

Cumulative E-File History 2013

Federal

Locator: 3962AU
Taxpayer Name: UPPER CHESAPEAKE MEDICAL CENTER
Return Type: 990, 990

Submitted Date 11/17/2014 3:11:45 PM
Acknowledgement Date 11/17/2014 3:32:01 PM
Status Accepted
Submission ID 23695320143215000008

Print

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IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2013, or fiscal year beginning _____, 2013, and ending _____, 20

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

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

2013

Department of the Treasury
Internal Revenue Service

Name of exempt organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

Name and title of officer

JOSEPH E. HOFFMAN III, CFO

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

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

1a	Form 990 check here ▶ <input checked="" type="checkbox"/>	b	Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	264128461.
2a	Form 990-EZ check here ▶ <input type="checkbox"/>	b	Total revenue, if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here ▶ <input type="checkbox"/>	b	Total tax (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here ▶ <input type="checkbox"/>	b	Tax based on investment income (Form 990-PF, Part VI, line 5).	4b	
5a	Form 8868 check here ▶ <input type="checkbox"/>	b	Balance Due (Form 8868, Part I, line 3c or Part II, line 8c)	5b	

Part II Declaration and Signature Authorization of Officer

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

Officer's PIN: check one box only

I authorize GRANT THORNTON LLP to enter my PIN

1	2	3	1	3
---	---	---	---	---

 as my signature
ERO firm name Enter five numbers, but do not enter all zeros

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

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

Officer's signature ▶ 

Date ▶ 11/12/2014

Part III Certification and Authentication

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

2	3	6	9	5	3	3	6	6	0	5
---	---	---	---	---	---	---	---	---	---	---

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2013 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature ▶ 

Date ▶ 11/12/2014

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

For Paperwork Reduction Act Notice, see back of form.

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

OMB No. 1545-0047

2013

Open to Public Inspection

A For the 2013 calendar year, or tax year beginning , 2013, and ending , 20

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization UPPER CHESAPEAKE MEDICAL CENTER			D Employer identification number 52-1253920	
	Doing Business As			E Telephone number (443) 643-1000	
	Number and street (or P.O. box if mail is not delivered to street address) Room/suite 500 UPPER CHESAPEAKE DRIVE		G Gross receipts \$ 267,179,532.		
	City or town, state or province, country, and ZIP or foreign postal code BEL AIR, MD 21014			H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)	
F Name and address of principal officer: LYLE E SHELDON 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014			H(c) Group exemption number ▶		
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527					
J Website: ▶ WWW.UMUCH.ORG					
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶				L Year of formation: 1997 M State of legal domicile: MD	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: DEDICATION TO MAINTAINING AND IMPROVING THE HEALTH OF THE PEOPLE IN ITS COMMUNITIES THROUGH AN INTEGRATED HEALTH DELIVERY SYSTEM THAT PROVIDES HIGH QUALITY CARE TO ALL.	
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.	
	3 Number of voting members of the governing body (Part VI, line 1a)	3 21.
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4 19.
	5 Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5 2,492.
	6 Total number of volunteers (estimate if necessary)	6 794.
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a 0
7b Net unrelated business taxable income from Form 990-T, line 34	7b 0	
Revenue	8 Contributions and grants (Part VIII, line 1h)	4,770,282. 7,601,117.
	9 Program service revenue (Part VIII, line 2g)	249,739,514. 253,940,506.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	488,058. 461,485.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	4,287,758. 2,125,353.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	259,285,612. 264,128,461.
	Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)
14 Benefits paid to or for members (Part IX, column (A), line 4)		0 0
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)		104,662,896. 107,432,514.
16a Professional fundraising fees (Part IX, column (A), line 11e)		0 0
b Total fundraising expenses (Part IX, column (D), line 25) ▶		0
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)		130,208,523. 130,529,625.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)		248,825,189. 251,720,299.
19 Revenue less expenses. Subtract line 18 from line 12	10,460,423. 12,408,162.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	353,410,774. 521,681,739.
	21 Total liabilities (Part X, line 26)	260,959,745. 254,168,978.
	22 Net assets or fund balances. Subtract line 21 from line 20.	92,451,029. 267,512,761.

COPY FOR PUBLIC INSPECTION

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here	▶ Signature of officer		Date	
	▶ Type or print name and title			
Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed PTIN
	RUSSLEE ARMSTRONG			P00288383
	Firm's name ▶ GRANT THORNTON LLP	Firm's EIN ▶ 36-6055558		Phone no. 215-561-4200

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

For Paperwork Reduction Act Notice, see the separate instructions.

Form **990** (2013)

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III Yes No

1 Briefly describe the organization's mission:

ATTACHMENT 1

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? Yes No

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

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

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses \$ 192,038,300. including grants of \$ 13,758,160.) (Revenue \$ 255,761,011.)

SEE SCHEDULE O

4b (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4c (Code:) (Expenses \$ including grants of \$) (Revenue \$)

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

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

4e Total program service expenses 192,038,300.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for line numbers (1a-14b), descriptions, and Yes/No checkboxes. Includes sections for backup withholding, employee reporting, foreign accounts, prohibited transactions, and charitable contributions.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (21), 1b (19), 2 (X), 3 (X), 4 (X), 5 (X), 6 (X), 7a (X), 7b (X), 8a (X), 8b (X), 9 (X).

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

Table with 3 columns: Question, Yes, No. Rows include: 10a (X), 10b, 11a (X), 11b, 12a (X), 12b (X), 12c (X), 13 (X), 14 (X), 15a (X), 15b (X), 16a (X), 16b (X).

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: JOSEPH E. HOFFMAN, III 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014 443-643-1000

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

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

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) ROGER E. SCHNEIDER, M.D. CHAIRMAN/DIRECTOR	1.00 2.50	X		X				0	0	0
(2) JAMES LAMB DIN VICE CHAIRMAN/DIRECTOR	1.00 2.50	X		X				0	0	0
(3) ADELE WILZACK SECRETARY/DIRECTOR	1.00 2.50	X		X				0	0	0
(4) RICHARD P. STREET, JR., V.M.D. TREASURER/DIRECTOR	1.00 2.50	X		X				0	0	0
(5) LYLE E. SHELDON PRESIDENT/CEO/DIRECTOR	5.00 50.00	X		X				0	1,287,691.	81,383.
(6) WILLIAM B. ALLEN, PH.D DIRECTOR	.50 1.00	X						0	0	0
(7) JOHN W. ASHWORTH III DIRECTOR/UMMS BOARD REP	.50 1.00	X						0	0	0
(8) JASON BIRNBAUM, M.D. DIRECTOR	.50 1.00	X						0	0	0
(9) JOHN H. CAIN DIRECTOR	.50 1.00	X						0	0	0
(10) ROBERT CHRENCIK DIRECTOR/UMMS BOARD REP	.50 1.00	X						0	0	0
(11) MELINDA L. CRAIG DIRECTOR	.50 1.00	X						0	0	0
(12) FRANKLIN J. HAJEK DIRECTOR	.50 1.00	X						0	0	0
(13) ROBERT J. JIRSA DIRECTOR	.50 1.50	X						0	0	0
(14) M. SCOT KAUFMAN DIRECTOR	.50 1.50	X						0	0	0

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
15) BRYAN E. KELLY DIRECTOR	.50 1.50	X						0	0	0
16) ANNE W. KINSLEY DIRECTOR	.50 1.50	X						0	0	0
17) ANDREW KLEIN DIRECTOR	.50 1.50	X						0	0	0
18) DONALD W. MATHIS DIRECTOR	.50 1.50	X						0	0	0
19) ANGELA POPPE RIES, M.D. DRCTOR/MED DIR-PALLIATIVE CARE	5.00 45.00	X						0	138,117.	18,590.
20) WILLIAM J. WARD, JR. DIRECTOR	.50 1.50	X						0	0	0
21) ALBERT J. A. YOUNG DIRECTOR	.50 1.00	X						0	0	0
22) JOSEPH E. HOFFMAN, III SR VP/CFO	5.00 50.00			X				0	620,604.	78,358.
23) JOYCE FOX VP - PATIENT SVCS/CNO	20.00 20.00				X			0	284,054.	49,558.
24) ROY H. PHILLIPS PHYSICIAN	50.00					X		0	265,972.	49,158.
25) OLUFUNMILAYO ONOBRAKPEYA PHYSICIAN	50.00					X		0	235,974.	49,198.
1b Sub-total								0	1,287,691.	81,383.
c Total from continuation sheets to Part VII, Section A								0	1,965,279.	333,524.
d Total (add lines 1b and 1c)								0	3,252,970.	414,907.

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization **82**

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 2		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **28**

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a						
	b Membership dues	1b						
	c Fundraising events	1c						
	d Related organizations	1d	7,601,117.					
	e Government grants (contributions) . .	1e						
	f All other contributions, gifts, grants, and similar amounts not included above .	1f						
	g Noncash contributions included in lines 1a-1f: \$							
	h Total. Add lines 1a-1f			7,601,117.				
Program Service Revenue	Business Code							
	2a NET PATIENT SERVICE REVENUE		621110	253,739,313.	253,739,313.			
	b SPINE CENTER/ENDOCRINOLOGY		621110	199,873.	199,873.			
	c POST REHAB FITNESS		621110	1,320.	1,320.			
	d _____							
	e _____							
	f All other program service revenue							
	g Total. Add lines 2a-2f			253,940,506.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			42,502.			42,502.	
	4 Income from investment of tax-exempt bond proceeds . . .			0				
	5 Royalties			0				
	6a Gross rents	(i) Real	1,470,574.					
		(ii) Personal						
		b Less: rental expenses	3,051,071.					
		c Rental income or (loss)	-1,580,497.					
	d Net rental income or (loss)			-1,580,497.			-1,580,497.	
	7a Gross amount from sales of assets other than inventory	(i) Securities	402,464.	16,519.				
		(ii) Other						
		b Less: cost or other basis and sales expenses						
		c Gain or (loss)	402,464.	16,519.				
	d Net gain or (loss)			418,983.			418,983.	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a						
	b Less: direct expenses	b						
c Net income or (loss) from fundraising events				0				
9a Gross income from gaming activities. See Part IV, line 19	a							
b Less: direct expenses	b							
c Net income or (loss) from gaming activities				0				
10a Gross sales of inventory, less returns and allowances	a							
b Less: cost of goods sold	b							
c Net income or (loss) from sales of inventory				0				
Miscellaneous Revenue			Business Code					
11a INCENTIVE PMTS-ELECTRONIC HLTH RECORDS		900099	1,820,505.	1,820,505.				
b CAFETERIA/VENDING		900099	1,201,742.			1,201,742.		
c PARKING GARAGE		900099	224,372.			224,372.		
d All other revenue		900099	459,231.			459,231.		
e Total. Add lines 11a-11d			3,705,850.					
12 Total revenue. See instructions			264,128,461.	255,761,011.			766,333.	

