

<b>Cumulative e-File History 2009</b>	
<b>FED</b>	
Locator:	55857Y
Taxpayer Name:	Chester River Hospital Center
Return Type:	990
Submitted Date:	05/10/2011 14:43:01
Acknowledgement Date:	05/10/2011 15:01:05
Status:	Accepted
Submission ID:	54028020111305000002

# Exempt Organization Declaration and Signature for Electronic Filing

For calendar year 2009, or tax year beginning 07/01, 2009, and ending 06/30, 20 10

# 2009

Department of the Treasury  
Internal Revenue Service

For use with Forms 990, 990-EZ, 990-PF, 1120-POL, and 8868

▶ See instructions on back.

Name of exempt organization

**CHESTER RIVER HOSPITAL CENTER**

Employer identification number

**52-0679694**

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

Check the box for the return for which you are using this Form 8453-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 for which you are filing this form was blank, then leave line 1b, 2b, 3b, 4b, or 5b, whichever is applicable, blank (do not enter -0-). If you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

1a Form 990 check here	▶ <input checked="" type="checkbox"/>	b Total revenue, if any (Form 990, Part VIII, column (A), line 12) . . .	1b	<u>55985318.</u>
2a Form 990-EZ check here	▶ <input type="checkbox"/>	b Total revenue, if any (Form 990-EZ, line 9) . . . . .	2b	_____
3a Form 1120-POL check here	▶ <input type="checkbox"/>	b Total tax (Form 1120-POL, line 22) . . . . .	3b	_____
4a Form 990-PF check here	▶ <input type="checkbox"/>	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b	_____
5a Form 8868 check here	▶ <input type="checkbox"/>	b Balance due (Form 8868, line 3c) . . . . .	5b	_____

## Part II Declaration of Officer

6  I authorize the U.S. Treasury and its designated Financial Agent to initiate an ACH 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.

If a copy of this return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I certify that I executed the electronic disclosure consent contained within this return allowing disclosure by the IRS of this Form 990/990-EZ/990-PF (as specifically identified in Part I above) to the selected state agency(ies).

Under penalties of perjury, I declare that I am an officer of the above named organization and that I have examined a copy of the organization's 2009 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 acknowledgment of receipt or reason for rejection of the transmission, (b) an indication of any refund offset, (c) the reason for any delay in processing the return or refund, and (d) the date of any refund.

Sign Here ▶ *Samuel P. Morenelli* ▶ 15/10/11 ▶ VP For Finance

Signature of officer Date Title

## Part III Declaration of Electronic Return Originator (ERO) and Paid Preparer (see instructions)

I declare that I have reviewed the above organization's return and that the entries on Form 8453-EO are complete and correct to the best of my knowledge. If I am only a collector, I am not responsible for reviewing the return and only declare that this form accurately reflects the data on the return. The organization officer will have signed this form before I submit the return. I will give the officer a copy of all forms and information to be filed with the IRS, and have followed all other requirements in Pub. 4163, Modernized e-File (MeF) information for Authorized IRS e-file Providers for Business Returns. If I am also the Paid Preparer, under penalties of perjury I declare that I have examined the above organization's return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. This Paid Preparer declaration is based on all information of which I have any knowledge.

ERO's Use Only	ERO's signature	<u><i>Jaime C. Halla</i></u>	Date	<u>5/10/11</u>	Check if also paid preparer	<input checked="" type="checkbox"/>	Check if self-employed	<input type="checkbox"/>	ERO's SSN or PTIN	<u>P00634378</u>
	Firm's name (or yours if self-employed), address, and ZIP code	<u>KPMG LLP</u>			<u>1676 INTERNATIONAL DRIVE</u>		<u>MCLEAN VA 22102</u>		EIN	<u>13-5565207</u>
										Phone no.

Under penalties of perjury, I declare that I have examined the above return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer is based on all information of which the preparer has any knowledge.

Paid Preparer's Use Only	Preparer's signature	_____	Date	_____	Check if self-employed	<input type="checkbox"/>	Preparer's SSN or PTIN	_____	
	Firm's name (or yours if self-employed), address, and ZIP code	_____			_____		EIN	_____	
									Phone no.

Return of Organization Exempt From Income Tax

2009

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

Open to Public Inspection

Department of the Treasury Internal Revenue Service

The organization may have to use a copy of this return to satisfy state reporting requirements.

Header section A-M containing organization name, EIN, address, and tax status.

Part I Summary

Table with 3 columns: Description, Prior Year, Current Year. Rows include mission statement, revenue, expenses, and net assets.

Part II Signature Block

Signature block containing declaration, officer signature, date, and preparer information.

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

For Privacy Act and Paperwork Reduction Act Notice, see the separate instructions.\* Form 990 (2009)

# Application for Extension of Time To File an Exempt Organization Return

▶ File a separate application for each return.

- If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** and check this box  **X**
- If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** (on page 2 of this form). **Do not complete Part II unless** you have already been granted an automatic 3-month extension on a previously filed Form 8868.

## Part I Automatic 3-Month Extension of Time. Only submit original (no copies needed).

A corporation required to file Form 990-T and requesting an automatic 6-month extension - check this box and complete Part I only

All other corporations (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

**Electronic Filing (e-file)** Generally, you can electronically file Form 8868 if you want a 3-month automatic extension of time to file one of the returns noted below (6 months for a corporation required to file Form 990-T). However, you cannot file Form 8868 electronically if (1) you want the additional (not automatic) 3-month extension or (2) you file Forms 990-BL, 6069, or 8870, group returns, or a composite or consolidated Form 990-T. Instead, you must submit the fully completed and signed page 2 (Part II) of Form 8868. For more details on the electronic filing of this form, visit [www.irs.gov/efile](http://www.irs.gov/efile) and click on *e-file for Charities & Nonprofits*.

<b>Type or print</b>	Name of Exempt Organization Chester River Hospital Center	Employer identification number 52-0679694
	Number, street, and room or suite no. If a P.O. box, see instructions. 100 Brown Street	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. Chestertown, MD 21620-1435	
	File by the due date for filing your return. See instructions.	

### Check type of return to be filed (file a separate application for each return):

- |  |   |                                    |
|--|---|------------------------------------|
| <input checked="" type="checkbox"/> Form 990 | <input type="checkbox"/> Form 990-T (corporation)                 | <input type="checkbox"/> Form 4720 |
| <input type="checkbox"/> Form 990-BL         | <input type="checkbox"/> Form 990-T (sec. 401(a) or 408(a) trust) | <input type="checkbox"/> Form 5227 |
| <input type="checkbox"/> Form 990-EZ         | <input type="checkbox"/> Form 990-T (trust other than above)      | <input type="checkbox"/> Form 6069 |
| <input type="checkbox"/> Form 990-PF         | <input type="checkbox"/> Form 1041-A                              | <input type="checkbox"/> Form 8870 |

• The books are in the care of ▶ SAMUEL MARINELLI, JR.

Telephone No. ▶ 410 778-3300 FAX No. ▶ \_\_\_\_\_

- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) \_\_\_\_\_ . If this is for the whole group, check this box  . If it is for part of the group, check this box  and attach a list with the names and EINs of all members the extension will cover.

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 02/15, 2011, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

- ▶  calendar year \_\_\_\_\_ or
- ▶  tax year beginning 07/01, 2009, and ending 06/30, 2010

2 If this tax year is for less than 12 months, check reason:  Initial return  Final return  Change in accounting period

<b>3a</b> If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	<b>3a</b>	\$
<b>b</b> If this application is for Form 990-PF or 990-T, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	<b>3b</b>	\$
<b>c</b> <b>Balance Due.</b> Subtract line 3b from line 3a. Include your payment with this form, or, if required, deposit with FTD coupon or, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	<b>3c</b>	\$

**Caution.** If you are going to make an electronic fund withdrawal with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

For Privacy Act and Paperwork Reduction Act Notice, see Instructions.

- If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** and check this box  **X**.
- Note.** Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.
- If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** (on page 1).

**Part II Additional (Not Automatic) 3-Month Extension of Time. Only file the original (no copies needed).**

Type or print  File by the extended due date for filing the return. See instructions.	Name of Exempt Organization <b>CHESTER RIVER HOSPITAL CENTER</b>	Employer identification number <b>52-0679694</b>
	Number, street, and room or suite no. If a P.O. box, see instructions. <b>100 BROWN STREET</b>	For IRS use only
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. <b>CHESTERTOWN, MD 21620-1435</b>	

Check type of return to be filed (File a separate application for each return):

<input checked="" type="checkbox"/> Form 990	<input type="checkbox"/> Form 990-PF	<input type="checkbox"/> Form 1041-A	<input type="checkbox"/> Form 6069
<input type="checkbox"/> Form 990-BL	<input type="checkbox"/> Form 990-T (sec. 401(a) or 408(a) trust)	<input type="checkbox"/> Form 4720	<input type="checkbox"/> Form 8870
<input type="checkbox"/> Form 990-EZ	<input type="checkbox"/> Form 990-T (trust other than above)	<input type="checkbox"/> Form 5227	

**STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.**

- The books are in the care of **SAMUEL MARINELLI, JR.**  
Telephone No. **410 778-3300** FAX No. \_\_\_\_\_
- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) \_\_\_\_\_ . If this is for the whole group, check this box  . If it is for part of the group, check this box  and attach a list with the names and EINs of all members the extension is for.

- I request an additional 3-month extension of time until **05/15/2011**
- For calendar year \_\_\_\_\_, or other tax year beginning **07/01/2009** and ending **06/30/2010**
- If this tax year is for less than 12 months, check reason:  Initial return  Final return  Change in accounting period
- State in detail why you need the extension **INFORMATION NECESSARY TO PREPARE A COMPLETE AND ACCURATE RETURN IS NOT YET AVAILABLE.**

<b>8a</b> If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	<b>8a</b> \$
<b>b</b> If this application is for Form 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	<b>8b</b> \$ 0.
<b>c</b> Balance Due. Subtract line 8b from line 8a. Include your payment with this form, or, if required, deposit with FTD coupon or, if required, by using EFIPS (Electronic Federal Tax Payment System). See instructions.	<b>8c</b> \$ 0.

**Signature and Verification**

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form.

Signature **[Signature]** Title **CPA** Date **12/17/10**  
**KPMG LLP**  
**1676 INTERNATIONAL DRIVE**  
**MCLEAN, VA 22102**

**Part III Statement of Program Service Accomplishments**

1 Briefly describe the organization's mission:  
AN ACUTE CARE HOSPITAL THAT SERVES THE RESIDENTS OF KENT AND QUEEN ANNE'S COUNTIES AND PORTIONS OF CAROLINE AND CECIL COUNTIES.

