

For calendar year 2009 or tax year beginning Jul 01, 2009 and ending Jun 30, 2010

Name: Western MD Health System Corp Inc
Name line 2: PO Box 539
Address: 12400 Willowbrook Road
City, State, and Zip Code: Cumberland MD 21501-0539

EIN: 52-0591531
Telephone No: 240-964-8007

Email address: MMARTZ@WMHS.COM
Web site address: WMHS.COM
Fiduciary name, if applicable:
Name of officer signing return: Michele R Martz
Title of officer/trustee/fiduciary signing return: Vice President, Financial Services
Group exemption number:
Check if exemption application is pending:
Accounting method: Cash: Accrual: Other: Specify:
List states desired:

Type of exempt organization:

- Organization exempt under section 501(c), 527 or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation) (Form 990)
Organization exempt under section 501(c), 527 or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation) with gross receipts less than \$1,000,000 and total assets less than \$2,500,000 at the end of the year (Form 990-EZ)
Private foundation or section 4947(a)(1) nonexempt charitable trust treated as a private foundation (Form 990-PF)
Exempt organization with unrelated business income (Form 990-T)

Preparer ID: Briskey
Preparer name: Michael Briskey
Preparer SSN:
Firm's name: Western Maryland Health System
Address: PO Box 539
City, State, ZIP Code: CUMBERLAND MD 21502-

Time in this return: 1506 minutes
Date: 11/12/2010
PTIN:
Self-employed:
Firm's EIN: 52-1971675
Phone: 240-964-8037

Preparer notes These notes will print and proforma.

Blank lines for preparer notes.

Preparer's use fields

1 2 3
4 5 6

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

2009

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.

A For the 2009 calendar year, or tax year beginning Jul 01, 2009, and ending Jun 30, 2010

Form header section containing organization name (Western MD Health System Corp Inc), EIN (52-0591531), address, officer name (MICHELE R MARTZ), and other identifying information.

Part I Summary

Summary table with columns for Activities & Governance, Revenue, Expenses, and Net Assets or Fund Balances. Rows include mission statement, membership counts, revenue breakdown, and asset/liability totals.

Part II Signature Block

Signature block section with declaration text, signature of Michele R Martz, date 11/12/2010, and preparer information.

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

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

**Part III Statement of Program Service Accomplishments**

1 Briefly describe the organization's mission:

The mission is to improve the health status and quality of life of the individuals and the communities served, especially those in need

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 \$ 167371160 . including grants of \$ ) (Revenue \$ 179100737 .)

Health Care Programs-Cystoscopy 27,802 min, Endo-Min 81,023 min, Operating Room 634,807 min, Anesthesiology 721,746 min, Lab services 15,521,827 RVUs, Electrocardiology 587,449 RVUs, Electroenceph 43,536 RVUs, Radiology Diagnostic 395,162 RVUs, Nuclear Med 241,345 RVUs, CT scan 607,699 RVUs, Inter Cardiology 95,074 Min, Radiation Therapy 356,010 RVUs, Respiratory Therapy 2,701,951 RVUs, Pulmonary 787,555 RVUs, Renal Dialysis 12,156 Treatments, Physical Therapy 283,948 RVUs, Speech/Occ Therapy 152,054 RVUs, Sleep Lab 147,574 RVUs, MRI 141,597 RVUs

4b (Code: ) (Expenses \$ 66001367 . including grants of \$ ) (Revenue \$ 70418857 .)

Inpatient Care - Direct Patient Care - 89,911 patient days of care

4c (Code: ) (Expenses \$ 11894392 . including grants of \$ ) (Revenue \$ 12690487 .)

Ambulatory and Primary Health Care - Outpatient Services provided 151,522 Visits

4d Other program services. (Describe in Schedule O.) (Expenses \$ 6119285 . including grants of \$ ) (Revenue \$ 6528850 . )

4e Total program service expenses ▶ 251386204 .

**Part IV Checklist of Required Schedules**

		Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	X	
2	Is the organization required to complete Schedule B, Schedule of Contributors?	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I		X
4	<b>Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities? If "Yes," complete Schedule C, Part II		X
5	<b>Section 501(c)(4), 501(c)(5), and 501(c)(6) organizations.</b> Is the organization subject to the section 6033(e) notice and reporting requirement and proxy tax? If "Yes," complete Schedule C, Part III		
6	Did the organization maintain any donor advised funds or any similar funds or accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III		X
9	Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV		X
10	Did the organization, directly or through a related organization, hold assets in term, permanent, or quasi-endowments? If "Yes," complete Schedule D, Part V	X	
11	Is the organization's answer to any of the following questions "Yes"? If so, complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable	X	
	<ul style="list-style-type: none"> <li>Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI.</li> <li>Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII.</li> <li>Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII.</li> <li>Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX.</li> <li>Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X.</li> <li>Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48? If "Yes," complete Schedule D, Part X.</li> </ul>		
12	Did the organization obtain a separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI, XII, and XIII.		X
12A	Was the organization included in consolidated, independent audited financial statement for the tax year? If "Yes," completing Schedule D, Parts XI, XII, and XIII is optional	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	X	
14b	Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, and program service activities outside the United States? If "Yes," complete Schedule F, Part I	X	
15	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the United States? If "Yes," complete Schedule F, Part II		X
16	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the United States? If "Yes," complete Schedule F, Part III		X
17	Did the organization report more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I		X
18	Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II		X
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III		X
20	Did the organization operate one or more hospitals? If "Yes," complete Schedule H	X	

**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? If "Yes," complete Schedule I, Parts I and II		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? If "Yes," complete Schedule I, Parts I and III		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 employee's? If "Yes," complete Schedule J	X	
24a	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? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to question 25	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
25a	<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? If "Yes," complete Schedule L, Part 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 990EZ? If "Yes," complete Schedule L, Part 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? If "Yes," complete Schedule L, Part II		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? If "Yes," complete Schedule L, Part III		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? If "Yes," complete Schedule L, Part IV	X	
b	A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV		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? If "Yes," complete Schedule L, Part IV	X	
29	Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II		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? If "Yes," complete Schedule R, Part I		X
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1	X	
35	Is any related organization a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2		X
36	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2		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? If "Yes," complete Schedule R, Part VI		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part IV, 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**

		Yes	No
<b>1a</b>	Enter the number reported in Box 3 of Form 1096, Annual Summary and Transmittal of U.S. Information Returns. Enter -0- if not applicable	1a	111
<b>b</b>	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	X
<b>2a</b>	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	2414
<b>b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file this return. (see instructions)	2b	X
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year covered by this return?	3a	X
<b>b</b>	If "Yes," has it filed a Form 990-T for this year? If "No," provide an explanation in Schedule O	3b	X
<b>4a</b>	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a	X
<b>b</b>	If "Yes," enter the name of the foreign country: <u>CJ</u> See the instructions for exceptions and filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.		
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a	X
<b>b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b	X
<b>c</b>	If "Yes," to question 5a or 5b, did the organization file Form 8886-T, Disclosure by Tax-Exempt Entity Regarding Prohibited Tax Shelter Transaction?	5c	
<b>6a</b>	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible?	6a	X
<b>b</b>	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b	
<b>7</b>	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
<b>a</b>	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a	X
<b>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b	
<b>c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c	X
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year	7d	
<b>e</b>	Did the organization, during the year, receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e	X
<b>f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f	X
<b>g</b>	For all contributions of qualified intellectual property, did the organization file Form 8899 as required?	7g	
<b>h</b>	For contributions of cars, boats, airplanes, and other vehicles, did the organization file a Form 1098-C as required?	7h	
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.</b> Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8	X
<b>9</b>	<b>Sponsoring organizations maintaining donor advised funds.</b>		
<b>a</b>	Did the organization make any taxable distributions under section 4966?	9a	X
<b>b</b>	Did the organization make a distribution to a donor, donor advisor, or related person?	9b	X
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter:		
<b>a</b>	Initiation fees and capital contributions included on Part VIII, line 12	10a	
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b	
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter:		
<b>a</b>	Gross income from members or shareholders	11a	
<b>b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b	
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?	12a	
<b>b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	12b	

**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**

		Yes	No
<b>1a</b>	Enter the number of voting members of the governing body		13
<b>1b</b>	Enter the number of voting members that are independent		10
<b>2</b>	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?		X
<b>3</b>	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?		X
<b>4</b>	Did the organization make any significant changes to its organizational documents since the prior Form 990 was filed?	X	
<b>5</b>	Did the organization become aware during the year of a material diversion of the organization's assets?		X
<b>6</b>	Does the organization have members or stockholders?		X
<b>7a</b>	Does the organization have members, stockholders, or other persons who may elect one of more members of the governing body?	X	
<b>7b</b>	Are any decisions of the governing body subject to approval by members, stockholders, or other persons?	X	
<b>8</b>	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
<b>8a</b>	The governing body?	X	
<b>8b</b>	Each committee with authority to act on behalf of the governing body?	X	
<b>9</b>	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		X

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

		Yes	No
<b>10a</b>	Does the organization have local chapters, branches, or affiliates?		X
<b>10b</b>	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?		
<b>11</b>	Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form?	X	
<b>11A</b>	Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
<b>12a</b>	Does the organization have a written conflict of interest policy? If "No," go to line 13	X	
<b>12b</b>	Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	X	
<b>12c</b>	Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done	X	
<b>13</b>	Does the organization have a written whistleblower policy?	X	
<b>14</b>	Does the organization have a written document retention and destruction policy?	X	
<b>15</b>	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?		
<b>15a</b>	The organization's CEO, Executive Director, or top management official?	X	
<b>15b</b>	Other officers or key employees of the organization?	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O. (See instructions)		
<b>16a</b>	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	X	
<b>16b</b>	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?	X	

**Section C. Disclosure**

- 17** List the states with which a copy of this Form 990 is required to be filed ▶
- 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    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: ▶ WMHS Financ De PO Box 539 Cumberland MD 21501-0539 240-964-8007

**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			
Kheder Ashker		X					0	0	0	
John Davis Treasurer				X			0	0	0	
David DeWitt		X					0	0	0	
Brian Hasslinger MD		X					0	0	0	
M Kathryn Burkey				X			0	0	0	
Robert Dawson MD		X					0	0	0	
Sharon Nicol		X					0	0	0	
Donald Alexander Chr Frederick				X			0	0	0	
Thayer		X					0	0	0	
Elizabeth Hurwitz-Schwab		X					0	0	0	
Kim Leonard Vice Chair				X			0	0	0	
Mary Pirolozzi		X					0	0	0	
Barry Ronan Pres, CEO	40			X			551408.	0	153809.	
James Raver Senior VP	40				X		358481.	0	47274.	
Thomas Dowdell VP, COO	40			X			311802.	0	56428.	
Kimberly Repac VP, CFO	40			X			298361.	0	50859.	

