,317
Net increase in cash and cash equivalents	32,776	16,974
Cash and cash equivalents:		
Beginning of year	219,711	181,529
End of year	$ 252,487	198,503
Supplemental cash flow disclosures:		
Cash paid during the year for interest	$ 17,022	17,526
Cash paid during the year for income taxes	12	70
Accounts payable related to purchase of operating property	2,188	2,113

THE PROJECT

The Project includes the facilities financed and refinanced with proceeds of the Refunded Bonds and the 2015 Project. The 2015 Project consists of the acquisition of a new generator and uninterruptible power supply at Sinai, renovations of certain of Sinai's inpatient units and its pediatrics emergency department area, operating room renovations and emergency department expansion at Northwest, facility infrastructure and renovation projects at CHC and the financing and refinancing of various renovations, improvements, equipment, and other routine capital expenditures at the Sinai, Northwest and CHC campuses.

The Obligated Group expects to complete the 2015 Project by October, 2017. The 2015 Project constitutes Additional Facilities under the Resolution and the Loan Agreement.

HISTORICAL AND PRO FORMA DEBT SERVICE COVERAGE RATIOS

The following table sets forth, for the Fiscal Years ended June 30, 2012, 2013 and 2014, historic and *pro forma* coverage of Maximum Annual Debt Service of Outstanding Long-Term Indebtedness of the Obligated Group. The *pro forma* ratios are based upon the assumption that the Series 2015 Bonds and the Taxable Loan Notes were issued, the Refunded Bonds and the Line of Credit Note were defeased or retired as described herein and the Affiliation had occurred, as of the first date of each of the Fiscal Years shown below.

	Fiscal Year Ended June 30, ($ in Thousands)		
	2012*	2013*	2014*
Adjusted unrestricted revenues and gains in excess of expenses	$25,760	$ 76,917	$100,344
Add: Depreciation, amortization and interest expense	96,645	96,919	95,614
Unrealized (gains)/losses on Hedging Transactions	11,116	(6,231)	804
Unrealized (gains)/losses on investments	11,655	(19,248)	(35,053)
Other	1,105	(10)	21
Net Income Available for Debt Service	$146,281	$148,347	$161,729
Historical Maximum Annual Debt Service	$33,996	$33,857	$33,661
Historical Coverage Ratio	4.30x	4.38x	4.80x
Pro Forma Maximum Annual Debt Service	$36,025	$36,025	$36,025
Pro Forma Coverage Ratio	4.06x	4.12x	4.49x

Source: The Obligated Group.
*Preliminary, subject to change.

HISTORICAL AND PRO FORMA CAPITALIZATION RATIOS

The following table sets forth the historical and *pro forma* capitalization of the Obligated Group as of June 30, 2014. The *pro forma* ratio for the Fiscal Year ended June 30, 2014 is based upon the assumption that the Series 2015 Bonds and the Taxable Loan Notes were issued, the Refunded Bonds and the Line of Credit Note were defeased or retired as described herein and the Affiliation had occurred, in each case on July 1, 2014.

	Actual June 30, 2014	Pro Forma* June 30, 2014
	($ in Thousands)	
Outstanding debt	$520,031	$631,870
Unrestricted net assets	799,768	799,768
Total capitalization	$1,319,799	$1,431,638
Debt to capitalization ratio	39.4%	44.1%

Source: The Obligated Group.
*Preliminary, subject to change.

REGULATORY ENVIRONMENT

Maryland Health Care Commission

Under current law, a person or non-federal health care facility in the State of Maryland may not develop, operate or participate in a covered health care project unless the Maryland Health Care Commission (the "Health Care Commission") has issued a Certificate of Need ("CON") for such project. The Health Care Commission is an independent commission functioning within the Maryland Department of Health and Mental Hygiene (the "State Health Department"). Covered health care projects include, among other things, the construction, development or other establishment of a new health care facility, the relocation of a covered health care facility to a new, non-contiguous site, certain changes in the type or scope of health care services offered in a covered health care facility, certain changes in bed capacity in a covered health care facility, certain health service-related obligations or capital expenditures by or on behalf of a health care facility and the offering of certain new institutional health services. A CON is a written certification by the Health Care Commission that the proposed health care project is in the public need and is in accordance with applicable state law. A CON, or determination of exemption, is a prerequisite to obtaining a license or certification to operate a health care facility or to offer certain health care services.