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 exempt purpose achievements for each of the organization's three largest program services by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts 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 \$ 49,756,470. including grants of \$ 0. ) (Revenue \$ 54,453,231. )  
CHESTER RIVER HOSPITAL CENTER IS A 53-BED HOSPITAL. IT IS SERVED BY APPROXIMATELY 100 ACTIVE AND CONSULTING STAFF PHYSICIANS REPRESENTING A WIDE ARRAY OF MEDICAL SPECIALTIES. THE COMMUNITY HOSPITAL, WHICH IS FULLY ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, PROVIDES INPATIENT MEDICAL SERVICES, 24-HOUR EMERGENCY CARE, SURGICAL SERVICES, OUTPATIENT DIAGNOSTIC SERVICES, LABORATORY SERVICES, REHABILITATION, MATERNITY/BIRTHING SUITES AND ONCOLOGY TO SERVE THE LOCAL COMMUNITY'S NEEDS. THE HOSPITAL WAS ESTABLISHED IN 1935. IT IS STAFFED BY APPROXIMATELY 500 EMPLOYEES.

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 ▶ 49,756,470.

Part IV Checklist of Required Schedules

Table with 3 columns: Question, Yes, No. Rows 1-20 covering various organizational requirements and reporting obligations.

**Part IV Checklist of Required Schedules (continued)**

	Yes	No
21 Did the organization report more than \$5,000 of grants and other assistance to governments and organizations in the United States 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 and 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 question 25.</i> . . . . .	X	
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .		X
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
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .		X
25 a <b>Section 501(c)(3) and 501(c)(4) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I.</i> . . . . .		X
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I.</i> . . . . .		X
26 Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? <i>If "Yes," complete Schedule L, Part II.</i> . . . . .		X
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? <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 of the organization (or a family member) 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, Parts II, III, IV, and V, line 1.</i> . . . . .	X	
35 Is any related organization a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2.</i> . . . . .		X
36 <b>Section 501(c)(3) organizations.</b> 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 11 and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O. . . . .	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 1a through 12b regarding IRS filings and tax compliance.

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body; 1b Enter the number of voting members that are independent; 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?; 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?; 4 Did the organization make any significant changes to its organizational documents since the prior Form 990 was filed?; 5 Did the organization become aware during the year of a material diversion of the organization's assets?; 6 Does the organization have members or stockholders?; 7a Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?; 7b Are any decisions of the governing body subject to approval by members, stockholders, or other persons?; 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body?; b Each committee with authority to act on behalf of the governing body?; 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O.

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 Does the organization have local chapters, branches, or affiliates?; 10b If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization?; 11 Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form?; 11A Describe in Schedule O the process, if any, used by the organization to review this Form 990.; 12a Does the organization have a written conflict of interest policy? If "No," go to line 13; 12b Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?; 12c Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done; 13 Does the organization have a written whistleblower policy?; 14 Does the organization have a written document retention and destruction policy?; 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?; 15a The organization's CEO, Executive Director, or top management official; 15b Other officers or key employees of the organization; 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?; 16b If "Yes," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken steps to safeguard the organization's exempt status with respect to such arrangements?

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 (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply. Own website Another's website X Upon request
19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: SAMUEL MARINELLI, JR 100 BROWN STREET CHESTERTOWN, MD 21620-1435 410-778-3300

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

**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. Use Schedule J-2 if additional space is needed.

- 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. 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 the organization did not compensate any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week	(C) Position (check all that apply)						(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			
WAYNE L GARDNER CHAIR	3.00	X						0.	0.	0.
CHARLES D MACLEOD DIRECTOR	2.00	X						0.	0.	0.
DAVID C BRAMBLE DIRECTOR	2.00	X						0.	0.	0.
JUDITH E COOPER DIRECTOR	2.00	X						0.	0.	0.
HENRY C JOHNSON DIRECTOR	2.00	X						0.	0.	0.
DAVID W KNUTSON M D DIRECTOR	2.00	X						0.	0.	0.
KAREN P O CONNOR DIRECTOR	2.00	X						0.	0.	0.
ERNEST W STRONG DIRECTOR	2.00	X						0.	0.	0.
EUGENIA C WOOTTON VICE CHAIR	2.00	X						0.	0.	0.
ANTHONY J MOORMAN M D DIRECTOR	2.00	X						0.	0.	0.
GLENN F ROBBINS MD DIRECTOR	2.00	X						0.	781,017	28,132.
JOHN W ASHWORTH DIRECTOR	2.00	X						0.	495,926	24,898.
MARY ELLEN VALLIANT DIRECTOR	2.00	X						0.	0.	0.
ROBERT A CHRENCIK DIRECTOR	2.00	X						0.	1,485,670	170,432.
SUSAN K ROSS MD DIRECTOR	2.00	X						0.	0.	0.
WILLIAM J WASHINGTON DIRECTOR	2.00	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week	(C) Position (check all that apply)						(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			
JANE E HUKILL DIRECTOR	2.00	X					0.	0.	0.	
JEFFREY L JOHNSON PRESIDENT & CEO	0.00			X			329,291.	0.	34,553.	
SAMUEL P MARINELLI JR TREASURER	40.00			X			227,647.	0.	36,312.	
JAMES E ROSS PRESIDENT & CEO	40.00			X			0.	404,294.	23,766.	
SCOTT BURLESON EXECUTIVE VICE PRESIDENT	40.00				X		191,400.	0.	37,768.	
MARY JO KEEFE VP PATIENT SERVICES	40.00				X		148,108.	0.	28,513.	
DEBORAH DAVIS ER DOCTOR	40.00					X	370,446.	0.	35,245.	
HENRY ARAKAKY ER DOCTOR	40.00					X	266,694.	0.	10,065.	
STEVEN LUCAS ER DOCTOR	40.00					X	301,304.	0.	32,566.	
MIN YU PATHOLOGY	40.00					X	177,183.	0.	28,055.	
CHERYL DICKASON ER DOCTOR	40.00					X	151,943.	0.	5,034.	
ROBIN KLINEFELTER SECRETARY	0.00						119,359.	0.	19,291.	
<b>1b Total</b>							2,283,375.	3,166,907.	514,630.	

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 in reportable compensation from the organization **30**

- 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
- 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
- 5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization for services rendered to the organization? If "Yes," complete Schedule J for such person

	Yes	No
3	X	
4	X	
5		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.

(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 **47**

**Part VIII Statement of Revenue**

52-0679694

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514	
<b>Contributions, gifts, grants and other similar amounts</b>	1a	Federated campaigns . . . . .	1a					
	b	Membership dues . . . . .	1b					
	c	Fundraising events . . . . .	1c					
	d	Related organizations . . . . .	1d	223,912.				
	e	Government grants (contributions) . . . . .	1e	226,891.				
	f	All other contributions, gifts, grants, and similar amounts not included above . . . . .	1f					
	g	Noncash contributions included in lines 1a-1f: \$						
	h	<b>Total.</b> Add lines 1a-1f . . . . .		450,803.				
<b>Program Service Revenue</b>	2a	PATIENT SERVICE REVENUE	Business Code 623000	55,023,498.	54,417,278.	606,220.		
	b	EASTERN SHORE AREA HEALTH CENTER	623000	35,953.	35,953.			
	c							
	d							
	e							
	f	All other program service revenue . . . . .						
	g	<b>Total.</b> Add lines 2a-2f . . . . .		55,059,451.				
<b>Other Revenue</b>	3	Investment income (including dividends, interest, and other similar amounts) . . . . .		162,811.			162,811.	
	4	Income from investment of tax-exempt bond proceeds . . . . .		0.				
	5	Royalties . . . . .		0.				
	6a	Gross Rents . . . . .	(i) Real	158,375.				
			(ii) Personal					
			b	Less: rental expenses . . . . .				
			c	Rental income or (loss) . . . . .	158,375.			
	d	Net rental income or (loss) . . . . .		158,375.			158,375.	
	7a	Gross amount from sales of assets other than inventory	(i) Securities					
			(ii) Other					
			b	Less: cost or other basis and sales expenses . . . . .				
			c	Gain or (loss) . . . . .				
	d	Net gain or (loss) . . . . .		0.				
	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.					
<b>Miscellaneous Revenue</b>			<b>Business Code</b>					
11a	MISCELLANEOUS REVENUE	900099	153,878.	153,878.				
b								
c								
d	All other revenue . . . . .							
e	<b>Total.</b> Add lines 11a-11d . . . . .		153,878.					
12	<b>Total Revenue.</b> See instructions . . . . .		55,985,318.	54,607,109.	606,220.	321,186.		

**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) but are not required to complete columns (B), (C), and (D).

<i>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</i>	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21 . . .	0.			
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22 . . . . .	16,724.	16,724.		
3 Grants and other assistance to governments, organizations, and individuals outside the U.S. 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 . . . . .	1,473,694.	1,291,659.	174,167.	7,868.
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 . . . . .	22,194,433.	19,452,906.	2,623,033.	118,494.
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions) . . .	1,393,406.	1,221,288.	164,679.	7,439.
9 Other employee benefits . . . . .	3,510,787.	3,075,058.	416,896.	18,833.
10 Payroll taxes . . . . .	1,675,607.	1,468,631.	198,030.	8,946.
11 Fees for services (non-employees):				
a Management . . . . .	3,748,968.	2,364,823.	1,384,145.	
b Legal . . . . .	0.			
c Accounting . . . . .	0.			
d Lobbying . . . . .	4,506.		4,506.	
e Professional fundraising services. See Part IV, line 17	0.			
f Investment management fees . . . . .	0.			
g Other . . . . .	275,238.		275,238.	
12 Advertising and promotion . . . . .	0.			
13 Office expenses . . . . .	66,198.	50,462.	15,736.	
14 Information technology . . . . .	1,185,889.	1,179,932.	5,957.	
15 Royalties . . . . .	0.			
16 Occupancy . . . . .	1,226,968.	1,131,587.	95,381.	
17 Travel . . . . .	36,230.	23,291.	12,939.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings . . . .	96,220.	59,076.	37,144.	
20 Interest . . . . .	393,234.	348,012.	45,222.	
21 Payments to affiliates . . . . .	0.			
22 Depreciation, depletion, and amortization . . .	3,129,736.	2,769,816.	359,920.	
23 Insurance . . . . .	681,125.	681,125.		
24 Other expenses. Itemize expenses not covered above. (Expenses grouped together and labeled miscellaneous may not exceed 5% of total expenses shown on line 25 below.)				
a <u>BAD DEBT EXPENSE</u> . . . . .	3,171,277.	3,171,277.		
b <u>PURCHASED SERVICES</u> . . . . .	3,799,826.	2,695,653.	1,104,173.	
c <u>SUPPLIES</u> . . . . .	9,045,483.	8,729,757.	315,726.	
d <u>PROFESSIONAL DUES &amp; LICENSES</u> . . . . .	146,245.	25,393.	120,852.	
e _____				
f All other expenses _____				
<b>25 Total functional expenses. Add lines 1 through 24f</b>	<b>57,271,794.</b>	<b>49,756,470.</b>	<b>7,353,744.</b>	<b>161,580.</b>
<b>26 Joint Costs.</b> Check here <input type="checkbox"/> If following SOP 98-2. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation . . . . .				