**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			
Nancy Adams Senior VP CNO	40			X			223063.	0	41390.	
Mark Sullivan Vice Pres	40			X			204735.	0	39956.	
Mark Nelson Physician	40				X		576298.	0	80961.	
Robert Chou Physician	40				X		468348.	0	69597.	
Stevan Zimmer Physician	40				X		523537.	0	67986.	
Alida Podrumar Physician	40				X		340883.	0	46816.	
Subrato Deb Physician	40				X		494628.	0	72867.	
Jo Wilson Vice Pres	40			X			176087.	0	34036.	
Kevin Turley Vice Pres	40			X			173029.	0	37832.	
Michele Martz Vice Pres	40			X			148242.	0	34591.	
Richard Jewell		X					0	0	0	
Lisa McIndoe		X					0	0	0	
John McMullen		X					0	0	0	
<b>1b Total</b>							<b>4848902.</b>	<b>0</b>	<b>834402.</b>	

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 **79**

	Yes	No
3 Did the organization list any <b>former</b> officer, director or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual	3	X
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual	4	X
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	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
Haystack I PO Box 539 21502 MD Cumberland	Diagnostic	10281277.
Cumberland PO Box 157 21502 MD Cumberland	Anesthesia	2185850.
Crothall S 13028 Coll 60693 IL Chicago	Housekeeping	938339.
Aramark Co PO Box 651 28265 NC Charlotte	Dietary	1361185.
Carl Belt PO Box 121 21502 MD Cumberland	Construction	1294972.

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 **25**

Part VIII Statement of Revenue			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514	
Contributions, gifts, grants and other similar amounts	1a	Federated campaigns .....	1a				
	b	Membership dues .....	1b				
	c	Fundraising events .....	1c				
	d	Related organizations .....	1d				
	e	Government grants (contributions) .....	1e				
	f	All other contributions, gifts, grants, and similar amounts not included above .....	1f	1141678.			
	g	Noncash contributions included in lines 1a-1f: .....	\$				
	h	<b>Total.</b> Add lines 1a-1f .....		1141678.			
Program Service Revenue	2a	Ancillary Care	Business Code	179100736.	179100736.		
	b	Patient Care		70418855.	70418855.		
	c	Clinics, Home Care		12690487.	12690487.		
	d	Emergency Care		6528850.	6528850.		
	e	Investment Income		164802.	164802.		
	f	All other program service revenue .....					
	g	<b>Total.</b> Add lines 2a-2f .....		268903730.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) .....		3019853.		3019853.	
	4	Income from investment of tax-exempt bond proceeds .....					
	5	Royalties .....					
	6a		(i) Real	(ii) Personal			
			Gross Rents .....	239361.	10164.		
		b	Less: rental expenses .....	531499.			
	c	Rental income or (loss) .....	-292138.	10164.			
	d	<b>Net rental income or (loss)</b> .....			-281974.		
	7a		(i) Securities	(ii) Other			
			Gross amount from sales of assets other than inventory ..	2809296.	2759457.		
		b	Less: cost or other basis and sales expenses .....	2667499.	2439085.		
	c	<b>Gain or (loss)</b> .....	141797.	320372.			
	d	<b>Net gain or (loss)</b> .....			462169.	462169.	
	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	<b>Net income or (loss) from fundraising events</b> .....						
9a	Gross income from gaming activities. See Part IV, line 19 ..	a					
b	Less: direct expenses .....	b					
c	<b>Net income or (loss) from gaming activities</b> .....						
10a	Gross sales of inventory, less returns and allowances .....	a					
b	Less: cost of goods sold .....	b					
c	<b>Net income or (loss) from sales of inventory</b> .....						
Miscellaneous Revenue			Business Code				
11a	Unrelated	621500	850707.		850707.		
b	Other Revenue		2851463.	2851463.			
c	Excluded		155681.			155681.	
d	All other revenue .....						
e	<b>Total.</b> Add lines 11a-11d .....		3857851.				
12	<b>Total revenue.</b> See instructions .....		277103307.	272217362.	850707.	2893560.	

**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).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.		(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1	Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21				
2	Grants and other assistance to individuals in the U.S. See Part IV, line 22				
3	Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16				
4	Benefits paid to or for members				
5	Compensation of current officers, directors, trustees, and key employees	3008899.	2798276.	210623.	
6	Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7	Other salaries and wages	80419165.	74789824.	5629341.	
8	Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	11740288.	10918468.	821820.	
9	Other employee benefits	13268724.	12339913.	928811.	
10	Payroll taxes	5996395.	5576647.	419748.	
11	Fees for services (non-employees):				
a	Management				
b	Legal	420669.		420669.	
c	Accounting				
d	Lobbying				
e	Professional fundraising services. See Part IV, line 17				
f	Investment management fees				
g	Other				
12	Advertising and promotion	536263.	498725.	37538.	
13	Office expenses	58901032.	54777960.	4123072.	
14	Information technology	2407800.	2239254.	168546.	
15	Royalties				
16	Occupancy	4878620.	4537116.	341504.	
17	Travel	483516.	449670.	33846.	
18	Payments of travel or entertainment expenses for any federal, state, or local public officials				
19	Conferences, conventions, and meetings				
20	Interest	10316174.		10316174.	
21	Payments to affiliates				
22	Depreciation, depletion, and amortization	16919441.	15735080.	1184361.	
23	Insurance	4178912.	3886388.	292524.	
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	Contractual/Charity	40872777.	38011683.	2861094.	
b	Bad Debts	5752939.	5350233.	402706.	
c	Medical Prof Fees	5692727.	5294236.	398491.	
d	Minority Interest	3449142.	3207702.	241440.	
e	Other	11801106.	10975029.	826077.	
f	All other expenses				
25	<b>Total functional expenses.</b> Add lines 1 through 24f	281044589.	251386204.	29658385.	
26	<b>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)		(B)	
		Beginning of year		End of year	
Assets	1	Cash - non-interest-bearing .....	34359439.	1	43737209.
	2	Savings and temporary cash investments .....	1901155.	2	16111486.
	3	Pledges and grants receivable, net .....		3	
	4	Accounts receivable, net .....	19214670.	4	36592311.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Sch. 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 .....	3905142.	8	7105896.
	9	Prepaid expenses and deferred charges .....	3618427.	9	5733178.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....	10a 576136760.		
	b	Less: accumulated depreciation .....	10b 181404987.	26423827.	10c 394731773.
	11	Investments - publicly traded securities .....		11	
	12	Investments - other securities. See Part IV, line 11 .....		12	
	13	Investments - program-related. See Part IV, line 11 .....		13	
	14	Intangible assets .....		14	
	15	Other assets. See Part IV, line 11 .....	15776945.	15	65606646.
16	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) .....	105199605.	16	569618499.	
Liabilities	17	Accounts payable and accrued expenses .....	22506919.	17	30171421.
	18	Grants payable .....		18	
	19	Deferred revenue .....		19	
	20	Tax-exempt bond liabilities .....		20	339841682.
	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 .....		23	
	24	Unsecured notes and loans payable to unrelated third parties .....		24	
	25	Other liabilities. Complete Part X of Schedule D .....	21884549.	25	79260853.
	26	<b>Total liabilities.</b> Add lines 17 through 25 .....	44391468.	26	449273956.
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.</b>				
	27	Unrestricted net assets .....	54109812.	27	118051720.
	28	Temporarily restricted net assets .....	6188433.	28	2046486.
	29	Permanently restricted net assets .....	509892.	29	246337.
	<b>Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.</b>				
	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> .....	60808137.	33	120344543.	
34	<b>Total liabilities and net assets/fund balances</b> .....	105199605.	34	569618499.	

**Part XI Financial Statements and Reporting**

	Yes	No
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**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.

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**2a** Were the organization's financial statements compiled or reviewed by an independent accountant? .....

<b>2a</b>		X
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**b** Were the organization's financial statements audited by an independent accountant? .....

<b>2b</b>	X	
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**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 selected process during the tax year, explain in Schedule O.

<b>2c</b>	X	
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**d** If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements of the year were issued on a consolidated basis, separate basis, or both:  
 Separate basis  Consolidated basis  Both consolidated and separate basis

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**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>3a</b>	X	
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**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.

<b>3b</b>	X	
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Form **990** (2009)

**Exempt Organization Business Income Tax Return**  
(and proxy tax under section 6033(e))

Department of the Treasury  
Internal Revenue Service (77)

For calendar year 2009 or other tax year beginning Jul 01, 2009, and ending Jun 30, 20 10.

▶ See separate instructions.

