

PUBLIC DISCLOSURE COPY

EXTENDED TO MAY 15, 2025

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Form 990

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

Do not enter social security numbers on this form as it may be made public.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

2023

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

A For the 2023 calendar year, or tax year beginning JUL 1, 2023 and ending JUN 30, 2024

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.		D Employer identification number 52-0619006
	Doing business as MEDSTAR ST. MARY'S HOSPITAL		E Telephone number 301-475-6003
	Number and street (or P.O. box if mail is not delivered to street address) Room/suite 25500 POINT LOOKOUT ROAD		G Gross receipts \$ 205,470,714.
	City or town, state or province, country, and ZIP or foreign postal code LEONARDTOWN, MD 20650		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	F Name and address of principal officer: MIMI NOVELLO SAME AS C ABOVE		H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. See instructions
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c)( ) (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			
J Website: WWW.STMARYSHOSPITALMD.ORG			
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other			
L Year of formation: 1912 M State of legal domicile: MD			

Part I Summary

Activities & Governance	1	Briefly describe the organization's mission or most significant activities: SEE SCHEDULE O		
	2	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3	Number of voting members of the governing body (Part VI, line 1a)	3	14
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	7
	5	Total number of individuals employed in calendar year 2023 (Part V, line 2a)	5	1371
	6	Total number of volunteers (estimate if necessary)	6	29
Revenue	7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
	7b	Net unrelated business taxable income from Form 990-T, Part I, line 11	7b	0.
	8	Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9	Program service revenue (Part VIII, line 2g)	2,328,531.	2,287,582.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	198,722,277.	197,543,401.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	37,523.	51,439.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	4,967,238.	5,427,610.
	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	206,055,569.	205,310,032.
	14	Benefits paid to or for members (Part IX, column (A), line 4)	91,133.	51,038.
	Expenses	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	0.
16a		Professional fundraising fees (Part IX, column (A), line 11e)	109,189,037.	93,322,641.
16b		Total fundraising expenses (Part IX, column (D), line 25)	4,448.	0.
17		Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	92,078,421.	105,398,065.
18		Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	201,363,039.	198,771,744.
19		Revenue less expenses. Subtract line 18 from line 12	4,692,530.	6,538,288.
Net Assets or Fund Balances		20	Total assets (Part X, line 16)	Beginning of Current Year
	21	Total liabilities (Part X, line 26)	136,029,917.	146,335,098.
	22	Net assets or fund balances. Subtract line 21 from line 20	22,730,303.	19,601,560.

Part II Signature Block

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

Sign Here	Signature of officer	Date
	JOEL BRYAN, VP/TREASURER/CIO	5/6/25
Paid	Print/Type preparer's name	Preparer's signature
	RAYMOND LY	Raymond Ly
Preparer Use Only	Firm's name	Firm's EIN
	KPMG LLP	13-5565207
Use Only	Firm's address	Phone no.
	8350 BROAD STREET, SUITE 900 MCLEAN, VA 22102	703-286-8000

May the IRS discuss this return with the preparer shown above? See instructions

☒ Yes ☐ No

LHA For Paperwork Reduction Act Notice, see the separate instructions.

332001 12-21-23

Form 990 (2023)

**Application for Extension of Time To File an Exempt Organization  
Return or Excise Taxes Related to Employee Benefit Plans**File a separate application for each return.  
Go to [www.irs.gov/Form8868](http://www.irs.gov/Form8868) for the latest information.

OMB No. 1545-0047

**Electronic filing (e-file).** You can electronically file Form 8868 to request up to a 6-month extension of time to file any of the forms listed below except for Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts. An extension request for Form 8870 must be sent to the IRS in a paper format (see instructions). For more details on the electronic filing of Form 8868, visit [www.irs.gov/e-file-providers/e-file-for-charities-and-non-profits](http://www.irs.gov/e-file-providers/e-file-for-charities-and-non-profits).

Caution: If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-TE and Form 8879-TE for payment instructions.

All corporations required to file an income tax return other than Form 990-T (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

**Part I - Identification**

<b>Type or Print</b>  File by the due date for filing your return. See instructions.	Name of exempt organization, employer, or other filer, see instructions. ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Taxpayer identification number (TIN)  52-0619006
	Number, street, and room or suite no. If a P.O. box, see instructions. 25500 POINT LOOKOUT ROAD	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. LEONARDTOWN, MD 20650	

Enter the Return Code for the return that this application is for (file a separate application for each return) 01

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 4720 (other than individual)	09
Form 4720 (individual)	03	Form 5227	10
Form 990-PF	04	Form 6069	11
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 8870	12
Form 990-T (trust other than above)	06	Form 5330 (individual)	13
Form 990-T (corporation)	07	Form 5330 (other than individual)	14
Form 1041-A	08		

• After you enter your Return Code, complete either Part II or Part III. Part III, including signature, is applicable only for an extension of time to file Form 5330.

• If this application is for an extension of time to file Form 5330, you must enter the following information.

Plan Name \_\_\_\_\_  
Plan Number \_\_\_\_\_  
Plan Year Ending (MM/DD/YYYY) \_\_\_\_\_

**Part II - Automatic Extension of Time To File for Exempt Organizations (see instructions)**

The books are in the care of JOEL BRYAN  
10980 GRANTCHESTER WAY - COLUMBIA, MD 21044

Telephone No. 410-772-6721 Fax No. \_\_\_\_\_

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

1 I request an automatic 6-month extension of time until MAY 15, 20 25, to file the exempt organization return for the organization named above. The extension is for the organization's return for:  
☐ calendar year 20 \_\_\_\_ or  
☒ tax year beginning JUL 1, 20 23, and ending JUN 30, 20 24

2 If the tax year entered in line 1 is for less than 12 months, check reason: ☐ Initial return ☐ Final return  
☐ Change in accounting period

<b>3a</b> If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	<b>3a</b>	\$	0.
<b>b</b> If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	<b>3b</b>	\$	0.
<b>c Balance due.</b> Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	<b>3c</b>	\$	0.

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

Form **8868** (Rev. 1-2024)

**Part III Statement of Program Service Accomplishments**Check if Schedule O contains a response or note to any line in this Part III ☒ **X****1** Briefly describe the organization's mission:

SEE SCHEDULE O

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

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

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

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

**4** Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

**4a** (Code: ) (Expenses \$ 128,857,689. including grants of \$ 51,038. ) (Revenue \$ 187,310,532. )  
SEE SCHEDULE O**4b** (Code: ) (Expenses \$ 18,511,982. including grants of \$ ) (Revenue \$ 10,232,869. )

MEDSTAR ST. MARY'S PROVIDED \$18.5M IN SUBSIDIZED (MISSION DRIVEN) HEALTH SERVICES IN FISCAL YEAR 2024. THESE CRITICAL SERVICES, WHICH ARE DRIVEN BY COMMUNITY NEEDS, OPERATE AT A LOSS. THEY ADDRESS PRIORITIES PRIMARILY THROUGH DISEASE PREVENTION AND IMPROVEMENT OF HEALTH STATUS. SERVICES PROVIDED INCLUDE EMERGENCY MEDICINE, WOMEN'S AND CHILDREN'S HEALTH, AND BEHAVIORAL HEALTH.

**4c** (Code: ) (Expenses \$ 4,452,862. including grants of \$ ) (Revenue \$ )

MEDSTAR ST. MARY'S PROVIDED \$4.5M IN CHARITY CARE SERVICES IN FISCAL YEAR 2024. CHARITY CARE IS PROVIDED PURSUANT TO MEDSTAR HEALTH'S FINANCIAL ASSISTANCE POLICY TO MEMBERS OF THE COMMUNITY WHOSE INCOME IS BELOW CERTAIN THRESHOLDS AND FOR WHICH THE HOSPITAL IS NOT COMPENSATED. UNDER MARYLAND'S UNIQUE PAYER SYSTEM, THE AMOUNT REPORTED REPRESENTS MEDSTAR ST. MARY'S CHARITY CARE EXPENSE. OTHER CHARITY CARE EXPENSES ARE INDIRECTLY REIMBURSED VIA THE STATE OF MARYLAND'S PAYMENT SYSTEM.

**4d** Other program services (Describe on Schedule O.)

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

**4e** Total program service expenses 151,822,533.Form **990** (2023)

**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	<b>1</b> X	
<b>2</b> Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ? See instructions	<b>2</b> X	
<b>3</b> Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>	<b>3</b>	X
<b>4</b> <b>Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	<b>4</b>	X
<b>5</b> Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Rev. Proc. 98-19? <i>If "Yes," complete Schedule C, Part III</i>	<b>5</b>	X
<b>6</b> Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>	<b>6</b>	X
<b>7</b> Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>	<b>7</b>	X
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>	<b>8</b>	X
<b>9</b> Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>	<b>9</b>	X
<b>10</b> Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>	<b>10</b> X	
<b>11</b> If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X, as applicable.		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	<b>11a</b> X	
<b>b</b> 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? <i>If "Yes," complete Schedule D, Part VII</i>	<b>11b</b>	X
<b>c</b> 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? <i>If "Yes," complete Schedule D, Part VIII</i>	<b>11c</b> X	
<b>d</b> 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? <i>If "Yes," complete Schedule D, Part IX</i>	<b>11d</b>	X
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	<b>11e</b> X	
<b>f</b> 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 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>	<b>11f</b> X	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>	<b>12a</b>	X
<b>b</b> Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	<b>12b</b> X	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>	<b>13</b>	X
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	X
<b>b</b> Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>	<b>14b</b>	X
<b>15</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>	<b>15</b>	X
<b>16</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>	<b>16</b>	X
<b>17</b> Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I. See instructions</i>	<b>17</b>	X
<b>18</b> Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	<b>18</b> X	
<b>19</b> Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>	<b>19</b>	X
<b>20a</b> Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	<b>20a</b> X	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<b>20b</b> X	
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	<b>21</b> X	

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

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

**Part V Statements Regarding Other IRS Filings and Tax Compliance**Check if Schedule O contains a response or note to any line in this Part V ☐

	Yes	No
<b>1a</b> Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable .....	<b>1a</b> 0	
<b>b</b> Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable .....	<b>1b</b> 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? .....	<b>1c</b>	

Form 990 (2023)

**Part V** Statements Regarding Other IRS Filings and Tax Compliance (continued)

		Yes	No
<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	<b>2a</b> 1371		
<b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	<b>2b</b>	X	
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year?	<b>3a</b>		X
<b>b</b> If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation on Schedule O	<b>3b</b>		
<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)?	<b>4a</b>		X
<b>b</b> If "Yes," enter the name of the foreign country See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).			
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	<b>5a</b>		X
<b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	<b>5b</b>		X
<b>c</b> If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	<b>5c</b>		
<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 as charitable contributions?	<b>6a</b>		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?	<b>6b</b>		
<b>7 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?	<b>7a</b>	X	
<b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided?	<b>7b</b>	X	
<b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	<b>7c</b>		X
<b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year	<b>7d</b>		
<b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	<b>7e</b>		X
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	<b>7f</b>		X
<b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	<b>7g</b>		
<b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	<b>7h</b>		
<b>8 Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	<b>8</b>		
<b>9 Sponsoring organizations maintaining donor advised funds.</b>			
<b>a</b> Did the sponsoring organization make any taxable distributions under section 4966?	<b>9a</b>		
<b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	<b>9b</b>		
<b>10 Section 501(c)(7) organizations.</b> Enter:			
<b>a</b> Initiation fees and capital contributions included on Part VIII, line 12	<b>10a</b>		
<b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	<b>10b</b>		
<b>11 Section 501(c)(12) organizations.</b> Enter:			
<b>a</b> Gross income from members or shareholders	<b>11a</b>		
<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.)	<b>11b</b>		
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?	<b>12a</b>		
<b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year	<b>12b</b>		
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>			
<b>a</b> Is the organization licensed to issue qualified health plans in more than one state? <b>Note:</b> See the instructions for additional information the organization must report on Schedule O.	<b>13a</b>		
<b>b</b> Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	<b>13b</b>		
<b>c</b> Enter the amount of reserves on hand	<b>13c</b>		
<b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year?	<b>14a</b>		X
<b>b</b> If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation on Schedule O	<b>14b</b>		
<b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see the instructions and file Form 4720, Schedule N.	<b>15</b>		X
<b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.	<b>16</b>		X
<b>17 Section 501(c)(21) organizations.</b> Did the trust, or any disqualified or other person engage in any activities that would result in the imposition of an excise tax under section 4951, 4952 or 4953? If "Yes," complete Form 6069.	<b>17</b>		



Form 990 (2023)

**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 on Schedule O. See instructions.

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

☒**Section A. Governing Body and Management**

	1a	1b	Yes	No
<b>1a</b> Enter the number of voting members of the governing body at the end of the tax year ..... If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain on Schedule O.	14			
<b>b</b> Enter the number of voting members included on line 1a, above, who are independent .....		7		
<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? .....			2	X
<b>3</b> Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person? .....			3	X
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? .....			4	X
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets? .....			5	X
<b>6</b> Did the organization have members or stockholders? .....			6	X
<b>7a</b> Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? .....			7a	X
<b>b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? .....			7b	X
<b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
<b>a</b> The governing body? .....			8a	X
<b>b</b> Each committee with authority to act on behalf of the governing body? .....			8b	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 on Schedule O .....			9	X

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

	Yes	No
<b>10a</b> Did the organization have local chapters, branches, or affiliates? .....	10a	X
<b>b</b> If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? .....	10b	
<b>11a</b> Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? .....	11a	X
<b>b</b> Describe on Schedule O the process, if any, used by the organization to review this Form 990. ....		
<b>12a</b> Did the organization have a written conflict of interest policy? If "No," go to line 13 .....	12a	X
<b>b</b> Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? .....	12b	X
<b>c</b> Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe on Schedule O how this was done .....	12c	X
<b>13</b> Did the organization have a written whistleblower policy? .....	13	X
<b>14</b> Did the organization have a written document retention and destruction policy? .....	14	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>a</b> The organization's CEO, Executive Director, or top management official .....	15a	X
<b>b</b> Other officers or key employees of the organization .....	15b	X
If "Yes" to line 15a or 15b, describe the process on 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? .....	16a	X
<b>b</b> If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? .....	16b	X

**Section C. Disclosure**

**17** List the states with which a copy of this Form 990 is required to be filed MD

**18** Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain on Schedule O)

**19** Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

**20** State the name, address, and telephone number of the person who possesses the organization's books and records  
 JOEL BRYAN - 410-772-6721  
 10980 GRANTCHESTER WAY, COLUMBIA, MD 21044



**Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**Check if Schedule O contains a response or note to any line in this Part VII ☐**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees****1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.

- List all of the organization's **current** key employees, if any. See the 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, box 6 of Form 1099-MISC, and/or box 1 of Form 1099-NEC) 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.

See the instructions for the order in which to list the persons above.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) KENNETH A. SAMET DIRECTOR	1.00 39.00	X						0.	7,083,748.	106,087.
(2) STEPHEN MICHAELS, M.D. FORMER SECRETARY	0.00 40.00						X	0.	1,030,317.	28,508.
(3) MIMI NOVELLO, M.D. PRESIDENT/DIRECTOR	40.00 0.00	X		X				955,238.	0.	11,521.
(4) ANNE BANFIELD DIRECTOR	40.00 0.00	X						708,957.	0.	9,362.
(5) JOHN HARVEY, M.D. DIRECTOR	40.00 0.00	X						632,677.	0.	32,190.
(6) YAHIA TAGOURI, M.D. DIRECTOR	40.00 0.00	X						529,318.	0.	29,971.
(7) ANNA CHOI, M.D. DIRECTOR (UNTIL 10/2023)	40.00 0.00	X						531,695.	0.	27,395.
(8) TARA SAGGAR, M.D. DIRECTOR	40.00 0.00	X						476,598.	0.	32,730.
(9) DAVID HAVRILLA FORMER CFO	0.00 40.00					X		0.	424,997.	27,650.
(10) MICHAEL MEISEL CFO/TREASURER (UNTIL 08/2023)	1.00 39.00			X				0.	413,879.	30,252.
(11) JAMES DAMALOUJI, M.D. DIRECTOR	40.00 0.00	X						403,708.	0.	25,473.
(12) DANIEL FEELEY FORMER CFO	0.00 40.00					X		0.	354,417.	32,365.
(13) PURVI JANI CFO/TREASURER	1.00 39.00			X				0.	320,315.	18,969.
(14) ANNETTE BRONER SECRETARY	1.00 39.00			X				0.	297,348.	31,248.
(15) JOHN GREELY VP OF OPERATIONS	40.00 0.00				X			288,554.	0.	31,483.
(16) DAWN YEITRAKIS CNO	40.00 0.00				X			287,305.	0.	19,517.
(17) HEATHER SWAN-JONES REGISTERED NURSE	40.00 0.00				X			240,575.	0.	24,776.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(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			
(18) MARY IBEGBU DIRECTOR OF PHARMACY	40.00 0.00					X		226,616.	0.	23,700.
(19) LORI WERRELL AVP, CARE TRANSFORMATION	40.00 0.00					X		222,644.	0.	7,520.
(20) ROBERT LALLY FORMER CFO	0.00 40.00						X	0.	213,730.	0.
(21) JENNIFER L. BLAKE CHAIR	1.00 0.00	X		X				0.	0.	0.
(22) BONNIE BOWES DIRECTOR (UNTIL 12/2023)	1.00 0.00	X						0.	0.	0.
(23) GLEN IVES DIRECTOR	1.00 0.00	X						0.	0.	0.
(24) SONYA POLLACK DIRECTOR	1.00 0.00	X						0.	0.	0.
(25) KAREN T. GARNER DIRECTOR	1.00 0.00	X						0.	0.	0.
(26) STEPHEN A. SCHMEISER DIRECTOR	1.00 0.00	X						0.	0.	0.
<b>1b Subtotal</b>								5,503,885.	10,138,751.	550,717.
<b>c Total from continuation sheets to Part VII, Section A</b>								0.	0.	0.
<b>d Total (add lines 1b and 1c)</b>								5,503,885.	10,138,751.	550,717.