**Part X Balance Sheet**

		(A) Beginning of year		(B) End of year	
<b>Assets</b>	1	Cash - non-interest-bearing . . . . .	7,182,503.	1	2,642,198.
	2	Savings and temporary cash investments . . . . .	4,376,534.	2	2,146,480.
	3	Pledges and grants receivable, net . . . . .		3	
	4	Accounts receivable, net . . . . .	7,916,532.	4	8,500,034.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L . . . . .		5	
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B). Complete Part II of Schedule L . . . . .		6	
	7	Notes and loans receivable, net . . . . .		7	
	8	Inventories for sale or use . . . . .	564,056.	8	686,463.
	9	Prepaid expenses and deferred charges . . . . .	929,438.	9	761,082.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D . . . . .	51,509,233.		
	b	Less: accumulated depreciation . . . . .	30,424,893.	10c	21,084,340.
	11	Investments - publicly traded securities . . . . .	1,998,703.	11	5,201,000.
	12	Investments - other securities. See Part IV, line 11 . . . . .	786,262.	12	2,046,000.
	13	Investments - program-related. See Part IV, line 11 . . . . .		13	
	14	Intangible assets . . . . .		14	
	15	Other assets. See Part IV, line 11 . . . . .	5,495,368.	15	5,903,731.
16	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	49,395,752.	16	48,971,328.	
<b>Liabilities</b>	17	Accounts payable and accrued expenses . . . . .	7,935,553.	17	8,615,235.
	18	Grants payable . . . . .		18	
	19	Deferred revenue . . . . .	114,701.	19	0.
	20	Tax-exempt bond liabilities . . . . .	5,026,745.	20	4,160,155.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D . . . . .		21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L . . . . .		22	
	23	Secured mortgages and notes payable to unrelated third parties . . . . .	4,179,429.	23	3,770,767.
	24	Unsecured notes and loans payable to unrelated third parties . . . . .		24	
	25	Other liabilities. Complete Part X of Schedule D . . . . .	9,120,012.	25	8,777,118.
	26	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .	26,376,440.	26	25,323,275.
<b>Net Assets or Fund Balances</b>	Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27	Unrestricted net assets . . . . .	21,825,637.	27	22,274,167.
	28	Temporarily restricted net assets . . . . .	-137,120.	28	20,146.
	29	Permanently restricted net assets . . . . .	1,330,795.	29	1,353,740.
	Organizations that do not follow SFAS 117, 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	<b>Total net assets or fund balances</b> . . . . .	23,019,312.	33	23,648,053.
34	<b>Total liabilities and net assets/fund balances</b> . . . . .	49,395,752.	34	48,971,328.	

**Part XI Financial Statements and Reporting**

- 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? . . . . .
- b Were the organization's financial statements audited by an independent accountant? . . . . .
- 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.
- d If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a consolidated basis, separate basis, or both:  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- 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		

Form **990** (2009)



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.)

Section A. Public Support

Table with 7 columns: (a) 2005, (b) 2006, (c) 2007, (d) 2008, (e) 2009, (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) 2005, (b) 2006, (c) 2007, (d) 2008, (e) 2009, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 3 columns: Description, Amount, Percentage. Rows include: 14 Public support percentage for 2009 (line 6, column (f) divided by line 11, column (f)); 15 Public support percentage from 2008 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2009; 16b 33 1/3% support test - 2008; 17a 10%-facts-and-circumstances test - 2009; 17b 10%-facts-and-circumstances test - 2008; 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.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a) 2005	(b) 2006	(c) 2007	(d) 2008	(e) 2009	(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) 2005	(b) 2006	(c) 2007	(d) 2008	(e) 2009	(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. . . . . <input type="checkbox"/>						

**Section C. Computation of Public Support Percentage**

15 Public support percentage for 2009 (line 8, column (f) divided by line 13, column (f)). . . . .	15	%
16 Public support percentage from 2008 Schedule A, Part III, line 15 . . . . .	16	%

**Section D. Computation of Investment Income Percentage**

17 Investment income percentage for 2009 (line 10c, column (f) divided by line 13, column (f)) . . . . .	17	%
18 Investment income percentage from 2008 Schedule A, Part III, line 17 . . . . .	18	%

- 19a **33 1/3% support tests - 2009.** 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 - 2008.** 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 ►

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**Part IV** **Supplemental Information.** Complete this part to provide the explanation required by Part II, line 10; Part II, line 17a or 17b; or Part III, line 12. Provide any other additional information. See instructions

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Schedule of Contributors

▶ Attach to Form 990, 990-EZ, or 990-PF.

2009

Name of the organization  
CHESTER RIVER HOSPITAL CENTER

Employer identification number  
52-0679694

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, aggregate 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 aggregate 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 line 2 of its Form 990-PF, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization **CHESTER RIVER HOSPITAL CENTER**

Employer identification number  
52-0679694

**Part I Contributors** (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
1	CHESTER RIVER HEALTH FOUNDATION 100 BROWN STREET CHESTERTOWN, MD 21620	\$ 223,912.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

**SCHEDULE C**  
(Form 990 or 990-EZ)

**Political Campaign and Lobbying Activities**  
For Organizations Exempt From Income Tax Under section 501(c) and section 527

OMB No. 1545-0047

**2009**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

▶ **Complete if the organization is described below.**  
▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions**

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part VI, 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), then

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

Name of organization <b>CHESTER RIVER HOSPITAL CENTER</b>	Employer identification number <b>52-0679694</b>
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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 payments were made. 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-.

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

	(a) Filing organization's totals	(b) Affiliated group totals												
<b>Limits on Lobbying Expenditures</b> (The term "expenditures" means amounts paid or incurred.)														
1 a 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%; border-collapse: collapse;"> <tr> <td style="width: 35%;"><b>If the amount on line 1e, column (a) or (b) is:</b></td> <td><b>The lobbying nontaxable amount is:</b></td> </tr> <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> </table>	<b>If the amount on line 1e, column (a) or (b) is:</b>	<b>The lobbying nontaxable amount is:</b>	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.		
<b>If the amount on line 1e, column (a) or (b) is:</b>	<b>The lobbying nontaxable amount is:</b>													
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 these 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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) Total
2 a Lobbying non-taxable 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 columns (a) Yes/No and (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation...; a Volunteers?; b Paid staff or management...; c Media advertisements?; d Mailings to members...; e Publications...; f Grants to other organizations...; g Direct contact with legislators...; h Rallies, demonstrations...; i Other activities?; j Total. Add lines 1c through 1i; 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?; b If "Yes," enter the amount of any tax incurred under section 4912; c If "Yes," enter the amount of any tax incurred by organization managers under section 4912; d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?

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 columns Yes/No. Rows include: 1 Were substantially all (90% or more) dues received nondeductible by members?; 2 Did the organization make only in-house lobbying expenditures of \$2,000 or less?; 3 Did the organization agree to carryover lobbying and political expenditures from the prior year?

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

Table with columns 1-5. Rows include: 1 Dues, assessments and similar amounts from members; 2 Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid); a Current year; b Carryover from last year; c Total; 3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues; 4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?; 5 Taxable amount of lobbying and political expenditures (see instructions)

Part IV Supplemental Information

Complete this part to provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; and Part II-B, line 1i. Also, complete this part for any additional information. SEE PAGE 4

Series of horizontal dashed lines for supplemental information.

**Part IV** Supplemental Information (continued)

LOBBYING ACTIVITIES

SCHEDULE C, PART II-B

THE ORGANIZATION DOES NOT ENGAGE IN ANY DIRECT LOBBYING ACTIVITIES. THE ORGANIZATION PAYS MEMBERSHIP DUES TO THE MARYLAND HOSPITAL ASSOCIATION (MHA) AND THE AMERICAN HOSPITAL ASSOCIATION (AHA). MHA AND AHA ENGAGE IN MANY SUPPORT ACTIVITIES INCLUDING LOBBYING AND ADVOCATING FOR THEIR MEMBER HOSPITALS. THE MHA AND AHA REPORTED THAT 8.73% AND 23.76% OF MEMBER DUES WERE USED FOR LOBBYING PURPOSES AND AS SUCH, THE ORGANIZATION HAS REPORTED THIS AMOUNT ON SCHEDULE C PART IV AS LOBBYING ACTIVITIES.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2009

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11, or 12.

Attach to Form 990. See separate instructions.

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

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...?, 6 Did the organization inform all grantees...

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

Table with 2 columns: Description, Held at the End of the Year. Rows include: 1 Purpose(s) of conservation easements, 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution... 2a Total number of conservation easements, 2b Total acreage restricted by conservation easements, 2c Number of conservation easements on a certified historic structure, 2d Number of conservation easements included in (c) acquired after 8/17/06, 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 170(h)(4)(B)(ii)?, 9 In Part XIV, 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: Description, Amount. Rows include: 1a If the organization elected, as permitted under SFAS 116, 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 XIV, the text of the footnote to its financial statements that describes these items. b If the organization elected, as permitted under SFAS 116, 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 relating to these items: a Revenues included in Form 990, Part VIII, line 1, b Assets included in Form 990, Part X

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

Schedule D (Form 990) 2009

**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 XIV.

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 XIV 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 XIV.

**Part V Endowment Funds.** Complete if 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 year end balance held as:

- a Board designated or quasi-endowment ▶ \_\_\_\_\_ %
- b Permanent endowment ▶ \_\_\_\_\_ %
- c Term endowment ▶ \_\_\_\_\_ %

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 XIV the intended uses of the organization's endowment funds.

**Part VI Investments - Land, Buildings, and Equipment.** See Form 990, Part X, line 10.

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land . . . . .		478,341		478,341
b Buildings . . . . .		22,987,308	9,922,619	13,064,689
c Leasehold improvements . . . . .				
d Equipment . . . . .		26,832,683	19,686,907	7,145,776
e Other . . . . .		1,210,901	815,367	395,534
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . . .				21,084,340



<b>Part XI Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements</b>		
1	Total revenue (Form 990, Part VIII, column (A), line 12)	1
2	Total expenses (Form 990, Part IX, column (A), line 25)	2
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3
4	Net unrealized gains (losses) on investments	4
5	Donated services and use of facilities	5
6	Investment expenses	6
7	Prior period adjustments	7
8	Other (Describe in Part XIV.)	8
9	Total adjustments (net). Add lines 4 through 8	9
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10

<b>Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return</b>		
1	Total revenue, gains, and other support per audited financial statements	1
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:	
a	Net unrealized gains on investments	2a
b	Donated services and use of facilities	2b
c	Recoveries of prior year grants	2c
d	Other (Describe in Part XIV.)	2d
e	Add lines 2a through 2d	2e
3	Subtract line 2e from line 1	3
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 XIV.)	4b
c	Add lines 4a and 4b	4c
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)	5

<b>Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return</b>		
1	Total expenses and losses per audited financial statements	1
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 XIV.)	2d
e	Add lines 2a through 2d	2e
3	Subtract line 2e from line 1	3
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 XIV.)	4b
c	Add lines 4a and 4b	4c
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)	5

**Part XIV Supplemental Information**

Complete this part to 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, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

SEE PAGE 5

**Part XIV Supplemental Information (continued)**

FIN 48 FOOTNOTE PER AUDIT REPORT

SCHEDULE D, PART X

THE ORGANIZATION IS A SUBSIDIARY OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (THE CORPORATION). THE CORPORATION ADOPTED THE PROVISIONS OF FASB INTERPRETATION NO. 48, ACCOUNTING FOR UNCERTAINTY IN INCOME TAXES (FIN 48) ON JULY 1, 2007. FIN 48 PRESCRIBES A THRESHOLD OF MORE-LIKELY-THAN-NOT FOR RECOGNITION AND DE-RECOGNITION OF TAX POSITIONS TAKEN OR EXPECTED TO BE TAKEN IN A TAX RETURN. FIN 48 ALSO RECOGNIZES RELATED GUIDANCE ON MEASUREMENT, CLASSIFICATION, INTEREST AND PENALTIES AND DISCLOSURE. THE IMPLEMENTATION OF FIN 48 DID NOT HAVE A SIGNIFICANT IMPACT ON THE CORPORATION'S BALANCE SHEET OR STATEMENT OF OPERATIONS. MANAGEMENT DOES NOT BELIEVE THAT THERE ARE ANY UNRECOGNIZED TAX BENEFITS THAT SHOULD BE RECOGNIZED.