Open to Public Inspection for  
501(c)(3) Organizations Only

<b>A</b> <input checked="" type="checkbox"/> Check box if address changed		Name of organization ( <input type="checkbox"/> Check box if name changed and see instr.) <b>Western MD Health System Corp Inc</b>	<b>D Employer ID number</b> (Employees' trust, see instructions for Block D.) <b>52-0591531</b>
<b>B Exempt under section</b> <input checked="" type="checkbox"/> 501(C) (3 ) <input type="checkbox"/> 408(e) <input type="checkbox"/> 220(e) <input type="checkbox"/> 408A <input type="checkbox"/> 530(a) <input type="checkbox"/> 529(a)	<b>Print or Type</b>	Number, street, and room or suite no. If a P.O. box, see instructions. <b>12400 Willowbrook Road</b>	<b>E Unrelated business activity codes</b> (See instr. for Block E.) <b>621500</b>
		City or town, state, and ZIP code <b>Cumberland MD 21501-0539</b>	
<b>C</b> Book value of all assets at end of year <b>569,618,499.</b>	<b>F</b> Group exemption number (See instructions for Block F) ▶	<b>G</b> Check organization type ▶ <input checked="" type="checkbox"/> 501(c) corporation <input type="checkbox"/> 501(c) trust <input type="checkbox"/> 401(a) trust <input type="checkbox"/> Other trust	
<b>H</b> Describe the organization's primary unrelated business activity. ▶ <b>Lab Svcs, rental, clean &amp; maintenance</b>			
<b>I</b> During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ..... ▶ <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," enter the name and identifying number of the parent corporation. ▶ <b>West MD Health Sys 52-1971675</b>			
<b>J</b> The books are in care of ▶ <b>WMHS Finance Department</b> Telephone number ▶ <b>240-964-8007</b>			

<b>Part I Unrelated Trade or Business Income</b>				<b>(A) Income</b>		<b>(B) Expenses</b>		<b>(C) Net</b>	
<b>1 a</b> Gross receipts or sales	850,707.								
<b>b</b> Less returns and allowances		<b>c Bal.</b> ▶	<b>1c</b>	850,707.					
<b>2</b> Cost of goods sold (Schedule A, line 7)			<b>2</b>						
<b>3</b> Gross profit. Subtract line 2 from line 1c			<b>3</b>	850,707.				850,707.	
<b>4 a</b> Capital gain net income (attach Schedule D)			<b>4a</b>						
<b>b</b> Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)			<b>4b</b>						
<b>c</b> Capital loss deduction for trusts			<b>4c</b>						
<b>5</b> Income (loss) from partnerships and S corps. (attach statement)			<b>5</b>						
<b>6</b> Rent income (Schedule C)			<b>6</b>						
<b>7</b> Unrelated debt-financed income (Schedule E)			<b>7</b>						
<b>8</b> Interest, annuities, royalties, and rents from controlled organizations (Schedule F)			<b>8</b>						
<b>9</b> Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)			<b>9</b>						
<b>10</b> Exploited exempt activity income (Schedule I)			<b>10</b>						
<b>11</b> Advertising income (Schedule J)			<b>11</b>						
<b>12</b> Other income (See instructions; attach schedule.)			<b>12</b>						
<b>13 Total.</b> Combine lines 3 through 12			<b>13</b>	850,707.				850,707.	

<b>Part II Deductions Not Taken Elsewhere</b> (See the instructions for limitations on deductions.) (Except for contributions, deductions must be directly connected with the unrelated business income.)									
<b>14</b> Compensation of officers, directors, and trustees (Schedule K)								<b>14</b>	
<b>15</b> Salaries and wages								<b>15</b>	259,954.
<b>16</b> Repairs and maintenance								<b>16</b>	
<b>17</b> Bad debts								<b>17</b>	82,896.
<b>18</b> Interest (attach schedule)								<b>18</b>	
<b>19</b> Taxes and licenses								<b>19</b>	
<b>20</b> Charitable contributions (See the instructions for limitation rules.)								<b>20</b>	
<b>21</b> Depreciation (attach Form 4562)			<b>21</b>	8,311.					
<b>22</b> Less depreciation claimed on Schedule A and elsewhere on return			<b>22 a</b>					<b>22 b</b>	8,311.
<b>23</b> Depletion			<b>23</b>						
<b>24</b> Contributions to deferred compensation plans			<b>24</b>						
<b>25</b> Employee benefit programs			<b>25</b>					<b>25</b>	77,986.
<b>26</b> Excess exempt expenses (Schedule I)			<b>26</b>						
<b>27</b> Excess readership costs (Schedule J)			<b>27</b>						
<b>28</b> Other deductions (attach schedule)			<b>28</b>					<b>28</b>	426,889.
<b>29 Total deductions.</b> Add lines 14 through 28			<b>29</b>					<b>29</b>	856,036.
<b>30</b> Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13			<b>30</b>					<b>30</b>	(5,329.)
<b>31</b> Net operating loss deduction (limited to the amount on line 30)			<b>31</b>						
<b>32</b> Unrelated business taxable income before specific deduction. Subtract line 31 from line 30			<b>32</b>					<b>32</b>	(5,329.)
<b>33</b> Specific deduction (Generally \$1,000, but see line 33 instructions for exceptions)			<b>33</b>					<b>33</b>	1,000.
<b>34 Unrelated business taxable income.</b> Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32			<b>34</b>					<b>34</b>	(5,329.)

**Part III Tax Computation**

**35 Organizations Taxable as Corporations.** See instructions for tax computation.  
 Controlled group members (sections 1561 and 1563) check here  **See instructions** and:  
**a** Enter your share of the \$50,000, \$25,000, and \$9,925,000 taxable income brackets (in that order):  
 (1) \$ \_\_\_\_\_ (2) \$ \_\_\_\_\_ (3) \$ \_\_\_\_\_  
**b** Enter organization's share of: (1) Additional 5% tax (not more than \$11,750) ..... \$ \_\_\_\_\_  
 (2) Additional 3% tax (not more than \$100,000) ..... \$ \_\_\_\_\_  
**c** Income tax on the amount on line 34 ..... **35c**

**36 Trusts Taxable at Trust Rates.** See instructions for tax computation. Income tax on the amount on line 34 from:  Tax rate schedule or  Schedule D (Form 1041) ..... **36**

**37 Proxy tax.** See instructions ..... **37**

**38 Alternative minimum tax** ..... **38**

**39 Total.** Add lines 37 and 38 to line 35c or 36, whichever applies ..... **39**

**Part IV Tax and Payments**

**40 a** Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116) ..... **40 a**

**b** Other credits (see the instructions) ..... **40 b**

**c** General business credit. Attach Form 3800 ..... **40 c**

**d** Credit for prior year minimum tax (attach Form 8801 or 8827) ..... **40 d**

**e Total credits.** Add lines 40a through 40d ..... **40e**

**41** Subtract line 40e from line 39 ..... **41**

**42** Other taxes. Check if from:  Form 4255  Form 8611  Form 8697  Form 8866  Other (attach schedule) ..... **42**

**43 Total tax.** Add lines 41 and 42 ..... **43**

**44 a** Payments: A 2008 overpayment credited to 2009 ..... **44 a**

**b** 2009 estimated tax payments ..... **44 b**

**c** Tax deposited with Form 8868 ..... **44 c**

**d** Foreign organizations: Tax paid or withheld at source (see instructions) ..... **44 d**

**e** Backup withholding (see instructions) ..... **44 e**

**f** Other credits and payments:  Form 2439  Form 4136  Other ..... **44 f**

**45 Total payments.** Add lines 44a through 44f ..... **45**

**46** Estimated tax penalty (see the instructions). Check if Form 2220 is attached  ..... **46**

**47 Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ..... **47**

**48 Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ..... **48**

**49** Enter the amount of line 48 you want: **Credited to 2010 estimated tax**  **Refunded**  ..... **49**

**Part V Statements Regarding Certain Activities and Other Information** (see instructions)

**1** At any time during the 2009 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.  
 If YES, enter the name of the foreign country here  ..... **Yes**  **No**

**2** During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? ..... **Yes**  **No**

**3** Enter the amount of tax-exempt interest received or accrued during the tax year  \$ ..... **Yes**  **No**

**Schedule A - Cost of Goods Sold.** Enter method of inventory valuation

<b>1</b> Inventory at beginning of year ..... <b>1</b>	<b>6</b> Inventory at end of year ..... <b>6</b>
<b>2</b> Purchases ..... <b>2</b>	<b>7</b> <b>Cost of goods sold.</b> Subtract line 6 from line 5. Enter here and in Part I, line 2 ..... <b>7</b>
<b>3</b> Cost of labor ..... <b>3</b>	<b>8</b> Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization? ..... <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>4 a</b> Additional section 263A costs (attach schedule) ..... <b>4a</b>	
<b>b</b> Other costs (attach schedule) ..... <b>4b</b>	
<b>5 Total.</b> Add lines 1 through 4b ..... <b>5</b>	

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

**Sign Here**  Signature of officer  Date  Vice President, Finan  Title

**Paid Preparer's Use Only** Preparer's signature  Date  Check if self-employed  Preparer's SSN or PTIN

Firm's name (or yours if self-employed), address, and ZIP code  CUMBERLAN MD 21502-  EIN  Phone no.

**Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property)**

(see instructions)

**1. Description of property**

(1)
(2)
(3)
(4)

**2. Rent received or accrued**

(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
(1)		
(2)		
(3)		
(4)		
<b>Total</b>	<b>Total</b>	<b>(b) Total deductions.</b> Enter here and on page 1, Part I, line 6, column (B) ... ▶

**(c) Total income.** Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) .... ▶

**Schedule E - Unrelated Debt-Financed Income**

(see instructions)

1. Description of debt-financed property	2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property		
		(a) Straight line depreciation (attach schedule)	(b) Other deductions (attach schedule)	
(1)				
(2)				
(3)				
(4)				
4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5. Average adjusted basis of or allocable to debt-financed property (attach schedule)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)		%		
(2)		%		
(3)		%		
(4)		%		
<b>Totals</b> .....			Enter here and on page 1, Part I, line 7, column (A).	Enter here & on page 1, Part I, line 7, column (B).