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21 .	13,728,955.	13,728,955.		
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	29,205.	29,205.		
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	0			
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	87,096,363.	64,699,029.	22,397,334.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	6,326,604.	4,699,681.	1,626,923.	
9 Other employee benefits	6,341,987.	4,711,108.	1,630,879.	
10 Payroll taxes	7,667,560.	5,695,803.	1,971,757.	
11 Fees for services (non-employees):				
a Management	1,780,360.		1,780,360.	
b Legal	0			
c Accounting	4,725.		4,725.	
d Lobbying	0			
e Professional fundraising services. See Part IV, line 17.	0			
f Investment management fees	0			
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	15,474,078.	8,920,783.	6,553,295.	
12 Advertising and promotion	656,507.	975.	655,532.	
13 Office expenses	63,635,995.	59,984,883.	3,651,112.	
14 Information technology	0			
15 Royalties	0			
16 Occupancy	4,696,507.	671,914.	4,024,593.	
17 Travel	25,723.	11,892.	13,831.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	94,492.	31,807.	62,685.	
20 Interest	4,359,730.	3,238,600.	1,121,130.	
21 Payments to affiliates	5,069,367.	595,024.	4,474,343.	
22 Depreciation, depletion, and amortization	12,800,202.	9,508,556.	3,291,646.	
23 Insurance	3,131,253.	2,326,033.	805,220.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <u>MANAGEMENT FEES - UCHS</u>	8,772,095.		8,772,095.	
b <u>REPAIRS & MAINTENANCE</u>	3,107,188.	907,278.	2,199,910.	
c <u>BAD DEBT</u>	12,072,108.	12,072,108.		
d <u>DUES</u>	371,900.	17,907.	353,993.	
e All other expenses	-5,522,605.	186,759.	-5,709,364.	
25 Total functional expenses. Add lines 1 through 24e	251,720,299.	192,038,300.	59,681,999.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	18,587,894.	1	22,349,642.
	2 Savings and temporary cash investments	0	2	0
	3 Pledges and grants receivable, net	0	3	0
	4 Accounts receivable, net	27,904,096.	4	26,360,350.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0	6	0
	7 Notes and loans receivable, net	0	7	0
	8 Inventories for sale or use	5,804,000.	8	0
	9 Prepaid expenses and deferred charges	1,191,840.	9	7,431,191.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 297,153,791.		
	b Less: accumulated depreciation	10b 97,038,099.	176,483,251.	10c 200,115,692.
	11 Investments - publicly traded securities	41,528,964.	11	41,931,427.
	12 Investments - other securities. See Part IV, line 11	0	12	0
	13 Investments - program-related. See Part IV, line 11	0	13	0
	14 Intangible assets	223,518.	14	62,899.
	15 Other assets. See Part IV, line 11	81,687,211.	15	223,430,538.
16 Total assets. Add lines 1 through 15 (must equal line 34)	353,410,774.	16	521,681,739.	
Liabilities	17 Accounts payable and accrued expenses	30,580,356.	17	18,298,981.
	18 Grants payable	0	18	0
	19 Deferred revenue	0	19	0
	20 Tax-exempt bond liabilities	162,519,495.	20	189,751,044.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23 Secured mortgages and notes payable to unrelated third parties	0	23	0
	24 Unsecured notes and loans payable to unrelated third parties	0	24	0
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	67,859,894.	25	46,118,953.
	26 Total liabilities. Add lines 17 through 25	260,959,745.	26	254,168,978.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	81,060,106.	27	106,122,761.
	28 Temporarily restricted net assets	11,390,923.	28	161,390,000.
	29 Permanently restricted net assets	0	29	0
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 Total net assets or fund balances	92,451,029.	33	267,512,761.
	34 Total liabilities and net assets/fund balances	353,410,774.	34	521,681,739.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	264,128,461.
2	Total expenses (must equal Part IX, column (A), line 25)	2	251,720,299.
3	Revenue less expenses. Subtract line 2 from line 1	3	12,408,162.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	92,451,029.
5	Net unrealized gains (losses) on investments	5	-34,829.
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	162,688,399.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	267,512,761.

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990: Cash Accrual Other _____
 If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
 If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
 If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
 If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.

	Yes	No
2a		X
2b	X	
2c	X	
3a		X
3b		

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support
Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

OMB No. 1545-0047

2013

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization UPPER CHESAPEAKE MEDICAL CENTER	Employer identification number 52-1253920
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Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

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

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

		Yes	No
(i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	11g(i)		
(ii) A family member of a person described in (i) above?	11g(ii)		
(iii) A 35% controlled entity of a person described in (i) or (ii) above?	11g(iii)		

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

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule A (Form 990 or 990-EZ) 2013

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Table with 7 columns: (a) 2009, (b) 2010, (c) 2011, (d) 2012, (e) 2013, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2009, (b) 2010, (c) 2011, (d) 2012, (e) 2013, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2013; 15 Public support percentage from 2012 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2013; b 33 1/3% support test - 2012; 17a 10%-facts-and-circumstances test - 2013; b 10%-facts-and-circumstances test - 2012; 18 Private foundation.

Part III Support Schedule for Organizations Described in Section 509(a)(2)
 (Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II.
 If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

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

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

19a 33 1/3% support tests - 2013. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

b 33 1/3% support tests - 2012. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

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

Schedule of Contributors

2013

▶ **Attach to Form 990, Form 990-EZ, or Form 990-PF.**
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at www.irs.gov/form990.

Name of the organization UPPER CHESAPEAKE MEDICAL CENTER	Employer identification number 52-1253920
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Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

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

For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions of \$5,000 or more during the year ▶ \$ _____

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

Name of organization UPPER CHESAPEAKE MEDICAL CENTER	Employer identification number 52-1253920
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Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	----- ----- -----	\$ 6,673,329.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

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

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

Name of organization UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number
52-1253920

Part III Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than \$1,000 for the year. Complete columns (a) through (e) and the following line entry.

For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this information once. See instructions.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
-----	----- ----- -----	----- ----- -----	----- ----- -----

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
----- ----- -----	----- ----- -----

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
-----	----- ----- -----	----- ----- -----	----- ----- -----

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
----- ----- -----	----- ----- -----

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
-----	----- ----- -----	----- ----- -----	----- ----- -----

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
----- ----- -----	----- ----- -----

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
-----	----- ----- -----	----- ----- -----	----- ----- -----

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
----- ----- -----	----- ----- -----

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2013

Open to Public Inspection

For Organizations Exempt From Income Tax Under section 501(c) and section 527
 ▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
 ▶ **See separate instructions.** ▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.**

Department of the Treasury
Internal Revenue Service

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35c (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization UPPER CHESAPEAKE MEDICAL CENTER	Employer identification number 52-1253920
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
- 2 Political expenditures ▶ \$ _____
- 3 Volunteer hours _____

Part I-B Complete if the organization is exempt under section 501(c)(3).

- 1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ \$ _____
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$ _____
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? Yes No
- 4a Was a correction made? Yes No
- b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ \$ _____
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ \$ _____
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ \$ _____
- 4 Did the filing organization file **Form 1120-POL** for this year? Yes No
- 5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
(1)	-----			
(2)	-----			
(3)	-----			
(4)	-----			
(5)	-----			
(6)	-----			

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

Schedule C (Form 990 or 990-EZ) 2013

Part II-A Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).

A Check if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a	Total lobbying expenditures to influence public opinion (grass roots lobbying)														
b	Total lobbying expenditures to influence a legislative body (direct lobbying)														
c	Total lobbying expenditures (add lines 1a and 1b)														
d	Other exempt purpose expenditures														
e	Total exempt purpose expenditures (add lines 1c and 1d)														
f	Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="text-align: left;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
g	Grassroots nontaxable amount (enter 25% of line 1f)														
h	Subtract line 1g from line 1a. If zero or less, enter -0-														
i	Subtract line 1f from line 1c. If zero or less, enter -0-														
j	If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes <input type="checkbox"/> No												

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

Table with 3 main columns: Description, (a) Yes/No, and (b) Amount. Rows include questions about lobbying activities and their tax consequences.

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

Table with 3 columns: Question, Yes, No. Rows include questions about dues, lobbying expenditures, and carryover.

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."

Table with 3 columns: Question, Yes, No. Rows include questions about dues, non-deductible lobbying expenditures, and carryover.

Part IV Supplemental Information

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

LOBBYING ACTIVITIES

SCHEDULE C, PART II-B, LINE 1I

LOBBYING EXPENSES IN THE AMOUNT OF \$9,450 FOR 12/31/13 REPRESENT A

PORTION OF THE DUES PAID TO MARYLAND HOSPITAL ASSOCIATION. THESE

ASSOCIATIONS ALLOCATE A PORTION OF MEMBER DUES TO LOBBYING ACTIVITY.

Part IV Supplemental Information *(continued)*

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

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

2013

Department of the Treasury Internal Revenue Service

Attach to Form 990.

Open to Public Inspection

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

Name of the organization

Employer identification number

UPPER CHESAPEAKE MEDICAL CENTER

52-1253920

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

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

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate contributions to (during year), 3 Aggregate grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?, 6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

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

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

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

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

Table with 2 columns: Revenues, Assets. Rows include: 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items., 1b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenues included in Form 990, Part VIII, line 1, (ii) Assets included in Form 990, Part X, 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items: a Revenues included in Form 990, Part VIII, line 1, b Assets included in Form 990, Part X

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

Schedule D (Form 990) 2013

JSA 3E1268 2.000

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

- 3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):
- a Public exhibition
 - b Scholarly research
 - c Preservation for future generations
 - d Loan or exchange programs
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b If "Yes," explain the arrangement in Part XIII and complete the following table:
- | | Amount |
|---|--------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a Did the organization include an amount on Form 990, Part X, line 21? Yes No
- b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII.

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment %
 - b Permanent endowment %
 - c Temporarily restricted endowment %
- The percentages in lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|--------|----|
| (i) unrelated organizations | 3a(i) | |
| (ii) related organizations | 3a(ii) | |
| b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R? | 3b | |
- 4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment. Complete if the organization answered "Yes" to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		6,948,000.		6,948,000.
b Buildings		140,159,837.	38,197,398.	101,962,439.
c Leasehold improvements		8,498,390.	1,754,546.	6,743,844.
d Equipment		53,378,222.	40,446,049.	12,932,173.
e Other		88,169,342.	16,640,106.	71,529,236.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).				200,115,692.