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

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- 3** Did the organization list any **former** officer, director, trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*
- 4** For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? *If "Yes," complete Schedule J for such individual*
- 5** Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*

	Yes	No
<b>3</b>	X	
<b>4</b>	X	
<b>5</b>		X

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
AYA HEALTHCARE INC, PO BOX 123519 DEPT 3519, DALLAS, TX 75312-3519	STAFFING SERVICES	2,798,518.
AMN HEALTHCARE INC, 2735 COLLECTION CENTER DR, CHICAGO, IL 60693	STAFFING SERVICES	2,168,634.
MEDICAL SOLUTIONS LLC PO BOX 850737, MINNEAPOLIS, MN 55485-0737	STAFFING SERVICES	2,098,507.
DIVERSIFIED CLINICAL SERVICES 28525 NETWORK PLACE, CHICAGO, IL 60673-1285	MEDICAL SERVICES	913,218.
FRESENIUS MEDICAL CARE, 16343 COLLECTION CENTER DRIVE, CHICAGO, IL 60693	MEDICAL SERVICES	729,430.
<b>2</b> Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization		32

SEE PART VII, SECTION A CONTINUATION SHEETS

Form **990** (2023)

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

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**Part VIII Statement of Revenue**Check if Schedule O contains a response or note to any line in this Part VIII ☐

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1 a</b> Federated campaigns .....	<b>1a</b>						
	<b>b</b> Membership dues .....	<b>1b</b>						
	<b>c</b> Fundraising events .....	<b>1c</b>	60,115.					
	<b>d</b> Related organizations .....	<b>1d</b>						
	<b>e</b> Government grants (contributions) .....	<b>1e</b>	1,466,125.					
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above ...	<b>1f</b>	761,342.					
	<b>g</b> Noncash contributions included in lines 1a-1f	<b>1g</b>	\$ 28,076.					
	<b>h Total.</b> Add lines 1a-1f .....							2,287,582.
<b>Program Service Revenue</b>	<b>2 a</b> NET PATIENT SERVICE RE	<b>Business Code</b>	621400	197,564,358.	197,564,358.			
	<b>b</b> OTHER HEALTH REVENUE		621400	18,402.	18,402.			
	<b>c</b> PHARMACY REVENUE		621400	-39,359.	-39,359.			
	<b>d</b> .....							
	<b>e</b> .....							
	<b>f</b> All other program service revenue .....							
	<b>g Total.</b> Add lines 2a-2f .....			197,543,401.				
	<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) .....			49,428.			49,428.
<b>4</b> Income from investment of tax-exempt bond proceeds .....								
<b>5</b> Royalties .....								
<b>6 a</b> Gross rents .....		<b>6a</b>	(i) Real 417,272.					
<b>b</b> Less: rental expenses ...		<b>6b</b>	0.					
<b>c</b> Rental income or (loss)		<b>6c</b>	417,272.					
<b>d</b> Net rental income or (loss) .....				417,272.			417,272.	
<b>7 a</b> Gross amount from sales of assets other than inventory .....		<b>7a</b>	(i) Securities 228.	(ii) Other 1,783.				
<b>b</b> Less: cost or other basis and sales expenses .....		<b>7b</b>	0.	0.				
<b>c</b> Gain or (loss) .....		<b>7c</b>	228.	1,783.				
<b>d</b> Net gain or (loss) .....				2,011.			2,011.	
<b>8 a</b> Gross income from fundraising events (not including \$ 60,115. of contributions reported on line 1c). See Part IV, line 18 .....		<b>8a</b>	343,627.					
<b>b</b> Less: direct expenses .....		<b>8b</b>	160,682.					
<b>c</b> Net income or (loss) from fundraising events .....				182,945.			182,945.	
<b>9 a</b> Gross income from gaming activities. See Part IV, line 19 .....		<b>9a</b>						
<b>b</b> Less: direct expenses .....	<b>9b</b>							
<b>c</b> Net income or (loss) from gaming activities .....								
<b>10 a</b> Gross sales of inventory, less returns and allowances .....	<b>10a</b>							
<b>b</b> Less: cost of goods sold .....	<b>10b</b>							
<b>c</b> Net income or (loss) from sales of inventory .....								
<b>Miscellaneous Revenue</b>	<b>11 a</b> EQUITY IN SUBSIDIARIES	<b>Business Code</b>	900099	1,834,669.			1,834,669.	
	<b>b</b> REBATE INCOME		900099	377,222.			377,222.	
	<b>c</b> .....							
	<b>d</b> All other revenue .....		900099	2,615,502.			2,615,502.	
	<b>e Total.</b> Add lines 11a-11d .....			4,827,393.				
<b>12 Total revenue.</b> See instructions .....				205,310,032.	197,543,401.	0.	5,479,049.	

**Part IX Statement of Functional Expenses**

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

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

☒ X

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 ...				
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 .....	51,038.	51,038.		
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 .....				
<b>4</b> Benefits paid to or for members .....				
<b>5</b> Compensation of current officers, directors, trustees, and key employees .....	4,406,834.	3,912,763.	494,071.	
<b>6</b> Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) .....				
<b>7</b> Other salaries and wages .....	73,737,746.	65,530,030.	8,207,716.	
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) .....	1,174,631.	1,030,998.	143,633.	
<b>9</b> Other employee benefits .....	8,647,975.	7,503,428.	1,144,547.	
<b>10</b> Payroll taxes .....	5,355,455.	4,715,862.	639,593.	
<b>11</b> Fees for services (nonemployees):				
<b>a</b> Management .....	21,217,425.		21,217,425.	
<b>b</b> Legal .....				
<b>c</b> Accounting .....				
<b>d</b> Lobbying .....				
<b>e</b> Professional fundraising services. See Part IV, line 17				
<b>f</b> Investment management fees .....				
<b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Sch O.)	22,100,301.	19,067,865.	3,032,436.	
<b>12</b> Advertising and promotion .....	243,910.	-2,491.	246,401.	
<b>13</b> Office expenses .....	1,087,160.	969,118.	118,042.	
<b>14</b> Information technology .....				
<b>15</b> Royalties .....				
<b>16</b> Occupancy .....	714,530.	593,626.	120,904.	
<b>17</b> Travel .....	189,216.	186,964.	2,252.	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials ...				
<b>19</b> Conferences, conventions, and meetings .....	35,590.	34,840.	750.	
<b>20</b> Interest .....	590,257.		590,257.	
<b>21</b> Payments to affiliates .....				
<b>22</b> Depreciation, depletion, and amortization .....	10,905,950.	4,301,305.	6,604,645.	
<b>23</b> Insurance .....	2,139,436.	-55,204.	2,194,640.	
<b>24</b> Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.)				
<b>a</b> MED/SURG SUPPLIES	28,143,040.	28,213,918.	-70,878.	
<b>b</b> IMPLANTS/PROSTHESES	4,675,407.	4,675,407.		
<b>c</b> MAINTENANCE	4,601,469.	4,466,257.	135,212.	
<b>d</b> UTILITIES	2,729,196.	2,499,049.	230,147.	
<b>e</b> All other expenses	6,025,178.	4,127,760.	1,897,418.	
<b>25</b> Total functional expenses. Add lines 1 through 24e	198,771,744.	151,822,533.	46,949,211.	0.
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing .....	636,559.	<b>1</b>	704,235.
	<b>2</b> Savings and temporary cash investments .....		<b>2</b>	
	<b>3</b> Pledges and grants receivable, net .....	378,781.	<b>3</b>	388,933.
	<b>4</b> Accounts receivable, net .....	21,408,366.	<b>4</b>	24,406,748.
	<b>5</b> Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....		<b>5</b>	
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) .....		<b>6</b>	
	<b>7</b> Notes and loans receivable, net .....		<b>7</b>	
	<b>8</b> Inventories for sale or use .....	3,885,637.	<b>8</b>	4,291,334.
	<b>9</b> Prepaid expenses and deferred charges .....	16,590,221.	<b>9</b>	21,425,783.
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....	<b>10a</b> 163,672,208.		
	<b>b</b> Less: accumulated depreciation .....	<b>10b</b> 88,320,727.		
	<b>11</b> Investments - publicly traded securities .....	77,760,367.	<b>10c</b>	75,351,481.
	<b>12</b> Investments - other securities. See Part IV, line 11 .....	1,460,318.	<b>11</b>	813,755.
	<b>13</b> Investments - program-related. See Part IV, line 11 .....	9,449,566.	<b>12</b>	
	<b>14</b> Intangible assets .....		<b>13</b>	11,284,235.
	<b>15</b> Other assets. See Part IV, line 11 .....	4,460,102.	<b>14</b>	
<b>16</b> <b>Total assets.</b> Add lines 1 through 15 (must equal line 33) .....	136,029,917.	<b>15</b>	7,668,594.	
<b>17</b> Accounts payable and accrued expenses .....	11,851,151.	<b>16</b>	146,335,098.	
<b>18</b> Grants payable .....		<b>17</b>	10,916,645.	
<b>19</b> Deferred revenue .....	208,661.	<b>18</b>		
<b>20</b> Tax-exempt bond liabilities .....		<b>19</b>	214,226.	
<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D .....		<b>20</b>		
<b>22</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....		<b>21</b>		
<b>23</b> Secured mortgages and notes payable to unrelated third parties .....		<b>22</b>		
<b>24</b> Unsecured notes and loans payable to unrelated third parties .....		<b>23</b>		
<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D .....	10,670,491.	<b>24</b>		
<b>26</b> <b>Total liabilities.</b> Add lines 17 through 25 .....	22,730,303.	<b>25</b>	8,470,689.	
<b>27</b> Net assets without donor restrictions .....	111,840,813.	<b>26</b>	19,601,560.	
<b>28</b> Net assets with donor restrictions .....	1,458,801.	<b>27</b>	124,839,415.	
<b>29</b> Capital stock or trust principal, or current funds .....		<b>28</b>	1,894,123.	
<b>30</b> Paid-in or capital surplus, or land, building, or equipment fund .....		<b>29</b>		
<b>31</b> Retained earnings, endowment, accumulated income, or other funds .....		<b>30</b>		
<b>32</b> Total net assets or fund balances .....	113,299,614.	<b>31</b>		
<b>33</b> Total liabilities and net assets/fund balances .....	136,029,917.	<b>32</b>	126,733,538.	
<b>33</b> Total liabilities and net assets/fund balances .....		<b>33</b>	146,335,098.	

Form **990** (2023)

**Part XI Reconciliation of Net Assets**

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

☒

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	205,310,032.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	198,771,744.
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	6,538,288.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	<b>4</b>	113,299,614.
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	10,262.
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain on Schedule O)	<b>9</b>	6,885,374.
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	<b>10</b>	126,733,538.

**Part XII Financial Statements and Reporting**

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

☒

	Yes	No
<b>1</b> Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.		
<b>2a</b> Were the organization's financial statements compiled or reviewed by an independent accountant? _____ If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		X
<b>b</b> Were the organization's financial statements audited by an independent accountant? _____ If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	X	
<b>c</b> If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? _____ If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.	X	
<b>3a</b> As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Uniform Guidance, 2 C.F.R. Part 200, Subpart F? _____	X	
<b>b</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 on Schedule O and describe any steps taken to undergo such audits _____	X	

Form **990** (2023)



Department of the Treasury  
Internal Revenue Service

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

2023

**Open to Public Inspection**

Employer identification number	52-0619006
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The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990).)
- 3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: \_\_\_\_\_
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9 ☐ An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: \_\_\_\_\_
- 10 ☐ An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions, subject to certain exceptions; and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box on lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
  - a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
  - b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
  - c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
  - d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
  - e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

**f** Enter the number of supported organizations

**g** Provide the following information about the supported organization(s).

g Provide the following information about the supported organization(s).						
(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
<b>Total</b>						

**Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>4 Total.</b> Add lines 1 through 3 .....						
<b>5</b> The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) .....						
<b>6 Public support.</b> Subtract line 5 from line 4.						

**Section B. Total Support**

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
<b>7</b> Amounts from line 4 .....						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources .....						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on .....						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions) .....					12	
<b>13 First 5 years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> .....						<input type="checkbox"/>

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

<b>14</b> Public support percentage for 2023 (line 6, column (f), divided by line 11, column (f)) .....	14	%
<b>15</b> Public support percentage from 2022 Schedule A, Part II, line 14 .....	15	%
<b>16a 33 1/3% support test - 2023.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....		
<input type="checkbox"/>		
<b>b 33 1/3% support test - 2022.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....		
<input type="checkbox"/>		
<b>17a 10% -facts-and-circumstances test - 2023.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization .....		
<input type="checkbox"/>		
<b>b 10% -facts-and-circumstances test - 2022.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization .....		
<input type="checkbox"/>		
<b>18 Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions .....		
<input type="checkbox"/>		

Schedule A (Form 990) 2023

**Part III Support Schedule for Organizations Described in Section 509(a)(2)**

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose .....						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 .....						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>6 Total.</b> Add lines 1 through 5 .....						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons .....						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year .....						
<b>c</b> Add lines 7a and 7b .....						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
<b>9</b> Amounts from line 6 .....						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources .....						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 .....						
<b>c</b> Add lines 10a and 10b .....						
<b>11</b> Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on .....						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.)						

**14 First 5 years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ☐

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

<b>15</b> Public support percentage for 2023 (line 8, column (f), divided by line 13, column (f)) .....	<b>15</b>	%
<b>16</b> Public support percentage from 2022 Schedule A, Part III, line 15 .....	<b>16</b>	%

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

<b>17</b> Investment income percentage for <b>2023</b> (line 10c, column (f), divided by line 13, column (f)) .....	<b>17</b>	%
<b>18</b> Investment income percentage from <b>2022</b> Schedule A, Part III, line 17 .....	<b>18</b>	%

**19a 33 1/3% support tests - 2023.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ☐

**b 33 1/3% support tests - 2022.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ☐

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

**Part IV Supporting Organizations**

(Complete only if you checked a box on line 12 of Part I. If you checked box 12a, Part I, complete Sections A and B. If you checked box 12b, Part I, complete Sections A and C. If you checked box 12c, Part I, complete Sections A, D, and E. If you checked box 12d, Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

	Yes	No
<b>1</b> Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
<b>2</b> Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
<b>3a</b> Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer lines 3b and 3c below.</i>		
<b>b</b> Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
<b>c</b> Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
<b>4a</b> Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.</i>		
<b>b</b> Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
<b>c</b> Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
<b>5a</b> Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
<b>b</b> <b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
<b>c</b> <b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?		
<b>6</b> Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
<b>7</b> Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
<b>8</b> Did the organization make a loan to a disqualified person (as defined in section 4958) not described on line 7? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
<b>9a</b> Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
<b>b</b> Did one or more disqualified persons (as defined on line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
<b>c</b> Did a disqualified person (as defined on line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
<b>10a</b> Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>		
<b>b</b> Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

**Part IV Supporting Organizations** (continued)

	Yes	No
<b>11</b> Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b> A person who directly or indirectly controls, either alone or together with persons described on lines 11b and 11c below, the governing body of a supported organization?		
<b>11a</b>		
<b>b</b> A family member of a person described on line 11a above?		
<b>11b</b>		
<b>c</b> A 35% controlled entity of a person described on line 11a or 11b above? If "Yes" to line 11a, 11b, or 11c, provide detail in <b>Part VI</b> .		
<b>11c</b>		

**Section B. Type I Supporting Organizations**

	Yes	No
<b>1</b> Did the governing body, members of the governing body, officers acting in their official capacity, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's officers, directors, or trustees at all times during the tax year? If "No," describe in <b>Part VI</b> how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove officers, directors, or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.		
<b>1</b>		
<b>2</b> Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in <b>Part VI</b> how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.		
<b>2</b>		

**Section C. Type II Supporting Organizations**

	Yes	No
<b>1</b> Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? If "No," describe in <b>Part VI</b> how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).		
<b>1</b>		

**Section D. All Type III Supporting Organizations**

	Yes	No
<b>1</b> Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
<b>1</b>		
<b>2</b> Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in <b>Part VI</b> how the organization maintained a close and continuous working relationship with the supported organization(s).		
<b>2</b>		
<b>3</b> By reason of the relationship described on line 2, above, did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in <b>Part VI</b> the role the organization's supported organizations played in this regard.		
<b>3</b>		