A CON is not required under existing law for certain projects, including, among others: (i) transfers or acquisitions of existing health care facilities not involving changes in services or bed capacity, (ii) the acquisition of, and related costs attributable to, medical equipment, (iii) business or office equipment not directly related to patient care, including health care clinical information systems, (iv) patient care related capital expenditures that do not exceed a specified review threshold, currently $11.75 million for hospitals and $5.85 million for other health care facilities, if the expenditures do not involve the addition of new beds or certain health care services, (v) patient care related capital expenditures for construction or renovation in excess of the current threshold of $11.75 million for hospitals, so long as the project does not require a total cumulative increase in patient charges or hospital rates of more than $1.5 million for the capital costs associated with the project over the entire period or schedule of debt service as

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

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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.

KPMG LLP is a Delaware limited liability partnership, the U.S. member firm of KPMG International Cooperative ("KPMG International"), a Swiss entity.

KPMG

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.

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.

(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.

- 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.

(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.

(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

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

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

(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)

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.

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)

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:

		2016		2015	
Joint Venture	Business purpose	Percentage ownership	Balance	Percentage ownership	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)

(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).

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)

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)

(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)

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.

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)

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)

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.

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.

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)

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)

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,

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

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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)

(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)

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)

(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

(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.

(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.

Schedule 1

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 12

Rec'd 8/19/03

STATE OF MARYLAND

Healthy People Healthy Communities

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

2 pages Rec'd copy Peggy Gaston from 9/15/03 9 am

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

Page Two

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

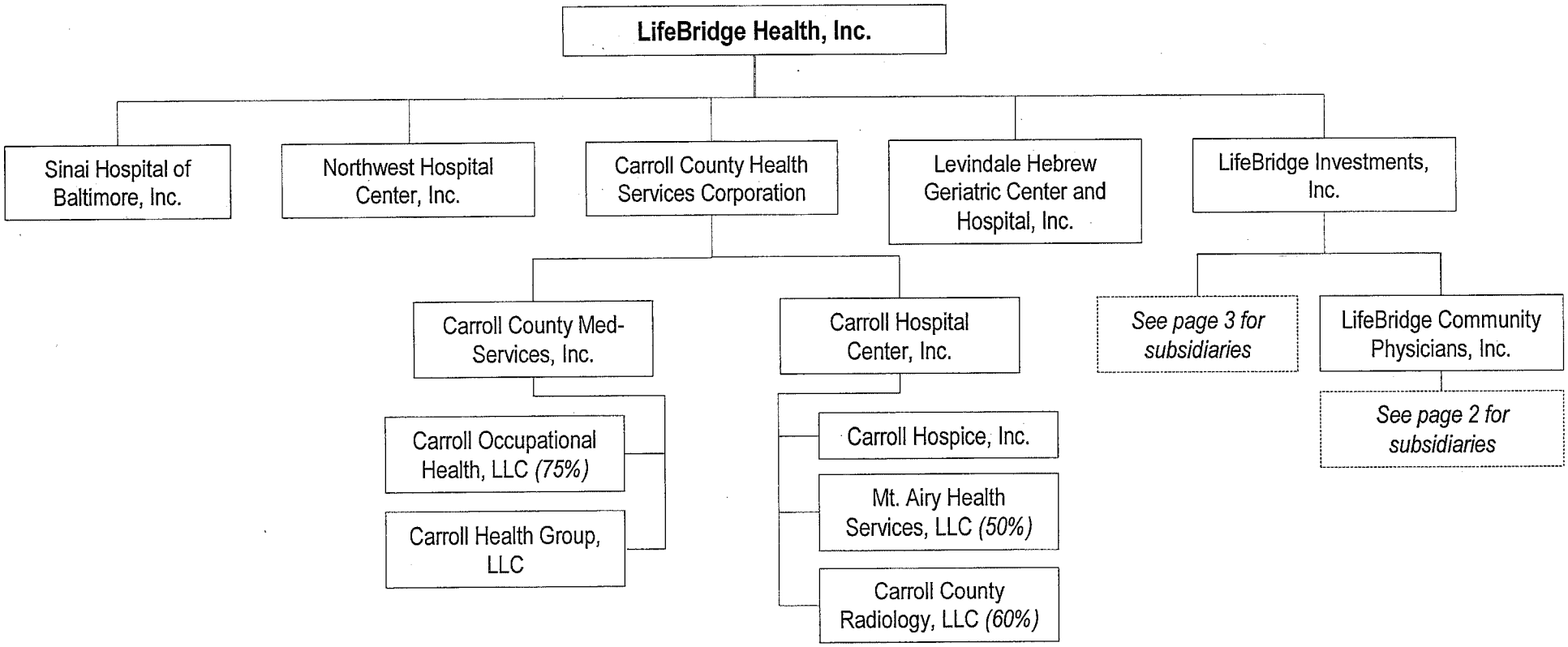
Carol Benner, Director
Office of Health Care Quality

EXHIBIT 13

LifeBridge Health, Inc.