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other _____		
(A) _____		
(B) _____		
(C) _____		
(D) _____		
(E) _____		
(F) _____		
(G) _____		
(H) _____		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶		

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 13.) ▶		

Part IX Other Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) OTHER ACCTS RECEIVABLE	3,328,044.
(2) DEFERRED FINANCING COSTS	922,900.
(3) DUE FROM AFFILIATES	51,914,521.
(4) FUNDS HELD BY TRUSTEE	3,362,073.
(5) ECON INT FOUNDATION NET ASSETS	161,390,000.
(6) CURRENT PORTION OF ASSETS LTD	2,513,000.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	223,430,538.

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ADVANCES FROM THIRD PARTIES	5,767,749.
(3) BOND INTEREST RATE SWAP	36,447,472.
(4) CAPITAL LEASE OBLIGATION	3,903,732.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	46,118,953.

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

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

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

1	Total revenue, gains, and other support per audited financial statements		1	404,032,039.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
a	Net unrealized gains on investments	2a	-34,829.	
b	Donated services and use of facilities	2b		
c	Recoveries of prior year grants	2c		
d	Other (Describe in Part XIII.)	2d	136,887,336.	
e	Add lines 2a through 2d	2e	136,852,507.	
3	Subtract line 2e from line 1	3	267,179,532.	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:			
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a		
b	Other (Describe in Part XIII.)	4b	-3,051,071.	
c	Add lines 4a and 4b	4c	-3,051,071.	
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)	5	264,128,461.	

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

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

1	Total expenses and losses per audited financial statements		1	228,970,307.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:			
a	Donated services and use of facilities	2a		
b	Prior year adjustments	2b		
c	Other losses	2c		
d	Other (Describe in Part XIII.)	2d	3,051,071.	
e	Add lines 2a through 2d	2e	3,051,071.	
3	Subtract line 2e from line 1	3	225,919,236.	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:			
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a		
b	Other (Describe in Part XIII.)	4b	25,801,063.	
c	Add lines 4a and 4b	4c	25,801,063.	
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)	5	251,720,299.	

Part XIII Supplemental Information.

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

SEE PAGE 5

Part XIII Supplemental Information (continued)

PART X, QUESTION 2

UPPER CHESAPEAKE MEDICAL CENTER ACCOUNTS FOR TAX PROVISIONS IN ACCORDANCE WITH FASB INTERPRETATION NO. 48 (FIN 48), ACCOUNTING FOR UNCERTAINTY IN INCOME TAXES, INCLUDED IN ASC SUBTOPIC 740-10, INCOME TAXES - OVERALL, WHICH CLARIFIES THE ACCOUNTING FOR UNCERTAINTY IN TAX PROVISIONS. FIN 48 REQUIRES THAT UPPER CHESAPEAKE MEDICAL CENTER RECOGNIZE THE EFFECT OF INCOME TAX POSITIONS ONLY IF THOSE POSITIONS ARE MORE LIKELY THAN NOT OF BEING SUSTAINED. RECOGNIZED INCOME TAX POSITIONS ARE MEASURED AT THE LARGEST AMOUNT THAT IS GREATER THAN 50% LIKELY OF BEING REALIZED. CHANGES IN RECOGNITION OR MEASUREMENT ARE REFLECTED IN THE PERIOD IN WHICH THE CHANGE IN JUDGMENT OCCURS.

SCHEDULE D, PART XI

LINE 2D - OTHER REVENUE ON BOOKS NOT ON RETURN

RECLASS-PROVISION FOR BAD DEBT	\$ (12,072,108)
MINIMUM PENSION LIABILITY	8,968,327
UNREALIZED GAIN/(LOSS) ON SWAP	3,720,072
ECONOMIC INTEREST IN UCH LEGACY FUNDING, INC.	150,000,000
RECLASS-GRANT TO: UC MEDICAL SERVICE	(13,426,146)
RECLASS-GRANT TO: UC PROPERTIES	(149,503)
RECLASS-GRANT TO: UC RES HOSPICE HOUSE	(153,306)

TOTAL LINE 2D	\$136,887,336

LINE 4B - OTHER REVENUE ON RETURN NOT ON BOOKS

RECLASS-RENTAL EXPENSES	\$ (3,051,071)
-------------------------	----------------

Part XIII Supplemental Information (continued)

SCHEDULE D, PART XII

LINE 2D - OTHER EXPENSES INCLUDED ON BOOKS NOT ON RETURN

RECLASS-RENTAL EXPENSES \$ 3,051,071

LINE 4B - OTHER EXPENSES INCLUDED ON RETURN NOT ON BOOKS

RECLASS-PROVISION FOR BAD DEBT \$ 12,072,108

RECLASS-GRANT TO: UC MEDICAL SERVICE 13,426,146

RECLASS-GRANT TO: UC PROPERTIES 149,503

RECLASS-GRANT TO: UC RES HOSPICE HOUSE 153,306

TOTAL LINE 4B \$ 25,801,063

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2013

Open to Public Inspection

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

▶ **Attach to Form 990. ▶ See separate instructions.**

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

Department of the Treasury
Internal Revenue Service

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
1b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	X	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		X
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a Did the organization prepare a community benefit report during the tax year?	X	
b If "Yes," did the organization make it available to the public?	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			18,408,513.		18,408,513.	7.68
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			18,408,513.		18,408,513.	7.68
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			1,473,506.	133,631.	1,339,874.	.56
f Health professions education (from Worksheet 5)			1,663,615.		1,663,615.	.69
g Subsidized health services (from Worksheet 6)			3,274,736.		3,274,736.	1.37
h Research (from Worksheet 7)			237,670.		237,670.	.10
i Cash and in-kind contributions for community benefit (from Worksheet 8)			130,832.		130,832.	.05
j Total. Other Benefits			6,780,359.	133,631.	6,646,727.	2.77
k Total. Add lines 7d and 7j.			25,188,872.	133,631.	25,055,240.	10.45

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

Schedule H (Form 990) 2013

JSA 3E1284 1.000

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support			69,047.	31,500.	37,547.	
4 Environmental improvements			5,909.		5,909.	
5 Leadership development and training for community members			1,747.		1,747.	
6 Coalition building			27,052.		27,052.	
7 Community health improvement advocacy						
8 Workforce development			2,327.		2,327.	
9 Other						
10 Total			106,082.	31,500.	74,582.	

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	101,888,326.
6 Enter Medicare allowable costs of care relating to payments on line 5	96,535,239.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	5,353,087.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other	

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year?	X	
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	X	

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

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

Part V Facility Information

Section A. Hospital Facilities

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

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

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

1 UPPER CHESAPEAKE MEDICAL CENTER, INC.
 500 UPPER CHESAPEAKE DRIVE
 BEL AIR MD 21014
 WWW.UMUCH.ORG

Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
X	X					X			1

Part V Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or facility reporting group UPPER CHESAPEAKE MEDICAL CENTER, INC.

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

Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)

Table with 3 columns: Question, Yes, No. Rows include questions 1 through 8c regarding CHNA assessment, website availability, and implementation strategies.

Part V Facility Information (continued)

Financial Assistance Policy UPPER CHESAPEAKE MEDICAL CENTER, INC.

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate the FPG family income limit for eligibility for free care: <u>2</u> <u>0</u> <u>0</u> % If "No," explain in Section C the criteria the hospital facility used.	X	
11	Used FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>3</u> <u>0</u> <u>0</u> % If "No," explain in Section C the criteria the hospital facility used.	X	
12	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply):	X	
a	<input checked="" type="checkbox"/> Income level		
b	<input checked="" type="checkbox"/> Asset level		
c	<input checked="" type="checkbox"/> Medical indigency		
d	<input type="checkbox"/> Insurance status		
e	<input type="checkbox"/> Uninsured discount		
f	<input type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input type="checkbox"/> Residency		
i	<input type="checkbox"/> Other (describe in Section C)		
13	Explained the method for applying for financial assistance?	X	
14	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input checked="" type="checkbox"/> The policy was attached to billing invoices		
c	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Section C)		

Billing and Collections

15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged:		X
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		

Part V Facility Information (continued) UPPER CHESAPEAKE MEDICAL CENTER, INC.

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

Policy Relating to Emergency Medical Care

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

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

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

Part V Facility Information (continued)

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

GENERAL INFORMATION:

THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WAS CONDUCTED OVER A NUMBER OF YEARS AND CONCLUDED IN JULY OF 2012. THE PURPOSE OF THE ASSESSMENT WAS TO GATHER INFORMATION ABOUT LOCAL HEALTH NEEDS AND HEALTH BEHAVIORS. THE UPPER CHESAPEAKE HEALTH SYSTEM BOARD QUALITY OF CARE COMMITTEE MET ON APRIL 8, 2014 TO REVIEW THE FINDINGS OF THE CHNA AND THE RECOMMENDED IMPLEMENTATION STRATEGY. THE COMMITTEE VOTED TO ADOPT THE FINAL SUMMARY REPORT AND IMPLEMENTATION STRATEGY AND PROVIDE THE NECESSARY RESOURCES AND SUPPORT TO CARRY OUT THE INITIATIVES THEREIN.

QUESTION 3:

UPPER CHESAPEAKE MEDICAL CENTER MAINTAINS A KEY LEADERSHIP ROLE IN HEALTHY HARFORD (AN IRC SECTION 501(C)(3) ORGANIZATION LABELED - THE HEALTHY COMMUNITIES INITIATIVE OF HARFORD COUNTY), ESTABLISHED IN 1995. IN 1996, HEALTHY HARFORD BEGAN COLLECTING COMMUNITY DATA VIA A COMPREHENSIVE COMMUNITY HEALTH ASSESSMENT PROJECT (CHAP) SURVEY THAT MEASURED THE INCIDENCE OF DISEASE, PREVENTIVE BEHAVIORS, AND LIFESTYLE BEHAVIORS OF HARFORD COUNTY RESIDENTS WITH AN EYE TOWARDS ASSESSING COMMUNITY HEALTH AND ESTABLISHING HEALTH PRIORITIES IN THE COMMUNITY. CHAP DATA WAS SUBSEQUENTLY COLLECTED IN 2000, 2005, AND 2010. THE GOALS OF THE CHAP SURVEY ARE MULTIPLE: ASSESSING THE OVERALL HEALTH OF HARFORD COUNTY ADULT RESIDENTS, INSURING THAT HEALTH EDUCATION AND PROGRAMMING EFFORTS IN HARFORD COUNTY MATCH ACTUAL NEEDS, ESTABLISHING A BASELINE OF HEALTH INDICATORS SO THAT PROGRESS CAN BE MEASURED OVER TIME, AND ALIGNING COMMUNITY STAKEHOLDERS AROUND THE COMMON GOAL OF IMPROVING HEALTH IN OUR COMMUNITY.