**SCHEDULE H**  
**(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2009**

**Open to Public Inspection**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

**Part I Charity Care and Certain Other Community Benefits at Cost**

	Yes	No
1a Does the organization have a charity care policy? If "No," skip to question 6a	X	
b If "Yes," is it a written policy?	X	
2 If the organization has multiple hospitals, indicate which of the following best describes application of the charity care policy to the various hospitals. <input type="checkbox"/> Applied uniformly to all hospitals <input type="checkbox"/> Applied uniformly to most hospitals <input type="checkbox"/> Generally tailored to individual hospitals		
3 Answer the following based on the charity care eligibility criteria that applies to the largest number of the organization's patients.		
a Does the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing free care to low income individuals? If "Yes," indicate which of the following is the 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 Does the organization use FPG to determine eligibility for providing discounted care to low income individuals? If "Yes," indicate which of the following is 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 does not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization uses an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.		
4 Does the organization's policy provide free or discounted care to the "medically indigent"?	X	
5a Does the organization budget amounts for free or discounted care provided under its charity care policy?	X	
b If "Yes," did the organization's charity care 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 Does the organization prepare an annual community benefit report?	X	
b If "Yes," does 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 Charity Care and Certain Other Community Benefits at Cost**

Charity Care 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 Charity care at cost (from Worksheets 1 and 2)			2,328,439.		2,328,439.	4.07
b Unreimbursed Medicaid (from Worksheet 3, column a)						
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)						
d Total Charity Care and Means-Tested Government Programs			2,328,439.		2,328,439.	4.07
<b>Other Benefits</b>						
e Community health improvement services and community benefit operations (from Worksheet 4)			400,583.		400,583.	.70
f Health professions education (from Worksheet 5)			160,274.		160,274.	.28
g Subsidized health services (from Worksheet 6)			2,548,197.	497,000.	2,051,197.	3.57
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)			14,655.		14,655.	.03
j Total Other Benefits			3,123,709.	497,000.	2,626,709.	4.58
k Total. Add lines 7d and 7j			5,452,148.	497,000.	4,955,148.	8.65

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

Schedule H (Form 990) 2009

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**Part II Community Building Activities** Complete this table if the organization conducted any community building activities.

	(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			9,133.		9,133.	.02
3 Community support		156	35,889.		35,889.	.06
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy			145,866.		145,866.	.25
8 Workforce development						
9 Other						
10 Total		156	190,888.		190,888.	.33

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

- Does the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? . . . . .
- Enter the amount of the organization's bad debt expense (at cost) . . . . .
- Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's charity care policy . . . . .
- Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including other bad debt amounts in community benefit.

	Yes	No
1	X	
2		
3		
5		
6		
7		
9a	X	
9b	X	

**Section B. Medicare**

- Enter total revenue received from Medicare (including DSH and IME) . . . . .
- Enter Medicare allowable costs of care relating to payments on line 5 . . . . .
- Subtract line 6 from line 5. This is the surplus or (shortfall) . . . . .
- 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:

Cost accounting system     Cost to charge ratio     Other

**Section C. Collection Practices**

- Does the organization have a written debt collection policy? . . . . .
- If "Yes," does the organization's collection policy contain provisions on the collection practices to be followed for patients who are known to qualify for charity care or financial assistance? Describe in Part VI. . . . .

**Part IV Management Companies and Joint Ventures**

	(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	N/A				
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					



**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves.
- 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 charity care policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Community building activities.** Describe how the organization's community building activities, as reported in Part II, promote the health of the communities the organization serves.
- 6 Provide any other information important to describing how the organization's hospitals 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.).
- 7 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.
- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

**PART I, LINE 3C:**

N/A

**PART I, LINE 6A:**

CHESTER RIVER HOSPITAL PREPARES A COMMUNITY BENEFIT REPORT FOR EACH  
 FISCAL YEAR ENDING JUNE 30, WHICH IT SUBMITS TO THE HEALTH SERVICES  
 COST REVIEW COMMISSION (HSCRC), A STATE REGULATORY AGENCY, BY  
 DECEMBER 31 OF EACH YEAR.

IN ADDITION, THE ANNUAL COMMUNITY BENEFIT REPORT IS AVAILABLE UPON  
 REQUEST AT THE ENTITY'S CORPORATE OFFICES.

**PART I, LINE 7G:**

CHESTER RIVER HOSPITAL SUBSIDIZES THE COST OF HOSPITALIST PHYSICIAN  
 COVERAGE AND ON-CALL COVERAGE FOR EMERGENCY ROOM PHYSICIANS TO  
 PROVIDE 24 HOUR COVERAGE TO ALL PATIENTS. IN ADDITION, CHESTER RIVER  
 SUPPORTS LOCAL MEDICAL EDUCATION STUDENTS THROUGH HIGH SCHOOL AND  
 NURSING SCHOLARSHIPS.

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves.
- 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 charity care policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
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- 6 Provide any other information important to describing how the organization's hospitals 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.).
- 7 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.
- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, LINE 7B, COLUMNS (C) THROUGH (F)

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL

PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH

SERVICES COST REVIEW COMMISSION, (HSCRC) DETERMINES PAYMENT THROUGH A

RATE SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS,

PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME

HOSPITAL. MARYLAND'S UNIQUE ALL PAYOR SYSTEM INCLUDES A METHOD FOR

REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT

ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED

TO UNCOMPENSATED CARE. COMMUNITY BENEFIT EXPENSES ARE EQUAL TO

MEDICAID REVENUES IN MARYLAND, AS SUCH, THE NET EFFECT IS ZERO.

ADDITIONALLY, NET REVENUES FOR MEDICAID SHOULD REFLECT THE FULL

IMPACT ON THE HOSPITAL OF ITS SHARE OF THE MEDICAID ASSESSMENT.

PART I, LINE 7:

SCHEDULE H, LINE 7A, COLUMN (D), LINE 7F, COLUMN (C), LINE 7F, COLUMN

(D)

**Part VI Supplemental Information**

Complete this part to provide the following information.

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MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL

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- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
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**PART III, LINE 4:**

-----  
 THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF  
 -----  
 HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING HISTORICAL  
 -----  
 BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE  
 -----  
 COVERAGE, AND OTHER COLLECTION INDICATORS. PERIODICALLY THROUGHOUT  
 -----  
 THE YEAR, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR  
 -----  
 UNCOLLECTIBLE ACCOUNTS BASED UPON HISTORICAL WRITE-OFF EXPERIENCE BY  
 -----  
 PAYOR CATEGORY. THE RESULTS OF THIS REVIEW ARE THEN USED TO MAKE  
 -----  
 MODIFICATIONS TO THE PROVISION FOR BAD DEBTS AND TO ESTABLISH AN  
 -----  
 ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES. AFTER COLLECTION OF AMOUNTS  
 -----  
 DUE FROM INSURERS, THE CORPORATION FOLLOWS INTERNAL GUIDELINES FOR  
 -----  
 PLACING CERTAIN PAST DUE BALANCES WITH COLLECTION AGENCIES. BAD DEBT  
 -----  
 EXPENSE IS REDUCED TO COST ON PART 3 LINE 2 BASED UPON WORKSHEET 2  
 -----  
 COST TO CHARGE RATIO.  
 -----

**PART III, LINE 8:**

-----  
 IN MARYLAND, THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC)  
 -----  
 STARTED SETTING HOSPITAL RATES IN 1974. AT THAT TIME, THE HSCRC  
 -----  
 APPROVED RATES APPLIED ONLY TO COMMERCIAL INSURERS. IN 1977, THE  
 -----

**Part VI Supplemental Information**

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HSCRC NEGOTIATED A WAIVER FROM MEDICARE HOSPITAL PAYMENT RULES FOR

MARYLAND HOSPITALS TO BRING THE FEDERAL MEDICARE PAYMENTS UNDER HSCRC

CONTROL.

MEDICARE REIMBURSES MARYLAND HOSPITALS ACCORDING TO RATES ESTABLISHED

BY THE HSCRC AS LONG AS THE STATE CONTINUES TO MEET A TWO-PART TEST.

THIS TWO-PART WAIVER TEST ALLOWS MEDICARE TO PARTICIPATE IN THE

MARYLAND SYSTEM AS LONG AS TWO CONDITIONS ARE MET:

- ALL OTHER PAYERS PARTICIPATING IN THE SYSTEM PAY HSCRC SET RATES AND

- THE RATE OF GROWTH IN MEDICARE PAYMENTS TO MARYLAND HOSPITALS FROM 1981 TO THE PRESENT IS NOT GREATER THAN THE RATE OF GROWTH IN MEDICARE PAYMENTS TO HOSPITALS NATIONALLY OVER THE SAME TIME FRAME.

**PART III, LINE 9B:**

ALL PATIENTS ARE ELIGIBLE TO APPLY FOR FINANCIAL ASSISTANCE. APPROVAL IS IN ACCORDANCE WITH CRHC'S PATIENT FINANCIAL ASSISTANCE POLICY.

**Part VI Supplemental Information**

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- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

THE ORGANIZATION EXPECTS PAYMENT AT THE TIME THE SERVICE IS PROVIDED.

OUR POLICY IS TO COMPLY WITH ALL STATE AND FEDERAL LAW AND THIRD

PARTY REGULATIONS AND TO PERFORM ALL CREDIT AND COLLECTION FUNCTIONS

IN A DIGNIFIED AND RESPECTFUL MANNER. EMERGENCY SERVICES WILL BE

PROVIDED TO ALL PATIENTS REGARDLESS OF ABILITY TO PAY. FINANCIAL

ASSISTANCE IS AVAILABLE FOR PATIENTS BASED ON FINANCIAL NEED AS

DEFINED IN THE FINANCIAL ASSISTANCE POLICY. THE ORGANIZATION DOES

NOT DISCRIMINATE ON THE BASIS OF AGE, RACE, CREED, SEX OR ABILITY TO

PAY.

PATIENTS WHO ARE UNABLE TO PAY MAY REQUEST A FINANCIAL ASSISTANCE

APPLICATION AT ANY TIME PRIOR TO SERVICE OR DURING THE BILLING AND

COLLECTION PROCESS. THE ORGANIZATION MAY REQUEST THE PATIENT TO

APPLY FOR MEDICAL ASSISTANCE PRIOR TO APPLYING FOR FINANCIAL

ASSISTANCE. THE ACCOUNT WILL NOT BE FORWARDED FOR COLLECTION DURING

THE MEDICAL ASSISTANCE APPLICATION PROCESS OR THE FINANCIAL

ASSISTANCE APPLICATION PROCESS.