**Section E. Type III Functionally Integrated Supporting Organizations**

<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).			
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.			
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.			
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in <b>Part VI</b> how you supported a governmental entity (see instructions).			
<b>2</b> Activities Test. Answer lines 2a and 2b below.			
<b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in <b>Part VI</b> identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.			
<b>2a</b>			
<b>b</b> Did the activities described on line 2a, above, constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in <b>Part VI</b> the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.			
<b>2b</b>			
<b>3</b> Parent of Supported Organizations. Answer lines 3a and 3b below.			
<b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? If "Yes" or "No" provide details in <b>Part VI</b> .			
<b>3a</b>			
<b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in <b>Part VI</b> the role played by the organization in this regard.			
<b>3b</b>			

**Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations**

- 1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 ( *explain in Part VI*). **See instructions.**  
All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3.	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	<b>Adjusted Net Income</b> (subtract lines 5, 6, and 7 from line 4)	8	

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	<b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e	<b>Discount</b> claimed for blockage or other factors ( <i>explain in detail in Part VI</i> ):		
2	Acquisition indebtedness applicable to non-exempt-use assets	2	
3	Subtract line 2 from line 1d.	3	
4	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by 0.035.	6	
7	Recoveries of prior-year distributions	7	
8	<b>Minimum Asset Amount</b> (add line 7 to line 6)	8	

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, column A)	1	
2	Enter 0.85 of line 1.	2	
3	Minimum asset amount for prior year (from Section B, line 8, column A)	3	
4	Enter greater of line 2 or line 3.	4	
5	Income tax imposed in prior year	5	
6	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

Schedule A (Form 990) 2023

**Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations** (continued)

Section D - Distributions		Current Year
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	<b>1</b>	
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	<b>2</b>	
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	<b>3</b>	
<b>4</b> Amounts paid to acquire exempt-use assets	<b>4</b>	
<b>5</b> Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i> )	<b>5</b>	
<b>6</b> Other distributions ( <i>describe in Part VI</i> ). See instructions.	<b>6</b>	
<b>7</b> <b>Total annual distributions.</b> Add lines 1 through 6.	<b>7</b>	
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive ( <i>provide details in Part VI</i> ). See instructions.	<b>8</b>	
<b>9</b> Distributable amount for 2023 from Section C, line 6	<b>9</b>	
<b>10</b> Line 8 amount divided by line 9 amount	<b>10</b>	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2023	(iii) Distributable Amount for 2023
<b>1</b> Distributable amount for 2023 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2023 (reasonable cause required - <i>explain in Part VI</i> ). See instructions.			
<b>3</b> Excess distributions carryover, if any, to 2023			
<b>a</b> From 2018			
<b>b</b> From 2019			
<b>c</b> From 2020			
<b>d</b> From 2021			
<b>e</b> From 2022			
<b>f</b> <b>Total</b> of lines 3a through 3e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2023 distributable amount			
<b>i</b> Carryover from 2018 not applied (see instructions)			
<b>j</b> Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
<b>4</b> Distributions for 2023 from Section D, line 7: \$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2023 distributable amount			
<b>c</b> Remainder. Subtract lines 4a and 4b from line 4.			
<b>5</b> Remaining underdistributions for years prior to 2023, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>6</b> Remaining underdistributions for 2023. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>7</b> <b>Excess distributions carryover to 2024.</b> Add lines 3j and 4c.			
<b>8</b> Breakdown of line 7:			
<b>a</b> Excess from 2019			
<b>b</b> Excess from 2020			
<b>c</b> Excess from 2021			
<b>d</b> Excess from 2022			
<b>e</b> Excess from 2023			

Schedule A (Form 990) 2023



## Part VI

**Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a, and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information.  
(See instructions.)

**Schedule B**  
(Form 990)Department of the Treasury  
Internal Revenue Service**Schedule of Contributors**Attach to Form 990, 990-EZ, or 990-PF.  
Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2023**

Name of the organization

ST. MARYS HOSPITAL OF ST. MARYS  
COUNTY INC.

Employer identification number

52-0619006

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 foundationCheck 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, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

**Special Rules**

- ☐ For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** \$5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.
- ☐ For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.
- ☐ For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled 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. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ..... \$ \_\_\_\_\_

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

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

Schedule B (Form 990) (2023)

Name of organization ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		\$ 200,000.	Person <input checked="checked" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2		\$ 102,000.	Person <input checked="checked" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3		\$ 60,685.	Person <input checked="checked" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4		\$ 38,014.	Person <input checked="checked" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5		\$ 25,100.	Person <input checked="checked" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6		\$ 25,000.	Person <input checked="checked" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7		\$ 22,423.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8		\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9		\$ 15,120.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10		\$ 15,100.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11		\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12		\$ 14,954.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13		\$ 14,744.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14		\$ 13,122.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
15		\$ 13,025.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16		\$ 13,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17		\$ 11,900.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18		\$ 11,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
20		\$ 9,470.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
21		\$ 9,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
22		\$ 8,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
23		\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
24		\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25		\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
26		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
27		\$ 6,470.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
28		\$ 6,400.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
29		\$ 6,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
30		\$ 6,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)



Name of organization ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31		\$ 6,082.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
32		\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
33		\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
34		\$ 5,675.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
35		\$ 5,100.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
36		\$ 5,095.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
37		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
38		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
39		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
40		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
41		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
42		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
43		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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**Part II** **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
12	SECURITIES	\$ 14,954.	06/30/24
14	SECURITIES	\$ 13,122.	06/30/24
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	

Name of organization ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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**Part III** Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this info. once.) \$ \_\_\_\_\_  
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee

**SCHEDULE D**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Financial Statements**

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

Attach to Form 990.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

Open to Public  
Inspection

Name of the organization **ST. MARYS HOSPITAL OF ST. MARYS  
COUNTY INC.**

Employer identification number  
**52-0619006**

**Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.** Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year .....		
2 Aggregate value of contributions to (during year) .....		
3 Aggregate value of 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 can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).  
☐ Preservation of land for public use (for example, recreation or education) ☐ Preservation of a historically important land area  
☐ Protection of natural habitat ☐ Preservation of a certified historic structure  
☐ 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 Tax 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 on line 2a .....	2c
d Number of conservation easements included on line 2c acquired after July 25, 2006, and not on a historic structure listed in the National Register .....	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year .....

4 Number of states where property subject to conservation easement is located .....

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? .....

☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year .....

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year .....

8 Does each conservation easement reported on line 2d above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? .....

☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

1a If the organization elected, as permitted under FASB ASC 958, not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide in Part XIII the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under FASB ASC 958, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items.

(i) Revenue included on 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 FASB ASC 958 relating to these items:

a Revenue included on Form 990, Part VIII, line 1 ..... \$ .....

b Assets included in Form 990, Part X ..... \$ .....

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

Schedule D (Form 990) 2023

**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 make significant use of its collection items (check all that apply).

**a** ☐ Public exhibition

**d** ☐ Loan or exchange program

**b** ☐ Scholarly research

**e** ☐ Other \_\_\_\_\_

**c** ☐ Preservation for future generations

**4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

**5** During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets

to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

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

**1a** Is the organization an agent, trustee, custodian, or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

**b** If "Yes," explain the arrangement in Part XIII and complete the following table:

	Amount
<b>1c</b> Beginning balance	
<b>1d</b> Additions during the year	
<b>1e</b> Distributions during the year	
<b>1f</b> Ending balance	

**2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☐ No

**b** If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
<b>1a</b> Beginning of year balance	809,381.	685,711.	115,377.	115,347.	114,569.
<b>b</b> Contributions	30.	121,486.	570,305.		
<b>c</b> Net investment earnings, gains, and losses	3,323.	2,184.	29.	30.	778.
<b>d</b> Grants or scholarships					
<b>e</b> Other expenditures for facilities and programs	36.				
<b>f</b> Administrative expenses					
<b>g</b> End of year balance	812,698.	809,381.	685,711.	115,377.	115,347.

**2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

**a** Board designated or quasi-endowment .0000 %

**b** Permanent endowment 85.1200 %

**c** Term endowment 14.8800 %

The percentages on lines 2a, 2b, and 2c should equal 100%.

**3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

(i) Unrelated organizations? ☐ Yes ☒ No

(ii) Related organizations? ☐ Yes ☒ No

**b** If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? ☐ Yes ☒ No

**4** Describe in Part XIII the intended uses of the organization's endowment funds.

**Part VI Land, Buildings, and Equipment**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land		5,733,422.		5,733,422.
<b>b</b> Buildings		105,863,447.	58,592,163.	47,271,284.
<b>c</b> Leasehold improvements		237,567.	315,016.	-77,449.
<b>d</b> Equipment		47,366,386.	29,041,077.	18,325,309.
<b>e</b> Other		4,471,386.	372,471.	4,098,915.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, line 10c, column (B))				75,351,481.

Schedule D (Form 990) 2023



**Part VII Investments - Other Securities**

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

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

**Part VIII Investments - Program Related.**

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

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) INVESTMENTS IN CONSOLIDATED	7,035,255.	END-OF-YEAR MARKET VALUE
(2) INVESTMENTS IN UNCONSOLIDATED	4,248,980.	END-OF-YEAR MARKET VALUE
(3) .....		
(4) .....		
(5) .....		
(6) .....		
(7) .....		
(8) .....		
(9) .....		
<b>Total.</b> (Col. (b) must equal Form 990, Part X, line 13, col. (B))	11,284,235.	

**Part IX Other Assets**

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

(a) Description	(b) Book value
(1) INTERCOMPANY DUE TO/FROM	5,981,415.
(2) OPERATING LEASE ROU ASSETS	1,687,179.
(3) .....	
(4) .....	
(5) .....	
(6) .....	
(7) .....	
(8) .....	
(9) .....	
<b>Total.</b> (Column (b) must equal Form 990, Part X, line 15, col. (B))	7,668,594.

**Part X Other Liabilities**

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ADVANCES	4,606,049.
(3) OPERATING LEASE LIABILITY	1,789,658.
(4) CREDIT BALANCES PATIENT A/R	639,004.
(5) UCC POOL LIABILITY	483,951.
(6) SHORT TERM LIAB-OTHER RESERVE	445,523.
(7) OTHER LIABILITIES	253,432.
(8) GBR LIABILITY	253,072.
(9) .....	
<b>Total.</b> (Column (b) must equal Form 990, Part X, line 25, col. (B))	8,470,689.

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

Schedule D (Form 990) 2023

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

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

<b>1</b>	Total revenue, gains, and other support per audited financial statements .....		<b>1</b>	
<b>2</b>	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
<b>a</b>	Net unrealized gains (losses) on investments .....	<b>2a</b>		
<b>b</b>	Donated services and use of facilities .....	<b>2b</b>		
<b>c</b>	Recoveries of prior year grants .....	<b>2c</b>		
<b>d</b>	Other (Describe in Part XIII.) .....	<b>2d</b>		
<b>e</b>	Add lines <b>2a</b> through <b>2d</b> .....		<b>2e</b>	
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b> .....		<b>3</b>	
<b>4</b>	Amounts included on Form 990, Part VIII, line 12, but not on line 1:			
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b .....	<b>4a</b>		
<b>b</b>	Other (Describe in Part XIII.) .....	<b>4b</b>		
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> .....		<b>4c</b>	
<b>5</b>	Total revenue. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 12.) .....		<b>5</b>	

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

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

<b>1</b>	Total expenses and losses per audited financial statements .....		<b>1</b>	
<b>2</b>	Amounts included on line 1 but not on Form 990, Part IX, line 25:			
<b>a</b>	Donated services and use of facilities .....	<b>2a</b>		
<b>b</b>	Prior year adjustments .....	<b>2b</b>		
<b>c</b>	Other losses .....	<b>2c</b>		
<b>d</b>	Other (Describe in Part XIII.) .....	<b>2d</b>		
<b>e</b>	Add lines <b>2a</b> through <b>2d</b> .....		<b>2e</b>	
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b> .....		<b>3</b>	
<b>4</b>	Amounts included on Form 990, Part IX, line 25, but not on line 1:			
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b .....	<b>4a</b>		
<b>b</b>	Other (Describe in Part XIII.) .....	<b>4b</b>		
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> .....		<b>4c</b>	
<b>5</b>	Total expenses. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 18.) .....		<b>5</b>	

**Part XIII Supplemental Information**

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

PART V, LINE 4:

ENDOWMENT FUNDS

EARNINGS FROM ENDOWMENT FUNDS ARE USED FOR SCHOLARSHIPS FOR RESIDENTS OF

SOUTHERN MARYLAND PURSUING CAREERS IN THE HEALTHCARE INDUSTRY AND TO FUND

THE NEEDS OF THE HOSPITAL.

PART X, LINE 2:

FIN 48 FOOTNOTE

INCOME TAXES ARE ACCOUNTED FOR UNDER THE ASSET AND LIABILITY METHOD.

DEFERRED TAX ASSETS AND LIABILITIES ARE RECOGNIZED FOR THE FUTURE TAX

CONSEQUENCES ATTRIBUTABLE TO DIFFERENCES BETWEEN THE FINANCIAL STATEMENT

CARRYING AMOUNTS OF EXISTING ASSETS AND LIABILITIES AND THEIR RESPECTIVE

**Part XIII** Supplemental Information *(continued)*

TAX BASES AND OPERATING LOSS AND TAX CREDIT CARRYFORWARDS. DEFERRED TAX

ASSETS AND LIABILITIES ARE MEASURED USING ENACTED TAX RATES EXPECTED TO

APPLY TO TAXABLE INCOME IN THE YEARS IN WHICH THOSE TEMPORARY DIFFERENCES

ARE EXPECTED TO BE RECOVERED OR SETTLED. THE EFFECT ON DEFERRED TAX ASSETS

AND LIABILITIES OF A CHANGE IN TAX RATES IS RECOGNIZED IN THE PERIOD THAT

INCLUDES THE ENACTMENT DATE. ANY CHANGES TO THE VALUATION ALLOWANCE ON THE

DEFERRED TAX ASSET ARE REFLECTED IN THE YEAR OF CHANGE. THE CORPORATION

ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH THE FASB

ACCOUNTING STANDARDS CODIFICATION (ASC) TOPIC 740, INCOME TAXES. THERE WAS

NO LIABILITY RECORDED FOR UNCERTAIN TAX POSITIONS AS OF JUNE 30, 2024.

Department of the Treasury  
Internal Revenue Service

### Supplemental Information Regarding Fundraising or Gaming Activities

**Complete if the organization answered "Yes" on Form 990, Part IV, line 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a.**

**Attach to Form 990 or Form 990-EZ.**

**Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

OMB No. 1545-0047

# 2023

**Open to Public Inspection**

Name of the organization	ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.
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Employer identification number	52-0619006
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## Part I

**Fundraising Activities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

**1** Indicate whether the organization raised funds through any of the following activities. Check all that apply.

- a** ☐ Mail solicitations
- b** ☐ Internet and email solicitations
- c** ☐ Phone solicitations
- d** ☐ In-person solicitations
- e** ☐ Solicitation of non-government grants
- f** ☐ Solicitation of government grants
- g** ☐ Special fundraising events

**2 a** Did the organization have a written or oral agreement with any individual (including officers, directors, trustees, or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services?

☐ Yes☐ **No**

**b** If "Yes," list the 10 highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization.

[illegible]

**3** List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

**Part II Fundraising Events.** Complete if the organization answered "Yes" on Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

		(a) Event #1	(b) Event #2	(c) Other events NONE	(d) Total events (add col. (a) through col. (c))
		GALA (event type)	(event type)	(total number)	
Revenue	1 Gross receipts .....	403,742.			403,742.
	2 Less: Contributions .....	60,115.			60,115.
	3 Gross income (line 1 minus line 2) .....	343,627.			343,627.
Direct Expenses	4 Cash prizes .....				
	5 Noncash prizes .....				
	6 Rent/facility costs .....	4,000.			4,000.
	7 Food and beverages .....	110,575.			110,575.
	8 Entertainment .....	11,000.			11,000.
	9 Other direct expenses .....	35,107.			35,107.
	10 Direct expense summary. Add lines 4 through 9 in column (d) .....				160,682.
	11 Net income summary. Subtract line 10 from line 3, column (d) .....				182,945.

**Part III Gaming.** Complete if the organization answered "Yes" on Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue .....				
	2 Cash prizes .....				
Direct Expenses	3 Noncash prizes .....				
	4 Rent/facility costs .....				
	5 Other direct expenses .....				
	6 Volunteer labor .....	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) .....				
	8 Net gaming income summary. Subtract line 7 from line 1, column (d) .....				

9 Enter the state(s) in which the organization conducts gaming activities: \_\_\_\_\_

a Is the organization licensed to conduct gaming activities in each of these states? ☐ Yes ☐ No

b If "No," explain: \_\_\_\_\_

10a Were any of the organization's gaming licenses revoked, suspended, or terminated during the tax year? ☐ Yes ☐ No

b If "Yes," explain: \_\_\_\_\_

- 11** Does the organization conduct gaming activities with nonmembers? ☐ Yes ☐ No
- 12** Is the organization a grantor, beneficiary or trustee of a trust, or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No
- 13** Indicate the percentage of gaming activity conducted in:
- |                                      |            |   |
|--------------------------------------|------------|---|
| <b>a</b> The organization's facility | <b>13a</b> | % |
| <b>b</b> An outside facility         | <b>13b</b> | % |
- 14** Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name \_\_\_\_\_

Address \_\_\_\_\_

- 15a** Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No

**b** If "Yes," enter the amount of gaming revenue received by the organization \$ \_\_\_\_\_ and the amount of gaming revenue retained by the third party \$ \_\_\_\_\_

**c** If "Yes," enter name and address of the third party:

Name \_\_\_\_\_

Address \_\_\_\_\_

- 16** Gaming manager information:

Name \_\_\_\_\_

Gaming manager compensation \$ \_\_\_\_\_

Description of services provided \_\_\_\_\_

☐ Director/officer ☐ Employee ☐ Independent contractor

- 17** Mandatory distributions:

**a** Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No

**b** Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year \$ \_\_\_\_\_

**Part IV Supplemental Information.** Provide the explanations required by Part I, line 2b, columns (iii) and (v); and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional information. See instructions.