Part V Facility Information (continued)

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

IN ADDITION TO THE CHAP SURVEY, A SECONDARY DATA PROFILE WAS CREATED UTILIZING SOURCES THAT INCLUDED DATA FROM THE HARFORD COUNTY HEALTH DEPARTMENT AND THE LOCAL HEALTH IMPROVEMENT PLAN (LHIP), THE HARFORD COUNTY DEPARTMENT OF COMMUNITY SERVICES, 2010 U.S. CENSUS, MARYLAND VITAL STATISTICS, THE CDC BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM, NATIONAL HEALTH INTERVIEW SURVEY, COMMUNITY HEALTH RANKINGS, AND THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE HEALTH IMPROVEMENT PLAN (SHIP).

INFORMATION FROM LOCAL HEALTH IMPROVEMENT COALITION AND THE RESULTING PLAN (LHIP) WAS USED AS A MAJOR SOURCE OF INFORMATION REGARDING COMMUNITY HEALTH NEEDS. DIRECTED BY THE HARFORD COUNTY HEALTH OFFICER, THIS LOCAL HEALTH ASSESSMENT UTILIZED THE COMMUNITY CAFE MODEL TO BRING TOGETHER OVER 60 COMMUNITY REPRESENTATIVES FROM A VARIETY OF BACKGROUNDS TO FOCUS ON THE MOST PRESSING HEALTH CONCERNS IN OUR COMMUNITY. LEADERSHIP FROM UCH PLAYED A SIGNIFICANT ROLE IN THIS EXERCISE AND SUBSEQUENTLY CHAIRED TWO OF THE LEADING WORKGROUPS (COMMUNITY ENGAGEMENT UNDER THE OBESITY PRIORITY, AND TOBACCO). DATA FROM THE SHIP WAS USED AS A BASIS FOR THIS EXERCISE. THE HEALTH AREAS THAT WERE DEEMED THE MOST PRESSING FOR OUR COMMUNITY BY THE LHIC WERE OBESITY, TOBACCO USE, AND BEHAVIORAL HEALTH (MENTAL HEALTH/SUBSTANCE ABUSE). CONCURRENT WITH THIS EXERCISE AN OBESITY TASK FORCE AND TOBACCO WORK GROUP WERE INITIATED AND CHAIRED BY UCH LEADERSHIP. AS A RESULT OF THE OBESITY TASK FORCE, THE COUNTY COUNCIL COMMISSIONED A COUNTY WIDE BOARD, NAMED THE HEALTHY COMMUNITY PLANNING BOARD, WHO REPORTS DIRECTLY TO THE COUNTY COUNCIL AND IS STAFFED

Part V Facility Information (continued)

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

BY THE COUNTY COUNCIL AND IS RESPONSIBLE FOR MAKING RECOMMENDATIONS FOR HEALTH POLICY PLANNING AND IMPLEMENTATION IN THE COUNTY.

QUESTION 4:

UPPER CHESAPEAKE MEDICAL CENTER'S CHNA WAS CONDUCTED IN CONJUNCTION WITH ITS RELATED AFFILIATE HOSPITAL, HARFORD MEMORIAL HOSPITAL.

QUESTION 7:

BEHAVIORAL HEALTH (MENTAL HEALTH/SUBSTANCE ABUSE) HAS BEEN IDENTIFIED AS A HEALTH PRIORITY IN THE HOSPITAL'S COMMUNITY. UPPER CHESAPEAKE HEALTH, HOWEVER, IS NOT ABLE TO FOCUS ITS EFFORTS ON THIS HEALTH PRIORITY. THIS PRIORITY IS INSTEAD BEING ADDRESSED BY THE HARFORD COUNTY HEALTH DEPARTMENT, ADDICTIONS DEPARTMENT; THE OFFICE ON MENTAL HEALTH - CORE SERVICE AGENCY; AND DEPARTMENT OF COMMUNITY SERVICES, OFFICE OF DRUG CONTROL POLICY AS THIS IS THEIR AREA OF EXPERTISE AND PRIMARY FOCUS.

QUESTION 20:

CHARGE RATES IN COMPLIANCE WITH STATE REGULATION TO ALL PAYERS.

Part V Facility Information (continued)

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

How many non-hospital health care facilities did the organization operate during the tax year? 1

Name and address	Type of Facility (describe)
1 UC HEALTH LINK CLINIC 2027 PULASKI HWY, SUITE 206 HAVRE DE GRACE MD 21078	PRIMARY CARE CLINIC FOR LOW INCOME INDIVIDUALS
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

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

PART III, SECTION A, LINES 2-4: BAD DEBT EXPENSE

THE HOSPITAL GRANTS CREDIT TO PATIENTS, SUBSTANTIALLY ALL OF WHOM ARE LOCAL RESIDENTS. THE HOSPITAL GENERALLY DOES NOT REQUIRE COLLATERAL OR OTHER SECURITY IN EXTENDING CREDIT; HOWEVER, THE HOSPITAL ROUTINELY OBTAINS ASSIGNMENT OF (OR ARE OTHERWISE ENTITLED TO RECEIVE) PATIENTS' BENEFITS RECEIVABLE UNDER THEIR HEALTH INSURANCE PROGRAMS, PLANS OR POLICIES.

PLEASE REFER TO FOOTNOTE 15 CHARITY CARE AND OTHER DEDUCTIONS FROM REVENUE FOR THE DESCRIPTION REGARDING THE ORGANIZATION'S BAD DEBT EXPENSE.

PART III, SECTION B, LINE 8: COMMUNITY BENEFIT AND SHORTFALL

THE HOSPITAL DID NOT HAVE A MEDICARE SHORTFALL.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, SECTION C, LINE 9B: FAP AND COLLECTION PROCESS

IT IS THE POLICY OF THE HOSPITAL TO ATTEMPT TO COLLECT PAYMENT FOR ALL SERVICES RENDERED TO PATIENTS IN THE MOST EFFICIENT AND PATIENT FRIENDLY MANNER. THE HOSPITAL IS COMMITTED TO PROVIDE FINANCIAL ASSISTANCE TO PERSONS WHO HAVE HEALTH CARE NEEDS AND ARE: UNINSURED, UNDERINSURED, INELIGIBLE FOR GOVERNMENT PROGRAMS, OR OTHERWISE UNABLE TO PAY FOR MEDICALLY NECESSARY CARE BASED ON INDIVIDUAL FINANCIAL SITUATION.

THE HOSPITAL WILL FIRST ATTEMPT TO COLLECT PAYMENT FROM THE PATIENT'S INSURANCE COMPANY. IN THE EVENT THE PATIENT HAS NO INSURANCE OR LIMITED INSURANCE COVERAGE, THE HOSPITAL WILL ATTEMPT TO QUALIFY THE PATIENT FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND/OR THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY.

THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY'S PROCEDURES ARE AS FOLLOWS:

-FINANCIAL ASSISTANCE IS MADE AVAILABLE TO ALL OF UPPER CHESAPEAKE HEALTH'S CUSTOMERS

Part VI Supplemental Information

Provide the following information.

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

-APPLICATIONS ARE PROVIDED TO EVERY UNINSURED PATIENT AND UPON REQUEST

-NOTICES OF AVAILABILITY ARE AT ALL PATIENT ACCESS POINTS, BILLING
OFFICES AND CASHIER'S STATIONS

-NOTICE OF AVAILABILITY PROVIDED TO PATIENTS ON PATIENTS BILLS AND BEFORE
DISCHARGE

-FREE CARE IS AVAILABLE TO PATIENTS IN HOUSEHOLDS BETWEEN 0 PERCENT AND
200 PERCENT OF FEDERAL POVERTY LEVEL

-REDUCED COST CARE IS AVAILABLE TO UNINSURED PATIENTS BETWEEN 200 PERCENT
AND 300 PERCENT OF FEDERAL POVERTY LEVEL

-INTEREST FREE PAYMENT PLANS ARE AVAILABLE TO UNINSURED PATIENTS WITH
INCOME BETWEEN 200 PERCENT AND 500 PERCENT OF FEDERAL POVERTY LEVEL

Part VI Supplemental Information

Provide the following information.

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

-FINANCIAL ASSISTANCE DETERMINATION APPEAL PROCESS IN PLACE

-MEDICAL HARDSHIP / CATASTROPHIC CARE POLICY IN PLACE

PATIENTS WHO ARE LEFT WITH A BALANCE AFTER ALL INSURANCES HAVE BEEN
PURSUED AND FINANCIAL ASSISTANCE HAS BEEN OFFERED - THEIR ACCOUNTS WILL
BE HANDLED IN THE FOLLOWING MANNER:

-THE ORGANIZATION WILL REFER THESE ACCOUNTS TO ITS EARLY-OUT VENDOR. THIS
EARLY-OUT VENDOR IS NOT A COLLECTION AGENCY; IT IS AN EXTENSION OF THE
HOSPITAL'S PATIENT ACCOUNTING OFFICE.

-THE EARLY-OUT VENDOR WILL FACILITATE THE NEGOTIATION OF SELF-PAY
NO-INTEREST PAYMENT ARRANGEMENTS THROUGH A SERIES OF LETTERS AND PHONE
CALLS.

-AN INITIAL NOTICE WILL BE SENT TO THE PATIENT'S GUARANTOR PROVIDING
OPTIONS FOR RESOLUTION. IF GUARANTOR IS UNABLE TO PAY THE BALANCE IN

Part VI Supplemental Information

Provide the following information.

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

FULL, AN ATTEMPT WILL BE MADE TO HAVE THE BALANCE RESOLVED WITHIN 3 TO 6 MONTHS. THE MINIMUM PAYMENT GUIDELINES REQUIRE THE ACCOUNT BALANCE BE PAID IN 12 MONTHS WITH A MINIMUM PAYMENT OF FIFTY DOLLARS. THERE IS EXCEPTIONS FOR CANCER CENTER PATIENTS.

-IF A VALID ADDRESS AND OR PHONE NUMBER IS LISTED A TOTAL OF 3 LETTERS AND 3 PHONE CALL ATTEMPTS WILL BE MADE ON ACCOUNTS THAT HAVE NOT BEEN PAID IN FULL OR WHERE AN APPROVED PAYMENT ARRANGEMENT HAS NOT BEEN MADE. DAY 15 TO 30 ONE PHONE CALL CAMPAIGN WILL BE MADE; DAY 68 TO 80 IF ACCOUNT HAS NOT BEEN PAID IN FULL OR HAS NOT BEEN SET UP ON AN APPROVED PAYMENT PLAN, THE EARLY-OUT VENDOR WILL RECOMMEND THAT THE ACCOUNT BE PLACED WITH A COLLECTION AGENCY.