**Total dividends-received deductions** included in column 8 .....

**Schedule F - Interest, Annuities, Royalties, and Rents From Controlled Organizations**

(see instructions)

1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations			
		3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)					
(2)					
(3)					
(4)					

**Nonexempt Controlled Organizations**

7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)				
(2)				
(3)				
(4)				
<b>Totals</b> .....			Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).

**Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization**

(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
<b>Totals</b> .....		Enter here and on page 1, Part I, line 9, column (A).		Enter here and on page 1, Part I, line 9, column (B).

**Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income**

(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
<b>Totals</b> .....		Enter here & on page 1, Part I, line 10, col. (A).	Enter here & on page 1, Part I, line 10, col. (B).			Enter here and on page 1, Part II, line 26.

**Schedule J - Advertising Income** (see instructions)

**Part I Income From Periodicals Reported on a Consolidated Basis**

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
<b>Totals</b> (carry to Part II, line (5)) .....						

**Part II Income From Periodicals Reported on a Separate Basis** (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 - 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (col. 6 minus col. 5, but not more than col. 4).
(1)						
(2)						
(3)						
(4)						
<b>Totals from Part I</b>						
<b>Totals, Part II (lines 1-5)</b> .....		Enter here & on page 1, Part I, line 11, col. (A).	Enter here & on page 1, Part I, line 11, col. (B).			Enter here and on page 1, Part II, line 27.

**Schedule K - Compensation of Officers, Directors, and Trustees** (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
		%	
		%	
		%	
		%	
<b>Total.</b> Enter here and on page 1, Part II, line 14 .....			





**Schedule of Contributors**

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

**2009**

<b>Name of the organization</b> Western MD Health System Corp Inc	<b>Employer identification number</b> 52-0591531
--	---

**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 Form 990-EZ, that met the 33 1/3% support test of the regulations under sections 509(a)(1)/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 Form 990, Part VIII, line 1h or 2% of the amount on Form 990-EZ, line 1. Complete Parts I and II.

For a section 501(c)(7), (8), or (10) organization filing Form 990, or Form 990-EZ, that received from any one contributor, during the year, aggregate contributions or bequests 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 Form 990-EZ, that received from any one contributor, during the year, some 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.** Organization that are not covered by the General Rule and/or the Special Rules do not file Schedule B (Form 990, 990-EZ, or 990-PF), but they **must** answer "No" on Part IV, line 2 of their Form 990, or check the box in the heading of their Form 990-EZ, or on line 2 of their Form 990-PF, to certify that they do not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

**For Privacy Act and Paperwork Reduction Act Notice, see the Instructions for Form 990.**  
**These instructions will be issued separately.**

**Schedule B (Form 990, 990-EZ, or 990-PF) (2009)**

<b>Name of organization</b> Western MD Health System Corp Inc	<b>Employer identification number</b> 52-0591531
--	---

**Part I Contributors (see instructions)**

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
1	Anderson Family Foundatio PO Box 32677 PHOENIX AZ 85064-2677	\$ 400,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
2	WMHS Foundation Inc PO Box 539 CUMBERLAND MD 21502-	\$ 509,379.	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.)

**SCHEDULE D  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Financial Statements**

- ▶ 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.

OMB No. 1545-0047

**2009**

**Open to Public Inspection**

**Name of the organization** Western MD Health System Corp Inc  
**Employer identification number** 52-0591531

**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.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate contributions to (during year)		
3 Aggregate grants from (during year)		
4 Aggregate value at end of year		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds may be used only for charitable purposes and not for the benefit of the donor or donor advisor or other impermissible private benefit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).

<input type="checkbox"/> Preservation of land for public use (e.g., recreation or pleasure)	<input type="checkbox"/> Preservation of an historically important land area
<input type="checkbox"/> Protection of natural habitat	<input type="checkbox"/> Preservation of certified historic structure
<input type="checkbox"/> Preservation of open space	

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

	Held at the End of the Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 8/17/06	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the taxable 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, reporting of violations, and enforcement of the conservation easements it holds?  Yes  No

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?  Yes  No

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.

1 a 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 ▶ \$ \_\_\_\_\_

**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 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	2,244,200.	185,778.			
b Contributions	353,302.	2,058,879.			
c Net investment earnings, gains, and losses	12,294.	9,552.			
d Grants or scholarships					
e Other expenditures for facilities and programs	328,591.	10,009.			
f Administrative expenses					
g End of year balance	2,281,205.	2,244,200.			

- 2 Provide the estimated percentage of the year end balance held as:
- a Board designated or quasi-endowment  0.00 %
  - b Permanent endowment  10.96 %
  - c Term endowment  89.04 %
- 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   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| (ii) related organizations  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R? | <input type="checkbox"/>            | <input type="checkbox"/>            |
- 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	6,391,698.			6,391,698.
b Buildings	401,660,485.		75,569,959.32	26,090,526.
c Leasehold improvements				
d Equipment	155,621,107.		102,925,081.	52,696,026.
e Other	12,463,470.		2,909,947.	9,553,523.
<b>Total.</b> Add lines 1a through 1e. (Column (d) should equal Form 990, Part X, column (B), line 10(c).)				894,731,773.



<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)	277,103,307.
2	Total expenses (Form 990, Part IX, column (A), line 25)	281,044,589.
3	Excess or (deficit) for the year. Subtract line 2 from line 1	(3,941,282.)
4	Net unrealized gains (losses) on investments	
5	Donated services and use of facilities	
6	Investment expenses	
7	Prior period adjustments	
8	Other (Describe in Part XIV)	(63,477,688.)
9	Total adjustments (net). Add lines 4 through 8	63,477,688.
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	59,536,406.

<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	236,762,000.
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 531,499.
e	Add lines 2a through 2d	2e 531,499.
3	Subtract line 2e from line 1	236,230,501.
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 40,872,806.
c	Add lines 4a and 4b	4c 40,872,806.
5	Total revenue. Add lines 3 and 4c. (This should equal Form 990, Part I, line 12.)	277,103,307.

<b>Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return</b>		
1	Total expenses and losses per audited financial statements	240,702,000.
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 531,499.
e	Add lines 2a through 2d	2e 531,499.
3	Subtract line 2e from line 1	240,170,501.
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 40,873,088.
c	Add lines 4a and 4b	4c 40,873,088.
5	Total expenses. Add lines 3 and 4c. (This should equal Form 990, Part I, line 18.)	281,043,589.

**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.  
 Part V, Line 4 - Intended uses of the income from the Pugh Endowment

Fund are to provide free beds and free service to those who may become patients and who through financial inability may be unable to make provisions for their own medical and/or surgical relief.

Part XI, Line 8 - Income Rel from Rest -1,785,205, Pension Liability  
 Adj (10,277,000), Rest Donations - 1,914,166, Transfer to Affiliates - (669,301), Change in Ben Trust - (11,993,097), Transfer to Operations (2,000,219), Unreal Gain on Invest - 73,091, Transfer Assets from

**Part XIV Supplemental Information** (continued)

Memorial Medical Center (EIN 52-1246048) - 84,644,844

Part XII, Line D - Rental Expenses

Part XII, Line 4b - Contractual/charity-40,872,777, rounding - 29

Part XIII, Line D - Rental Expenses

Part XIII, Line 4b - Contractual/charity-40,872,777, rounding-311

Part V, Line 4 - Endowment

The Anderson Family Foundation endowment fund is restricted for  
use to address hospital-acquired infections



**SCHEDULE H  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Hospitals**

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

▶ Attach to Form 990.

▶ See separate instructions.

OMB No. 1545-0047

**2009**

**Open to Public Inspection**

Name of the organization

Western MD Health System Corp Inc

Employer identification number

52-0591531

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

	Yes	No
<b>1 a</b> Does the organization have a charity care policy? If "No," skip to question 6a	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>b</b> If "Yes," is it a written policy?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>2</b> If the organization has multiple hospitals, indicate which of the following best describes application of the charity care policy to the various hospitals. <input checked="" type="checkbox"/> Applied uniformly to all hospitals <input type="checkbox"/> Applied uniformly to most hospitals <input type="checkbox"/> Generally tailored to individual hospitals		
<b>3</b> Answer the following based on the charity care eligibility criteria that applies to the largest number of the organization's patients. <b>a</b> 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 _____ %	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>b</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 _____ %	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>c</b> 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.		
<b>4</b> Does the organization's policy provide free or discounted care to the "medically indigent"?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>5 a</b> Does the organization budget amounts for free or discounted care provided under its charity care policy?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>b</b> If "Yes," did the organization's charity care expenses exceed the budgeted amount?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>c</b> 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?	<input type="checkbox"/>	<input type="checkbox"/>
<b>6 a</b> Does the organization prepare an annual community benefit report?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>b</b> If "Yes," does the organization make it available to the public?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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
<b>a</b> Charity care at cost (from Worksheets 1 and 2)		3696	8,869,071.		3,869,071.	1.41
<b>b</b> Unreimbursed Medicaid (from Worksheet 3, column a)						0.00
<b>c</b> Unreimbursed costs-other means-tested government programs (from Worksheet 3, column b)						0.00
<b>d Total</b> Charity Care and Means-Tested Government Programs		3696	8,869,071.		3,869,071.	1.41
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)		11128	339,413.	32,041.	307,372.	0.11
<b>f</b> Health professions education (from Worksheet 5)		69225	1,109,943.	24,000.1	1,085,943.	0.39
<b>g</b> Subsidized health services (from Worksheet 6)		24934	1,968,426.	2,798,012.2	2,170,414.	0.79
<b>h</b> Research (from Worksheet 7)						0.00
<b>i</b> Cash and in-kind contributions to community groups (from Worksheet 8)		14368	218,971.	55,846.	163,125.	0.06
<b>j Total.</b> Other Benefits		119650	6,636,753.	2,909,899.3	7,226,854.	1.35
<b>k Total.</b> Add lines 7d and 7j		123340	15,505,824.	2,909,899.7	15,595,925.	2.76

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

Schedule H (Form 990) 2009

**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					0.00
2	Economic development					0.00
3	Community support					0.00
4	Environmental improvements					0.00
5	Leadership development and training for community members					0.00
6	Coalition building					0.00
7	Community health improvement advocacy		80,135.		80,135.	0.03
8	Workforce development		540,613.		540,613.	0.20
9	Other					0.00
10	<b>Total</b>		620,748.		620,748.	0.23

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

**Section A. Bad Debt Expense**

	Yes	No
1 Does the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? .....	X	
2 Enter the amount of the organization's bad debt expense (at cost) .....	2	6,713,264.
3 Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's charity care policy .....	3	960,325.
4 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.		