**PART V:**

**Part VI Supplemental Information**

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N/A

**NEEDS ASSESSMENT:**

TO IDENTIFY THE HEALTH NEEDS OF THE COMMUNITY IT SERVES, CHESTER

RIVER HOSPITAL CENTER (CRHC) HAS USED THE NEEDS ASSESSMENTS DEVELOPED

BY THE LOCAL KENT COUNTY HEALTH DEPARTMENT (LAST CONDUCTED IN 2008)

WHICH WAS A COLLABORATION THAT INCLUDED CRHC ALONG WITH OTHER LOCAL

ORGANIZATIONS. THE NEEDS ASSESSMENT INCORPORATED SURVEYS OF COMMUNITY

RESIDENTS; DATA AND STATISTICS COMPILED BY STATE AND LOCAL

GOVERNMENTS; AND INFORMATION GATHERED BY CONSULTATION OF KENT COUNTY

HEALTH DEPARTMENT, ELEVEN PRIMARY CARE PHYSICIANS, AND THE LOCAL

MANAGEMENT BOARD (LMB).

CHESTER RIVER HOSPITAL CENTER UTILIZES ADDITIONAL DATA SOURCES THAT

INCLUDE:

" MORBIDITY AND MORTALITY DATA FROM THE MARYLAND DEPARTMENT OF

HEALTH AND MENTAL HYGIENE;

" POPULATION AND DEMOGRAPHIC DATA FROM THE MARYLAND DEPARTMENT OF

PLANNING AND CLARITAS, INC.;

" PATIENT ORIGIN AND MARKET SHARE DATA FROM THE PATIENT CARE

**Part VI Supplemental Information**

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ANALYST DATABASE OF SMA INFORMATICS, PROVIDED BY HSCRC.

DURING FY2010 CHESTER RIVER HEALTH SYSTEM (CRHS) COMPLETED A STRATEGIC PLANNING PROCESS FROM NOVEMBER 2009 THROUGH APRIL 2010. THE PURPOSE OF THE STRATEGIC PLAN WAS TO PROVIDE DIRECTION FOR CHESTER RIVER HEALTH SYSTEM FOR THE NEXT THREE TO FIVE YEARS. CRHS RETAINED THE SERVICES OF A CONSULTANT AND FORMED A PLANNING COMMITTEE TO DEVELOP THE STRATEGIC PLAN. THE STRATEGIC PLANNING PROCESS GATHERED INPUT AND INFORMATION FROM A VARIETY OF COMMUNITY SOURCES, INCLUDING:

" INTERVIEWS WITH BOARD MEMBERS, MEDICAL STAFF, MANAGEMENT AND COMMUNITY MEMBERS/LEADERS

" MEETINGS/INTERVIEWS WITH CRHS EMPLOYEES

" MEETINGS/INTERVIEWS WITH PHYSICIANS

" CONSUMER TELEPHONE SURVEY (500 TELEPHONE INTERVIEWS WITH AREA RESIDENTS)

" CONSUMER SURVEY (438 COMMUNITY MEMBERS COMPLETED A PRINTED FORM SURVEY)

(NOTE: ALTHOUGH THE STRATEGIC PLANNING PROCESS OCCURRED DURING

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FY2010, THE FINDINGS FROM THE STRATEGIC PLAN VALIDATED WHAT CRHC HAD  
 IN PLACE FOR COMMUNITY BENEFITS PROGRAM, AND ALSO IDENTIFIED AREAS  
 THAT NEED MORE ATTENTION IN THE FY2011 COMMUNITY BENEFITS PROGRAM.)

**PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE:**

CHESTER RIVER HOSPITAL CENTER INFORMS AND EDUCATES PATIENTS AND  
 PERSONS WHO MAY BE BILLED FOR PATIENT CARE ABOUT THEIR ELIGIBILITY  
 FOR ASSISTANCE UNDER FEDERAL, STATE OR LOCAL GOVERNMENT OR UNDER THE  
 CHESTER RIVER HOSPITAL CENTER'S CHARITY CARE POLICY THROUGH THE  
 PATIENT FINANCIAL SERVICES DEPARTMENT AND REGISTRATION. WHEN A  
 PATIENT IS REGISTERED, THERE IS A SERIES OF QUESTIONS THAT  
 REGISTRATION ASKS TO DETERMINE THE ELIGIBILITY OF A PATIENT FOR A  
 MEDICAL ASSISTANCE PROGRAM. CHESTER RIVER HOSPITAL CENTER USES THE  
 COMPANY ROI TO HELP WITH THIS PROCESS. SELF-PAY PATIENTS ARE  
 IDENTIFIED AND ROI CONTACTS THE PATIENT DIRECTLY REGARDING  
 ELIGIBILITY FOR ASSISTANCE. ROI WORKS WITH THE PATIENT TO MAKE SURE  
 ALL APPLICABLE PAPERWORK IS COMPLETED, AND ADDRESSES CONCERNS OR  
 QUESTIONS THE PATIENT MAY HAVE REGARDING ASSISTANCE WITH MEDICAL  
 BILLS. CHESTER RIVER HOSPITAL CENTERS NOTIFIES PATIENTS OF

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AVAILABILITY OF FINANCIAL ASSISTANCE FUNDS PRIOR TO SERVICE DURING

OUR CALLS TO PATIENTS, THROUGH SIGNAGE AT ALL OF OUR REGISTRATION

LOCATIONS, THROUGH OUR PATIENT BILLING BROCHURE AND THROUGH OUR

DISCUSSIONS WITH PATIENTS DURING REGISTRATION. IN ADDITION, THE

INFORMATION SHEET IS MAILED TO PATIENTS WITH ALL STATEMENTS AND/OR

HANDED TO THEM IF NEEDED. THERE IS A PATIENT FINANCIAL COORDINATOR AT

CHESTER RIVER HOSPITAL CENTER WHO HELPS PATIENTS TO COMPLETE THE

FINANCIAL ASSISTANCE PROGRAM APPLICATION AND ADDRESSES ANY QUESTIONS

OR CONCERNS ABOUT ELIGIBILITY FOR ASSISTANCE. THE PATIENT FINANCIAL

COORDINATOR WORKS WITH PATIENTS AND THEIR FAMILIES ON HOW THEIR

BILL(S) MAY BE REDUCED OR EVEN PAID UP TO 100% THROUGH FINANCIAL

ASSISTANCE. THE PATIENT FINANCIAL COORDINATOR NOT ONLY WORKS WITH

SELF-PAY PATIENTS, BUT ALSO WITH PATIENTS WHO HAVE INSURANCE, BUT

HAVE LARGE DEDUCTIBLES AND CO-PAYS, AND/OR OTHER FINANCIAL HARDSHIPS.

CHESTER RIVER UTILIZES A SOFTWARE PROGRAM THAT THE PATIENT FINANCIAL

COORDINATOR USES TO IDENTIFY WHETHER OR NOT A PATIENT IS ELIGIBLE FOR

MEDICAL ASSISTANCE.

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**COMMUNITY INFORMATION:**

CHESTER RIVER HOSPITAL CENTER (CRHC) SERVES THE COMMUNITIES OF KENT

COUNTY AND UPPER QUEEN ANNE'S COUNTY. CRHC ALSO SERVES PORTIONS OF

SOUTHERN CECIL COUNTY AND NORTHERN CAROLINE COUNTY. THESE RURAL AREAS

ARE POPULATED BY ACTIVE FARMERS AND SMALL, CLOSE-KNIT COMMUNITIES.

TRANSPORTATION IS OFTEN A BARRIER FOR ACCESS TO HEALTH CARE

SERVICES.

THE SERVICE AREA POPULATION FOR CHESTER RIVER HOSPITAL CENTER IS

43,704 PEOPLE, WITH 7,560 OF THE PEOPLE AGE 65 OR OLDER. KENT COUNTY,

WITH A TOTAL POPULATION OF 24,685, ACCOUNTS FOR MORE THAN HALF OF

CHESTER RIVER HOSPITAL CENTER'S SERVICE AREA. KENT COUNTY IS UNIQUE

IN THAT 19.6% OF ITS RESIDENTS ARE 65 YEARS OF AGE OR OLDER, WHICH IS

65% HIGHER THAN MARYLAND'S PERCENTAGE AND HIGHER THAN OTHER RURAL

AREAS IN THE STATE BY ALMOST A QUARTER. THIS MAKES KENT COUNTY'S

POPULATION ONE OF THE OLDEST, AGING POPULATIONS IN MARYLAND.

APPROXIMATELY 19% OF THE RESIDENTS OF KENT COUNTY ARE

AFRICAN-AMERICAN. THE HISPANIC POPULATION IS RAPIDLY GROWING, BUT

ACCOUNTS FOR ONLY A SMALL PERCENTAGE OF THE POPULATION.

THIRTY PERCENT OF THE POPULATION IS CLASSIFIED AS LOW INCOME, WITH

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15% WITHOUT INSURANCE. IN A 2010 STUDY OF MARYLAND COUNTIES, KENT

COUNTY RANKED 16 OUT OF 24 IN HEALTH FACTORS AND HEALTH OUTCOMES.

KENT COUNTY RANKED NUMBER ONE IN THE STATE FOR PERCENTAGE OF DEATHS

RELATED TO ALZHEIMER'S, A DISEASE MOSTLY ASSOCIATED WITH THE AGING

POPULATION. THE REPORT ALSO NOTED THAT KENT COUNTY HAS A HIGHER

PREVALENCE OF HYPERTENSION, HIGH CHOLESTEROL, OBESITY AND DIABETES

THAN OTHER AREAS OF MARYLAND. CHILDREN LIVING ON THE EASTERN SHORE

ARE MORE LIKELY TO HAVE DENTAL CARIES, YET LESS LIKELY TO HAVE DENTAL

SEALANT OR RESTORATION THAN OTHER PARTS OF THE STATE. ALCOHOL ABUSE

AND MENTAL HEALTH DIAGNOSES OCCUR AT SIGNIFICANTLY HIGHER RATES THAN

THE STATE AVERAGE, TOO.

**COMMUNITY BUILDING ACTIVITIES:**

CHESTER RIVER HOSPITAL CENTER PARTICIPATES IN A VARIETY OF COMMUNITY

BUILDING ACTIVITIES, SPECIFICALLY IN KENT COUNTY AND QUEEN ANNE'S

COUNTY. THE PRESIDENT AND VICE PRESIDENT OF CHESTER RIVER HOSPITAL

CENTER BOTH PARTICIPATE IN THE LOCAL CHAMBER OF COMMERCE. THE

PRESIDENT IS ON THE BOARD OF THE KENT COUNTY CHAMBER OF COMMERCE AND

ATTENDS REGULAR, MONTHLY MEETINGS REGARDING THE ECONOMIC GROWTH AND

**Part VI Supplemental Information**

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DEVELOPMENT IN AND AROUND KENT COUNTY. THE VICE PRESIDENT ALSO

ATTENDS CHAMBER MEETINGS, AS WELL AS THE DIRECTOR OF PUBLIC

RELATIONS.