-ACCOUNTS MAINTAINED UNDER AN APPROVED PAYMENT ARRANGEMENT WILL RECEIVE MONTHLY STATEMENTS 30 DAYS PRIOR TO THE PAYMENT DUE DATE.

AS A LAST RESORT, ACCOUNTS THAT ARE FORWARDED TO A COLLECTION AGENCY, HAVE THE FOLLOWING PROCEDURES:

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

-TWO COLLECTION AGENCIES ARE EMPLOYED BY THE HOSPITAL; EACH RECEIVING APPROXIMATELY FIFTY PERCENT OF THE ACCOUNT (BASED ON THE FIRST LETTER OF THE LAST NAME OF EACH PATIENT). ACCOUNTS PLACED WITH ONE OF THE COLLECTION AGENCIES ARE CLASSIFIED AS BAD DEBTS AND REMOVED FROM ACCOUNTS RECEIVABLE.

-AFTER THE INITIAL PLACEMENT WITH A COLLECTION AGENCY, AN INITIAL NOTICE WILL BE SENT TO THE GUARANTOR ADVISING THAT THE AGENCY HAS BEEN CONTRACTED TO MANAGE THE ACCOUNT AND THE NOTICE WILL PROVIDE THE GUARANTOR WITH OPTIONS FOR RESOLUTION.

IN RARE CASES, ACCOUNTS MAY WARRANT LEGAL ACTION. ONCE AN ACCOUNT HAS MET THE FOLLOWING CRITERIA, THE ACCOUNT IS CLOSED BY THE COLLECTION AGENCY AS UNCOLLECTIBLE AND FORWARDED BACK TO PATIENT ACCOUNTING FOR REVIEW TO ESTABLISH GROUNDS FOR LEGAL ACTION. THIS ONLY OCCURS AFTER ALL EFFORTS TO RESOLVE THE DEBT HAVE BEEN EXHAUSTED. CRITERIA: THE DEBT IS VALID; THE ACCOUNT IS EQUAL TO OR GREATER THAN 120 DAYS OLD; PATIENTS

Part VI Supplemental Information

Provide the following information.

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

REFUSES TO ACKNOWLEDGE THE DEBT; UPON REVIEW AND INVESTIGATION, THE HOSPITAL HAS DETERMINED THAT LIQUID ASSETS ARE AVAILABLE; AND THE HOSPITAL'S VP OF FINANCE MUST AUTHORIZE LEGAL ACTION.

PART VI, LINE 2: NEEDS ASSESSMENT

EVERY THREE YEARS A COMMUNITY HEALTH ASSESSMENT SURVEY/PLAN IS PERFORMED.

PART VI, LINE 3: PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

THE HOSPITAL DISPLAYS SIGNS AT EVERY REGISTRATION POINT, THE PATIENT ACCOUNTING OFFICE, ON ALL PATIENT BILLS, AND OTHER KEY PATIENT ACCESS AREAS INFORMING THE PATIENTS ABOUT THE AVAILABILITY OF THE VARIOUS FINANCIAL AND MEDICAL ASSISTANCE PROGRAMS. A PATIENT BILLING AND FINANCIAL ASSISTANCE INFORMATION SHEET WILL BE PROVIDED BEFORE DISCHARGE AND WILL BE AVAILABLE TO ALL PATIENTS UPON REQUEST. THE HOSPITAL OFFERS EVERY SELF-PAY PATIENT OR ANY PATIENT WHO INQUIRES THE FINANCIAL ASSISTANCE INFORMATIONAL PACKET AND APPLICATION. THE COVER SHEET FOR THE FINANCIAL ASSISTANCE PACKET ALSO INCLUDES INFORMATION ON OBTAINING MEDICAL ASSISTANCE. IN ADDITION, THE HOSPITAL HAS A FINANCIAL COUNSELOR

Part VI Supplemental Information

Provide the following information.

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

THAT VISITS THE SELF-PAY PATIENT IN THE EMERGENCY DEPARTMENT OR IN THE PATIENT'S ROOM TO DISCUSS WHAT IS AVAILABLE TO THEM. THE HOSPITAL ALSO EMPLOYS A MEDICAL ASSISTANCE ADVOCACY COMPANY TO ASSIST THE HOSPITAL'S PATIENTS GET MEDICAL ASSISTANCE.

DETERMINATION FOR FINANCIAL ASSISTANCE ELIGIBILITY IS BASED ON ASSETS, INCOME AND FAMILY SIZE. A FEW ITEMS TO NOTE AS FOLLOWS:

-LIQUID ASSETS GREATER THAN \$15,000 FOR INDIVIDUALS, AND \$25,000 FOR FAMILIES WILL DISQUALIFY THE PATIENT FOR 100% ASSISTANCE

-EQUITY OF \$150,000 IN A PRIMARY RESIDENCE WILL BE EXCLUDED FROM THE CALCULATION FOR DETERMINATION OF FINANCIAL ASSISTANCE

-RETIREMENT ASSETS WILL NOT BE USED FOR DETERMINATION OF FINANCIAL ASSISTANCE

-THERE IS SPECIAL QUALIFICATIONS FOR NON-CITIZENS/NON-RESIDENTS OF THE

Part VI Supplemental Information

Provide the following information.

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

UNITED STATES

PATIENTS MAY ALSO BE CONSIDERED FOR PRESUMPTIVE FINANCIAL ASSISTANCE

ELIGIBILITY WITH PROOF OF ENROLLMENT IN ONE OF THE PROGRAMS LISTED

BELOW:

- ACTIVE MEDICAL ASSISTANCE PHARMACY COVERAGE
- SPECIAL LOW INCOME MEDICARE BENEFICIARY COVERAGE
- PRIMARY ADULT CARE COVERAGE
- HOMELESSNESS
- MEDICAL ASSISTANCE AND MEDICAID MANAGED CARE PATIENTS
- MARYLAND PUBLIC HEALTH SYSTEM EMERGENCY PETITION PATIENTS
- PARTICIPATING IN WOMEN, INFANTS AND CHILDREN PROGRAM
- SUPPLEMENTAL NUTRITIONAL ASSISTANCE PROGRAM
- ELIGIBILITY FOR OTHER STATE OR LOCAL ASSISTANCE PROGRAMS
- DECEASED WITH NO KNOWN ESTATE
- ELIGIBILITY FOR STATE ONLY MEDICAL ASSISTANCE PROGRAM
- HOUSEHOLDS WITH CHILDREN IN THE FREE OR REDUCED LUNCH PROGRAM

Part VI Supplemental Information

Provide the following information.

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

-LOW INCOME HOUSEHOLD ENERGY ASSISTANCE PROGRAM

-SELF-ADMINISTERED DRUGS

-MEDICAL ASSISTANCE SPENDDOWN AMOUNTS

PART VI, LINE 4: COMMUNITY INFORMATION

THE SERVICE AREA OF THE UPPER CHESAPEAKE HEALTH SYSTEM, WHICH INCLUDES UPPER CHESAPEAKE MEDICAL CENTER, CONSISTS OF THE NORTHEAST PART OF MARYLAND, INCLUDING HARFORD COUNTY, WESTERN CECIL COUNTY AND PORTION OF BALTIMORE COUNTY. THIS SERVICE AREA IS LOCATED AT THE APEX OF THE CHESAPEAKE BAY AND IS SPREAD ACROSS 536 SQUARE MILES. IT CONTAINS, AMONG OTHERS, THE CITIES AND TOWNS OF HAVRE DE GRACE, ABERDEEN, BEL AIR, FALLSTON, AND EDGEWOOD. THE SERVICE AREA ENJOYS A DIVERSE ECONOMIC BASE, RANGING FROM CONCENTRATIONS IN SERVICE, MANUFACTURING, DISTRIBUTION, AND RETAIL, TO FEDERAL GOVERNMENT EMPLOYMENT. HARFORD COMMUNITY COLLEGE PROVIDES A LOCAL VENUE FOR ADVANCED EDUCATION AND HARFORD COUNTY'S PROXIMITY TO BALTIMORE GIVES IT ACCESS TO NATIONALLY RECOGNIZED UNIVERSITIES WHICH HELP PROVIDE A SKILLED WORKFORCE. THE SERVICE AREA IS SERVED BY INTERSTATE 95, AMTRAK AND FREIGHT RAIL LINES ALONG THE BUSY

Part VI Supplemental Information

Provide the following information.

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

EAST-COAST TRANSPORTATION CORRIDOR BETWEEN NEW YORK AND WASHINGTON, DC.

IN 2010, THE SERVICE AREA HAD A TOTAL POPULATION OF 244,826 PEOPLE WITH HISTORICAL ANNUAL GROWTH RATES OF APPROXIMATELY 1.8% PER YEAR. THIS GROWTH HAS BEEN CHARACTERIZED BY AN INFLUX OF YOUNG FAMILIES SEEKING SUBURBAN ENVIRONMENT IN WHICH TO LIVE AND IS COMPLEMENTED BY A GROWTH IN BUSINESSES AND OTHER SERVICES THAT FOLLOW YOUNG, MIDDLE CLASS FAMILIES.

IN 2010, THE SERVICE AREA HAD AN ESTIMATED 90,218 HOUSEHOLDS WITH A MEDIAN FAMILY INCOME OF \$76,808. 91% OF THE SERVICE AREA'S ADULTS OVER THE AGE OF 25 ARE HIGH SCHOOL GRADUATES OR HIGHER; 30% ACHIEVED BACHELOR'S DEGREES OR HIGHER. THE SERVICE AREA'S GROWTH AND GEOGRAPHIC LOCATION EXPLAIN ITS ABILITY TO ATTRACT MAJOR EAST-COAST DISTRIBUTION CENTER AND INDUSTRY, WHICH HAVE PROVIDED ADDITIONAL EMPLOYMENT OPPORTUNITIES IN THE SERVICE AREA.

PART VI, LINE 5: PROMOTION OF COMMUNITY HEALTH

MONIES SPENT FOR HOSPITAL AND COMMUNITY PREPAREDNESS FOR HAZARDOUS ACCIDENTS, NATURAL DISASTERS, AND COALITION BUILDING IN THE COMMUNITY.

Part VI Supplemental Information

Provide the following information.