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME) .....	5	105,877,611.
6 Enter Medicare allowable costs of care relating to payments on line 5 .....	6	689,995,969.
7 Subtract line 6 from line 5. This is the surplus or (shortfall) .....	7	715,881,642.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

**Section C. Collection Practices**

9a Does the organization have a written debt collection policy? .....	9a	X
b 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 .....	9b	X

**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 Cumberland Prop	Rental	50.00	0.00	0.00
2 Wlbrk Health Svcs	Health care	100.00	0.00	0.00
3 Johnson Heights	Rental	83.95	0.00	16.05
4 Mem Med Ctr Svcs	Building maint	100.00	0.00	0.00
5 Haystack Imaging	Health care	50.00	0.00	50.00
6		0.00	0.00	0.00
7		0.00	0.00	0.00
8		0.00	0.00	0.00
9		0.00	0.00	0.00
10		0.00	0.00	0.00
11		0.00	0.00	0.00
12		0.00	0.00	0.00
13		0.00	0.00	0.00
14		0.00	0.00	0.00



**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 6a:

In response to the growing interest in the types and scope of community benefit services provided by Maryland Hospitals, the Maryland General Assembly passed House Bill 15 during the 2001 Legislative Session, which created a new responsibility under the Health Services Cost Review Commission (HSCRC). Under the law, HSCRC is responsible for collecting hospital community benefit information from individual hospitals to compile into a publicly available statewide Community Benefit Report. This larger statewide document contains summary information as well as individual hospital reports.

Part I, line 7g:

Included as subsidized health services were costs attributable to a physician clinic. This amounted to \$1,660,946.

Part I, line 7, column (f):

Bad debt expense included on Part IX, line 25 column (A), line 25 column (A), subtracted for the purpose of calculating the percentage in this column totaled \$5,752,939.

**Part VI Supplemental Information**

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Part I, line 7:

Amounts reported in the table were calculated based upon the community benefit expenses entered in a community benefit cost accounting system by the appropriate individuals involved with the service provided. All patient segments (inpatient, outpatient, emergency room, etc) were included. Where appropriate, indirect costs were determined by a ratio calculation of overhead and capital costs in relation to direct costs from the HSCRC Annual Cost Report.

Part I, line 7a, 7b, 7f and Part III Section B:

Maryland's regulatory system creates a unique process for hospital payment that differs from the rest of the nation. The 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

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Part I, line 7a, 7b, 7f and Part III Section B (cont):

effect is zero. Additionally, net revenues for Medicaid should reflect the full impact on the hospital of its share of the Medicaid assessment.

Part III, line 4:

Bad debt expenses are for those services rendered to patients who have been determined to have the financial capacity to pay, but are unwilling to pay. The total expense is bad debt write-offs, made after following the provisions of the hospital's collection and write-off policy, less gross bad debt recoveries.

Hospital charges written-off for the following are not bad debts:

- a. Contractual allowances and adjustments.
- b. Administrative, policy discounts, and adjustments
- c. Charges for medically unnecessary hospital services.
- d. Charges written off that are not the result of patient's inability to pay or where the hospital has not expended a reasonable collection effort.

An estimate of the amount of charity care attributable to patients who likely would qualify for financial assistance under the hospital's

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Part III, line 4 (cont):

charity care policy, if sufficient information had been available to make a determination of their eligibility, was based upon a review of records of patients who had accounts written off. Western Maryland Health System, (WMHS), has an audit prepared at the system level. The system's financial statements do not contain a footnote that describes bad debt expense. The explanation of the accounting for bad debts is shown above.

Part III, line 9b:

An evaluation of patient or guarantor ability to pay for hospital services shall be conducted as follows:

1. Determination should be made that all forms of insurance are not available to pay the patient's bill (Medicare, Medicaid, Blue Cross, or private commercial insurance).

2. Determination of income will be made after reviewing all available documents such as copies of income tax returns, pay stubs, bank statements showing direct deposits of social security checks, etc. Certain medical expenses may be allowed in calculating available income to

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Part III, line 9b (cont):

cover hospital bills.

3. Determine Assets and Resources - In some situations, a patient or guarantor's assets such as certificates of deposits or checking accounts with a balance of \$5,000 or greater may be considered in determining need.

4. Considerations in Applying for the Financial Assistance Program:

A. Working, able-bodied patients, over the age of 21, with no disabilities and not pregnant do not usually qualify for Medical Assistance. At the discretion of the Supervisor and Department Director, the requirement of the patient making application for Medical Assistance may be waived.

B. The Financial Assistance application, when approved, is backdated for services rendered 12 months prior to approval and valid 24 months after approval.

C. In certain situations, a 12-month waiting period to reapply for the Financial Assistance Program may be waived.

D. Approved applicants will be subject to recertification 12 months from the date their application was approved, if it is determined that their income may be changed since the patient or guarantor

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Part III, line 9b (cont):

originally applied.

E.Account(s) of the applicant which have been previously placed with a Collection Agency are not included in the application for the Financial Assistance Program.

#### 5.Application

A.The cover letter attached to the Financial Assistance Program application specifies the application to be returned within 10 working days with requested information. If the patient or guarantor does not respond the patient or guarantor will be considered as not interested. If partial information is returned, the applicant will be given additional time provided all the information that was requested in the application.

B.Decisions on probable eligibility will be made within two business days of an initial application. The applicant will be notified in writing by the WMHS Business Office of the determination. If additional information is needed for a final determination the patient or guarantor will be told what additional information is required and the final determination will be communicated to the patient or guarantor in writing within two business days of receiving the

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**5. Application (cont)**

additional information.

C. The patient or guarantor will be made aware that they are attesting to the fact that the information they have provided is a complete and accurate statement of their financial situation by having the Financial Disclosure Statement signed.

6. Patient Financial Obligation - Applicants receiving assistance through the Financial Assistance Program must agree to make monthly payments based on the current policy regarding extended payment terms.

Needs assessment:

During FY10, WMHS completed an extensive planning process that culminated with the opening of the Western Maryland Regional Medical Center in November 2009. Numerous partners and employees had input in the new hospital facility and relocation of many WMHS services. Most of WMHS is now located near the local health department and community college, improving access for the community. WMHS has a long history addressing community needs and is often approached by members of the community for support. The mission of WMHS is to improve the health status and quality of life of the individuals we serve, especially those in need. Commitment to the cause extends from the employees to

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**5. Needs Assessment (cont)**

the Board of Directors and is reflected in the strategic plan and goals. Through the strategic planning process, adequate resources are identified and community service initiatives are aligned with system-wide objectives. Community service priorities are to promote healthy behaviors, create safe environments, and increase access to services for the vulnerable.

The last formal assessment completed by the local health department was in 2001 as part of the Maryland Health Improvement Plan. Since then the Allegany County Health Department has depended on secondary data and input from unit chiefs and executive staff. In FY10 they identified the top three priorities as; lack of primary care/adult dental, mental health/substance abuse, and inadequate social support poverty. A summary of this information was reviewed by WMHS, and found it reflected their plans to address access to care, poverty, and health improvement.

When exploring the needs and feasibility of various projects, WMHS also uses data compiled by the state or federal government such as, Maryland Vital Statistics, Healthy People 2010, Behavioral Risk Factor Surveillance System, US Census Bureau, and various reports from the

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**5. Needs Assessment (cont)**

Maryland Department of Health and Mental Hygiene, Maryland Health Care Commission, and Health Services & Cost Review Commission. Utilization and discharge data is also analyzed to determine or clarify needs when appropriate.

In 2009, WMHS participated in a community needs assessment lead by the County United Way to identify key priorities in the surrounding counties. This year, WMHS remained engaged in County United Way's efforts to address the priorities.

Community needs related to health improvement and access to care are regularly discussed via community partners and the Workgroup on Access to Care. The groups usually meet bimonthly and include representatives from the local health department, social services, local non-profit organizations, health care organizations, and community leaders. Subgroups of the same partners worked throughout FY10 on oral health issues, medication safety, and obesity.

Patient education of eligibility for assistance:

WMHS grants charity care to those patients who demonstrate a financial need. WMHS has signs posted at all sites where patients are admitted

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Patient education of eligibility for assistance (cont):

for inpatient care and all sites where patients receive outpatient services, including the emergency room.

Applications for Financial Assistance are made available to patients at the time services are rendered. Applications for Financial Assistance are also made available to any patient or their family members who request the form be mailed to them.

WMHS contracts with an outside agency to interview all inpatients who do not have insurance coverage. When feasible the initial contact is made prior to discharge. The contractor explains to the patient or their family member(s) the benefits that may be available to them through the federal, state and local programs including Medical Assistance, Primary Adult Care and Medicare. The contractor assists the patient or their families in completing applications and accompanies them if needed to any appointments for the purpose of obtaining benefits through the various public programs.

WMHS provides a telephone number for financial assistance on patient statements. WMHS also has staff dedicated to follow-up and assist any patient or their family member(s) who needs support in obtaining financial assistance.

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Patient education of eligibility for assistance (cont):

Patients determined to be ineligible for government benefits may be referred to the WMHS Wellness Center and its Community Health Access Program, (CHAP). This unique program, a joint venture of the Western Maryland Health System and Allegany Health Right, links participants to a primary care physician and appropriate health and social services such as prescription programs, nutritional counseling, and diagnostic care. Through CHAP enrollment individuals are screened for potential eligibility in over 40 area programs.