Organizational Chart – Selected Entities

December 8, 2016



Notes

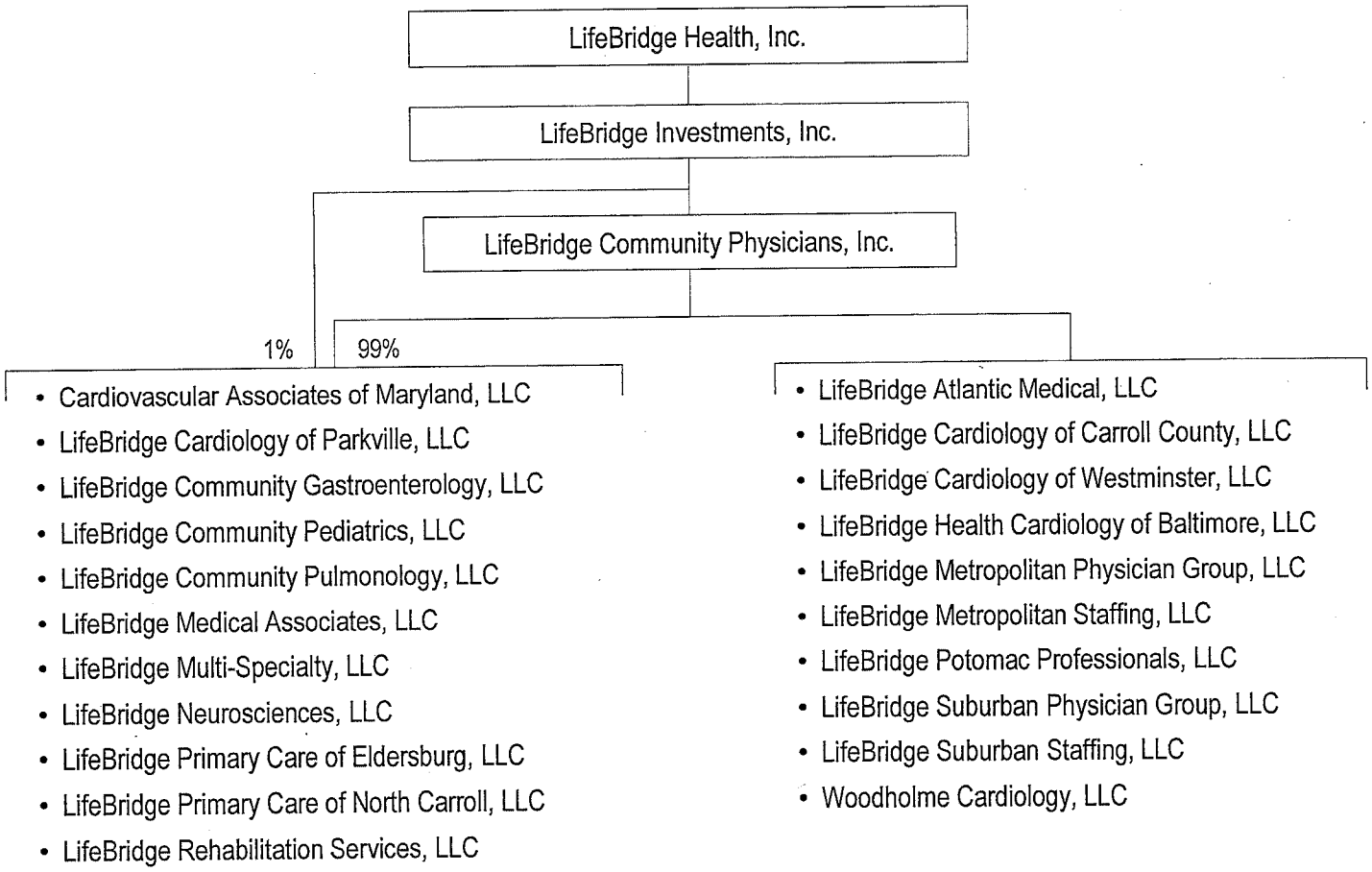
Ownership is 100% unless otherwise noted

501(c)(3) entity

LifeBridge Health, Inc.

Organizational Chart – Selected Entities

December 8, 2016



LifeBridge Health, Inc.