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

PART VI, LINE 6: AFFILIATED HEALTH CARE SYSTEM

UPPER CHESAPEAKE MEDICAL CENTER, INC. (UCMC) IS ONE HOSPITAL IN AN "AFFILIATED HEALTH CARE SYSTEM" THAT INCLUDES A SECOND HOSPITAL, HARFORD MEMORIAL HOSPITAL, INC. (HMH), A PHYSICIAN SERVICES ORGANIZATION (UPPER CHESAPEAKE MEDICAL SERVICES, INC.), A PROPERTY HOLDING COMPANY (UPPER CHESAPEAKE PROPERTIES, INC.), A HOSPICE RESIDENCE (UPPER CHESAPEAKE RESIDENTIAL HOSPICE HOUSE, INC. & HOSPICE OF HARFORD COUNTY LLC) AND A FOR-PROFIT VENTURE WITH INVESTMENTS IN PRIVATE IMAGING SERVICES (UPPER CHESAPEAKE HEALTH VENTURES, INC.).

THE "SYSTEM" PROVIDES A BROAD RANGE OF COMMUNITY HEALTH CARE SERVICES, INCLUDING PREVENTIVE, AMBULATORY, ACUTE AND HOSPICE SERVICES, THROUGH AN INTEGRATED HEALTH CARE DELIVERY SYSTEM IN HARFORD COUNTY AND PARTS OF BALTIMORE AND CECIL COUNTIES, IN NORTHEAST MARYLAND.

UCMC AND HMH ARE THE ONLY HOSPITALS IN HARFORD COUNTY, MARYLAND. UCMC OFFERS ACUTE CARE SERVICES, INCLUDING INTENSIVE CARE, EMERGENCY AND OTHER OUTPATIENT SERVICES, AND HAS THE ONLY ACUTE CARE MATERNITY SERVICES IN

Part VI Supplemental Information

Provide the following information.

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

HARFORD COUNTY.

PART VI, LINE 7: STATE FILING OF COMMUNITY BENEFIT REPORT

THE HEALTH SERVICES COST REVIEW COMMISSION, THE STATE AGENCY THAT
REGULATES HOSPITAL RATES IN MARYLAND, REQUIRES A COMMUNITY BENEFIT REPORT
TO BE FILED ANNUALLY.

**SCHEDULE I
(Form 990)**

**Grants and Other Assistance to Organizations,
Governments, and Individuals in the United States**

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 or 22.

▶ Attach to Form 990.

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

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Governments and Organizations in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) UPPER CHESAPEAKE PROPERTIES 520 UPPER CHESAPEAKE DRIVE BEL AIR MD 21014	52-1907237	501(C)(2)	149,503.				GENERAL SUPPORT
(2) UPPER CHESAPEAKE MEDICAL SERVICES 520 UPPER CHESAPEAKE DRIVE BEL AIR MD 21014	52-1501734	501(C)(3)	13,426,146.				PHYSICIAN PRACTICE SUPPORT
(3) UPPER CHESAPEAKE HOSPICE HOUSE 520 UPPER CHESAPEAKE DRIVE BEL AIR MD 21014	26-0737028	501(C)(3)	153,306.				GENERAL SUPPORT
(4) -----							
(5) -----							
(6) -----							
(7) -----							
(8) -----							
(9) -----							
(10) -----							
(11) -----							
(12) -----							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 2.

3 Enter total number of other organizations listed in the line 1 table 1.

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

Schedule I (Form 990) (2013)

Part III Grants and Other Assistance to Individuals in the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1 SCHOLARSHIPS TO STUDY IN THE MEDICAL FIELD	18.	27,493.			
2					
3					
4					
5					
6					
7					

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

SCHEDULE I - GRANTS & OTHER ASSISTANCE

PART I, QUESTION 2 - GENERAL INFORMATION ON GRANTS AND ASSISTANCE

ALTHOUGH THE FILING ORGANIZATION DOES NOT HAVE FORMALIZED INTERNAL PROCEDURES FOR MONITORING THE USE OF GRANT FUNDS IN THE UNITED STATES, THE FILING ORGANIZATION DOES HAVE A WRITTEN AND APPROVED CHARITABLE GIVING POLICY AND PROCEDURE. THERE IS WRITTEN CRITERIA REGARDING THE RECOMMENDATIONS FOR CONSIDERATION WHEN EVALUATING CONTRIBUTION REQUESTS SUCH AS FOLLOWS:

- (1) THAT CONTRIBUTIONS WILL BE MADE ONLY TO ORGANIZATIONS FOR PURPOSES

Part III Grants and Other Assistance to Individuals in the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 22.
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1					
2					
3					
4					
5					
6					
7					

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

CONSISTENT WITH UPPER CHESAPEAKE HEALTH SYSTEM'S (PARENT ENTITY) VISION
AND MISSION.

(2) CONTRIBUTIONS WILL BE MADE ONLY TO NOT-FOR-PROFIT ORGANIZATIONS.

(3) CONTRIBUTIONS WILL PREFERABLY BE MADE TO ORGANIZATIONS WHICH DIRECTLY
SERVE THE CITIZENS OF HARFORD AND CECIL COUNTIES.

(4) CONTRIBUTIONS WILL NOT BE GIVEN TO INDIVIDUALS (EXCLUDING
SCHOLARSHIPS).

(5) CONTRIBUTIONS WILL NOT BE MADE FOR RELIGIOUS PURPOSES; HOWEVER, THERE
MAY BE CONTRIBUTIONS GIVEN FOR A SPECIFIC EFFORT OR PROGRAM WITHIN A
CHURCH OR RELIGIOUS FACILITY WHICH PROVIDES HEALTH-RELATED SERVICES TO

Part III Grants and Other Assistance to Individuals in the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 22.
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1					
2					
3					
4					
5					
6					
7					

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

THE BROADER COMMUNITY.

(6) CONTRIBUTIONS WILL NOT BE MADE IN SUPPORT OF POLITICAL ADVOCACY.

(7) UPPER CHESAPEAKE HEALTH SYSTEM WILL STRIVE TO DONATE TO ORGANIZATIONS

WHERE THE MAJORITY OF THE FUNDS RECEIVED ARE APPLIED DIRECTLY TO THE NEED

THE ORGANIZATION IS DESIGNED TO MEET.

*** REQUESTS FOR \$5,000 AND UNDER ARE REFERRED TO THE PRESIDENT/CEO FOR

REVIEW AND APPROVAL

*** REQUESTS FOR GREATER THAN \$5,000 ARE REFERRED TO THE COMMUNITY

DEVELOPMENT COMMITTEE FOR DISCUSSION AND APPROVAL

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

- ▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.
- ▶ Attach to Form 990. ▶ See separate instructions.
- ▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

Part I Questions Regarding Compensation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Schedule J (Form 990) 2013

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 LYLE E. SHELDON PRESIDENT/CEO/DIRECTOR	(i)	0	0	0	0	0	0	
	(ii)	539,669.	288,074.	459,948.	55,799.	25,584.	1,369,074.	
2 ANGELA POPPE RIES, M.D. DRCTOR/MED DIR-PALLIATIVE CARE	(i)	0	0	0	0	0	0	
	(ii)	138,009.	0	108.	18,005.	585.	156,707.	
3 JOSEPH E. HOFFMAN, III SR VP/CFO	(i)	0	0	0	0	0	0	
	(ii)	313,531.	150,656.	156,417.	53,250.	25,108.	698,962.	
4 ROY H. PHILLIPS PHYSICIAN	(i)	0	0	0	0	0	0	
	(ii)	212,447.	52,000.	1,525.	29,485.	19,673.	315,130.	
5 OLUFUNMILAYO ONOBRAKPEY PHYSICIAN	(i)	0	0	0	0	0	0	
	(ii)	189,952.	40,000.	6,022.	24,141.	25,057.	285,172.	
6 ANGELA M. KAITIS PHYSICIAN/DIR PHARMA SERVICES	(i)	0	0	0	0	0	0	
	(ii)	125,611.	12,684.	1,918.	33,038.	10,203.	183,454.	
7 GAIL L. JUDD PERIOPERATIVE SRVCS BUS DIR	(i)	0	0	0	0	0	0	
	(ii)	125,667.	8,499.	693.	15,049.	21,417.	171,325.	
8 LORI J. WILSON ASST VP - PATIENT SERVICES	(i)	0	0	0	0	0	0	
	(ii)	129,100.	16,160.	226.	1,484.	7,471.	154,441.	
9 JOYCE FOX VP - PATIENT SVCS/CNO	(i)	0	0	0	0	0	0	
	(ii)	191,267.	47,646.	45,141.	46,319.	3,239.	333,612.	
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SCHEDULE J, PART I, QUESTION 3

THIS ORGANIZATION DOES NOT DIRECTLY PAY THE CHIEF EXECUTIVE OFFICER. ALL COMPENSATION TO THE CEO REPORTED ON PART VII OF THE FORM 990 WAS PAID BY A RELATED ORGANIZATION, UPPER CHESAPEAKE HEALTH SYSTEM.

UPPER CHESAPEAKE HEALTH SYSTEM UNDERTAKES A THOROUGH PROCESS TO ENSURE THAT THE EXECUTIVE COMPENSATION IT PAYS TO ITS TOP MANAGEMENT OFFICIALS IS REASONABLE GIVEN THE MARKET IN WHICH THE ORGANIZATION OPERATES. UPPER CHESAPEAKE HEALTH SYSTEM CHECKS THE FOLLOWING BOXES FOR SCHEDULE J, PART I, QUESTION 3 ON ITS FORM 990:

COMPENSATION COMMITTEE

WRITTEN EMPLOYMENT CONTRACT

INDEPENDENT COMPENSATION CONSULTANT

COMPENSATION SURVEY OR STUDY

APPROVAL BY THE BOARD OF COMPENSATION COMMITTEE

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

SCHEDULE J, PART I, QUESTION 4B

THE ORGANIZATION MADE INTERNAL REVENUE CODE SECTION 457F PLAN

CONTRIBUTIONS TO THE FOLLOWING MEMBERS OF SENIOR LEADERSHIP WHO ARE

LISTED ON THE ORGANIZATION'S FORM 990, PART VII, SECTION A, LINE 1A. THE

OFFICERS AND KEY EMPLOYEES LISTED BELOW HAVE VESTED IN THE PLAN IN A

PRIOR YEAR; THEREFORE, THE CONTRIBUTION TO THE PLAN IS REPORTED AS

TAXABLE COMPENSATION AND REPORTED ON SCHEDULE J, PART II, COLUMN

(B)(III), OTHER REPORTABLE COMPENSATION.