<b>Part IV</b>	<b>Supplemental Information</b> <i>(continued)</i>
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[illegible]

**SCHEDULE H  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Hospitals**

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

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

Open to Public  
Inspection

<b>Name of the organization</b>	ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	<b>Employer identification number</b>	52-0619006
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**Part I Financial Assistance and Certain Other Community Benefits at Cost**

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

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

**7 Financial Assistance and Certain Other Community Benefits at Cost**

	(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>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1)			4,452,862.		4,452,862.	2.24%
<b>b</b> Medicaid (from Worksheet 3, column a)						
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)						
<b>d Total.</b> Financial Assistance and Means-Tested Government Programs			4,452,862.		4,452,862.	2.24%
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			1,548,008.	7,940.	1,540,068.	.77%
<b>f</b> Health professions education (from Worksheet 5)			184,286.		184,286.	.09%
<b>g</b> Subsidized health services (from Worksheet 6)			18,511,982.	10,232,869.	8,279,113.	4.17%
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)			115,570.		115,570.	.06%
<b>j Total.</b> Other Benefits			20,359,846.	10,240,809.	10,119,037.	5.09%
<b>k Total.</b> Add lines 7d and 7j			24,812,708.	10,240,809.	14,571,899.	7.33%







**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**

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

Name of hospital facility or letter of facility reporting group: ST MARYS HOSPITAL OF ST MARYS COUNTYLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

	Yes	No
<b>Community Health Needs Assessment</b>		
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? .....		X
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C .....		X
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 .....	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA: <u>20 23</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted .....	X	
<b>6a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C .....		X
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C .....		X
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? .....	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>HTTP://WWW.MEDSTARSTMARYS.ORG/</u>		
<b>b</b> <input type="checkbox"/> Other website (list url): .....		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 .....	X	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy: <u>20 23</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? .....	X	
<b>a</b> If "Yes," (list url): <u>HTTP://WWW.MEDSTARSTMARYS.ORG/</u>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....		
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? .....		X
<b>b</b> If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....		
<b>c</b> If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

**Part V Facility Information** (continued)**Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group: ST MARYS HOSPITAL OF ST MARYS COUNTY

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....	<b>13</b> X	
If "Yes," indicate the eligibility criteria explained in the FAP:		
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients? .....	<b>14</b> X	
<b>15</b> Explained the method for applying for financial assistance? .....	<b>15</b> X	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of their application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of their application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
<b>16</b> Was widely publicized within the community served by the hospital facility? .....	<b>16</b> X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>HTTP://WWW.MEDSTARSTMARYS.ORG/</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>HTTP://WWW.MEDSTARSTMARYS.ORG/</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
j <input type="checkbox"/> Other (describe in Section C)		

Schedule H (Form 990) 2023

**Part V Facility Information** (continued)**Billing and Collections**

Name of hospital facility or letter of facility reporting group: ST MARYS HOSPITAL OF ST MARYS COUNTY

	Yes	No
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? .....		
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? .....		
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? .....		
If "No," indicate why:		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b <input type="checkbox"/> The hospital facility's policy was not in writing		
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d <input type="checkbox"/> Other (describe in Section C)		

Schedule H (Form 990) 2023

**Part V Facility Information** (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

Name of hospital facility or letter of facility reporting group: ST MARYS HOSPITAL OF ST MARYS COUNTY

**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care:

- a** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☒ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? .....

If "Yes," explain in Section C.

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? .....

If "Yes," explain in Section C.

	Yes	No
<b>23</b>		X
<b>24</b>		X

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**Part V Facility Information** *(continued)*

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

ST MARYS HOSPITAL OF ST MARYS COUNTY:

PART V, SECTION B, LINE 5: CHNA INPUT

HOSPITAL LEAD

ROLE DESCRIPTION

THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) HOSPITAL LEAD SERVES AS THE

COORDINATOR OF ALL ASPECTS OF THE COMMUNITY HEALTH ASSESSMENT PROCESS.

HE/SHE HELPS ESTABLISH AND COORDINATE THE ACTIVITIES OF THE ADVISORY TASK

FORCE. THE LEAD ALSO HELPS PRODUCE THE HOSPITAL'S COMMUNITY HEALTH NEEDS

ASSESSMENT AND IMPLEMENTATION STRATEGY. HE/SHE WORKS COLLABORATIVELY WITH

REPRESENTATIVES FROM THE CORPORATE COMMUNITY HEALTH DEPARTMENT AND

GEORGETOWN UNIVERSITY. THE LEAD ALSO WORKS CLOSELY WITH THE WRITER. HE/SHE

REVIEWS ALL NARRATIVES PRIOR TO PUBLICATION.

NAME OF HOSPITAL LEAD: LORI WERRELL

EXECUTIVE SPONSOR

ROLE DESCRIPTION

THE EXECUTIVE SPONSOR SERVES AS THE CONDUIT BETWEEN THE ADVISORY TASK

FORCE AND THE SENIOR MANAGEMENT TEAM. THE SPONSOR IS AN ACTIVE PARTICIPANT

OF THE ADVISORY TASK FORCE AND HE/SHE COMMUNICATES THE HOSPITAL'S CLINICAL

STRENGTHS AND PROGRAM PRIORITIES TO DIVERSE AUDIENCES.

NAME OF EXECUTIVE SPONSOR: MIMI NOVELLO, M.D.

ADVISORY TASK FORCE

ROLE DESCRIPTION

THE ADVISORY TASK FORCE (ATF) REVIEWS PRIMARY/SECONDARY DATA AND

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

LOCAL/STATE/FEDERAL COMMUNITY HEALTH GOALS. BASED ON FINDINGS, THE ATF

PROVIDES INPUT INTO THE HOSPITAL'S THREE-YEAR IMPLEMENTATION STRATEGY.

AS AMBASSADORS FOR THE CHNA PROCESS, THE ATF MEMBERS SUPPORT EFFORTS TO

OPTIMIZE COMMUNITY PARTICIPATION.

NOTE: THE ATF SHOULD BE A COMBINATION OF COMMUNITY REPRESENTATIVES AND

STAFF. COMMUNITY REPRESENTATIVES SHOULD MAKEUP AT LEAST 50% OF TOTAL

PARTICIPANTS.

NAME : ALEXIS ZOSS

TITLE : DIRECTOR

NAME OF ORGANIZATION : ST. MARY'S COUNTY DEPT. OF SOCIAL SERVICES

NAME : ANNA COTTON

TITLE : BOARD CO-CHAIR- LOCAL MANAGEMENT BOARD

NAME OF ORGANIZATION : ST. MARY'S COUNTY GOVT./COMMUNITY MEMBER

NAME : ASHLEY LAGANA

TITLE : MATERNAL AND CHILD HEALTH

NAME OF ORGANIZATION : ST. MARY'S COUNTY HEALTH DEPT.

NAME : CHRISIE MULCAHEY

TITLE : DIRECTOR

NAME OF ORGANIZATION : HEALTH PARTNERS, INC.

NAME : CYNTHIA BROWN



**Part V Facility Information** *(continued)*

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

TITLE : HUMAN SERVICES DIV. MANAGER

NAME OF ORGANIZATION : ST. MARY'S COUNTY GOVERNMENT

NAME : DANA WEST

TITLE : DIRECTOR OF OPERATIONS

NAME OF ORGANIZATION : MEDSTAR MEDICAL GROUP

NAME : DENNIS NICHOLSON

TITLE : PRESIDENT, EXECUTIVE DIRECTOR

NAME OF ORGANIZATION : ST. MARY'S HOUSING AUTHORITY

NAME : GERARD MCGLOIN

TITLE : VICE PRESIDENT

NAME OF ORGANIZATION : PATHWAYS

NAME : GLENN IVES

TITLE : BOARD OF TRUSTEES

NAME OF ORGANIZATION : ST. MARY'S COLLEGE OF MARYLAND

NAME : GREGORY REUSS

TITLE : COMMUNITY REPRESENTATIVE

NAME OF ORGANIZATION : AMERICAN FOUNDATION FOR SUICIDE PREVENTION

NAME : SASHA SEENATH

TITLE : CEO

NAME OF ORGANIZATION : THREE OAKS SHELTER

**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

NAME : JACQUELINE HEANEY-WELLS

TITLE : DIRECTOR OF THE OFFICE OF COMMUNITY ENGAGEMENT & POLICY

NAME OF ORGANIZATION : ST. MARY'S COUNTY HEALTH DEPT.

NAME : JAMES DAMALOUJI, M.D.

TITLE : ASSOCIATE MEDICAL DIRECTOR OF MEDICAL AFFAIRS

NAME OF ORGANIZATION : MEDSTAR ST. MARY'S HOSPITAL

NAME : JUANITA BUTLER

TITLE : FOOD PANTRY COORDINATOR

NAME OF ORGANIZATION : GOSPEL TABERNACLE OF PRAYER

NAME : JOHN HARTLINE

TITLE : EXECUTIVE DIRECTOR

NAME OF ORGANIZATION : TRI-COUNTY COUNCIL OF SOUTHERN MARYLAND

NAME : LAURA STEWART-WEBB

TITLE : DIRECTOR OF ENGAGEMENT AND SPECIAL PROJECTS

NAME OF ORGANIZATION : WALDEN-A PYRAMID HEALTHCARE COMPANY

NAME : LORI JENNINGS-HARRIS

TITLE : DIRECTOR OF AGING AND HUMAN SERVICES

NAME OF ORGANIZATION : ST. MARY'S COUNTY GOVERNMENT

NAME : LORI WERRELL

TITLE : ASST. VICE PRESIDENT OF CARE TRANSFORMATION

NAME OF ORGANIZATION : MEDSTAR ST. MARY'S HOSPITAL

**Part V Facility Information** *(continued)*

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

NAME : LT. KRYSTLE ROSSIGNOL

TITLE : BARRACK COMMANDER

NAME OF ORGANIZATION : MARYLAND STATE POLICE

NAME : MEENAKSHI BREWSTER, M.D.

TITLE : HEALTH OFFICER

NAME OF ORGANIZATION : ST. MARY'S COUNTY HEALTH DEPT.

NAME : MIKE BROWN

TITLE : COMMUNITY MEMBER

NAME OF ORGANIZATION : COMMUNITY RESIDENT

NAME : MIMI NOVELLO, M.D.

TITLE : EXECUTIVE SPONSOR CHIEF OPERATING/ MEDICAL OFFICER

NAME OF ORGANIZATION : MEDSTAR ST. MARY'S HOSPITAL

NAME : NATHANIEL SCROGGINS

TITLE : PRESIDENT

NAME OF ORGANIZATION : MINORITY OUTREACH COALITION MEMBER

NAME : RACHEL SOLOMON

TITLE : DIVERSITY AND INCLUSION COORDINATOR

NAME OF ORGANIZATION : PATHWAYS, INC.

NAME : RENEE GRUBBS, NP

TITLE : WOCN CLINICAL SPECIALIST

**Part V Facility Information** *(continued)*

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

NAME OF ORGANIZATION : MEDSTAR ST. MARY'S HOSPITAL

NAME : DR. SCOTT SMITH

TITLE : SUPERINTENDENT

NAME OF ORGANIZATION : ST. MARY'S COUNTY PUBLIC SCHOOLS

NAME : SHANNON HEANEY

TITLE : DIRECTOR, CHRONIC DISEASE PREVENTION & CONTROL

NAME OF ORGANIZATION : ST. MARY'S COUNTY HEALTH DEPT.

NAME : SHAWN KINGSTON

TITLE : DIRECTOR

NAME OF ORGANIZATION : CALVERT HOUSING AUTHORITY

NAME : SIMONE ROSS

TITLE : EXECUTIVE DIRECTOR

NAME OF ORGANIZATION : HOUSING AUTHORITY OF ST. MARY'S COUNTY

NAME : SONYA POLLACK

TITLE : DIRECTOR

NAME OF ORGANIZATION : MEDSTAR ST. MARY'S HOSPITAL

NAME : TAMMY LOEWE

TITLE : DIRECTOR, BEHAVIORAL HEALTH

NAME OF ORGANIZATION : ST. MARY'S COUNTY HEALTH DEPT.

NAME : TIMOTHY CAMERON

**Part V Facility Information** *(continued)*

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

TITLE : SHERIFF

NAME OF ORGANIZATION : ST. MARY'S COUNTY SHERIFF'S DEPARTMENT

ST MARYS HOSPITAL OF ST MARYS COUNTY:

PART V, SECTION B, LINE 11: IMPLEMENTATION STRATEGIES

THE IMPLEMENTATION STRATEGIES SERVE AS A ROADMAP FOR HOW COMMUNITY BENEFIT

RESOURCES WILL BE ALLOCATED AND DEPLOYED. MEDSTAR'S HOSPITALS WILL BE ABLE

TO MEASURE OUR CONTRIBUTION TO IMPROVING THE HEALTH OF UNDERSERVED AND

VULNERABLE POPULATIONS IN THE REGIONS WE SERVE.

THREE-YEAR IMPLEMENTATION STRATEGIES WITH MEASURABLE OBJECTIVES WERE

DEVELOPED FOR EACH HOSPITAL'S COMMUNITY BENEFIT SERVICE AREA - A SPECIFIC

COMMUNITY OR TARGET POPULATION OF FOCUS. PRIORITIES WERE BASED ON

COMMUNITY NEED AS DETERMINED BY QUANTITATIVE DATA AND COMMUNITY INPUT, AS

WELL AS ON HOSPITAL EXPERTISE, RESOURCES, STRENGTHS OF EXISTING

PROGRAMMING AND PARTNERSHIPS, AND ALIGNMENT WITH NATIONAL, STATE, AND

LOCAL HEALTH GOALS. THE MEDSTAR HEALTH CORPORATE COMMUNITY HEALTH

DEPARTMENT WILL PROVIDE SYSTEM-WIDE COORDINATION AND OVERSIGHT OF

COMMUNITY BENEFIT PROGRAMMING.

HOSPITAL ADVISORY TASK FORCES CONVENE AT LEAST ANNUALLY TO MONITOR

PROGRESS OF STRATEGY EXECUTION AND TO PROVIDE ONGOING RECOMMENDATIONS

RELATED TO OUTCOMES ACHIEVEMENT, PROGRAM DEVELOPMENT, PARTNERSHIP

APPROACHES, AND OVERALL IMPLEMENTATION IMPROVEMENT.

FOR SIGNIFICANT NEEDS IDENTIFIED IN THE CHNA THAT THE HOSPITAL HAS NOT

**Part V Facility Information** *(continued)*

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

PRIORITIZED AS FOCUS AREAS THROUGH ITS IMPLEMENTATION STRATEGY, THESE

NEEDS WILL BE ADDRESSED BY COLLABORATING WITH OTHER LEADING ORGANIZATIONS,

AND BY TAKING A SUPPORTER ROLE ON IDENTIFIED NEEDS THAT ARE BEYOND THE

SCOPE OF THE HOSPITAL'S STRENGTHS.

ST MARYS HOSPITAL OF ST MARYS COUNTY

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

[HTTP://WWW.MEDSTARSTMARYS.ORG/](http://WWW.MEDSTARSTMARYS.ORG/)

<b>Part V</b>	<b>Facility Information</b> <i>(continued)</i>
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## Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

How many non-hospital health care facilities did the organization operate during the tax year? 0

[illegible]

Schedule H (Form 990) 2023

**Part VI Supplemental Information**

Provide the following information.

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

CHARITY CARE AT COST

PART I, LINE 7A

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL

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

COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A

RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY

THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL.

MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING

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

MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO

UNCOMPENSATED CARE.

UNREIMBURSED MEDICAID

PART I, LINE 7B

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL

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

COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A



RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY  
THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL.  
MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING  
UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE  
MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO  
UNCOMPENSATED CARE. COMMUNITY BENEFIT EXPENSES ARE EQUAL TO MEDICAID  
REVENUES IN MARYLAND, AS SUCH, THE NET EFFECT IS ZERO. THE EXCEPTION TO  
THIS IS THE IMPACT ON THE HOSPITAL OF ITS SHARE OF THE MEDICAID  
ASSESSMENT. IN RECENT YEARS, THE STATE OF MARYLAND HAS CLOSED FISCAL  
GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING HOSPITALS THROUGH THE  
RATE-SETTING SYSTEM.