Organizational Chart – Selected Entities

December 8, 2016

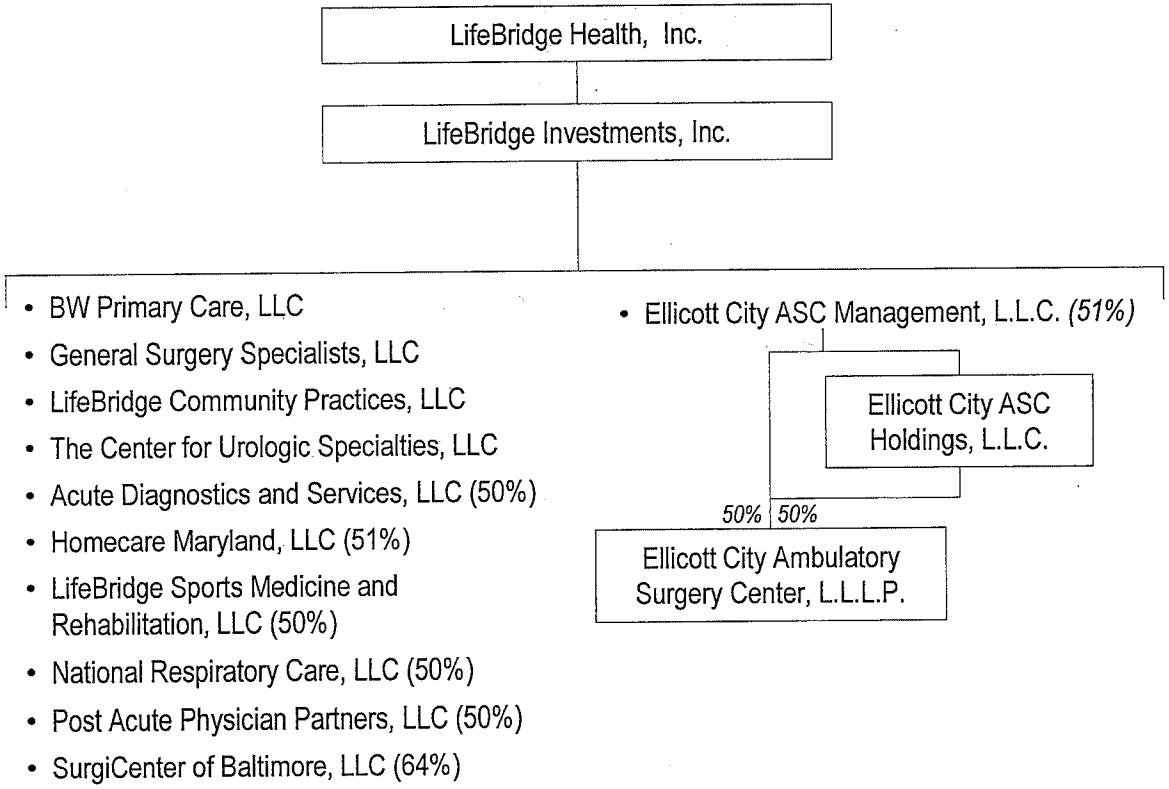


EXHIBIT 14

CARROLL HOSPICE, INC.

RESOLUTIONS OF THE BOARD OF TRUSTEES

WHEREAS, the Board of Trustees of Carroll Hospice, Inc. ("***Carroll Hospice***") has determined after review and consideration that it is in the best interests of Carroll Hospice to amend and restate its current Bylaws.

NOW, THEREFORE, be it

Amendment of Bylaws

RESOLVED, that the Board of Trustees recommends that the current Bylaws of Carroll Hospice be amended and restated substantially in the form attached hereto as Exhibit A (the "***Amended and Restated Bylaws***"); and be it

FURTHER RESOLVED, that a copy of the Amended and Restated Bylaws shall be submitted to the Sole Member of Carroll Hospice for its approval; and be it

FURTHER RESOLVED, that upon approval by the Sole Member (the "***Effective Date***"), a copy of the Amended and Restated Bylaws shall be inserted into the records of Carroll Hospice.

Change of Language

RESOLVED, that upon the Effective Date and pursuant to Article III, Mission of the Amended and Restated Bylaws has been changed.

RESOLVED, that upon the Effective Date and pursuant to Article IV, Section 1, of the Amended and Restated Bylaws that "Carroll County General" be changed to "Carroll Hospital Center."

RESOLVED, that upon the Effective Date and pursuant to Article V, Section 3, Election and Tenure of Trustees of the Amended and Restated Bylaws has been changed.