LYLE E. SHELDON \$285,657

JOSEPH E. HOFFMAN III \$ 45,896

JAMES J. HURSEY \$ 22,440

DEAN C. KASTER \$ 16,197

JOHN K. LYNCH \$ 22,565

**SCHEDULE K
(Form 990)**

Supplemental Information on Tax-Exempt Bonds

OMB No. 1545-0047

2013

**Open to Public
Inspection**

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

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

Department of the Treasury
Internal Revenue Service

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A MARYLAND HEALTH & HIGHER ED FACILITIES AUTHORITY	52-0936091	5742172P9	08/08/2008	46,473,000.	REFI EXISTING DEBT-SERIES 2008C		X		X		X
B MARYLAND HEALTH & HIGHER ED FACILITIES AUTHORITY	52-0936091		10/01/2011	42,000,000.	CAPITAL PROJECTS-SERIES 2011A		X		X		X
C MARYLAND HEALTH & HIGHER ED FACILITIES AUTHORITY	52-0936091		12/01/2011	49,749,000.	REFI EXISTING DEBT-SERIES 2011B		X		X		X
D MARYLAND HEALTH & HIGHER ED FACILITIES AUTHORITY	52-0936091		12/01/2011	49,749,000.	REFI EXISTING DEBT-SERIES 2011C		X		X		X

Part II Proceeds

	A		B		C		D	
1 Amount of bonds retired	45,465,000.				51,912,000.		48,787,200.	
2 Amount of bonds legally defeased								
3 Total proceeds of issue	49,220,640.		50,000,000.		49,749,000.		49,749,000.	
4 Gross proceeds in reserve funds	2,109,965.							
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows								
7 Issuance costs from proceeds								
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds								
11 Other spent proceeds								
12 Other unspent proceeds								
13 Year of substantial completion	2008		2013		2000		2000	
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?	X			X	X		X	
15 Were the bonds issued as part of an advance refunding issue?		X		X		X		X
16 Has the final allocation of proceeds been made?	X		X		X		X	
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III Private Business Use

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		X
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X		X

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

Part III Private Business Use (Continued)	TAX EXEMPT BOND LIABILITIES							
	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		X
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X		X		X	
c Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?	X		X		X		X	
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶								
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶								
6 Total of lines 4 and 5								
7 Does the bond issue meet the private security or payment test?		X		X		X		X
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		X
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X		X		X	

Part IV Arbitrage								
	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?								
b Exception to rebate?								
c No rebate due?								
If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X		X		X		X
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X		X
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions) *(Continued)*

SCHEDULE K

THE OBLIGATED GROUP ON THE BOND ISSUES IDENTIFIED IN SCHEDULE K INCLUDE BOTH UPPER CHESAPEAKE MEDICAL CENTER, INC. (52-1253920) AND HARFORD MEMORIAL HOSPITAL, INC. (52-0591484). THE ALLOCATION IS AS FOLLOWS: UPPER CHESAPEAKE MEDICAL CENTER 84%; HARFORD MEMORIAL HOSPITAL 16%.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Employer identification number

52-1253920

PART VI, SECTION A, GOVERNING BODY & MANAGEMENT, QUESTION 2

FAMILY OR BUSINESS RELATIONSHIP

LYLE E SHELDON AND JOSEPH E HOFFMAN III ARE OFFICERS IN THE SAME BUSINESS ENTITIES. THE SAME BUSINESS ENTITIES ARE THE FOR-PROFIT CORPORATIONS OR PARTNERSHIPS THAT ARE RELATED TO THIS FILING ENTITY. PLEASE SEE FORM 990, SCHEDULE R.

PART VI, SECTION A, GOVERNING BODY & MANAGEMENT, QUESTION 6

EXISTENCE OF MEMBERS

UPPER CHESAPEAKE HEALTH SYSTEM AND UNIVERSITY OF MARYLAND MEDICAL SYSTEM ARE PARTNERS IN A MARYLAND LIMITED LIABILITY COMPANY NAMED UCHS/UMMS VENTURE LLC ("VENTURE"). THE VENTURE WAS ORGANIZED FOR CHARITABLE PURPOSES TO COORDINATE ACTIVITIES OF HEALTHCARE FACILITIES AND OTHER CORPORATE BODIES WHOSE PURPOSES INCLUDE THE PROVISION OF HEALTHCARE SERVICES OR FINANCIAL ASSISTANCE TO HEALTHCARE FACILITIES IN HARFORD COUNTY, MARYLAND. VENTURE IS THE SOLE MEMBER OF THIS FILING ORGANIZATION.

PART VI, SECTION B, POLICIES, QUESTION 11B

ORGANIZATIONAL REVIEW OF FORM 990

THE BOARD OF UPPER CHESAPEAKE HEALTH SYSTEM, INC. ("HEALTH SYSTEM") HAS

Name of the organization UPPER CHESAPEAKE MEDICAL CENTER	Employer identification number 52-1253920
---	--

ASSIGNED THE EXECUTIVE COMMITTEE OF THE HEALTH SYSTEM'S BOARD TO REVIEW AND APPROVE ALL CONTENTS OF FORM 990 ON BEHALF OF THE BOARDS OF ALL HEALTH SYSTEM'S TAX-EXEMPT AFFILIATES. IN TURN, ONCE THE FORM 990 HAS BEEN APPROVED BY HEALTH SYSTEM'S EXECUTIVE COMMITTEE, A FINAL VERSION OF THE FORM 990 WILL BE MADE AVAILABLE TO ALL BOARD MEMBERS OF THE RESPECTIVE HEALTH SYSTEM'S TAX-EXEMPT AFFILIATES. FORMAL NOTIFICATION OF THE FINAL AND APPROVED FORM 990 FOR EACH OF THE HEALTH SYSTEM'S AFFILIATES AS WELL AS ITS AVAILABILITY WILL BE COMMUNICATED TO THE APPLICABLE BOARD MEMBERS ON OR BEFORE THE FILING OF THE FORM 990.

PART VI, SECTION B, POLICIES, QUESTION 12C
CONFLICT OF INTEREST POLICY

THE ORGANIZATION'S WRITTEN CONFLICT OF INTEREST POLICY COVERS THE FOLLOWING INDIVIDUALS: DIRECTORS, PRINCIPAL OFFICERS, AND SENIOR MANAGEMENT. FURTHERMORE, THE POLICY EXTENDS TO THE FAMILY MEMBERS (PER INTERNAL REVENUE SERVICE DEFINITION) OF SUCH DIRECTORS, PRINCIPAL OFFICERS, AND SENIOR MANAGEMENT. THE BOARD OF DIRECTORS AND ANY COMMITTEE CONSIDERING A CONTRACT, TRANSACTION OR ARRANGEMENT TO WHICH A KNOWN OR POTENTIAL CONFLICT OF INTEREST RELATES, DETERMINES WHETHER A CONFLICT EXISTS. ACTUAL CONFLICTS ARE REVIEWED BY THE CHAIRMAN OF THE BOARD. AN INDIVIDUAL WITH A KNOWN OR POTENTIAL CONFLICT OF INTEREST MUST REFRAIN FROM PARTICIPATING IN, OR ACTING ON, THE DECISION ON ANY MATTER IN WHICH A CONFLICT OF INTEREST, OR EVEN THE APPEARANCE OF SUCH A CONFLICT OF INTEREST, IS PRESENT WITH RESPECT TO SUCH INDIVIDUAL AND WILL REMOVE HIMSELF OR HERSELF FROM ANY MEETING OR DELIBERATIONS ON THE

Name of the organization UPPER CHESAPEAKE MEDICAL CENTER	Employer identification number 52-1253920
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MATTER.

PART VI, SECTION B, POLICIES, QUESTION 15

PROCESS FOR DETERMINING COMPENSATION

THE EXECUTIVE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS APPROVES COMPENSATION FOR THE CHIEF EXECUTIVE OFFICER, CHIEF OPERATING OFFICER, CHIEF FINANCIAL OFFICER, AND ALL KEY EMPLOYEES. THE EXECUTIVE COMPENSATION COMMITTEE UTILIZES BUT IS NOT LIMITED TO THE FOLLOWING RESOURCES IN EVALUATING AND ESTABLISHING REASONABLE COMPENSATION: INDEPENDENT COMPENSATION CONSULTANTS, COMPENSATION SURVEYS AND COMPENSATION STUDIES. THIS ORGANIZATION AND ITS TAX-EXEMPT AFFILIATES STRIVE TO MAINTAIN AN ARM'S LENGTH RELATIONSHIP BETWEEN ITSELF AND ITS EMPLOYEES. IT IS THE GOAL OF THE EXECUTIVE COMPENSATION COMMITTEE TO ENSURE THAT TOTAL COMPENSATION (COMPENSATION AND BENEFITS) PAID TO ITS EMPLOYEES IS FAIR AND REASONABLE. FINALLY, THE PROCESS OF SETTING AND APPROVING SUCH COMPENSATION IS PERFORMED ANNUALLY BY THE BOARD'S EXECUTIVE COMPENSATION COMMITTEE.

PART VI, SECTION C, DISCLOSURE, QUESTION 19

DOCUMENTS AVAILABLE TO THE PUBLIC

THE ORGANIZATION WILL MAKE THE FOLLOWING DOCUMENTS AVAILABLE TO THE PUBLIC UPON REQUEST: ARTICLES OF INCORPORATION, BYLAWS, CONFLICT OF INTEREST POLICY, AND AUDITED FINANCIAL STATEMENTS.

Name of the organization UPPER CHESAPEAKE MEDICAL CENTER	Employer identification number 52-1253920
---	--

LINE 2A - PROGRAM SERVICE REVENUE

GROSS PATIENT REVENUE..... \$ 292,154,458

LESS: ALLOWANCES & CHARITY POLICIES... (38,415,145)

NET PATIENT REVENUE..... \$ 253,739,313

PART XI, LINE 8, OTHER CHANGES IN NET ASSETS

UNREALIZED GAIN/(LOSS) ON SWAP \$ 3,720,072

MINIMUM PENSION LIABILITY 8,968,327

ECONOMIC INTEREST IN UCH LEGACY FUNDING, INC. 150,000,000

TOTAL \$162,688,399

PART III, PROGRAM SERVICE ACCOMPLISHMENTS

TO PROVIDE HEALTHCARE SERVICES TO PATIENTS REGARDLESS OF THEIR ABILITY TO PAY FOR SUCH SERVICES. FOR MORE THAN 90 YEARS, UPPER CHESAPEAKE HEALTH HAS BEEN PROVIDING COMPREHENSIVE, HIGH QUALITY HEALTHCARE. ITS TWO HOSPITALS, HARFORD MEMORIAL HOSPITAL AND UPPER CHESAPEAKE MEDICAL CENTER OFFER SOME OF THE AREA'S MOST ADVANCED INPATIENT AND OUTPATIENT SERVICES SO THAT PATIENTS CAN ENJOY THE SUPERIOR WELLNESS RESOURCES A HEALTHY LIFESTYLE NEEDS, WITHOUT LEAVING THEIR NEIGHBORHOOD. UPPER CHESAPEAKE HEALTH SYSTEM IS A COMMUNITY-BASED, NON-PROFIT HEALTH SYSTEM LOCATED IN HARFORD COUNTY, MARYLAND. OUR VISION IS BASED ON CREATING THE HEALTHIEST COMMUNITY IN MARYLAND. BUILDING ON THAT VISION, WE HAVE A STRONG COMMITMENT TO SERVICE EXCELLENCE. SO MUCH SO THAT IT HAS BECOME PART OF THE FABRIC OF THE HEALTHCARE EXPERIENCE AT UPPER CHESAPEAKE HEALTH. UPPER