Community information and community building activities:

The Western Maryland Health System provides primary and secondary acute care services for a six county region covering: Upper Potomac region of Maryland, Eastern West Virginia, and Southwestern Pennsylvania. The service area encompasses the majority of Allegany and Garrett Counties in Maryland, Mineral County and selected zip codes in Hampshire County in West Virginia, and Bedford and Somerset Counties in Pennsylvania. WMHS leads the market with a 76.1% market share in its total service area with a population of approximately 128,500 people. 81.3% of WMHS patients come from the

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Community information and community building activities (cont):

two MD counties, 16.4% from the two counties in WV, and 2.3% from the two counties in PA. 76.6% of WMHS patients reside in Allegany County.

The service area contains a larger percentage of elderly than the United States overall, and several common characteristics are linked to the financial hardship in the region. The median household income for all of the counties in the area is below the United States. Only the two Pennsylvania counties, from which the least patients are pulled, has less individuals living below the federal poverty level when compared to the US overall. Between 30-44% of each county in the service area is either uninsured or receives Medical Assistance.

The average life expectancy in the counties range from 75.2 years to 77.5 years, which is around the US average of 76.5 years. When reviewing the measures of death in the Community Health Status Indicators (2009), two of the leading causes of death found in 5 of the 6 counties are heart disease and breast cancer.

WMHS is in a medically underserved and economically depressed region of western Maryland. The major needs are to address the barriers associated with poverty, access to care, and preventable risk factors. Whether it is a discussion with the Western Maryland Health System

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Community information and community building activities (cont):

Foundation, the Workgroup on Access to Care, County United Way, or clients at the various health and human services agencies; access to health care and prevention remain community priorities. WMHS's community benefits initiatives continue to include health improvement, community investment, and access for the low income uninsured.

WMHS targets the needs of the low-income uninsured and underserved populations, prevalence of chronic disease and associated risk factors and community asset development, reflective of the needs listed above. Priorities are to promote healthy behaviors, create safe environments, and increase access to services for the vulnerable.

As a not-for-profit health system, WMHS provides care to all, regardless of their ability to pay. There are a number of patient care services that are not self-supporting that we continue to provide since we are the community's only provider.

Making sure that patients have the follow-up resources that they need is also a priority and we work cooperatively with many other community organizations. WMHS maintains the software used by many community service agencies, including WMHS, to screen low income, uninsured and underinsured residents for assistance. Residents can visit any one of

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Community information and community building activities (cont):

the various agencies to determine their eligibility for support

services from all agencies. WMHS provides both financial support and

in-kind support to numerous community organizations that share our

mission.

Through Community Health & Wellness preventive health screenings,

health fairs and education programs are offered throughout the

the community. With the Community Health Improvement Partners and

Workgroup on Access to Care, WMHS is able to increase its outreach and

enhance the impact.

In FY10, WMHS made substantial strides in strengthening the visibility

of its community health role:

-Established WMHS as the regional resource for the state's Healthiest

Maryland campaign

-Engaged 11 community partners to provide 20 resource stations at the

annual health fair addressing specific deficiencies identified in the

County health Rankings

-Led a coalition of WMHS, United Way, the YMCA, and several other area

agencies in applying for a \$25,000 grant for comprehensive planning

to reduce obesity; planning grant denied but, recommended for

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Community information and community building activities (cont):

future consideration for implementation funding

-Total participation increased during FY10 by 7.3%.

-Special attention to obesity was demonstrated by the increase of related visits by over 30% from 3400 to over 4500.

-Special attention to lifestyle choices was demonstrated by the increase of related visits by almost 20% from 1566 to 1865.

-Total health screenings increased by 23% from 7046 to 8668, including the increases noted above for weight control.

-WMHS established the on-grounds farmers' market to reinforce healthy eating and the CDC promotion of locally grown fresh produce.

-Participation in the community-wide CAP database increased by over 9% from 13,027 to 14,214 reflecting the expected increase in the uninsured and underinsured population due to the economy.

**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**

<b>Name of the organization</b> Western MD Health System Corp Inc	<b>Employer identification number</b> 52-0591531
--	---

**Part I Questions Regarding Compensation**

Yes	No
-----	----

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

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

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

**2** Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all 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 checked="" type="checkbox"/> Written employment contract
<input checked="" type="checkbox"/> Independent compensation consultant	<input checked="" type="checkbox"/> Compensation survey or study
<input type="checkbox"/> Form 990 or 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)?

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

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)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
Barry Ronan	(i)	475,368.	78,300.	2,646.	139,021.	14,788.	710,123.	667,953.
	(ii)							
James Raver	(i)	315,037.	39,380.	6,066.	45,949.	1,325.	407,757.	324,953.
	(ii)							
Thomas Dowdell	(i)	267,758.	48,470.	1,661.	41,082.	15,347.	374,318.	274,080.
	(ii)							
Kimberly Repac	(i)	254,821.	46,853.	809.	37,812.	13,046.	353,341.	256,618.
	(ii)							
Nancy Adams	(i)	192,171.	34,021.	577.	28,470.	12,920.	268,159.	196,361.
	(ii)							
Mark Sullivan	(i)	178,610.	27,326.	1,631.	27,041.	12,915.	247,523.	185,040.
	(ii)							
Jo Wilson	(i)	143,715.	32,625.	764.	21,208.	12,827.	211,139.	
	(ii)							
Kevin Turley	(i)	144,997.	33,125.	420.	22,742.	15,089.	216,373.	
	(ii)							
Michele Martz	(i)	129,808.	20,920.	191.	19,533.	15,057.	185,509.	
	(ii)							
Mark Nelson	(i)	575,088.	400.	3,811.	66,793.	14,168.	660,260.	613,930.
	(ii)							
Stevan Zimmer	(i)	524,992.	400.	2,322.	60,678.	7,308.	595,700.	
	(ii)							
Subrato Deb	(i)	471,644.	25,400.	810.	57,327.	15,540.	570,721.	252,059.
	(ii)							
Robert Chou	(i)	440,003.	30,400.	810.	56,314.	13,284.	540,811.	440,143.
	(ii)							
Alida Podrumar	(i)	339,997.	400.	2,355.	39,508.	7,308.	389,568.	264,423.
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Schedule J (Form 990) 2009

**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.

None are present

**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

Western MD Health System Corp Inc

Employer identification number

52-0591531

**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
A	MHHEFA	52-0936091	574217ZY4	11/14/2006	48,650,000.	Replace facility		X		X
B	MHHEFA	52-0936091	574217ZZ1	11/14/2006	2,180,000.	Replace facility		X		X
C										
D										
E										

**Part II Proceeds**

	A		B		C		D		E	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1 Total proceeds of issue	360,637,993.		2,180,000.							
2 Gross proceeds in reserve funds	25,500,000.		170,000.							
3 Proceeds in refunding or defeasance escrows	8,371,923.		1,895,000.							
4 Other unspent proceeds										
5 Issuance costs from proceeds	2,823,891.		104,754.							
6 Working capital expenditures from proceeds										
7 Capital expenditures from proceeds	323,942,179.		10,246.							
8 Year of substantial completion	2009		2009							
9 Were the bonds issued as part of a current refunding issue?		X		X						
10 Were the bonds issued as part of an advance refunding issue?	X		X							
11 Has the final allocation of proceeds been made?	X		X							
12 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								
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X						
2 Are there any lease arrangements with respect to the financed property which may result in private business use?		X		X						

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

Schedule K (Form 990) 2009

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

	A		B		C		D		E	
	Yes	No								
<b>3a</b> Are there any management or service contracts with respect to the financed property which may result in private business use? .....		X		X						
<b>b</b> Are there any research agreements with respect to the financed property which may result in private business use? .....		X		X						
<b>c</b> 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							
<b>4</b> 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 .....	0.0	%	0.0	%	0.0	%	0.0	%	0.0	%
<b>5</b> 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 .....	0.0	%	0.0	%	0.0	%	0.0	%	0.0	%
<b>6</b> Total of lines 4 and 5 .....	0.0	%	0.0	%	0.0	%	0.0	%	0.0	%
<b>7</b> 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	Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b> 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						
<b>2</b> Is the bond issue a variable rate issue? .....		X		X						
<b>3a</b> Has the organization or the governmental issuer identified a hedge with respect to the bond issue on its books and records? .....		X		X						
<b>b</b> Name of provider .....										
<b>c</b> Term of hedge .....										
<b>4a</b> Were gross proceeds invested in a GIC? .....	X			X						
<b>b</b> Name of provider .....	Wachovia									
<b>c</b> Term of GIC .....	1									
<b>d</b> Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied? .....	X									
<b>5</b> Were any gross proceeds invested beyond an available temporary period? .....		X		X						
<b>6</b> Did the bond issue qualify for an exception to rebate? .....		X		X						

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

Department of the Treasury  
Internal Revenue Service

**Transactions with Interested Persons**

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.  
▶ Attach to Form 990 or Form 990-EZ. ▶ See instructions.

OMB No. 1545-0047

**2009**

**Open To Public  
Inspection**

Name of the organization: Western MD Health System Corp Inc Employer identification number: 52-0591531

**Part I Excess Benefit Transactions** (section 501(c)(3) and section 501(c)(4) organizations only).  
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Description of transaction	(c) Corrected?	
			Yes	No

2 Enter the amount of tax imposed on the organization managers or disqualified persons during the year under section 4958 ..... ▶ \$ \_\_\_\_\_

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ..... ▶ \$ \_\_\_\_\_

**Part II Loans to and/or From Interested Persons.**  
Complete if the organization answered "Yes" on Form 990, Part IV, line 26, or Form 990-EZ, Part V, line 38a.