BAD DEBT  
PART III, LINES 2 & 4  
MEDSTAR HEALTH AND ITS AFFILIATED ORGANIZATIONS REPORT BAD DEBT EXPENSE  
IN ACCORDANCE WITH ASU 2011-07, WHICH REQUIRES CERTAIN HEALTHCARE  
ENTITIES TO CHANGE THE PRESENTATION OF THEIR STATEMENT OF OPERATIONS BY  
RECLASSIFYING THE PROVISION FOR BAD DEBTS ASSOCIATED WITH PATIENT  
SERVICE REVENUE FROM AN OPERATING EXPENSE TO A DEDUCTION FROM PATIENT  
SERVICE REVENUE (NET OF CONTRACTUAL ALLOWANCES AND DISCOUNTS). HOWEVER,  
MEDSTAR AND ITS AFFILIATED ENTITIES DO NOT MAKE A DETERMINATION AS TO  
WHETHER SELF PAY AMOUNTS ARE COLLECTIBLE IN DETERMINING REVENUE  
RECOGNITION. RESERVE MODELS, WHICH HAVE BEEN DEVELOPED BASED ON  
HISTORICAL COLLECTION RESULTS AND WHICH ARE ADJUSTED PERIODICALLY BASED  
ON ACTUAL COLLECTIONS EXPERIENCE, ARE USED TO ESTIMATE UNCOLLECTIBLE  
AMOUNTS ACROSS ALL PAYORS INCLUDING SELF PAY. BAD DEBT DETERMINATIONS  
ARE MADE ONLY AFTER SUFFICIENT EVIDENCE IS OBTAINED TO SUPPORT THAT AN  
AMOUNT IS NOT COLLECTIBLE.

**Part VI** Supplemental Information (Continuation)

MEDICARE

PART III, LINE 8

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL  
PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES  
COST REVIEW COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A

RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY

THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL.

MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING

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

MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO

UNCOMPENSATED CARE. AS SUCH, THE NET EFFECT FOR MEDICARE EXPENSES AND

REVENUES IN MARYLAND IS ZERO.

PART III, LINE 9B

IF IT IS DETERMINED THAT A PATIENT MAY POTENTIALLY QUALIFY FOR A

CHARITABLE/FINANCIAL PROGRAM, A HOLD IS PLACED ON THE ACCOUNT TO

PREVENT IT FROM BEING REPORTED AS BAD DEBT UNTIL PROGRAM APPROVALS HAVE

BEEN OBTAINED. IF IT IS APPROVED, THE ACCOUNT IS DOCUMENTED AND THE

NECESSARY ADJUSTMENTS ARE MADE TO CLOSE THE ACCOUNT.

NEEDS ASSESSMENT

PART VI, LINE 2

IN FY21, MEDSTAR ST. MARY'S HOSPITAL (MSMH) CONDUCTED A COMMUNITY

HEALTH NEEDS ASSESSMENT (CHNA) IN ACCORDANCE WITH THE GUIDELINES

ESTABLISHED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE

INTERNAL REVENUE SERVICE. THE HOSPITAL'S CHNA AND THREE-YEAR

IMPLEMENTATION STRATEGIES WERE ENDORSED BY MSMH'S BOARD OF DIRECTORS

AND APPROVED BY THE MEDSTAR HEALTH BOARD OF DIRECTORS. THE DOCUMENT  
BECAME AVAILABLE ON THE HOSPITAL'S WEBSITE ON JUNE 30, 2021, AND SERVED  
AS A GUIDE FOR PROGRAMMING PRIORITIES IN FISCAL YEARS 2022-2024.

THE CATEGORIES HEALTH AND WELLNESS, ACCESS TO CARE AND SOCIAL  
DETERMINANTS OF HEALTH WERE USED TO DETERMINE WHAT PROGRAMMING TO  
PRIORITIZE FOR THE CHNA. TWO TO THREE STRATEGIES IN EACH CATEGORY WERE  
SELECTED AS PRIORITIES DUE TO THE SIZE AND SCALE OF IMPACT AND  
MEASURABLE OUTCOMES. ALL OTHER PROGRAMMING WAS INTEGRATED AS PART OF  
THE HOSPITAL'S OVERALL COMMUNITY HEALTH PORTFOLIO. THESE ADDITIONAL  
PROGRAMS WERE CAPTURED IN THE INVENTORY FOR THE WHOLE PICTURE OF  
CONTRIBUTING TO THE HEALTH OF THE COMMUNITIES SERVED AS WELL AS SORTED  
FOR WHAT COUNTS AS COMMUNITY BENEFIT FOR REGULATORY REPORTING.

THE HOSPITAL'S COMMUNITY BENEFIT SERVICE AREA (CBSA) IS BASED ON THE  
ADVISORY TASK FORCE (ATF) RECOMMENDATION. THE HOSPITAL IDENTIFIED  
LEXINGTON PARK AS ITS CBSA, WHICH INCLUDES ALL RESIDENTS LIVING IN ZIP  
CODE 20653. THE HOSPITAL SELECTED THIS GEOGRAPHIC AREA BASED ON  
HOSPITAL UTILIZATION DATA AND SECONDARY PUBLIC HEALTH DATA AS WELL AS  
ITS PROXIMITY TO THE HOSPITAL. THE ATF INCLUDED A DIVERSE GROUP OF  
INDIVIDUALS, INCLUDING HOSPITAL LEADERS, GRASSROOTS ACTIVISTS,  
COMMUNITY RESIDENTS, FAITH-BASED LEADERS, HOSPITAL REPRESENTATIVES,  
PUBLIC HEALTH LEADERS AND OTHER STAKEHOLDER ORGANIZATIONS, SUCH AS  
REPRESENTATIVES FROM LOCAL HEALTH DEPARTMENTS.

HEALTH PRIORITIES FOR THE CBSA INCLUDE HEALTH AND WELLNESS (CHRONIC  
DISEASE PREVENTION AND MANAGEMENT AND BEHAVIORAL HEALTH), ACCESS TO  
HEALTH CARE AND SERVICES (TRANSPORTATION AND ACCESS TO AFFORDABLE

**Part VI** Supplemental Information (Continuation)

HEALTH CARE AND INSURANCE) AND SOCIAL DETERMINANTS OF HEALTH (HOUSING  
AND EMPLOYMENT).

REPRESENTATIVES FROM THE HOSPITAL ROUTINELY PARTICIPATE IN THE MEDSTAR  
HEALTH COMMUNITY HEALTH WORKGROUP. THE WORKGROUP IS COMPRISED OF  
COMMUNITY HEALTH PROFESSIONALS WHO REPRESENT ALL TEN MEDSTAR HEALTH  
HOSPITALS. THE TEAM ANALYZES LOCAL AND REGIONAL COMMUNITY HEALTH DATA,  
ESTABLISHES SYSTEM-WIDE COMMUNITY HEALTH PROGRAMMING PERFORMANCE AND  
EVALUATION MEASURES AND SHARES BEST PRACTICES.

IN FY24, MSMH CONDUCTED A CHNA AND PRODUCED A THREE-YEAR IMPLEMENTATION  
STRATEGY. THE DOCUMENT BECAME AVAILABLE ON THE HOSPITAL'S WEBSITE BY  
JUNE 30, 2024, AND WILL GUIDE PROGRAMMING PRIORITIES IN FISCAL YEARS  
2025-2027.

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

AS ONE OF THE REGION'S LEADING NOT-FOR-PROFIT HEALTHCARE SYSTEMS,  
MEDSTAR HEALTH IS COMMITTED TO ENSURING THAT UNINSURED AND UNDERINSURED  
PATIENTS MEETING ELIGIBILITY CRITERIA, AND PATIENTS DETERMINED ELIGIBLE  
FOR PRESUMPTIVE ELIGIBILITY WITHIN THE COMMUNITIES WE SERVE WHO LACK  
FINANCIAL RESOURCES HAVE ACCESS TO MEDICALLY NECESSARY HOSPITAL  
SERVICES. MEDSTAR HEALTH HOSPITALS AND HOSPITAL BASED-PHYSICIAN  
PRACTICES WILL:

. TREAT ALL PATIENTS EQUITABLY, WITH DIGNITY, RESPECT, AND COMPASSION.

. SERVE THE EMERGENCY HEALTH CARE NEEDS OF EVERYONE WHO PRESENTS TO OUR

MEDSTAR HEALTH HOSPITALS AND HOSPITAL-BASED PHYSICIAN PRACTICES

REGARDLESS OF A PATIENT'S ABILITY TO PAY FOR CARE.

. ASSIST THOSE PATIENTS WHO ARE ADMITTED THROUGH OUR ADMISSION PROCESS

FOR NON-URGENT, MEDICALLY NECESSARY CARE WHO CANNOT PAY FOR THE CARE

THEY RECEIVE.

. BALANCE NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH BROADER

FISCAL RESPONSIBILITIES IN ORDER TO KEEP ITS HOSPITALS' DOORS OPEN FOR

ALL WHO MAY NEED CARE IN THE COMMUNITY.

IN MEETING ITS COMMITMENTS, MEDSTAR HEALTH HOSPITALS AND HOSPITAL-BASED

PHYSICIAN PRACTICES WILL WORK WITH THEIR PATIENTS SEEKING EMERGENCY AND

MEDICALLY NECESSARY CARE TO GAIN AN UNDERSTANDING OF EACH PATIENT'S

FINANCIAL RESOURCES. BASED ON THIS INFORMATION, MEDSTAR HEALTH

HOSPITALS AND HOSPITAL-BASED PHYSICIAN PRACTICES WILL MAKE ELIGIBILITY

DETERMINATIONS FOR FINANCIAL ASSISTANCE FOR PATIENTS WHO RESIDE WITHIN

THE COMMUNITIES THAT WE SERVE. IN DETERMINING ELIGIBILITY FOR FINANCIAL

ASSISTANCE, MEDSTAR HEALTH HOSPITALS AND HOSPITAL-BASED PHYSICIAN

PRACTICES WILL:

- DETERMINE WHETHER THE PATIENT HAS HEALTH INSURANCE.

- DETERMINE WHETHER THE PATIENT IS PRESUMPTIVELY ELIGIBLE FOR FREE OR

REDUCED-COST CARE.

- DETERMINE WHETHER UNINSURED PATIENTS ARE ELIGIBLE FOR PUBLIC OR

PRIVATE HEALTH INSURANCE.

- TO THE EXTENT POSSIBLE, OFFER ASSISTANCE TO UNINSURED PATIENTS IF THE

PATIENT CHOOSES TO APPLY FOR PUBLIC OR PRIVATE HEALTH INSURANCE.

- TO THE EXTENT PRACTICABLE, DETERMINE WHETHER THE PATIENT IS ELIGIBLE

FOR OTHER PUBLIC PROGRAMS THAT MAY ASSIST WITH HEALTH CARE COSTS.

- USE INFORMATION IN THE POSSESSION OF THE HOSPITAL, IF AVAILABLE, TO

**Part VI** Supplemental Information (Continuation)

DETERMINE WHETHER THE PATIENT IS QUALIFIED FOR FREE OR REDUCED-COST

CARE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY.

MEDSTAR HEALTH WILL WIDELY PUBLICIZE THE MEDSTAR FINANCIAL ASSISTANCE

POLICY BY:

. PROVIDING ACCESS TO THE MEDSTAR FINANCIAL ASSISTANCE POLICY,

FINANCIAL ASSISTANCE APPLICATIONS, AND MEDSTAR PATIENT INFORMATION

SHEET ON ALL HOSPITAL WEBSITES AND PATIENT PORTALS.

. PROVIDING HARD COPIES OF THE MEDSTAR FINANCIAL ASSISTANCE POLICY,

MEDSTAR UNIFORM FINANCIAL ASSISTANCE APPLICATION, AND MEDSTAR PATIENT

INFORMATION SHEET TO PATIENTS UPON REQUEST.

. PROVIDING HARD COPIES OF THE MEDSTAR FINANCIAL ASSISTANCE POLICY,

MEDSTAR UNIFORM FINANCIAL ASSISTANCE APPLICATION, AND MEDSTAR PATIENT

INFORMATION SHEET TO PATIENTS UPON REQUEST BY MAIL AND WITHOUT CHARGE.

. PROVIDING NOTIFICATION AND INFORMATION ABOUT THE MEDSTAR FINANCIAL

ASSISTANCE POLICY BY:

. OFFERING COPIES AS PART OF ALL REGISTRATION OR DISCHARGES

PROCESSES, AND ANSWERING QUESTIONS ON HOW TO APPLY FOR ASSISTANCE.

. PROVIDING WRITTEN NOTICES ON BILLING STATEMENTS.

. DISPLAYING MEDSTAR FINANCIAL ASSISTANCE POLICY INFORMATION AT ALL

HOSPITAL REGISTRATION POINTS, INCLUDING THE BUSINESS OFFICE, INFORMING

PATIENTS OF THEIR RIGHTS TO APPLY FOR FINANCIAL ASSISTANCE AND WHO TO

CONTACT AT THE HOSPITAL FOR ADDITIONAL INFORMATION.

. TRANSLATING THE MEDSTAR FINANCIAL ASSISTANCE POLICY, MEDSTAR

UNIFORM FINANCIAL ASSISTANCE APPLICATION, AND THE MEDSTAR PATIENT

INFORMATION SHEET INTO PRIMARY LANGUAGES THAT CONSTITUTE THE LESSER OF

1000 INDIVIDUALS OR 5% OF THE OVERALL POPULATION WITHIN THE CITY OR

**Part VI** Supplemental Information (Continuation)

COUNTY IN WHICH THE HOSPITAL IS LOCATED AS MEASURED BY THE MOST RECENT  
CENSUS.

. MEDSTAR HEALTH WILL PROVIDE PUBLIC NOTICES YEARLY IN LOCAL NEWSPAPERS  
SERVING ALL HOSPITAL TARGET POPULATIONS.

THE MEDSTAR HEALTH PATIENT INFORMATION SHEET SHALL BE PROVIDED TO THE  
PATIENT, THE PATIENT'S FAMILY, OR THE PATIENT'S AUTHORIZED  
REPRESENTATIVE:

. BEFORE DISCHARGE;

. WITH THE HOSPITAL BILL;

. ON REQUEST; AND

. IN EACH WRITTEN COMMUNICATION TO THE PATIENT REGARDING COLLECTION OF  
THE HOSPITAL BILL.

MEDSTAR HEALTH WILL PROVIDE A FINANCIAL ASSISTANCE PROBABLE AND LIKELY  
ELIGIBILITY DETERMINATION TO THE PATIENT WITHIN TWO BUSINESS DAYS FROM  
RECEIPT OF THE INITIAL MEDSTAR HEALTH UNIFORM FINANCIAL ASSISTANCE  
APPLICATION. FINAL ELIGIBILITY DETERMINATIONS ARE MADE AND COMMUNICATED  
TO THE PATIENT BASED ON RECEIPT AND REVIEW OF A COMPLETED APPLICATION.

MEDSTAR HEALTH BELIEVES THAT ITS PATIENTS HAVE PERSONAL  
RESPONSIBILITIES RELATED TO THE FINANCIAL ASPECTS OF THEIR HEALTHCARE  
NEEDS. FINANCIAL ASSISTANCE AND PERIODIC PAYMENT PLANS AVAILABLE UNDER  
THIS POLICY WILL NOT BE AVAILABLE TO THOSE PATIENTS WHO FAIL TO FULFILL  
THEIR RESPONSIBILITIES. FOR PURPOSES OF THIS POLICY, PATIENT  
RESPONSIBILITIES INCLUDE:

. COMPLY WITH PROVIDING THE NECESSARY FINANCIAL DISCLOSURE FORMS TO  
EVALUATE THEIR ELIGIBILITY FOR PUBLICLY-FUNDED HEALTHCARE PROGRAMS,  
CHARITY CARE PROGRAMS, AND OTHER FORMS OF FINANCIAL ASSISTANCE. THESE  
DISCLOSURE FORMS MUST BE COMPLETED ACCURATELY, TRUTHFULLY, AND TIMELY  
TO ALLOW MEDSTAR HEALTH'S FACILITIES TO PROPERLY COUNSEL PATIENTS  
CONCERNING THE AVAILABILITY OF FINANCIAL ASSISTANCE.

. WORKING WITH MEDSTAR HOSPITAL PATIENT ADVOCATES AND PATIENT FINANCIAL  
SERVICES STAFF TO ENSURE THERE IS A COMPLETE UNDERSTANDING OF THE  
PATIENT'S FINANCIAL SITUATION AND CONSTRAINTS.

. MAKING APPLICABLE PAYMENTS FOR SERVICES IN A TIMELY FASHION,  
INCLUDING ANY PAYMENTS MADE PURSUANT TO DEFERRED AND PERIODIC PAYMENT  
SCHEDULES.

. PROVIDING UPDATED FINANCIAL INFORMATION TO MEDSTAR HOSPITAL PATIENT  
ADVOCATES OR CUSTOMER SERVICE REPRESENTATIVES ON A TIMELY BASIS AS THE  
PATIENT'S FINANCIAL CIRCUMSTANCES MAY CHANGE.

. IT IS A PATIENT'S RESPONSIBILITY, DURING THEIR 12-MONTH ELIGIBILITY  
PERIOD, TO NOTIFY MEDSTAR HEALTH OF THEIR EXISTING HOUSEHOLD  
ELIGIBILITY FOR FREE CARE, REDUCED COST-CARE, AND/OR ELIGIBILITY UNDER  
FINANCIAL HARDSHIP PROVISIONS FOR MEDICAL NECESSARY CARE RECEIVED  
DURING THE 12-MONTH ELIGIBILITY PERIOD.