SEVERAL EMPLOYEES OF CHESTER RIVER HOSPITAL CENTER ARE INVOLVED WITH

OTHER LOCAL COMMUNITY ORGANIZATIONS AND GROUPS, SUCH AS THE ROTARY

AND LIONS CLUB OF BOTH KENT AND QUEEN ANNE'S COUNTIES. THESE

ORGANIZATIONS PROVIDE HUMANITARIAN SERVICES AND HELP TO BUILD

GOODWILL IN THE COMMUNITY. CHESTER RIVER HOSPITAL EMPLOYEES ARE

INVOLVED WITH EDUCATIONAL ACTIVITIES-WE REGULARLY SEND NURSES TO

SPEAK AT MEETINGS ADDRESSING HEALTH CARE ISSUES. CHESTER RIVER

HOSPITAL EMPLOYEES ARE ALSO INVOLVED WITH JOB TRAINING ACTIVITIES AND

YOUTH DEVELOPMENT IN THE LOCAL COMMUNITIES WE SERVE.

CHESTER RIVER HOSPITAL CENTER'S SAFETY AND EOC DEPARTMENT PARTNERS

WITH OTHER COMMUNITY ORGANIZATIONS, SUCH AS KENT COUNTY HEALTH

DEPARTMENT AND THE KENT COUNTY OFFICE OF EMERGENCY SERVICES, TO PLAN

AND PREPARE FOR DISASTERS. CHESTER RIVER HOSPITAL CENTER ORGANIZES

YEARLY PRACTICES AND DRILLS TO TRAIN ITS EMPLOYEES IN DISASTER

PREPAREDNESS. CHESTER RIVER HOSPITAL CENTER ALSO PARTICIPATES IN

COMMUNITY-WIDE DISASTER PLANNING DRILLS AND EXERCISES.

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves.
- 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 charity care policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Community building activities.** Describe how the organization's community building activities, as reported in Part II, promote the health of the communities the organization serves.
- 6 Provide any other information important to describing how the organization's hospitals 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.).
- 7 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.
- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

IN REGARDS TO COMMUNITY HEALTH IMPROVEMENT ADVOCACY, CHESTER RIVER

HOSPITAL CENTER'S EMPLOYEES ARE INVOLVED IN A VARIETY OF COMMITTEES

AND HEALTH EVENTS THROUGHOUT THE YEAR. SOME OF THE HEALTH FAIRS AND

EVENTS INCLUDE THE ANNUAL DEPARTMENT OF AGING SENIOR SUMMIT, WHICH IS

AN EVENT GEARED TOWARD THE AGING POPULATION AND ATTRACTS

APPROXIMATELY 300 ATTENDEES EACH YEAR. CHESTER RIVER HOSPITAL CENTER

PROVIDES INFORMATION ON CHRONIC DISEASES, CANCER AND OTHER HEALTH

TOPICS, AS WELL AS FREE HEALTH SCREENINGS.

**OTHER INFORMATION:**

N/A

**AFFILIATED HEALTH CARE SYSTEM ROLES:**

CHESTER RIVER HOSPITAL IS AFFILIATED WITH THE UNIVERSITY OF MARYLAND

MEDICAL SYSTEM BUT THE COMMUNITY BENEFIT ACTIVITIES ARE DETERMINED

LOCALLY AT THE HOSPITAL LEVEL.

**ALL STATES WHICH ORGANIZATION FILES A COMMUNITY BENEFIT REPORT:**

MD,



**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. Use Part IV and Schedule I-1 (Form 990) 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
EMPLOYEE EDUCATION	10	16,724.			

**Part IV** Supplemental Information. Complete this part to provide the information required in Part I, line 2, and any other additional information.

SCHEDULE I, PART I

PROCEDURE FOR GRANT MONITORING

CHESTER RIVER HOSPITAL CENTER HAS WRITTEN POLICIES INCLUDED IN

ADMINISTRATIVE POLICIES/MANAGEMENT OF HUMAN RESOURCES. ASSISTANCE IS

PROVIDED TO EMPLOYEES WHO ARE ELIGIBLE BY NEED/ELIGIBILITY.

**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.

OMB No. 1545-0047

**2009**

**Open to Public Inspection**

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

**Part I Questions Regarding Compensation**

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

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

**b** If any of the boxes on line 1a is 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 officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?

**3** Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director. Check all that apply.

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

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

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

**Only section 501(c)(3) 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 Regs. 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
<b>1b</b>	X	
<b>2</b>	X	
<b>4a</b>		X
<b>4b</b>	X	
<b>4c</b>		X
<b>5a</b>		X
<b>5b</b>		X
<b>6a</b>		X
<b>6b</b>		X
<b>7</b>		X
<b>8</b>		X
<b>9</b>		

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

Schedule J (Form 990) 2009

**Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use Schedule J-1 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) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a.

(A) Name	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ	
	(i) Base compensation	(ii) Bonus & Incentive compensation	(iii) Other reportable compensation					
ROBIN KLINEFELTER	(i)	104,131.	0.	15,228.	19,291.	0.	138,650.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
SCOTT BURLESON	(i)	155,639.	33,280.	2,481.	22,080.	15,688.	229,168.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
DEBORAH DAVIS	(i)	299,306.	32,000.	39,140.	15,479.	19,766.	405,691.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
GLENN F ROBBINS MD	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	473,057.	167,019.	140,941.	9,360.	18,772.	809,149.	101,497.
HENRY ARAKAKY	(i)	253,194.	13,500.	0.	10,065.	0.	276,759.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
JEFFREY L JOHNSON	(i)	217,623.	54,120.	57,548.	8,619.	25,934.	363,844.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
JOHN W ASHWORTH	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	341,524.	139,526.	14,876.	9,782.	15,116.	520,824.	0.
MARY JO KEEFE	(i)	119,480.	24,669.	3,959.	13,483.	15,030.	176,621.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
ROBERT A CHRENCIK	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	891,638.	585,000.	9,032.	151,615.	18,817.	1,656,102.	0.
SAMUEL P MARINELLI JR	(i)	182,966.	43,000.	1,681.	22,546.	13,766.	263,959.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
STEVEN LUCAS	(i)	283,804.	17,500.	0.	12,106.	20,460.	333,870.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
JAMES E ROSS	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	274,706.	83,594.	45,994.	8,789.	14,977.	428,060.	0.
MIN YU	(i)	177,183.	0.	0.	8,538.	19,517.	205,238.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
CHERYL DICKASON	(i)	148,943.	3,000.	0.	5,034.	0.	156,977.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							

**Part III Supplemental Information**

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

SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN

PART I, LINE 4B

THE FOLLOWING INDIVIDUALS PARTICIPATE IN A SECTION 457(F) SUPPLEMENTAL,

NONQUALIFIED RETIREMENT PLAN ("THE PLAN") SPONSORED BY THE FILING

ORGANIZATION OR A RELATED ORGANIZATION:

JAMES E. ROSS

JOHN W. ASHWORTH

SCOTT BURLESON

ROBERT A. CHRENCIK

JEFFREY L. JOHNSON

MARY JO KEEFE

GLENN F. ROBBINS, MD.

SAMUEL P. MARINELLI

IN ADDITION, THE FOLLOWING INDIVIDUALS BECAME VESTED IN OR RECEIVED

PAYMENTS FROM THE PLAN THAT HAVE BEEN REPORTED ON SCHEDULE J, PART II,

COLUMN B(III):



**SCHEDULE K  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Information on Tax-Exempt Bonds**

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information on Schedule O (Form 990).

▶ Attach to Form 990. See separate instructions.

OMB No. 1545-0047

**2009**

Open to Public  
Inspection

Name of the organization  
**CHESTER RIVER HOSPITAL CENTER**

Employer identification number  
**52-0679694**

**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	
						Yes	No	Yes	No
<b>A</b> MARYLAND HEALTH AND HIGHER EDUCATIONAL FACILITIES	52-0936091		05/01/2006	3,952,807.	TAX EXEMPT BOND MHEFA MASTER		X		X
<b>B</b> MARYLAND HEALTH AND HIGHER EDUCATIONAL FACILITIES	52-0936091		12/01/2003	4,000,000.	TAX EXEMPT BOND MHEFA SERIES		X		X
<b>C</b>									
<b>D</b>									
<b>E</b>									

**Part II Proceeds**

	A		B		C		D		E	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b> Total proceeds of issue . . . . .		3,952,807.		4,000,000.						
<b>2</b> Gross proceeds in reserve funds . . . . .		0.		0.						
<b>3</b> Proceeds in refunding or defeasance escrows . . . . .		0.		0.						
<b>4</b> Other unspent proceeds . . . . .		0.		0.						
<b>5</b> Issuance costs from proceeds . . . . .		48,200.		81,072.						
<b>6</b> Working capital expenditures from proceeds . . . . .		0.		0.						
<b>7</b> Capital expenditures from proceeds . . . . .		3,904,607.		3,918,928.						
<b>8</b> Year of substantial completion . . . . .		2006		2004						
<b>9</b> Were the bonds issued as part of a current refunding issue?		X		X						
<b>10</b> Were the bonds issued as part of an advance refunding issue?		X		X						
<b>11</b> Has the final allocation of proceeds been made?	X		X							
<b>12</b> Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X							

**Part III Private Business Use**

	A		B		C		D		E	
	Yes	No								
<b>1</b> Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds? . . . . .		X		X						
<b>2</b> Are there any lease arrangements with respect to the financed property which may result in private business use?		X		X						

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

Schedule K (Form 990) 2009

JSA

**Part III Private Business Use (Continued)**

	A		B		C		D		E	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts with respect to the financed property which may result in private business use? . . . . .		X		X						
b Are there any research agreements with respect to the financed property which may result in private business use? . . . . .		X		X						
c Does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts or research agreements relating to the financed property? . . . . .		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 . . . . . ▶	0.0000%		0.0000%							
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 . . . . . ▶	0.0000%		0.0000%							
6 Total of lines 4 and 5 . . . . .	0.0000%		0.0000%							
7 Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities? . . . . .	X		X							

**Part IV Arbitrage**

	A		B		C		D		E	
	Yes	No								
1 Has a Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate, been filed with respect to the bond issue? . . . . .		X		X						
2 Is the bond issue a variable rate issue? . . . . .	X		X							
3a Has the organization or the governmental issuer identified a hedge with respect to the bond issue on its books and records? . . . . .		X		X						
b Name of provider . . . . .										
c Term of hedge . . . . .										
4a Were gross proceeds invested in a GIC? . . . . .		X		X						
b Name of provider . . . . .										
c Term of GIC . . . . .										
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied? . . . . .										
5 Were any gross proceeds invested beyond an available temporary period? . . . . .		X		X						
6 Did the bond issue qualify for an exception to rebate? . . . . .		X		X						

**SCHEDULE O  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Information to Form 990**

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

OMB No. 1545-0047

**2009**

**Open to Public  
Inspection**

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

ATTACHMENT 1

SECURED MORTGAGE NOTES PAYABLE

PART X, LINE 23

FARMERS HOME ADMINISTRATION LOAN AND MHHEFA POOLED LOAN WERE USED TO ADD  
ADDITIONS TO THE HOSPITAL.