(a) Name of interested person & purpose	(b) Loan to or from the organization?		(c) Original principal amount	(d) Balance due	(e) In default?		(f) Approved by board or committee?		(g) Written agreement?	
	To	From			Yes	No	Yes	No	Yes	No

Total ..... ▶ \$ \_\_\_\_\_

**Part III Grants or Assistance Benefiting Interested Persons.**  
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount and type of assistance

**Part IV Business Transactions Involving Interested Persons.**  
Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
Kheder Ashker MD	Board Member	121,675.	Neurosurgeon		X
Mary Beth Pirolozzi	Board Member	14,000.	Contributions		X
Kimberly S Repac	Sr VP, CFO	14,787,918.	MD Phy Cr As Tr		X
Barry P Ronan	President, CEO	14,787,918.	MD Phy Cr Vc Ch		X

For Privacy Act and Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule L (Form 990 or 990-EZ) 2009

**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

Western MD Health System Corp Inc

Employer identification number

52-0591531

Part VIII, Line 4d - Other Program Services

Emergency Medical Care - Emergency Room Visits - 38,977 visits

Form 990, Part VI, Section A, Question 2

Thomas C Dowdell and Kimberly S Repac serve on the Board of the United  
Way of the Potomac Highlands of which Mary Beth Pirolozzi is the  
Executive Director

M Kathryn Burkey also serves on the Board of First United Corporation  
and First United Bank and Trust

Form 990, Part VI, Section A, Question 4

Memorial Hospital and Medical Center of Cumberland, Inc ceased  
operations on November 30, 2009 and transferred all assets to the  
Western Maryland Health System Corporation, Inc

Form 990, Part VI, Section A, Question 10

On an annual basis, the Executive Committee of the Board of Directors  
meets to review IRS Form 990 and 990T before it is filed with the  
Internal Revenue Service

The Vice President of Financial Services for the hospital presents an  
executive summary and then provides a detailed review and explanation  
of each form

Any open items or questions are resolved prior to the timely filing of  
the form on November 15th

Subsequent to its review, the Executive Committee reports back to the

Name of the organization Western MD Health System Corp Inc	Employer identification number 52-0591531
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Form 990, Part VI, Section A, Question 10 (cont)

Board regarding its oversight of the Form 990

Form 990, Part VI, Section B, Question 12C

The Western Maryland Health System Board of Directors is charged with monitoring proposed or ongoing transactions for conflicts of interest and addressing any potential or actual conflicts Pursuant to the Conflicts of Interest Policy, an annual conflict of interest questionnaire, aimed at determining any family or business relationships and transactions or other transactions that may pose a potential conflict is distributed to all interested persons, ie board members, officers and executive leadership or key employees Interested persons are required to disclose real or potential conflicts at the time when such conflicts arise When someone becomes an interested person and annually thereafter, each interested person is required to sign a statement affirming that he/she 1 has received a copy of the Conflicts of Interest Policy 2 has read the Policy and understands said Policy and 3 agrees to comply with all the requirements of the Policy, including completing the conflicts of interest questionnaire The completed questionnaires are reviewed by the Board of Directors The procedures for addressing any conflict of interest includes, but is not limited to, the following 1 the conflicting interest is fully disclosed to the Board 2 the interested person responds to factual questions related to the substance of the transaction or arrangement being considered, after which he/she shall leave the meeting 3 the person with the conflict of interest is excluded from the discussion and approval of such transaction 4 alternatives to the proposed transaction

Name of the organization Western MD Health System Corp Inc	Employer identification number 52-0591531
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Form 990, Part VI, Section B, Question 12C (cont)

are investigated, competitive bids or comparable valuations are obtained 5 the transaction or action must be approved by a majority of disinterested persons

Form 990, Part VI, Section B, Question 15

The Board appoints a Compensation Committee, comprised solely of independent directors, none of which have a conflict of interest with respect to the compensation arrangement, to be accountable for setting reasonable compensation packages for each officer or key employee, including the CEO. The Compensation Committee develops, consistent with the organizations philosophy and principles, the annual performance goals and criteria to be used in determining merit increases and variable compensation criteria for officers and key employees. The Compensation Committee also hires a qualified independent compensation and benefits specialist, independent expert, to review, analyze and provide benchmarking data for the total compensation and benefits packages of officers and key employees. Appropriate comparability data is obtained from the independent experts, ie total economic benefits paid by similarly situated organizations, both taxable and tax-exempt, for similar job responsibilities. The Committees written records include the 1 terms of the arrangement with the disqualified person, including the date the arrangement was approved 2 a list of members present during the debate on the transaction, and how the members voted when it was approved, and 3 a description of the comparable data relied on by the Committee. Key deliberations of the Committee are also documented in minutes which were approved at the next Committee meeting.



**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2009**

**Open to Public  
Inspection**

▶ **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**  
Western MD Health System Corp Inc

**Employer identification number**  
52-0591531

**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
Western MD Health System 52-1971675 PO Box 539 Cumberland MD 21502-0539	Hlth Care	MD	501c3	Line 3	no
Seton Regional Health Sytm 52-1333566 900 Seton Drive Cumberland MD 21502-	Charitable	MD	501c3	Line 3	no
Cumberland Properties Inc 52-1522252 PO Box 539 Cumberland MD 21502-0539	Rental	MD	501c7	Line 3	no
Willowbrook Health Services 52-2005140 PO Box 539 Cumberland MD 21502-0539	Hlth Care	MD	501c3	Line 3	no
WMHS Foundation Inc 35-2289841 PO Box 539 Cumberland MD 21502-0539	Charitable	MD	501c3	Line 3	no

**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
Johnson He 52-1775175 625 Ke 21502 MD Cumbe	Rental	MD	no	Excluded	(68,771.1	850,156.		X		X	
Haystack I 04-3783141 900 Se 21502 MD Cumbe	Hlth Care	MD	no	Excluded	4,322,264.2	698,392.		X			X

**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
Haystack Consolid 52-1335895 900 Seton 21502 MD Cumbe	Med Svcs	MD	no	C Corp			100.00
Western MD Med Su 26-0119241 11110 Medi 21742 MD Hagersto	Med Sales	MD	no	C Corp			33.33
Memorial Med Ctr 52-1317704 PO Box 539 21501 MD Cumbe	Bldg Maint	MD	no	C Corp	8,959.	616,726.	100.00
Willowbrook HC Co 37-1538510 PO Box 539 21501 MD Cumbe	Condo Mgmt	MD	no	H Corp	275.	83,764.	53.30
							0.00
							0.00
							0.00

**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 <b>(i)</b> interest <b>(ii)</b> annuities <b>(iii)</b> royalties or <b>(iv)</b> rent from a controlled entity .....	<input checked="" type="checkbox"/>	
<b>b</b> Gift, grant, or capital contribution to other organization(s) .....		<input checked="" type="checkbox"/>
<b>c</b> Gift, grant, or capital contribution from other organization(s) .....	<input checked="" type="checkbox"/>	
<b>d</b> Loans or loan guarantees to or for other organization(s) .....	<input checked="" type="checkbox"/>	
<b>e</b> Loans or loan guarantees by other organization(s) .....	<input checked="" type="checkbox"/>	
<b>f</b> Sale of assets to other organization(s) .....		<input checked="" type="checkbox"/>
<b>g</b> Purchase of assets from other organization(s) .....		<input checked="" type="checkbox"/>
<b>h</b> Exchange of assets .....	<input checked="" type="checkbox"/>	
<b>i</b> Lease of facilities, equipment, or other assets to other organization(s) .....	<input checked="" type="checkbox"/>	
<b>j</b> Lease of facilities, equipment, or other assets from other organization(s) .....	<input checked="" type="checkbox"/>	
<b>k</b> Performance of services or membership or fundraising solicitations for other organization(s) .....	<input checked="" type="checkbox"/>	
<b>l</b> Performance of services or membership or fundraising solicitations by other organization(s) .....	<input checked="" type="checkbox"/>	
<b>m</b> Sharing of facilities, equipment, mailing lists, or other assets .....	<input checked="" type="checkbox"/>	
<b>n</b> Sharing of paid employees .....	<input checked="" type="checkbox"/>	
<b>o</b> Reimbursement paid to other organization for expenses .....		<input checked="" type="checkbox"/>
<b>p</b> Reimbursement paid by other organization for expenses .....	<input checked="" type="checkbox"/>	
<b>q</b> Other transfer of cash or property to other organization(s) .....	<input checked="" type="checkbox"/>	
<b>r</b> Other transfer of cash or property from other organization(s) .....	<input checked="" type="checkbox"/>	

**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) Memorial Hospital and Medical Center	hklmn	21,523,731.
(2) Memorial Hospital and Medical Center	pdeqr	
(3) Johnson Heights Medical Building Partnership	jpa	194,679.
(4) Haystack Imaging	ikmnp	11,270,116.
(5) Memorial Medical Center Services	p	59,137.
(6) Willowbrook Health Center Condominium	kp	351,181.

**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-r)	(c) Amount involved
(7) Haystack Consolidated Services	a	26,027.
(8) WMHS Foundation Inc	cnpr	700,316.
(9) Haystack Imaging	qr	
(10)		
(11)		
(12)		
(13)		
(14)		
(15)		
(16)		
(17)		
(18)		
(19)		
(20)		
(21)		
(22)		
(23)		
(24)		

# Depreciation and Amortization (Including Information on Listed Property)

▶ See separate instructions. ▶ Attach to your tax return.