. IN THE EVENT A PATIENT FAILS TO MEET THESE RESPONSIBILITIES, MEDSTAR  
RESERVES THE RIGHT TO PURSUE ADDITIONAL BILLING AND COLLECTION EFFORTS.  
IN THE EVENT OF NON-PAYMENT BILLING, AND COLLECTION EFFORTS ARE DEFINED  
IN THE MEDSTAR BILLING AND COLLECTION POLICY. A FREE COPY IS AVAILABLE  
ON ALL HOSPITAL WEBSITES AND PATIENT PORTALS VIA THE FOLLOWING URL:  
[WWW.MEDSTARHEALTH.ORG/FINANCIALASSISTANCE](http://WWW.MEDSTARHEALTH.ORG/FINANCIALASSISTANCE), OR BY CALLING CUSTOMER  
SERVICE AT 1-800-280-9006.



**Part VI** Supplemental Information (Continuation)

PATIENTS OF MEDSTAR HEALTH'S HOSPITALS AND HOSPITAL-BASED PHYSICIAN  
PRACTICES MAY BE ELIGIBLE FOR FULL FINANCIAL ASSISTANCE OR PARTIAL  
SLIDING-SCALE FINANCIAL ASSISTANCE AS SET FORTH UNDER THIS POLICY. THE  
PATIENT ADVOCATE AND PATIENT FINANCIAL SERVICES STAFF WILL DETERMINE  
ELIGIBILITY FOR FULL FINANCIAL ASSISTANCE AND PARTIAL SLIDING-SCALE  
FINANCIAL ASSISTANCE BASED ON REVIEW OF INCOME FOR THE PATIENT AND  
THEIR FAMILY (HOUSEHOLD), OTHER FINANCIAL RESOURCES AVAILABLE TO THE  
PATIENT'S FAMILY, FAMILY SIZE, AND THE EXTENT OF THE MEDICAL COSTS TO  
BE INCURRED BY THE PATIENT.

COMMUNITY INFORMATION

PART VI, LINE 4

THE COMMUNITY THE ORGANIZATION SERVES INCLUDES ZIP CODE 20653.

ZIP CODE 20653 IS A RURAL GEOGRAPHIC SERVICE AREA. THERE ARE 24,481  
RESIDENTS AND THE MEDIAN HOUSEHOLD INCOME IS \$63,676. THE COMMUNITY  
INCLUDES RESIDENTS WITH INCOMES BELOW THE FEDERAL POVERTY GUIDELINE  
(15%), UNINSURED RESIDENTS (7%), AND MEDICAID RECIPIENTS (25%). THERE  
IS ONE HOSPITAL SERVING THE COMMUNITY AND TWO FEDERALLY DESIGNATED  
MEDICALLY UNDERSERVED AREAS OR POPULATIONS PRESENT.

BASED ON PATIENT RATIOS, ACCESS TO CARE CONTINUES TO BE A  
COMMUNITY-WIDE CHALLENGE WITH PRIMARY CARE PROVIDERS (2,440:1),  
DENTISTS (1,974:1), AND MENTAL HEALTH PROVIDERS (715:1). BEYOND THE  
DEFICIENCY OF HEALTHCARE RESOURCES, THERE ARE ALSO TRANSPORTATION  
BARRIERS TO ACCESSING SERVICES. RESIDENTS ARE HINDERED BY A DEFINED BUS  
ROUTE THAT LACKS ACCESSIBILITY IN TERMS OF COST, LOCATION OR  
ACCOMMODATION TO MOBILITY LIMITATIONS OR DISABILITIES.

FROM AN ECONOMIC PERSPECTIVE, 35% OF SCHOOL-AGED CHILDREN ARE ELIGIBLE FOR FREE OR REDUCED-COST LUNCH AND 20% OF CHILDREN ARE FROM SINGLE-PARENT HOMES. HOUSING COSTS ARE ALSO A BURDEN FOR 12% OF THE COMMUNITY, WHO SPEND 50% OR MORE OF THEIR HOUSEHOLD INCOME ON HOUSING. ADULT OBESITY IS AN ONGOING HEALTH CHALLENGE IMPACTING MORE THAN ONE-THIRD OF ADULTS (36%) IN THE COUNTY AND 9% HAVE BEEN OFFICIALLY DIAGNOSED WITH DIABETES

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

AS A COMMUNITY PARTNER, MSMH ENGAGES IN SEVERAL COMMUNITY BENEFIT ACTIVITIES TO IMPROVE AND PROMOTE THE HEALTH AND WELL-BEING OF THE COMMUNITY. PRIORITY AREAS, AS DETERMINED BY THE CHNA, FALL UNDER THREE AREAS OF FOCUS INCLUDING HEALTH AND WELLNESS, ACCESS TO CARE, AND SOCIAL DETERMINANTS OF HEALTH. PROGRAMS INCLUDE (BUT ARE NOT LIMITED TO):

HEALTH AND WELLNESS

EDUCATIONAL PROGRAMS ARE OFFERED WITH THE GOAL OF IMPROVING COMMUNITY HEALTH AND WELL-BEING. FOR EXAMPLE, THE NATIONAL DIABETES PREVENTION PROGRAM (NDPP) IS A YEARLONG PROGRAM THAT PROVIDES LIFESTYLE CHANGE EDUCATION FOR RESIDENTS WHO HAVE ELEVATED A1C LEVELS, THOUGH ARE NOT DIAGNOSED WITH TYPE 2 DIABETES. THE PROGRAM IS AIMED AT PREVENTING THE DEVELOPMENT OF TYPE 2 DIABETES THROUGH WEIGHT LOSS, PHYSICAL ACTIVITY AND FOOD TRACKING. THESE LIFESTYLE CHANGES HELP TO FURTHER DELAY THE ONSET OF DIABETES AND OTHER CHRONIC DISEASES. CONVERSATION MAPS, A FREE FOUR-WEEK SELF-MANAGEMENT WORKSHOP, IS OFFERED TO FACILITATE

GUIDED DISCUSSIONS ON DIABETES MANAGEMENT, MEDICATIONS, NUTRITION, AND

PHYSICAL ACTIVITY. ADDITIONALLY, MSMH CONTINUES TO OFFER TOBACCO

CESSATION CLASSES AND THE PARENTS TO BE WORKSHOP, A FULL-DAY PROGRAM

THAT OFFERS HEALTH EDUCATION ON INFANT CPR, CHILDBIRTH, BREASTFEEDING

BASICS, AND BABY CARE BASICS.

SUPPORT GROUPS ARE OFFERED TO COMMUNITY MEMBERS FOR A VARIETY OF TOPICS

INCLUDING CANCER, PARKINSON'S DISEASE, BARIATRIC, DIABETES PREVENTION,

BREASTFEEDING, AND STROKE. STAFF ALSO SHARE THEIR KNOWLEDGE WITH THE

COMMUNITY THROUGH INTERVIEWS, SEMINARS, BLOGS, VIDEOS, AS WELL AS

DISCUSSIONS OR SCREENINGS AT COMMUNITY HEALTH FAIRS.

ACCESS TO CARE

EAST RUN MEDICAL CENTER IS HOME TO A PRIMARY CARE SAFETY-NET DENTAL

CLINIC AND A VETERAN'S AFFAIRS CLINIC. THESE SERVICES, ALONG WITH

TRANSITIONAL CARE OUTPATIENT NURSES AND COMMUNITY HEALTH ADVOCATES

ASSIST IN BRIDGING THE GAPS IN SERVICE THAT OUR MOST VULNERABLE

COMMUNITY MEMBERS FACE. THE HOSPITAL ALSO SUBSIDIZES HEALTH SERVICES TO

ENSURE RESIDENTS HAVE ACCESS TO THE CLINICAL CARE THEY NEED.

THE HOSPITAL PARTNERS WITH THE CENTER FOR LIFE ENRICHMENT TO PROMOTE

ACCESS TO CARE FOR VULNERABLE POPULATIONS. THROUGH THIS PARTNERSHIP,

TRANSPORTATION IS PROVIDED TO RESIDENTS WITH FINANCIAL NEED. THIS

TRANSPORTATION ASSISTANCE ALLOWS RESIDENTS TO ACCESS HEALTH CARE

PROVIDERS AND OTHER COMMUNITY-BASED SERVICES, LIKE FOOD BANKS, TO

IMPROVE HEALTH OUTCOMES.

SOCIAL DETERMINANTS OF HEALTH

**Part VI** Supplemental Information (Continuation)

THE SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)

PROGRAM IS PROVIDED TO SUPPORT SUBSTANCE ABUSE RECOVERY IN THE

COMMUNITY AND PROMOTE ACCESS TO BEHAVIORAL HEALTH PROGRAMS. THIS

PROGRAM INCLUDES THREE MAIN COMPONENTS: SCREENING, BRIEF INTERVENTION,

AND REFERRAL TO TREATMENT. THOSE WHO SCREEN POSITIVE FOR HIGH-RISK

BEHAVIORS ARE CONNECTED TO PEER RECOVERY COACHES WHO CONDUCT A BRIEF

INTERVENTION AND REFER TO TREATMENT IF APPROPRIATE. OPIOID OVERDOSE

SURVIVOR OUTREACH COACHES LINK COMMUNITY MEMBERS WITH A HISTORY OF

SUBSTANCE ABUSE TREATMENT WITH THE RESOURCES THEY NEED TO PREVENT A

FUTURE OVERDOSE. THIS TEAM WORKS IN COORDINATION WITH OUR COMMUNITY

HEALTH WORKERS AS WELL AS TRANSITIONAL CARE NURSES TO SUPPORT COMMUNITY

MEMBERS WITH THE RESOURCES NEEDED TO MANAGE THEIR ADDICTIONS AND

PROMOTE RECOVERY.

COMMUNITY HEALTH WORKERS IMPROVE THE HEALTH OF THEIR COMMUNITIES BY

CONNECTING VULNERABLE RESIDENTS TO LOCAL RESOURCES INCLUDING PRIMARY

CARE PROVIDERS, HEALTH INSURANCE, AND SOCIAL SERVICES, INCLUDING FOOD

ACCESS, TRANSPORTATION, HOUSING, AND UTILITY ASSISTANCE. COMMUNITY

HEALTH WORKERS REFER INDIVIDUALS TO RESOURCES THROUGH THE FINDHELP.ORG

RESOURCE DATABASE THAT HELPS BRIDGE THE GAP FOR A VARIETY OF NEEDS

INCLUDING FINANCIAL RESOURCES, HOUSING, UTILITIES, CHILDCARE, AND FOOD

PANTRIES.

THE WORKFORCE DEVELOPMENT PROGRAM PROVIDED ROBUST STUDENT INTERNSHIP

EXPERIENCES FOR HIGH SCHOOL-LEVEL YOUTH. THIS EIGHT-WEEK SUMMER

INTERNSHIP CONNECTED THE COURSE CURRICULUM WITH TANGIBLE ONSITE

EXPERIENCE. THIS OFFERED STUDENTS THE ABILITY TO DEVELOP SKILLS WHILE

RECEIVING RELEVANT WORK EXPERIENCE IN THE MEDICAL FIELD.

**Part VI** Supplemental Information (Continuation)

SOCIAL NEEDS SCREENINGS ARE PROVIDED TO SCREEN FOR ISSUES SUCH AS FOOD

AND HOUSING INSECURITY, AND BARRIERS RELATED TO TRANSPORTATION,

EMPLOYMENT, AND UTILITIES. IDENTIFIED NEEDS ARE ADDRESSED BY A

COMMUNITY HEALTH WORKER CONNECTING THE PARTICIPANT TO SOCIAL SERVICES

AND OTHER COMMUNITY RESOURCES. THE FINDHELP.ORG ONLINE PLATFORM ALLOWS

OUR ASSOCIATES THE ABILITY TO REFER, TRACK, AND MANAGE CONNECTIONS WITH

LOCAL NONPROFIT GROUPS AND PUBLIC SERVICE AGENCIES THAT MAY BE ABLE TO

AID THOSE REQUIRING SUPPORT.

AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

MSMH IS PROUDLY PART OF MEDSTAR HEALTH, AND AS A RESULT, IS ABLE TO

EXPAND ITS CAPACITY TO MEET THE NEEDS OF THE COMMUNITY BY PARTNERING

WITH OTHER MEDSTAR HOSPITALS AND ASSOCIATED ENTITIES. MEDSTAR HEALTH

RESOURCES ASSIST THE HOSPITAL IN COMMUNITY HEALTH PLANNING TO MEET THE

NEEDS OF THE UNINSURED AND OTHER VULNERABLE POPULATIONS. THROUGH ITS

COMMUNITY HEALTH FUNCTION, MEDSTAR HEALTH PROVIDES MSMH WITH TECHNICAL

SUPPORT TO ENHANCE COMMUNITY HEALTH PROGRAMMING AND EVALUATION. MEDSTAR

HEALTH'S CORPORATE PHILANTHROPY DEPARTMENT IDENTIFIES AND SEEKS PUBLIC

AND PRIVATE FUNDING SOURCES TO ENSURE THE AVAILABILITY OF HIGH-QUALITY

HEALTH SERVICES, REGARDLESS OF ABILITY TO PAY.

STATE FILING OF COMMUNITY BENEFIT REPORT

PART VI, LINE 7

THE COMMUNITY BENEFIT REPORT FOR MSMH IS FILED IN THE STATE OF

MARYLAND.

SCHEDULE I  
(Form 990)

Department of the Treasury  
Internal Revenue Service

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

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

Attach to Form 990.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

2023

Open to Public  
Inspection

Name of the organization ST. MARYS HOSPITAL OF ST. MARYS  
COUNTY INC.

Employer identification number  
52-0619006

Part I General Information on Grants and Assistance

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

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

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of noncash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance

- 2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 0.
- 3 Enter total number of other organizations listed in the line 1 table 0.

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

Schedule I (Form 990) 2023

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
SCHOLARSHIPS	10	51,038.	0.		

**Part IV Supplemental Information.** Provide the information required in Part I, line 2; Part III, column (b); and any other additional information.

MONITORING FUNDS

WE HAVE AN EMPLOYEE SCHOLARSHIP ("ES") PROGRAM AT ST. MARY'S HOSPITAL.

THE EMPLOYEE SCHOLARSHIPS UNDERGO A THOROUGH REVIEW AND APPROVAL PHASE

DEPENDENT UPON PROPER SUBMISSIONS BY THE REQUESTING RECIPIENT. ANY

CHANGES TO THE ES PROGRAM MUST GO THROUGH THE PRESIDENT'S OFFICE FOR

APPROVAL. ALL APPLICANTS WILL BE ASSIGNED A HRD ASSOCIATE THAT WILL

RECEIVE AND STAMP APPLICATIONS WHEN RECEIVED. ALL APPLICANTS WILL BE

INTERVIEWED BY HRD DEPARTMENT LEADER OF THE NURSING RECRUITER/HR

GENERALIST FOR REVIEW OF THE APPLICATION AND AGREEMENT EXPECTATIONS.

Part IV

Supplemental Information

APPLICANTS MAY BE INTERVIEWED IF NEEDED BY THE SELECTION COMMITTEE.

WITHIN 10 DAYS APPLICANT IS NOTIFIED IN WRITING OF SCHOLARSHIP DECISION

AND THE HRD ASSOCIATE WILL REVIEW WITH EACH RECIPIENT THE REQUIREMENTS

OF THE PROGRAM. ALL INVOICES WILL BE REVIEWED FOR REQUIRED INFORMATION

AND VERIFICATION BEFORE PROCESSING, THE PAYMENT IS REQUESTED.



**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" on Form 990, Part IV, line 23.  
Attach to Form 990.  
Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

Open to Public  
Inspection

Name of the organization  
ST. MARYS HOSPITAL OF ST. MARYS  
COUNTY INC.

Employer identification number  
52-0619006

**Part I Questions Regarding Compensation**

**1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed on 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 (such as maid, chauffeur, chef) |

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

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

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

- |   |   |
|---|---|
| <input 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 checked="" type="checkbox"/> Form 990 of other organizations     | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

**4** During the year, did any person listed on 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), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.**

**5** For persons listed on 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" on line 5a or 5b, describe in Part III.

**6** For persons listed on 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" on line 6a or 6b, describe in Part III.

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

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

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

Yes No

--	--	--

**1b**

**2**

--	--	--

**4a** X

**4b** X

**4c** X

--	--	--

**5a** X

**5b** X

--	--	--

**6a** X

**6b** X

--	--	--

**7** X

**8** X

--	--	--

**9**

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

Schedule J (Form 990) 2023

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

For each individual whose compensation must be reported on 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 aren't listed on Form 990, Part VII.