MEMBERS

PART VI LINE 6, 7A, AND 7B

CHESTER RIVER HEALTH SYSTEM, INC. AND THE UNIVERSITY OF MARYLAND MEDICAL  
SYSTEM CORPORATION MAY ELECT MEMBERS AND APPROVE DECISIONS OF CHESTER  
RIVER HOSPITAL CENTER.

FORM 990 PREPARATION AND REVIEW PROCESS

PART VI, SECTION B, LINE 11

THE IRS FORM 990 IS PREPARED AND REVIEWED BY THE ACCOUNTING FIRM OF KPMG.  
ACCOUNTING PERSONNEL IN FINANCE SHARED SERVICES AT THE UNIVERSITY OF  
MARYLAND MEDICAL SYSTEM GATHER THE INFORMATION NEEDED TO COMPLETE THE  
RETURN AND INPUT THE DATA INTO THE KPMG TAX ORGANIZER, WHICH IS A  
WEB-BASED SYSTEM.

WHEN ALL DATA HAS BEEN ENTERED, THE INFORMATION IS SUBMITTED TO KPMG FOR  
IMPORTATION INTO THEIR TAX SOFTWARE. AT THIS POINT, KPMG STAFF MEMBERS  
REVIEW THE DATA, ASK FOR ADDITIONAL INFORMATION IF NEEDED AND PREPARE THE  
TAX RETURN. EACH RETURN IS REVIEWED AT SEVERAL LEVELS AT KPMG INCLUDING  
THE TAX PARTNER. AFTER THEIR REVIEW PROCESS, A DRAFT RETURN IS SENT TO

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

ATTACHMENT 1 (CONT'D)

THE ACCOUNTING STAFF AT UMMS FOR AN IN-HOUSE REVIEW.

UPON COMPLETION OF THE IN-HOUSE REVIEW, KPMG IS INSTRUCTED TO MAKE ANY NECESSARY CHANGES AND TO PREPARE THE FINAL TAX RETURN. THE FINAL RETURN UNDERGOES ANOTHER REVIEW BY THE ACCOUNTING STAFF AT FINANCE SHARED SERVICES AND IS ALSO REVIEWED BY THE ACCOUNTING MANAGER, THE DIRECTOR OF FINANCIAL REPORTING, THE VICE PRESIDENT OF FINANCE AND THE CFO, WHO SIGNS THE RETURN.

PRIOR TO FILING THE IRS FORM 990, THE ORGANIZATION'S BOARD CHAIRMAN, TREASURER, AUDIT COMMITTEE CHAIRMAN, EXECUTIVE COMMITTEE CHAIRMAN OR OTHER MEMBER OF THE BOARD WITH SIMILAR AUTHORITY WILL REVIEW THE IRS FORM 990. AT THE DISCRETION OF THE REVIEWING BOARD MEMBER, SUCH MEMBER WILL BRING ANY ISSUES OR QUESTIONS RELATED TO THE COMPLETED IRS FORM 990 TO THE ATTENTION OF THE BOARD. NOTWITHSTANDING THE ABOVE, A BOARD RESOLUTION IS NOT REQUIRED FOR THE FILING OF THE ORGANIZATION'S IRS FORM 990. EACH BOARD MEMBER IS PROVIDED WITH A COPY OF THE FINAL IRS FORM 990 BEFORE FILING.

CONFLICT OF INTEREST POLICY

PART VI, SECTION B, LINE 12C

THE ORGANIZATION'S OFFICERS, DIRECTORS, EMPLOYEES AND MEDICAL STAFF MEMBERS, AS APPLICABLE, SHALL DISCLOSE CONFLICTS OF INTEREST OR POTENTIAL CONFLICTS OF INTEREST BETWEEN THEIR PERSONAL INTERESTS AND THE INTERESTS OF THE ORGANIZATION, OR ANY ENTITY CONTROLLED BY OR OWNED IN SUBSTANTIAL PART BY THE ORGANIZATION.

Name of the organization CHESTER RIVER HOSPITAL CENTER	Employer identification number 52-0679694
---	--

ATTACHMENT 1 (CONT'D)

A QUESTIONNAIRE WHICH DISCLOSES POTENTIAL CONFLICTS OF INTEREST IS DISTRIBUTED ANNUALLY TO ALL OFFICERS, DIRECTORS AND KEY EMPLOYEES. THE GENERAL COUNSEL OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (UMMSC) REVIEWS THE RESPONSES FOR UMMSC, UNIVERSITY SPECIALTY HOSPITAL AND JAMES LAWRENCE KERNAN HOSPITAL. THE CEO OR CFO OF EACH OF THE OTHER ENTITIES IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM REVIEWS THE RESPONSES FOR THOSE ENTITIES.

THE GENERAL COUNSEL, IN CONSULTATION WITH THE AUDIT COMMITTEE, IF NECESSARY, WOULD DETERMINE IF A CONFLICT OF INTEREST EXISTED FOR UMMSC, UNIVERSITY SPECIALTY HOSPITAL AND JAMES LAWRENCE KERNAN HOSPITAL. WITH RESPECT TO THE OTHER ENTITIES IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM, THE GENERAL COUNSEL MAY BE CALLED FOR CONSULT. IF SO, THE GENERAL COUNSEL MAY CONSULT THE AUDIT COMMITTEE, IF NECESSARY.

WHENEVER A CONFLICT OR POTENTIAL CONFLICT OF INTEREST EXISTS, THE NATURE OF THE CONFLICT OR POTENTIAL CONFLICT OF INTEREST MUST BE DISCLOSED IN WRITING TO THE ORGANIZATION'S BOARD, BOARD COMMITTEE, AN OFFICER OF THE ORGANIZATION OR OTHER APPROPRIATE EXECUTIVE. SUCH INDIVIDUAL HAVING A POTENTIAL CONFLICT OF INTEREST SHALL PLAY NO ROLE ON BEHALF OF THE ORGANIZATION, OR ANY ORGANIZATION CONTROLLED OR SUBSTANTIALLY OWNED, IN ANY TRANSACTION IN WHICH A CONFLICT EXISTS.

ALL INVITATIONS FOR BIDS, PROPOSALS OR SOLICITATIONS FOR OFFERS INCLUDE THE FOLLOWING PROVISION: ANY VENDOR, SUPPLIER OR CONTRACTOR MUST

Name of the organization CHESTER RIVER HOSPITAL CENTER	Employer identification number 52-0679694
---	--

ATTACHMENT 1 (CONT'D)

DISCLOSE ANY ACTUAL OR POTENTIAL TRANSACTION WITH ANY ORGANIZATION OFFICER, DIRECTOR, EMPLOYEE OR MEMBER OF THE MEDICAL STAFF, INCLUDING FAMILY MEMBERS WITHIN FIVE DAYS OF THE TRANSACTION. FAILURE TO COMPLY WITH THIS PROVISION IS A MATERIAL BREACH OF AGREEMENT.

IN ADDITION, A BOARD DISCLOSURE REPORT IS FILED WITH THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION ON AN ANNUAL BASIS SHOWING ANY BUSINESS TRANSACTIONS BETWEEN THE BOARD MEMBERS AND THE ORGANIZATION.

## EXECUTIVE COMPENSATION

PART VI, SECTION B, LINE 15

THE ORGANIZATION DETERMINES THE EXECUTIVE COMPENSATION PAID TO ITS EXECUTIVES IN THE FOLLOWING MANNER PRESCRIBED IN THE IRS REGULATIONS:

EXECUTIVE COMPENSATION PACKAGES ARE DETERMINED BY A COMMITTEE OF THE BOARD THAT IS COMPOSED ENTIRELY OF BOARD MEMBERS WHO HAVE NO CONFLICT OF INTEREST.

THE COMMITTEE ACQUIRES CREDIBLE COMPARABILITY MARKET DATA CONCERNING THE COMPENSATION PACKAGES OF SIMILARLY SITUATED EXECUTIVES. THE COMMITTEE CAREFULLY REVIEWS THAT DATA, THE EXECUTIVE'S PERFORMANCE AND THE PROPOSED COMPENSATION PACKAGES DURING THE DECISION MAKING PROCESS.

THE COMMITTEE MEMORIALIZES ITS DELIBERATIONS IN DETAILED MINUTES REVIEWED AND ADOPTED AT THE NEXT-FOLLOWING MEETING.

THE COMMITTEE SEEKS AN OPINION OF COUNSEL THAT IT HAS MET THE

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

ATTACHMENT 1 (CONT'D)

REQUIREMENTS OF THE IRS INTERMEDIATE SANCTIONS REGULATIONS.

THIS PROCESS IS USED TO DETERMINE THE COMPENSATION PACKAGES FOR ALL  
MANAGEMENT EMPLOYEES FROM THE VICE PRESIDENT LEVEL AND UP.

PUBLIC DISCLOSURE

PART VI, SECTION C, LINE 19

IN GENERAL, FINANCIAL AND TAX INFORMATION RELATING TO THE ORGANIZATION IS  
DEEMED PROPRIETARY AND NOT SUBJECT TO DISCLOSURE UPON REQUEST. HOWEVER,  
SPECIFIC PROVISIONS OF FEDERAL AND STATE LAW REQUIRE THE ORGANIZATION TO  
DISCLOSE CERTAIN LIMITED FINANCIAL AND TAX DATA UPON A SPECIFIC REQUEST  
FOR THAT INFORMATION.

REQUESTS FOR FORM 990 AND FORM 1023:

A REQUESTOR SEEKING TO REVIEW AND/OR OBTAIN A COPY OF THE ORGANIZATION'S  
IRS FORM 990 OR FORM 1023 AS FILED WITH THE INTERNAL REVENUE SERVICE,  
INCLUDING ALL SCHEDULES AND ATTACHMENTS, MAY APPEAR IN PERSON OR SUBMIT A  
WRITTEN REQUEST. THE MOST RECENT THREE YEARS OF IRS FORM 990 MAY BE  
REQUESTED.

IF THE REQUESTER APPEARS IN PERSON, THE INDIVIDUAL IS DIRECTED TO THE  
OFFICE OF THE CHIEF FINANCIAL OFFICER FOR THE ORGANIZATION AND THE FORM  
990 AND/OR FORM 1023 ARE MADE AVAILABLE FOR INSPECTION. THE INDIVIDUAL  
IS PERMITTED TO REVIEW THE RETURN, TAKE NOTES AND REQUEST A COPY. IF  
REQUESTED, A COPY IS PROVIDED ON THE SAME DAY. A NOMINAL FEE IS CHARGED  
FOR MAKING THE COPIES. THE ORGANIZATION MAY HAVE AN EMPLOYEE PRESENT

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

ATTACHMENT 1 (CONT'D)

DURING THE PUBLIC INSPECTION OF THE DOCUMENT.

WRITTEN REQUESTS FOR AN ENTITY'S FORM 990 OR FORM 1023 ARE DIRECTED IMMEDIATELY TO THE OFFICE OF THE CHIEF FINANCIAL OFFICER FOR THE ORGANIZATION. THE REQUESTED COPIES ARE MAILED WITHIN 30 DAYS OF THE REQUEST. REPRODUCTION FEES AND MAILING COSTS ARE CHARGED TO THE REQUESTOR.