Name(s) shown on return Western MD Health System Corp	Business or activity to which this form relates Form 990	Identifying number 52-0591531
--	---	----------------------------------

**Part I Election To Expense Certain Property Under Section 179**

**Note:** If you have any listed property, complete Part V before you complete Part I.

1 Maximum amount. See the instructions for a higher limit for certain businesses .....	<b>1</b>	
2 Total cost of section 179 property placed in service (see instructions) .....	<b>2</b>	
3 Threshold cost of section 179 property before reduction in limitation (see instructions) .....	<b>3</b>	
4 Reduction in limitation. Subtract line 3 from line 2. If zero or less, enter -0- .....	<b>4</b>	
5 Dollar limitation for tax year. Subtract line 4 from line 1. If zero or less, enter -0-. If married filing separately, see instructions .....	<b>5</b>	
<b>6 (a) Description of property</b>	<b>(b) Cost (business use only)</b>	<b>(c) Elected cost</b>
7 Listed property. Enter the amount from line 29 .....	<b>7</b>	
8 Total elected cost of section 179 property. Add amounts in column (c), lines 6 and 7 .....	<b>8</b>	
9 Tentative deduction. Enter the <b>smaller</b> of line 5 or line 8. ....	<b>9</b>	
10 Carryover of disallowed deduction from line 13 of your 2008 Form 4562 .....	<b>10</b>	
11 Business income limitation. Enter the smaller of business income (not less than zero) or line 5 (see instructions) .....	<b>11</b>	
12 Section 179 expense deduction. Add lines 9 and 10, but do not enter more than line 11 .....	<b>12</b>	
13 Carryover of disallowed deduction to 2010. Add lines 9 and 10, less line 12 .....	<b>13</b>	

**Note:** Do not use Part II or Part III below for listed property. Instead, use Part V.

**Part II Special Depreciation Allowance and Other Depreciation (Do not include listed property.) (See instructions.)**

14 Special depreciation allowance for qualified property (other than listed property) placed in service during the tax year (see instructions) .....	<b>14</b>	
15 Property subject to section 168(f)(1) election .....	<b>15</b>	
16 Other depreciation (including ACRS) .....	<b>16</b>	

**Part III MACRS Depreciation (Do not include listed property.) (See instructions.)**

**Section A**

17 MACRS deductions for assets placed in service in tax years beginning before 2009 .....	<b>17</b>	16,919,441.
18 If you are electing to group any assets placed in service during the tax year into one or more general asset accounts, check here .....	<input type="checkbox"/>	

**Section B-Assets Placed in Service During 2009 Tax Year Using the General Depreciation System**

(a) Classification of property	(b) Month and year placed in service	(c) Basis for depr. (business/investment use only - see instructions)	(d) Recovery period	(e) Convention	(f) Method	(g) Depreciation deduction
19a 3-year property						
b 5-year property						
c 7-year property						
d 10-year property						
e 15-year property						
f 20-year property						
g 25-year property			25 yrs.		S/L	
h Residential rental property			27.5 yrs.	MM	S/L	
i Nonresidential real property			39 yrs.	MM	S/L	

**Section C-Assets Placed in Service During 2009 Tax Year Using the Alternative Depreciation System**

20a Class life					S/L	
b 12-year			12 yrs.		S/L	
c 40-year			40 yrs.	MM	S/L	

**Part IV Summary (See instructions)**

21 Listed property. Enter amount from line 28 .....	<b>21</b>	
22 <b>Total.</b> Add amounts from line 12, lines 14 through 17, lines 19 and 20 in column (g), and line 21. Enter here and on the appropriate lines of your return. Partnerships and S corporations - see instructions .....	<b>22</b>	16,919,441.
23 For assets shown above and placed in service during the current year, enter the portion of the basis attributable to section 263A costs .....	<b>23</b>	

**For Paperwork Reduction Act Notice, see separate instructions.**

# Depreciation and Amortization (Including Information on Listed Property)

▶ See separate instructions. ▶ Attach to your tax return.

Name(s) shown on return <b>Western MD Health System Corp</b>	Business or activity to which this form relates <b>Form 990</b>	Identifying number <b>52-0591531</b>
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**Part I Election To Expense Certain Property Under Section 179**

**Note:** If you have any listed property, complete Part V before you complete Part I.

1 Maximum amount. See the instructions for a higher limit for certain businesses .....	<b>1</b>	
2 Total cost of section 179 property placed in service (see instructions) .....	<b>2</b>	
3 Threshold cost of section 179 property before reduction in limitation (see instructions) .....	<b>3</b>	
4 Reduction in limitation. Subtract line 3 from line 2. If zero or less, enter -0- .....	<b>4</b>	
5 Dollar limitation for tax year. Subtract line 4 from line 1. If zero or less, enter -0-. If married filing separately, see instructions .....	<b>5</b>	
<b>6 (a) Description of property</b>	<b>(b) Cost (business use only)</b>	<b>(c) Elected cost</b>
7 Listed property. Enter the amount from line 29 .....	<b>7</b>	
8 Total elected cost of section 179 property. Add amounts in column (c), lines 6 and 7 .....	<b>8</b>	
9 Tentative deduction. Enter the <b>smaller</b> of line 5 or line 8. ....	<b>9</b>	
10 Carryover of disallowed deduction from line 13 of your 2008 Form 4562 .....	<b>10</b>	
11 Business income limitation. Enter the smaller of business income (not less than zero) or line 5 (see instructions) .....	<b>11</b>	
12 Section 179 expense deduction. Add lines 9 and 10, but do not enter more than line 11 .....	<b>12</b>	
13 Carryover of disallowed deduction to 2010. Add lines 9 and 10, less line 12 .....	<b>13</b>	

**Note:** Do not use Part II or Part III below for listed property. Instead, use Part V.

**Part II Special Depreciation Allowance and Other Depreciation (Do not include listed property.) (See instructions.)**

14 Special depreciation allowance for qualified property (other than listed property) placed in service during the tax year (see instructions) .....	<b>14</b>	
15 Property subject to section 168(f)(1) election .....	<b>15</b>	
16 Other depreciation (including ACRS) .....	<b>16</b>	

**Part III MACRS Depreciation (Do not include listed property.) (See instructions.)**

**Section A**

17 MACRS deductions for assets placed in service in tax years beginning before 2009 .....	<b>17</b>	
18 If you are electing to group any assets placed in service during the tax year into one or more general asset accounts, check here .....	<input type="checkbox"/>	

**Section B-Assets Placed in Service During 2009 Tax Year Using the General Depreciation System**

(a) Classification of property	(b) Month and year placed in service	(c) Basis for depr. (business/investment use only - see instructions)	(d) Recovery period	(e) Convention	(f) Method	(g) Depreciation deduction
<b>19a</b> 3-year property						
<b>b</b> 5-year property						
<b>c</b> 7-year property						
<b>d</b> 10-year property						
<b>e</b> 15-year property						
<b>f</b> 20-year property						
<b>g</b> 25-year property			25 yrs.		S/L	
<b>h</b> Residential rental property			27.5 yrs.	MM	S/L	
			27.5 yrs.	MM	S/L	
<b>i</b> Nonresidential real property			39 yrs.	MM	S/L	
				MM	S/L	

**Section C-Assets Placed in Service During 2009 Tax Year Using the Alternative Depreciation System**

<b>20a</b> Class life					S/L	
<b>b</b> 12-year			12 yrs.		S/L	
<b>c</b> 40-year			40 yrs.	MM	S/L	

**Part IV Summary (See instructions)**

21 Listed property. Enter amount from line 28 .....	<b>21</b>	
22 <b>Total.</b> Add amounts from line 12, lines 14 through 17, lines 19 and 20 in column (g), and line 21. Enter here and on the appropriate lines of your return. Partnerships and S corporations - see instructions .....	<b>22</b>	
23 For assets shown above and placed in service during the current year, enter the portion of the basis attributable to section 263A costs .....	<b>23</b>	

**For Paperwork Reduction Act Notice, see separate instructions.**

**IRS e-file Signature Authorization  
for an Exempt Organization**

For calendar year 2009, or fiscal year beginning Jul 01, 2009, & ending Jun 30, 2010

Department of the Treasury  
Internal Revenue Service

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

**2009**

Name of exempt organization Western MD Health System Corp Inc Employer identification number 52-0591531

Name and title of officer  
Michele R Martz Vice President, Financial Services

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

Check the box for the return for which you are using this Form 8879-EO and enter the applicable amount, if any, from the return. If you check the box on line **1a**, **2a**, **3a**, **4a**, or **5a**, below, and the amount on that line for the return 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-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

<b>1a</b> Form 990 check here ▶ <input checked="" type="checkbox"/>	<b>b Total revenue</b> , if any (Form 990, Part VIII, column (A), line 12) .....	<b>1b</b> <u>277,103,307.</u>
<b>2a</b> Form 990-EZ check here ▶ <input type="checkbox"/>	<b>b Total revenue</b> , if any (Form 990-EZ, line 9) .....	<b>2b</b> _____
<b>3a</b> Form 1120-POL check here ▶ <input type="checkbox"/>	<b>b Total tax</b> (Form 1120-POL, line 22) .....	<b>3b</b> _____
<b>4a</b> Form 990-PF check here ▶ <input type="checkbox"/>	<b>b Tax based on investment income</b> (Form 990-PF, Part VI, line 5) .....	<b>4b</b> _____
<b>5a</b> Form 8868 check here ▶ <input type="checkbox"/>	<b>b Balance Due</b> (Form 8868, line 3c) .....	<b>5b</b> _____

**Part II Declaration and Signature Authorization of Officer**

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 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. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

**Officer's PIN: check one box only**

I authorize Western Maryland Health Sys to enter my PIN 12345 as my signature  
**ERO firm name** **Enter five numbers, but do not enter all zeros**

on the organization's tax year 2009 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2009 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ \_\_\_\_\_ Date ▶ 11/12/2010

**Part III Certification and Authentication**

ERO's EFIN/PIN. Enter your six-digit EFIN followed by your five-digit self-selected PIN. 52822512345  
**do not enter all zeros**

I certify that the above numeric entry is my PIN, which is my signature on the 2009 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163**, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO signature ▶ \_\_\_\_\_ Date ▶ 11/22/2010

**ERO Must Retain This Form - See Instructions**

**Do Not Submit This Form To the IRS Unless Requested To Do So**

**For Paperwork Reduction Act Notice, see instructions.**

Form **8879-EO** (2009)