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) KENNETH A. SAMET DIRECTOR	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	2,308,151.	3,403,165.	1,372,432.	68,539.	37,548.	7,189,835.	0.
(2) STEPHEN MICHAELS, M.D. FORMER SECRETARY	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	579,655.	450,662.	0.	9,150.	19,358.	1,058,825.	0.
(3) MIMI NOVELLO, M.D. PRESIDENT/DIRECTOR	(i)	538,066.	417,172.	0.	9,150.	2,371.	966,759.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) ANNE BANFIELD DIRECTOR	(i)	461,596.	135,799.	111,562.	0.	9,362.	718,319.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) JOHN HARVEY, M.D. DIRECTOR	(i)	419,866.	212,811.	0.	9,150.	23,040.	664,867.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) YAHIA TAGOURI, M.D. DIRECTOR	(i)	417,587.	111,731.	0.	9,150.	20,821.	559,289.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) ANNA CHOI, M.D. DIRECTOR (UNTIL 10/2023)	(i)	489,695.	42,000.	0.	9,150.	18,245.	559,090.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) TARA SAGGAR, M.D. DIRECTOR	(i)	360,039.	91,559.	25,000.	9,150.	23,580.	509,328.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) DAVID HAVRILLA FORMER CFO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	294,810.	130,187.	0.	9,150.	18,500.	452,647.	0.
(10) MICHAEL MEISEL CFO/TREASURER (UNTIL 08/2023)	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	307,987.	105,892.	0.	9,150.	21,102.	444,131.	0.
(11) JAMES DAMALOUJI, M.D. DIRECTOR	(i)	403,708.	0.	0.	2,750.	22,723.	429,181.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) DANIEL FEELEY FORMER CFO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	294,324.	60,093.	0.	9,129.	23,236.	386,782.	0.
(13) PURVI JANI CFO/TREASURER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	320,315.	0.	0.	8,956.	10,013.	339,284.	0.
(14) ANNETTE BRONER SECRETARY	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	241,602.	55,746.	0.	8,573.	22,675.	328,596.	0.
(15) JOHN GREELY VP OF OPERATIONS	(i)	231,794.	56,760.	0.	8,484.	22,999.	320,037.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) DAWN YEITRAKIS CNO	(i)	238,358.	48,947.	0.	1,300.	18,217.	306,822.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.

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

For each individual whose compensation must be reported on 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 aren't listed on Form 990, Part VII.

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(17) HEATHER SWAN-JONES	(i)	240,575.	0.	0.	9,150.	15,626.	265,351.	0.
REGISTERED NURSE	(ii)	0.	0.	0.	0.	0.	0.	0.
(18) MARY IBEGBU	(i)	226,616.	0.	0.	5,772.	17,928.	250,316.	0.
DIRECTOR OF PHARMACY	(ii)	0.	0.	0.	0.	0.	0.	0.
(19) LORI WERRELL	(i)	189,142.	33,502.	0.	6,071.	1,449.	230,164.	0.
AVP, CARE TRANSFORMATION	(ii)	0.	0.	0.	0.	0.	0.	0.
(20) ROBERT LALLY	(i)	0.	0.	0.	0.	0.	0.	0.
FORMER CFO	(ii)	9,348.	0.	204,382.	0.	0.	213,730.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

**Part III** Supplemental Information

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

SCHEDULE J, PART III:

DETAILED BELOW ARE SEVERAL ONE-TIME PAYMENTS TO CERTAIN EXECUTIVES

RELATED TO VARIOUS RETIREMENT, RETENTION AND LONG-TERM INCENTIVE PLANS.

THESE PLANS AND PAYMENTS ARE NOT A ROUTINE PART OF THE TYPICAL MEDSTAR

EXECUTIVE COMPENSATION PROGRAM, AND SUPPORTED IMPORTANT OBJECTIVES OF

OUR ORGANIZATION.

MR. SAMET'S OTHER REPORTABLE COMPENSATION IN PART II, COLUMN (B)(III)

INCLUDES A PAYMENT OF \$1,372,432, WHICH REPRESENTS THE CASH VALUE OF

THE SPLIT DOLLAR LIFE INSURANCE POLICY ASSIGNED TO MR. SAMET.

ANNE BANFIELD'S OTHER REPORTABLE COMPENSATION IN PART II, COLUMN

(B)(III) INCLUDES \$40,000 REPRESENTING RETENTION BONUS PAYMENTS

RECEIVED BY DR. BANFIELD.

MICHAEL MEISEL'S COMPENSATION IS FOR SERVICES PROVIDED AS CFO TO BOTH

MEDSTAR ST. MARY'S HOSPITAL AND MEDSTAR SOUTHERN MARYLAND HOSPITAL

CENTER.

**Part III** Supplemental Information

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

ROBERT LALLY'S COMPENSATION IS FOR SERVICES PREVIOUSLY PROVIDED AS CFO

TO MEDSTAR FRANKLIN SQUARE MEDICAL CENTER, MEDSTAR HARBOR HOSPITAL,

MEDSTAR ST. MARY'S HOSPITAL, AND MEDSTAR SOUTHERN MARYLAND HOSPITAL.

ROBERT LALLY'S OTHER REPORTABLE COMPENSATION IN PART II, COLUMN

(B)(III) INCLUDES \$204,382 REPRESENTING SEVERANCE PAYMENTS RECEIVED BY

MR. LALLY.

**SCHEDULE L**  
**(Form 990)**

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.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

Open to Public  
Inspection

Name of the organization **ST. MARYS HOSPITAL OF ST. MARYS  
COUNTY INC.**

Employer identification number  
**52-0619006**

**Part I Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and section 501(c)(29) 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) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
			Yes	No
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

2 Enter the amount of tax incurred by 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-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												

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 of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				

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

Schedule L (Form 990) 2023

**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
(1) CMI GENERAL CONTRACTORS,	SEE PART V	270,556.	CONSTRUCTIO		X
(2) MARYLAND HOSPITAL ASSOCI	SEE PART V	101,569.	MEMBERSHIP		X
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

**Part V Supplemental Information**

Provide additional information for responses to questions on Schedule L. See instructions.

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: CMI GENERAL CONTRACTORS, INC.

(D) DESCRIPTION OF TRANSACTION: CONSTRUCTION

(A) NAME OF PERSON: MARYLAND HOSPITAL ASSOCIATION

(D) DESCRIPTION OF TRANSACTION: MEMBERSHIP DUES

BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

THE FOLLOWING IS A SUBSTANTIAL CONTRIBUTOR (IN EXCESS OF \$5,000) THAT

ALSO PROVIDED SERVICES TO MEDSTAR ST. MARY'S HOSPITAL VALUED IN EXCESS

OF \$100,000: CMI GENERAL CONTRACTORS, INC. AND MARYLAND HOSPITAL

ASSOCIATION. PER MEDSTAR'S CONFLICT OF INTEREST POLICY, THESE

TRANSACTIONS ARE AT ARMS-LENGTH FOR FAIR MARKET VALUE.

**SCHEDULE M  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Noncash Contributions**

OMB No. 1545-0047

**2023**

Open to Public  
Inspection

Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.

Attach to Form 990.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

Name of the organization	ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number	52-0619006
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**Part I Types of Property**

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art .....				
2 Art - Historical treasures .....				
3 Art - Fractional interests .....				
4 Books and publications .....				
5 Clothing and household goods .....				
6 Cars and other vehicles .....				
7 Boats and planes .....				
8 Intellectual property .....				
9 Securities - Publicly traded .....				
10 Securities - Closely held stock .....				
11 Securities - Partnership, LLC, or trust interests .....				
12 Securities - Miscellaneous .....	X	2	28,076.	FMV
13 Qualified conservation contribution - Historic structures .....				
14 Qualified conservation contribution - Other ...				
15 Real estate - Residential .....				
16 Real estate - Commercial .....				
17 Real estate - Other .....				
18 Collectibles .....				
19 Food inventory .....				
20 Drugs and medical supplies .....				
21 Taxidermy .....				
22 Historical artifacts .....				
23 Scientific specimens .....				
24 Archeological artifacts .....				
25 Other ( ..... )				
26 Other ( ..... )				
27 Other ( ..... )				
28 Other ( ..... )				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part V, Donee Acknowledgement .....	29
--	----

	Yes	No
30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least 3 years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period? .....		X
b If "Yes," describe the arrangement in Part II.		
31 Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions? .....		X
32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? .....		X
b If "Yes," describe in Part II.		
33 If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.		

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

Schedule M (Form 990) 2023



**Part II** **Supplemental Information.** Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

PART I, COLUMN (B).

THIS COLUMN IS REPORTING THE NUMBER OF CONTRIBUTIONS, NOT THE NUMBER OF  
ITEMS RECEIVED.

SCHEDULE O  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on  
Form 990 or 990-EZ or to provide any additional information.  
Attach to Form 990 or Form 990-EZ.  
Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

2023  
Open to Public  
Inspection

Name of the organization	ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

MEDSTAR ST. MARY'S HOSPITAL UPHOLDS ITS TRADITION OF CARING BY  
CONTINUOUSLY PROMOTING, MAINTAINING AND IMPROVING HEALTH THROUGH  
EDUCATION AND SERVICE.

FORM 990, PART III, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR ST. MARY'S HOSPITAL'S  
(MEDSTAR ST. MARY'S) MISSION IS TO UPHOLD ITS TRADITION OF CARING BY  
CONTINUOUSLY PROMOTING, MAINTAINING, AND IMPROVING HEALTH THROUGH  
EDUCATION AND SERVICE WHILE ASSURING QUALITY CARE, PATIENT SAFETY AND  
FISCAL INTEGRITY. MEDSTAR ST. MARY'S IS LOCATED IN LEONARDTOWN,  
MARYLAND, IN THE SOUTHERN REGION.

IN FISCAL YEAR 2024, MSMH HAD 6,901 INPATIENT ADMISSIONS AND 110,600  
OUTPATIENT VISITS INCLUDING 42,666 EMERGENCY VISITS.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

MEDSTAR ST. MARY'S HOSPITAL'S LARGEST PROGRAM IS ACCESS TO AND THE  
PROVISION OF ACUTE HOSPITAL SERVICES FOR COMMUNITIES OF ST. MARY'S  
COUNTY, MARYLAND AND THE SURROUNDING AREAS. IN ADDITION TO THE PROGRAM  
SERVICE EXPENSES LISTED ABOVE, MEDSTAR ST. MARY'S INCURRED \$46.9M OF  
MANAGEMENT AND GENERAL EXPENSES IN PROVIDING SERVICES TO ITS  
COMMUNITIES. MEDSTAR ST. MARY'S PROVIDES GENERAL, ACUTE CARE SERVICES  
IN MEDICINE, SURGERY, OBSTETRICS AND GYNECOLOGY, ONCOLOGY,  
ORTHOPAEDICS, PULMONARY AND CARDIAC REHABILITATION, AND PSYCHIATRY. IT  
ALSO PROVIDES EMERGENCY DEPARTMENT CARE. ALSO INCLUDED IN OUR RANGE OF

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

Schedule O (Form 990) 2023

Name of the organization	ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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SERVICES IS HOSPICE CARE AND A JOINT VENTURE THAT PROVIDES HOME CARE

SERVICES WITH 2 OTHER LOCAL HOSPITALS IN ADJACENT COUNTIES. AN

OUTPATIENT PAVILION INCLUDES CANCER CARE AND INFUSION SERVICES, AND

IMAGING. SERVICES ALSO INCLUDE A CENTER FOR WOUND HEALING.

MEDSTAR ST. MARY'S HOSPITAL IS A MARYLAND INSTITUTE FOR EMERGENCY

MEDICAL SERVICES SYSTEMS (MIEMSS) ACCREDITED PRIMARY STROKE CENTER. IT

HAS A CANCER CENTER THAT HAS COMMISSION ON CANCER CERTIFICATION, IS A

CERTIFIED BABY FRIENDLY HOSPITAL AND IS A MAGNET FACILITY.

FORM 990, PART VI, SECTION A, LINE 6:

ORGANIZATION MEMBERS

THE ORGANIZATION IS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A

TAX-EXEMPT MARYLAND NON-STOCK CORPORATION. MEDSTAR HEALTH, INC., OR ONE OF

ITS AFFILIATES AND SUBSIDIARIES, IS THE SOLE MEMBER OF THE ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7A:

DESCRIPTION OF MEMBERS

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT

MARYLAND NON-STOCK CORPORATION, THE ORGANIZATION MAY RECOMMEND PERSON(S)

FOR MEMBERSHIP ON THE ORGANIZATION'S GOVERNING BODY. ANY SUCH

RECOMMENDATION BY THE ORGANIZATION IS SUBJECT TO APPROVAL BY THE GOVERNANCE

COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR HEALTH, INC. THE BOARD OF

MEDSTAR HEALTH, INC. HAS DELEGATED CERTAIN APPROVAL AUTHORITY TO THE

GOVERNANCE COMMITTEE AND THE PRESIDENT & CEO OF MEDSTAR HEALTH, INC.

FORM 990, PART VI, SECTION A, LINE 7B:

DECISIONS OF GOVERNING BODY

Name of the organization ST. MARYS HOSPITAL OF ST. MARYS  
COUNTY INC.

Employer identification number  
52-0619006

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT

MARYLAND NON-STOCK CORPORATION, THE BYLAWS OF THE ORGANIZATION ARE SUBJECT

TO CERTAIN RESERVED POWERS, WHICH PROVIDE THAT THE SOLE MEMBER OF THE

ORGANIZATION MUST APPROVE CERTAIN DECISIONS, INCLUDING BUT NOT LIMITED TO

MATTERS CONCERNING THE SALE OR PURCHASE OF REAL OR PERSONAL PROPERTY,

CAPITAL BUDGETS, STRATEGIC PLANNING, INVESTMENTS, AND CORPORATE GOVERNANCE.

FORM 990, PART VI, SECTION B, LINE 11B:

PROCESS FOR REVIEWING FORM 990

THE PROCESS FOR REVIEWING THE FORM 990 INCLUDED EDUCATION AND TRANSPARENCY.

SENIOR FINANCIAL EXECUTIVES, WORKING WITH INDEPENDENT OUTSIDE EXPERTS,

THOROUGHLY REVIEWED FORM 990 AND ACCOMPANYING INSTRUCTIONS. IN ADDITION,

SENIOR EXECUTIVES REVIEWED THE RELEVANT SECTIONS OF THE FORM 990 WITH THE

FOLLOWING COMMITTEES OF THE ORGANIZATION'S GOVERNING BODY: FINANCE, AUDIT,

GOVERNANCE, AND EXECUTIVE COMPENSATION. FOLLOWING THESE MEETINGS, THE

GOVERNING BODY WAS PROVIDED A COPY OF THE FORM 990 IN ITS FINAL FORM AND

GIVEN AN OPPORTUNITY TO PROVIDE ANY INPUT OR COMMENTS RELATING TO THE FORM

990 PRIOR TO ITS FILING.

FORM 990, PART VI, SECTION B, LINE 12C:

CONFLICT OF INTEREST POLICY

APPOINTMENT OF BOARDS OF DIRECTORS MEDSTAR HEALTH (AND ITS SUBSIDIARIES)

REQUIRE ALL NOMINATED DIRECTORS, PRIOR TO THEIR APPOINTMENT OR ELECTION, TO

DISCLOSE THE EXISTENCE OF (OR POTENTIAL EXISTENCE OF) ANY TRANSACTION WITH

MEDSTAR THAT WOULD RESULT IN A CONFLICT OF INTEREST. SUCH DISCLOSURES (IF

ANY) ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD

OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE RESOLVED.

Name of the organization	ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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ANNUAL DISCLOSURES - ALL OFFICERS, DIRECTORS, AND SENIOR MANAGERS ALL

OFFICERS, DIRECTORS AND SENIOR MANAGERS ARE REQUIRED, NOT LESS THAN

ANNUALLY, TO COMPLETE A SURVEY OF QUESTIONS CONCERNING ANY TRANSACTIONS OR

RELATIONSHIPS WHICH WOULD OR COULD REPRESENT A CONFLICT OF INTEREST. SUCH

DISCLOSURES (IF ANY) ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE

MEDSTAR HEALTH BOARD OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE

RESOLVED.

FORM 990, PART VI, SECTION B, LINE 15:

EXECUTIVE COMPENSATION PROCESS

THE EXECUTIVE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR

HEALTH, INC. (THE "COMMITTEE") HAS OVERSIGHT OF THE EXECUTIVE COMPENSATION

PROGRAM (THE "PROGRAM") OF MEDSTAR HEALTH, INC. AND ITS AFFILIATES. TOTAL

COMPENSATION FOR THE TOP MANAGEMENT OFFICIALS, OFFICERS AND KEY EMPLOYEES

OF MEDSTAR HEALTH, INC. AND ITS AFFILIATES ARE REVIEWED AND APPROVED BY THE

COMMITTEE WITH ASSISTANCE AND GUIDANCE FROM AN INDEPENDENT THIRD PARTY

ADVISOR. THE MEMBERS OF THE COMMITTEE ARE INDEPENDENT FROM ALL OF THE

PARTICIPANTS IN THE PROGRAM.