CONFLICT OF INTEREST POLICY AND GOVERNING DOCUMENTS:

IF THE GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY OF OUR ORGANIZATION ARE SUBJECT TO THE FEDERAL PUBLIC DISCLOSURE RULES (OR STATE PUBLIC DISCLOSURE RULES), THESE DOCUMENTS WILL BE MADE PUBLICLY AVAILABLE AS APPLICABLE LAW MAY REQUIRE. OTHERWISE, THE GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY WILL BE PROVIDED TO THE PUBLIC AT THE DISCRETION OF MANAGEMENT.

ATTACHMENT 2990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
CARDINAL HEALTH PHARMACY OWEN HEALTHCARE PHARMACY 21377 NETWORK PLACE CHICAGO, IL 60673		2,777,965.
CHESTERTOWN PHYSICAL THERAPY SUITE#1 818 HIGH STREET CHESTERTOWN, MD 21620	PHYSICAL THERAPISTS	390,358.
BLOOD BANK OF DELMARVA 100 HYGENIA DRIVE NEWARK, DE 19713	BLOOD PROCESS SERV	350,794.

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

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>
CONSOLIDATED COATINGS, INC. 8629 PHILADELPHIA ROA BALTIMORE, MD 21237	BUILDING CONTRACTOR	455,612.
EAGLE HOSPITAL PHYSICIANS, LLC SUITE 350 5901-C PEACHTREE DUNWOODY RD ATLANTA, GA 30328	PHYSICIAN SVCS	974,628.
TOTAL COMPENSATION		<u>4,949,357.</u>

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2009**

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36 or 37.  
▶ Attach to Form 990. ▶ See separate instructions.

Name of the organization  
**CHESTER RIVER HOSPITAL CENTER**

Employer identification number  
**52-0679694**

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

(a) Name, address, and EIN 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

**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
BALTIMORE WASHINGTON EMERGENCY PHYS, INC 52-1756326 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTH CARE	MD	501 (C) (3)	11	BWMS
BALTIMORE WASHINGTON HEALTHCARE SERVICES 52-1830243 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTH CARE	MD	501 (C) (3)	11	BWMS
BALTIMORE WASHINGTON MEDICAL CENTER, INC 52-0689917 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTH CARE	MD	501 (C) (3)	3	BWMS
BALTIMORE WASHINGTON MEDICAL SYSTEM, INC 52-1830242 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTH CARE	MD	501 (C) (3)	11	UMMSC
BW MEDICAL CENTER FOUNDATION, INC. 52-1813656 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	FUNDRAISING	MD	501 (C) (3)	11	BWMS
NORTH ARUNDEL DEVELOPMENT CORPORATION 52-1318404 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	REAL ESTATE	MD	501 (C) (2)		BWMS
NORTH COUNTY CORPORATION 52-1591355 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	REAL ESTATE	MD	501 (C) (2)		BWMS

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?	
							Yes	No		Yes	No
ARUNDEL PHYSICIANS ASSOCIATES, 301 HOSPITAL DRIVE	HEALTH CARE	MD	N/A								
CENTRAL MARYLAND RADIOLOGY ONC 10710 CHARTER DRIVE	HEALTH CARE	MD	N/A								
CENTRAL MD REHABILITATION CENT 22 SOUTH GREENE STREET	HEALTH CARE	MD	N/A								
HELEN P. DENIT CANCER TREATMEN 22 SOUTH GREENE STREET	HEALTH CARE	MD	N/A								
INNOVATIVE HEALTH, LLC 52-1997 29165 CANVASBACK DRIVE, SUITE	BILLING	MD	N/A								
NORTH ARUNDEL PET CENTER, LLC 301 HOSPITAL DRIVE	HEALTH CARE	MD	N/A								
NORTH ARUNDEL SENIOR LIVING, L 301 HOSPITAL DRIVE	HEALTH CARE	MD	N/A								

**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
ARUNDEL PHYSICIANS ASSOCIATES, INC. 52-1992649 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTH CARE	MD	N/A	C CORP			
BALTIMORE WASHINGTON HEALTH ENTERPRISES 52-1936656 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTH CARE	MD	N/A	C CORP			
BW PROFESSIONAL SERVICES, INC. 52-1655640 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTH CARE	MD	N/A	C CORP			
COUNCIL OF UNIT OWNERS OF MD GEN PC 52-1891126 827 LINDEN AVENUE BALTIMORE, MD 21201	REAL ESTATE	MD	N/A	C CORP			
SHORE HEALTH ENTERPRISES, INC. 52-1363201 219 SOUTH WASHINGTON STRBET EASTON, MD 21601	REAL ESTATE	MD	N/A	C CORP			
UNIVERSITY LITHOTRIPTER, INC. 52-1451021 22 SOUTH GREENE STREET BALTIMORE, MD 21201	HEALTH CARE	MD	N/A	C CORP			
UMMS SELF INSURANCE TRUST 52-6315433 22 SOUTH GREENE STREET BALTIMORE, MD 21201	INSURANCE	MD	N/A	TRUST			

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

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

	Yes	No
<b>1</b> 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?		
<b>a</b> Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity . . . . .		X
<b>1a</b>		X
<b>b</b> Gift, grant, or capital contribution to other organization(s) . . . . .		X
<b>1b</b>		X
<b>c</b> Gift, grant, or capital contribution from other organization(s) . . . . .	X	
<b>1c</b>	X	
<b>d</b> Loans or loan guarantees to or for other organization(s) . . . . .	X	
<b>1d</b>	X	
<b>e</b> Loans or loan guarantees by other organization(s) . . . . .		X
<b>1e</b>		X
<b>f</b> Sale of assets to other organization(s) . . . . .		X
<b>1f</b>		X
<b>g</b> Purchase of assets from other organization(s) . . . . .		X
<b>1g</b>		X
<b>h</b> Exchange of assets . . . . .		X
<b>1h</b>		X
<b>i</b> Lease of facilities, equipment, or other assets to other organization(s) . . . . .		X
<b>1i</b>		X
<b>j</b> Lease of facilities, equipment, or other assets from other organization(s) . . . . .		X
<b>1j</b>		X
<b>k</b> Performance of services or membership or fundraising solicitations for other organization(s) . . . . .	X	
<b>1k</b>	X	
<b>l</b> Performance of services or membership or fundraising solicitations by other organization(s) . . . . .	X	
<b>1l</b>	X	
<b>m</b> Sharing of facilities, equipment, mailing lists, or other assets . . . . .	X	
<b>1m</b>	X	
<b>n</b> Sharing of paid employees . . . . .	X	
<b>1n</b>	X	
<b>o</b> Reimbursement paid to other organization for expenses . . . . .	X	
<b>1o</b>	X	
<b>p</b> Reimbursement paid by other organization for expenses . . . . .	X	
<b>1p</b>	X	
<b>q</b> Other transfer of cash or property to other organization(s) . . . . .		X
<b>1q</b>		X
<b>r</b> Other transfer of cash or property from other organization(s) . . . . .		X
<b>1r</b>		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 other organization	(b) Transaction type (a-r)	(c) Amount involved
(1) CHESTER RIVER HEALTH FOUNDATION	C	223,912.
(2)		
(3)		
(4)		
(5)		
(6)		





**Part II** Continuation of Identification of Related Tax-Exempt Organizations

(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
CHESTER RIVER HEALTH FOUNDATION, INC. 52-1338861 100 BROWN STREET CHESTERTOWN, MD 21620	FUNDRAISING	MD	501 (C) (3)	11	CRHS
CHESTER RIVER HEALTH SYSTEM, INC. 52-2046500 100 BROWN STREET CHESTERTOWN, MD 21620	HEALTH CARE	MD	501 (C) (3)	11	UMMSC
CHESTER RIVER MANOR, INC. 52-6070333 200 MORGNEC ROAD CHESTERTOWN, MD 21620	HEALTH CARE	MD	501 (C) (3)	11	CRHS
MARYLAND GENERAL CLINICAL PRACTICE GROUP 52-1566211 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTH CARE	MD	501 (C) (3)	11	MGHS
MARYLAND GENERAL COMM HEALTH FOUNDATION 52-2147532 827 LINDEN AVENUE BALTIMORE, MD 21201	FUNDRAISING	MD	501 (C) (3)	11	MGHS
MARYLAND GENERAL HEALTH SYSTEMS, INC. 52-1175337 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTH CARE	MD	501 (C) (3)	11	UMMSC
MARYLAND GENERAL HOSPITAL, INC. 52-0591667 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTH CARE	MD	501 (C) (3)	3	MGHS
CARE HEALTH SERVICES, INC. 52-1510269 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTH CARE	MD	501 (C) (3)	11	SHS
DORCHESTER GENERAL HOSPITAL FOUNDATION 52-1703242 219 SOUTH WASHINGTON STREET EASTON, MD 21601	FUNDRAISING	MD	501 (C) (3)	11	SHS
MEMORIAL HOSPITAL FOUNDATION, INC. 52-1282080 219 SOUTH WASHINGTON STREET EASTON, MD 21601	FUNDRAISING	MD	501 (C) (3)	11	SHS
SHORE CLINICAL FOUNDATION, INC. 52-1874111 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTH CARE	MD	501 (C) (3)	11	SHS
SHORE HEALTH SYSTEM, INC. 52-0610538 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTH CARE	MD	501 (C) (3)	3	UMMSC
JAMES LAWRENCE KERNAN HOSP ENDOW FD 23-7360743 2200 KERNAN DRIVE BALTIMORE, MD 21207	FUNDRAISING	MD	501 (C) (3)	11	UMMSC
JAMES LAWRENCE KERNAN HOSPITAL, INC. 52-0591639 2200 KERNAN DRIVE BALTIMORE, MD 21207	HEALTH CARE	MD	501 (C) (3)	3	UMMSC
SHIPLEY'S CHOICE MEDICAL PARK, INC. 04-3643849 22 SOUTH GREENE STREET BALTIMORE, MD 21201	REAL ESTATE	MD	501 (C) (2)		UMMSC
UMMS FOUNDATION, INC. 52-2238893 22 SOUTH GREENE STREET BALTIMORE, MD 21201	FUNDRAISING	MD	501 (C) (3)	11	UMMSC
UNIVERSITY OF MD MEDICAL SYSTEM CORP 52-1362793 22 SOUTH GREENE STREET BALTIMORE, MD 21201	HEALTH CARE	MD	501 (C) (3)	3	UMMSC
UNIVERSITY SPECIALTY HOSPITAL 52-0882914 611 SOUTH CHARLES STREET BALTIMORE, MD 21230	HEALTH CARE		501 (C) (3)	3	UMMSC

Schedule R-1 (Form 990) 2009





**Part V** Continuation of Transactions With Related Organizations (Schedule R (Form 990), Part V, line 2)

(A) Name of other organization	(B) Transaction type (a-i)	(C) Amount involved
(7)		
(8)		
(9)		
(10)		
(11)		
(12)		
(13)		
(14)		
(15)		
(16)		
(17)		
(18)		
(19)		
(20)		
(21)		
(22)		
(23)		
(24)		