RESOLVED, that upon the Effective Date and pursuant to Article VI, Section 9, of the Amended and Restated Bylaws that "two" be changed "three."

RESOLVED, that upon the Effective Date and pursuant to Article VII, Section 4, Term of Office, of the Amended and Restated Bylaws has been changed.

RESOLVED, that upon the Effective Date and pursuant to Article VII, Section 5(a) of the Amended and Restated Bylaws that a "number 6" be added "Act as liaison with hospital and foundation boards. Lead and focus discussion during meeting."

RESOLVED, that upon the Effective Date and pursuant to Article VII, Section 5(e) 1 & 2 of the Amended and Restated Bylaws have been changed.

RESOLVED, that upon the Effective Date and pursuant to Article VII, Section 5(e) 3, 4 & 5 of the Amended and Restated Bylaws have been deleted.

RESOLVED, that upon the Effective Date and pursuant to Article VIII, Section 2 of the Amended and Restated Bylaws has added "at the discretion of Chair and Board."

RESOLVED, that upon the Effective Date and pursuant to Article VIII, Section 2(b) of the Amended and Restated Bylaws added at the end of sentence 2 "and act as a liaison with the sole member."

RESOLVED, that upon the Effective Date and pursuant to Article VIII, Section 2(d) of the Amended and Restated Bylaws have added "act as liaison."

RESOLVED, that upon the Effective Date and pursuant to Article VIII, Section 2(e) of the Amended and Restated Bylaws changed Committee name from "Governance and Ethics Committee" to "Governance and Ethics & Corporate Compliance Committee" and have added "The committee will act as a liaison with the ethics and corporate compliance committee as needed."

RESOLVED, that upon the Effective Date and pursuant to Article VIII, Section 2(f) of the Amended and Restated Bylaws changed Committee name from "Nominating Committee" to "Board Development Committee" and have added "The committee will also be responsible for mentoring new members and be responsive to the education needs of the board."

RESOLVED, that upon the Effective Date and pursuant to Article IX, Section 1 of the Amended and Restated Bylaws have been changed.

RESOLVED, that upon the Effective Date and pursuant to Article IX, Section 4 of the Amended and Restated Bylaws have been changed.

Added Committee

RESOLVED, that upon the Effective Date and pursuant to Article VIII, Section 2 of the Amended and Restated Bylaws that the Advocacy Committee be added.

FURTHER RESOLVED, that the Secretary of Carroll Hospice be, and hereby is, directed to file a copy of these resolutions with the records of Carroll Hospice.

Dated as of: June 18, 2013.

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Exhibit A

Amended and Restated Bylaws of Carroll Hospice, Inc.

(please see attached)

CARROLL HOSPICE, INC.

AMENDED AND RESTATED BYLAWS

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

Mission

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. 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 15 but no less than seven trustees, as may be fixed from time to time by the Board. 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.

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 (i) any trustee designated by the Sole member as a Founding Trustee or (ii) 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 September 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 from three (3) consecutive regular meetings, 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 shall appoint the Executive Director, who shall serve ex-officio as President, having general supervision of the business and affairs 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 any time.

SECTION 3. Election. No later than the Board meeting prior to the annual meeting, the Nominating 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 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) **Advocacy Committee.** The Advocacy Committee shall assist the board and executive director in overseeing and promoting Carroll Hospice in the community. The advocacy committee will assist with marketing outreach, community education and legislative issues on a federal and state level.

(b) **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.

(c) **Finance Committee.** The Finance Committee shall assist the Board in overseeing the finances of the Corporation, including oversight of audits, making

budget recommendations, and monitoring financial performance relative to the budget. (The Finance Committee may meet with its counterpart committee at Carroll Home Care, Inc. in the execution of its duties.)

(d) **Fund Development Committee.** The Fund Development Committee shall assist the Board in overseeing all fundraising activities, initiatives and events necessary to support the purposes and activities of the Corporation act as liaison.

(e) **Governance and Ethics & Corporate Compliance Committee.** The Governance and Ethics Committee shall assist the Board in overseeing the ethical and corporate governance issues of the Corporation, including the periodic review of these Bylaws. The committee will act as a liaison with the ethics and corporate compliance committee as needed.

(f) **Board Development Committee.** The Board Development Committee shall be responsible for 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 Finance Committee shall act as a liaison with Carroll Hospital Center. Together with the AVP of Finance or delegated representative from Carroll Hospital Center and the Finance Committee 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 18th DAY OF JUNE 2012

Mark E. Blacksten
Chair, Carroll Hospice
Board of Trustees

6/18/12
Date