Name of the organization UPPER CHESAPEAKE MEDICAL CENTER	Employer identification number 52-1253920
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CHESAPEAKE HEALTH SYSTEM HAS OVER 2,500 PHYSICIANS AND HEALTHCARE PROFESSIONALS WHO ARE DELIVERING CARE FOR THE MIND, BODY, AND SPIRIT IN SETTINGS FROM OFFICES, TO OUTPATIENT CENTERS, TO HOSPITALS, TO SHOPPING CENTERS, TO BUSINESSES, AND TO HOMES. UPPER CHESAPEAKE MEDICAL CENTER IS A MEMBER OF THE UPPER CHESAPEAKE HEALTH SYSTEM. UPPER CHESAPEAKE MEDICAL CENTER IS AN ACUTE CARE, NON-PROFIT FACILITY OFFERING A FULL COMPLEMENT OF MEDICAL, DIAGNOSTIC AND EMERGENCY CARE SERVICES. THE HOSPITAL IS FULLY ACCREDITED BY THE JOINT COMMISSION ON THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO). THIS PREMIER HEALTH CARE FACILITY INCORPORATES SEVERAL TRENDS THAT REFLECT HOW HEALTH CARE IS CHANGING, INCLUDING REORIENTATION TOWARDS OUTPATIENT CARE, MORE ACUTELY ILL PATIENTS IN THE HOSPITAL AND FLEXIBILITY FOR GROWTH AND CHANGE TO MEET OUR COMMUNITY'S FUTURE HEALTH CARE NEEDS. LOCATED ON THE MEDICAL CAMPUS IS THE UPPER CHESAPEAKE MEDICAL CENTER WITH 194 ACUTE CARE BEDS. ADJACENT TO THE MEDICAL CENTER IS THE AMBULATORY CARE CENTER OF HARFORD COUNTY, CONTAINING PHYSICIAN OFFICES, OUTPATIENT IMAGING AND LABORATORY PROCEDURES, OUTPATIENT PRE-ASSESSMENT TESTING AND ASSESSMENT, UPPER CHESAPEAKE CARDIOVASCULAR INSTITUTE, AND THE ADMINISTRATIVE OFFICES OF UPPER CHESAPEAKE HEALTH. ALSO LOCATED NEXT TO THE MEDICAL CENTER, IS A PRE-EXISTING MEDICAL OFFICE BUILDING WITH PHYSICIAN OFFICES AND OTHER HEALTHCARE RELATED SERVICES, A PARKING GARAGE AND A SECOND MEDICAL OFFICE BUILDING WHICH INCLUDES OUTPATIENT SERVICES AND PHYSICIAN OFFICES. HARFORD MEMORIAL HOSPITAL AND UPPER CHESAPEAKE MEDICAL CENTER MAINTAIN CHARITY CARE PROGRAMS AND, IN ADDITION, CONDUCT MANY COMMUNITY OUTREACH AND COMMUNITY BUILDING ACTIVITIES INCLUDING:

Name of the organization UPPER CHESAPEAKE MEDICAL CENTER	Employer identification number 52-1253920
---	--

- COMMUNITY HEALTH EDUCATION PROGRAMS WHICH INCLUDE NEWBORN BABY CARE, SITTER SAFETY PROGRAM, INFANT CPR, INFANT SAFETY, STOP SMOKING CLASS, KIDS SAFETY CLASS, AND PRENATAL BREAST FEEDING CLASS
- SUPPORT GROUPS INCLUDING BREAST FEEDING SUPPORT, BREAST CANCER AWARENESS GROUPS, PERINATAL BEREAVEMENT, ASTHMA SUPPORT GROUP, WIDOW AND WIDOWERS SUPPORT GROUP, GRIEF SUPPORT GROUP, PROSTATE CANCER SUPPORT GROUP, AMPUTEE NETWORK, BRAIN INJURY SUPPORT GROUP, STROKE CLUB, LUPUS SUPPORT GROUP, AND OTHERS
- HEALTH SCREENINGS INCLUDING SCREENINGS FOR OSTEOPOROSIS, CARDIAC PROBLEMS, BLOOD PRESSURE, AND OTHER ISSUES
- FREE AND MOBILE CLINIC

ATTACHMENT 1

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

UPPER CHESAPEAKE MEDICAL CENTER IS DEDICATED TO MAINTAINING AND IMPROVING THE HEALTH OF THE PEOPLE IN ITS COMMUNITIES THROUGH AN INTEGRATED HEALTH DELIVERY SYSTEM THAT PROVIDES HIGH QUALITY CARE TO ALL. UCMC IS COMMITTED TO SERVICE EXCELLENCE AS IT OFFERS A BROAD RANGE OF HEALTH CARE SERVICES, TECHNOLOGY AND FACILITIES. UCMC WORKS COLLABORATIVELY WITH ITS COMMUNITIES AND OTHER HEALTH ORGANIZATIONS TO SERVE AS A RESOURCE FOR HEALTH PROMOTION AND EDUCATION.

ATTACHMENT 2

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

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
NORTHERN CHESAPEAKE ANESTHESIA ASSOCIATE PO BOX 89 BEL AIR, MD 21014	PHYSICIAN FEES	2,059,119.

Name of the organization UPPER CHESAPEAKE MEDICAL CENTER	Employer identification number 52-1253920
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ATTACHMENT 2 (CONT'D)

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

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
BRAIN AND SPINE SPECIALISTS PA 206 SOUTH HAYS STREET BEL AIR, MD 21014	PHYSICIAN FEES	504,187.
ROCK GLENN COMMERCIAL, LLC 101 N. MAIN STREET, SUITE B BEL AIR, MD 21014	OFFICE RENT	401,733.
BEL AIR CENTER FOR PLASTIC/HAND SURGERY PO BOX 845 BEL AIR, MD 21014-0845	PHYSICIAN FEES	347,442.
KPMG LLP 111 SOUTH CALVERT ST. BALTIMORE, MD 21202	AUDIT FEES	333,162.

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) UNIV OF MD UPPER CHESAPEAKE HLTH SYSTEM 52-1398513 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HLTHCARE SVCS	MD	501(C)(3)	11C; III-FI	N/A		X
(2) UPPER CHESAPEAKE HEALTH FOUNDATION, INC. 52-1398507 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	FIN SUPPORT	MD	501(C)(3)	11A	UCHS		X
(3) UPPER CHESAPEAKE MEDICAL SERVICES, INC. 52-1501734 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	PHYSICIAN SVC	MD	501(C)(3)	9	UCHS/UMMS VN		X
(4) HARFORD MEMORIAL HOSPITAL, INC. 52-0591484 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HOSPITAL CARE	MD	501(C)(3)	3	UCHS/UMMS VN		X
(5) UPPER CHESAPEAKE PROPERTIES, INC. 52-1907237 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	TITLE HOLDING	MD	501(C)(2)	N/A	UCHS/UMMS VN		X
(6) UPPER CHESAPEAKE/ST JOE'S HOME CARE, INC 52-1229742 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HOSPICE CARE	MD	501(C)(3)	9	UCHS/UMMS VN		X
(7) UPPER CHESAPEAKE RESIDENTIAL HOSPICE HOUSE 26-0737028 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HOSPICE CARE	MD	501(C)(3)	7	UCHS/UMMS VN		X

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

Schedule R (Form 990) 2013

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

Name of the organization

UPPER CHESAPEAKE MEDICAL CENTER

Employer identification number

52-1253920

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) HEALTHY HARFORD, INC. 52-1944325 2027 PULASKI HWY, SUITE 215 HAVRE DE GRACE, MD 21078	HEALTH INIATV	MD	501(C)(3)	7	N/A		X
(2) -----							
(3) -----							
(4) -----							
(5) -----							
(6) -----							
(7) -----							

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

Schedule R (Form 990) 2013

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) UCBS/UMMS VENTURE 52-2178070 520 UPPER CHESAPEAKE	MEDICAL SERVICES	MD	N/A	N/A								
(2) UCBS/UMMS R/E TRUST 27-6803540 520 UPPER CHESAPEAKE DRIVE	HOLD LAND	MD	N/A	N/A								
(3) -----												
(4) -----												
(5) -----												
(6) -----												
(7) -----												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) UPPER CHESAPEAKE HEALTH VENTURES, INC. 52-2031264 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	MISC. SERVICES	MD	N/A	C CORP					
(2) UPPER CHESAPEAKE MED. OFFICE BLDG, INC. 52-1946829 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	REAL ESTATE	MD	N/A	C CORP					
(3) UPPER CHESAPEAKE MGMT SVCS ORG, INC. 52-1946025 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	MANAGEMENT SRVCS	MD	N/A	C CORP					
(4) UC MEDICAL CENTER LAND CONDOMINIUM, INC. 77-0674478 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	REAL ESTATE	MD	N/A	C CORP					
(5) UPPER CHESAPEAKE INSURANCE COMPANY, LTD. 98-0468438 P.O. BOX 1109 KY1-1102 GRAND CAYMAN, CAYMAN ISLANDS CJ	CAPTIVE INSURANCE	CJ	N/A	LTD.					
(6) -----									
(7) -----									

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to related organization(s)	X	
c Gift, grant, or capital contribution from related organization(s)	X	
d Loans or loan guarantees to or for related organization(s)		X
e Loans or loan guarantees by related organization(s)		X
f Dividends from related organization(s)		
g Sale of assets to related organization(s)		X
h Purchase of assets from related organization(s)		X
i Exchange of assets with related organization(s)		X
j Lease of facilities, equipment, or other assets to related organization(s)		X
k Lease of facilities, equipment, or other assets from related organization(s)		X
l Performance of services or membership or fundraising solicitations for related organization(s)		X
m Performance of services or membership or fundraising solicitations by related organization(s)	X	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
o Sharing of paid employees with related organization(s)		X
p Reimbursement paid to related organization(s) for expenses		X
q Reimbursement paid by related organization(s) for expenses	X	
r Other transfer of cash or property to related organization(s)		X
s Other transfer of cash or property from related organization(s)		X

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

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

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

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

Part VII **Supplemental Information**

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