THE MAIN OBJECTIVE OF THE PROGRAM IS TO PROVIDE MARKET COMPETITIVE TOTAL

COMPENSATION THAT IS INTERNALLY EQUITABLE AND HAS A STRONG

PAY-FOR-PERFORMANCE LINKAGE. PERFORMANCE IS EVALUATED AT THE SYSTEM,

OPERATING UNIT, AND INDIVIDUAL LEVELS. THE OVERALL TOTAL COMPENSATION

PHILOSOPHY IS MANAGED AT THE 75TH PERCENTILE OF THE COMPETITIVE MARKET FOR

COMPARABLE SIZE (NET REVENUE) AND TYPE (TAX-EXEMPT HEALTHCARE

ORGANIZATIONS). WHERE APPROPRIATE, ADDITIONAL INDUSTRY DATA IS CONSIDERED

(GENERAL BUSINESS AND/OR TAXABLE HEALTHCARE) FOR SELECTED POSITIONS THAT

CAN BE RECRUITED FROM OR POTENTIALLY LOST TO THESE INDUSTRIES (E.G.,

Name of the organization	ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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INFORMATION TECHNOLOGY, FINANCE, ETC.).

THE COMMITTEE HAS ENGAGED ERNST & YOUNG LLP ("E&Y") TO SERVE AS AN ADVISOR

ON THE REASONABLENESS AND COMPETITIVENESS OF THE PROGRAM. IN DETERMINING

REASONABLENESS AND COMPETITIVENESS, E&Y REVIEWS MARKET PRACTICES AND

TRENDS, AND MAKES RECOMMENDATIONS RELATED TO THE PROGRAM. E&Y UTILIZES

INFORMATION FROM CUSTOM SURVEYS, NATIONAL COMPENSATION SURVEYS, PROPRIETARY

DATABASES, AND CLIENT EXPERIENCES TO DETERMINE ITS FINAL RECOMMENDATIONS.

E&Y PRESENTS THEIR FINDINGS AND RECOMMENDATIONS TO THE COMMITTEE. THE

COMMITTEE MAKES THE FINAL DECISIONS ON ALL OF THE COMPENSATION

DETERMINATIONS OF THE PROGRAM. ALL DECISIONS MADE BY THE COMMITTEE ARE

CONTEMPORANEOUSLY DOCUMENTED.

FORM 990, PART VI, SECTION C, LINE 19:

FINANCIAL STATEMENT AVAILABILITY

MEDSTAR HEALTH POSTS ITS ANNUAL FINANCIAL AUDIT AND QUARTERLY FINANCIAL

REPORTS TO THE ELECTRONIC MUNICIPAL MARKET ACCESS (EMMA) SYSTEM. THE

ORGANIZATION ALSO E-MAILS ITS ANNUAL AND QUARTERLY DISCLOSURES TO HOLDERS

OF THE COMPANY'S PUBLICLY TRADED DEBT. THE COMPANY'S GOVERNANCE DOCUMENTS

AND CONFLICTS OF INTEREST POLICIES ARE AVAILABLE UPON REQUEST THROUGH ITS

CORPORATE (OR AS APPLICABLE ENTITY) PUBLIC INFORMATION OFFICES.

FORM 990, PART IX, LINE 11G, OTHER FEES:

OTHER:

PROGRAM SERVICE EXPENSES 19,067,865.

MANAGEMENT AND GENERAL EXPENSES 3,032,436.

FUNDRAISING EXPENSES 0.

TOTAL EXPENSES 22,100,301.

Name of the organization	ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number	52-0619006
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TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A22,100,301.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

EQUITY TRANSFERS3,933,934.

MINIMUM PENSION LIABILITY ADJUSTMENT2,951,440.

TOTAL TO FORM 990, PART XI, LINE 96,885,374.

PART XII, LINE 2

ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC. IS AN AFFILIATE OF THE  
MEDSTAR HEALTH, INC. AUDIT AND SUBJECT TO OVERSIGHT BY THE AUDIT  
COMMITTEE OF THE MEDSTAR BOARD.

**SCHEDULE R**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Related Organizations and Unrelated Partnerships**  
Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.  
Attach to Form 990.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Name of the organization	ST. MARYS HOSPITAL OF ST. MARYS COUNTY INC.	Employer identification number 52-0619006
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**Part I Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
CHURCH HOME CORPORATION - 23-7374724 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL FUND	MARYLAND	501(C)(3)	PF	N/A		X
FRANKLIN SQUARE HOSPITAL CENTER, INC. - 52-0608007, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237	HOSPITAL	MARYLAND	501(C)(3)	LINE 3	N/A		X
HARBOR HOSPITAL, INC. - 52-0491660 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225	HOSPITAL	MARYLAND	501(C)(3)	LINE 3	N/A		X
MEDSTAR HEALTH, INC. - 52-2087445 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SVCS	MARYLAND	501(C)(3)	LINE 12C, III-FI	N/A		X

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

Schedule R (Form 990) 2023



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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
MONTGOMERY GENERAL HOSPITAL - 52-0646893 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	HOSPITAL	MARYLAND	501(C)(3)	LINE 3	N/A		X
THE GOOD SAMARITAN HOSPITAL OF MARYLAND, - 52-0591607, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239	HOSPITAL	MARYLAND	501(C)(3)	LINE 3	N/A		X
THE UNION MEMORIAL HOSPITAL - 52-0591685 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218	HOSPITAL	MARYLAND	501(C)(3)	LINE 3	N/A		X
MEDSTAR HEALTH RESEARCH INSTITUTE - 52-6056274, 108 IRVING STREET NW, WASHINGTON, DC 20010	HOSPITAL	DISTRICT OF COLUMBIA	501(C)(3)	LINE 4	N/A		X
THE MEDSTAR-GEORGETOWN MEDICAL CENTER, I - 52-2218584, HOPSITAL ADMIN, 1 MAIN BLDG, WASHINGTON, DC 20007	HOSPITAL	DISTRICT OF COLUMBIA	501(C)(3)	LINE 3	N/A		X
WASHINGTON HOSPITAL CENTER CORPORATION - 52-1272129, 110 IRVING STREET NW, WASHINGTON, DC 20010	HOSPITAL	DISTRICT OF COLUMBIA	501(C)(3)	LINE 3	N/A		X
HH MEDSTAR HEALTH, INC. - 52-1542230 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SVCS	MARYLAND	501(C)(3)	LINE 12C, III-FI	N/A		X
MEDSTAR AMBULATORY SERVICES, INC. - 52-1132992, 10980 GRANTCHESTER WAY, COLUMBIA, MD 21044	ADMIN SVCS	MARYLAND	501(C)(3)	LINE 12C, III-FI	N/A		X
BAY LIFE SERVICES, INC. - 52-1496539 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MENTAL HEALTH	MARYLAND	501(C)(3)	LINE 10	N/A		X
CHURCH HOME AND HOSPITAL OF THE CITY OF - 52-0591600, 10980 GRANTCHESTER WAY, COLUMBIA, MD 21044	MEDICAL FUND	MARYLAND	501(C)(3)	LINE 12B, II	N/A		X
GOOD SAMARITAN NURSING CENTER, INC. - 52-1672866, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239	MEDICAL SVCS	MARYLAND	501(C)(3)	LINE 10	N/A		X
GS HOUSING, INC. - 52-1481656 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ELDER HOUSING	MARYLAND	501(C)(3)	LINE 10	N/A		X

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
GS PROPERTIES, INC. - 52-1429853 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ADMIN SVCS	MARYLAND	501(C)(3)	LINE 12A, I	N/A		X
MEDSTAR HEALTH VISITING NURSES ASSOCIATI - 53-0196597, 4061 POWDERMILL ROAD, CALVERTON, MD 20705	MEDICAL SVCS	MARYLAND	501(C)(3)	LINE 10	N/A		X
MEDSTAR VNA HEALTHCARE - 52-1458516 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SVCS	MARYLAND	501(C)(3)	LINE 10	N/A		X
MGH WOMEN'S BOARD - 52-6039600 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	FOUNDATION	MARYLAND	501(C)(3)	LINE 12C, III-FI	N/A		X
NATIONAL REHABILITATION HOSPITAL - 52-1369749, 102 IRVING STREET NW, WASHINGTON, DC 20010	HOSPITAL	DISTRICT OF COLUMBIA	501(C)(3)	LINE 3	N/A		X
NRH REGIONAL REHAB AT OLNEY, INC. - 52-2310902, 18101 PRINCE PHILIP DRIVE, OLNEY, MD 20832	MEDICAL SVCS	MARYLAND	501(C)(3)	LINE 3	N/A		X
SUBURBAN / NRH MEDICAL REHABILITATION, I - 52-1931151, 102 IRVING STREET NW, WASHINGTON, DC 20010	MEDICAL SVCS	DISTRICT OF COLUMBIA	501(C)(3)	LINE 3	N/A		X
VNA, INC. - 52-1332411 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	ADMIN SVCS	MARYLAND	501(C)(3)	LINE 12B, II	N/A		X
WOODBOURNE WOODS, INC. - 52-2299070 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ELDER HOUSING	MARYLAND	501(C)(3)	LINE 10	N/A		X
HOSPICE OF ST. MARY'S, INC. - 52-2153926 PO BOX 527 LEONARDTOWN, MD 20650	SUPPORT ORG	MARYLAND	501(C)(3)	LINE 12A, I	N/A		X
MEDSTAR SOUTHERN MD HOSPITAL CENTER INC. - 46-0726303, 7503 SURRATTS ROAD, CLINTON, MD 20735	HOSPITAL	MARYLAND	501(C)(3)	LINE 3	N/A		X

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
MEDSTAR SHAH MSO, LLC - 46-2700536, 10980 GRANTCHESTER WAY, COLUMBIA, MD 21044	MGMT SVCS	MD	N/A	N/A				X	N/A		X	
22590 SHADY COURT, LLC - 47-3361777, 24035 THREE NOTCH ROAD, HOLLYWOOD, MD 20636	REAL ESTATE	MD	N/A	N/A				X	N/A		X	
24035 THREE NOTCH ROAD, LLC - 47-3375076, 24035 THREE NOTCH ROAD, HOLLYWOOD, MD 20636	REAL ESTATE	MD	N/A	N/A				X	N/A		X	
37767 MARKET DRIVE, LLC 37767 MARKET DRIVE CHARLOTTE HALL, MD 20622	REAL ESTATE	MD	N/A	N/A				X	N/A		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	(i) Section 512(b)(13) controlled entity?	
								Yes	No
MEDSTAR PHARMACIES - 52-1513056 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	DRUG SALES	MD	N/A	C CORP					X
EXTENCARE, INC. - 52-1556228 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SVCS	MD	N/A	C CORP					X
HELIX RESOURCES MANAGEMENT, INC. - 52-1913070, 10980 GRANTCHESTER WAY, COLUMBIA, MD 21044	ADMIN SVCS	MD	N/A	C CORP					X
HELIXCARE PROPERTIES, LLC - 52-1966695 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SVCS	MD	N/A	C CORP					X
PARKWAY VENTURES, INC. - 52-1893569 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	HOLDING CO.	MD	N/A	C CORP					X

**Part III** Continuation of Identification of Related Organizations Taxable as a Partnership

(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) Disproportion- ate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
26840 POINT LOOKOUT ROAD, LLC - 47-3393670, 24035 THREE NOTCH ROAD, HOLLYWOOD, MD 20636	REAL ESTATE	MD	N/A	N/A				X	N/A		X	
MONTGOMERY COMMUNITY MRI LP - 52-1534253, 4110 ASPEN HILL ROAD, ROCKVILLE, MD 20853	MRI SCREENING	MD	N/A	N/A				X	N/A		X	
PHYSIOTHERAPY ASSOCIATES NRH REHAB, LLC - 52-2212036, 4714 GETTYSBURG ROAD, MECHANICSBURG, PA 17055	PHYSIOTHERAPY	PA	N/A	N/A				X	N/A		X	
PHYSICIAN IMAGING OF WASHINGTON HOSPITAL CENTER, LLC - 56-2616090, 840 CRESCENT CENTRE DR, FRANKLIN,	RADIOLOGY SVC	TN	N/A	N/A				X	N/A		X	
FRANKLIN IMAGING, LLC - 52-1588688, 7253 AMBASSADOR RD., BALTIMORE, MD 21244	IMAGING	MD	N/A	N/A				X	N/A		X	
10 ST. PATRICK'S DRIVE, LLC - 83-2261766, 10 ST. PATRICK'S DRIVE, WALDORF, MD 20603	REAL ESTATE	MD	N/A	N/A				X	N/A		X	
MEDSTAR ENDOSCOPY CTR AT LUTHERVILLE, LLC - 82-3193901, 1300 BELLONA AVE, LUTHERVILLE, MD 21093	SURGERY	MD	N/A	N/A				X	N/A		X	
CAPITAL ENDOSCOPY, LLC - 13-4244093, 6475 NEW HAMPSHIRE AVE, HYATTSVILLE, MD 20783	SURGERY	MD	N/A	N/A				X	N/A		X	
4240 ALTAMONT PLACE, LLC - 86-1202310, 103 CENTENNIAL STREET, SUITE K, LA PLATA, MD 20646	REAL ESTATE	MD	N/A	N/A				X	N/A		X	



**Part IV** Continuation of Identification of Related Organizations Taxable as a Corporation or Trust

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
PHYSICIANS ADMINISTRATIVE SERVICES, INC. - 23-7042074, 10980 GRANTCHESTER WAY, COLUMBIA, MD 21044	BILLING SVCS	MD	N/A	C CORP					X
MEDSTAR FAMILY CHOICE, INC. - 52-1995521 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MANAGED CARE	MD	N/A	C CORP					X
MEDSTAR ENTERPRISES, INC. - 52-2139841 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	ADMIN SERVICE	MD	N/A	C CORP					X
SITEL, INC. - 90-0753340 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	EDUCATIONAL	MD	N/A	C CORP					X
STAR BILLING, INC. - 52-1850113 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	BILLING SVCS	MD	N/A	C CORP					X
WASHINGTON RISK NETWORK MANAGEMENT, INC. - 52-2132677, 4061 POWDERMILL ROAD, SUITE 210, CALVERTON, MD 20705	MEDICAL SVCS	MD	N/A	C CORP					X
WASHINGTON HOSPITAL CENTER PHYSICIAN HOS - 52-1931000, 100 IRVING STREET NW, WASHINGTON, DC 20010	MEDICAL SVCS	DC	N/A	C CORP					X
MEDSTAR PHYSICIAN PARTNERS, INC. - 52-2030809, 4061 POWDERMILL ROAD, SUITE 210, CALVERTON, MD 20705	MEDICAL SVCS	MD	N/A	C CORP					X
FRANKLIN SQUARE DRIVE LAND CONDO ASSOCIA - 76-0756352, 10980 GRANTCHESTER WAY, COLUMBIA, MD 21044	CONDOMINIUMS	MD	N/A	C CORP					X
MGH DIVERSIFIED SERVICES, INC. - 52-1943602 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SVCS	MD	N/A	C CORP					X
ST. MARY'S HEALTH ALLIANCE, INC. - 52-1930331, 25500 POINT LOOKOUT ROAD, LEONARDTOWN, MD 20650	MEDICAL SVCS	MD	N/A	C CORP			100%	X	
GREENSPRING FINANCIAL INSURANCE LIMITED - 98-0188617, 878 WEST BAY RD., PO BOX 1159, GRAND CAYMAN, CAYMAN ISLANDS KY1-1102	INSURANCE	CAYMAN ISLANDS	N/A	C CORP					X



**Part V Transactions With Related Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.**Note:** Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

	Yes	No
<b>1</b> During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
<b>a</b> Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity .....	<b>1a</b>	X
<b>b</b> Gift, grant, or capital contribution to related organization(s) .....	<b>1b</b>	X
<b>c</b> Gift, grant, or capital contribution from related organization(s) .....	<b>1c</b>	X
<b>d</b> Loans or loan guarantees to or for related organization(s) .....	<b>1d</b>	X
<b>e</b> Loans or loan guarantees by related organization(s) .....	<b>1e</b>	X
<b>f</b> Dividends from related organization(s) .....	<b>1f</b>	X
<b>g</b> Sale of assets to related organization(s) .....	<b>1g</b>	X
<b>h</b> Purchase of assets from related organization(s) .....	<b>1h</b>	X
<b>i</b> Exchange of assets with related organization(s) .....	<b>1i</b>	X
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) .....	<b>1j</b>	X
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) .....	<b>1k</b>	X
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) .....	<b>1l</b>	X
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) .....	<b>1m</b>	X
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) .....	<b>1n</b>	X
<b>o</b> Sharing of paid employees with related organization(s) .....	<b>1o</b>	X
<b>p</b> Reimbursement paid to related organization(s) for expenses .....	<b>1p</b>	X
<b>q</b> Reimbursement paid by related organization(s) for expenses .....	<b>1q</b>	X
<b>r</b> Other transfer of cash or property to related organization(s) .....	<b>1r</b>	X
<b>s</b> Other transfer of cash or property from related organization(s) .....	<b>1s</b>	X
<b>2</b> If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.		

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) HOSPICE OF ST. MARY'S INC.	Q	124,568.	FMV
(2)			
(3)			
(4)			
(5)			
(6)			



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

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

[illegible]

Part VII

Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions.

PART III, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS PARTNERSHIP:

NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:

PHYSICIAN IMAGING OF WASHINGTON HOSPITAL CENTER, LLC

EIN: 56-2616090

840 CRESCENT CENTRE DR

FRANKLIN, TN 37067

NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:

MEDSTAR ENDOSCOPY CENTER-SILVER SPRING, LLC

EIN: 87-2341245

12002 VEIRS MILL ROAD

SILVER SPRING, MD 20906