Form **8879-EO**

Department of the Treasury
Internal Revenue Service

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

For calendar year 2014, or fiscal year beginning 07/01 , 2014, and ending 06/30 , 20 15

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

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

OMB No. 1545-1878

2014

Name of exempt organization

PENINSULA REGIONAL MEDICAL CENTER

Employer identification number

52-0591628

Name and title of officer

BRUCE RITCHIE, CFO

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

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

1a	Form 990 check here ▶ [X]	b	**Total revenue,** if any (Form 990, Part VIII, column (A), line 12) . . .	1b	423687572.
2a	Form 990-EZ check here ▶ [ ]	b	**Total revenue,** if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here ▶ [ ]	b	**Total tax** (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here ▶ [ ]	b	**Tax based on investment income** (Form 990-PF, Part VI, line 5).	4b	
5a	Form 8868 check here ▶ [ ]	b	**Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	5b	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2014 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize GRANT THORNTON LLP to enter my PIN 1 4 2 1 9 as my signature

ERO firm name

Enter five numbers, but do not enter all zeros

on the organization's tax year 2014 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2014 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ Bruce E Ritchie Bruce E. Ritchie Date ▶ 5/09/16

Part III Certification and Authentication

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

5 4 6 8 1 4 3 6 6 0 5

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2014 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ Mary O'Toole Date ▶ 05/09/2016

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

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

▶ **Do not enter Social Security numbers on this form as it may be made public.**

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

OMB No. 1545-0047

2014

Open to Public Inspection

A For the 2014 calendar year, or tax year beginning 07/01, **2014, and ending** 06/30, **20** 15

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
PENINSULA REGIONAL MEDICAL CENTER

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
100 EAST CARROLL STREET

City or town, state or province, country, and ZIP or foreign postal code
SALISBURY, MD 21801

D Employer identification number
52-0591628

E Telephone number
(410) 546-6400

G Gross receipts $ 553,526,452.

F Name and address of principal officer: MARGARET NALEPPA, CEO
100 EAST CARROLL STREET SALISBURY, MD 21801

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No

If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J **Website:** ▶ WWW.PENINSULA.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶ **L** Year of formation: 1897 **M** State of legal domicile: MD

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE.

2 Check this box ▶ ☐ 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	16.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	13.
5	Total number of individuals employed in calendar year 2014 (Part V, line 2a)	5	3,332.
6	Total number of volunteers (estimate if necessary)	6	319.
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	4,916,384.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	0

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	476,043.	639,051.
9	Program service revenue (Part VIII, line 2g)	389,447,738.	403,960,086.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	22,081,011.	18,313,873.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	729,289.	774,562.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	412,734,081.	423,687,572.

COPY FOR PUBLIC INSPECTION

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0	0
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	190,652,104.	187,534,771.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 421,936.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	193,374,899.	210,226,154.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	384,027,003.	397,760,925.
19	Revenue less expenses. Subtract line 18 from line 12	28,707,078.	25,926,647.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	585,875,889.	641,573,965.
21	Total liabilities (Part X, line 26)	182,269,635.	212,476,437.
22	Net assets or fund balances. Subtract line 21 from line 20	403,606,254.	429,097,528.

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

▶ BRUCE RITCHIE CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
MARY TORRETTA	Mary Torretta	05/09/2016		P00847851

Firm's name ▶ GRANT THORNTON LLP — Firm's EIN ▶ 36-6055558

Firm's address ▶ 2010 CORPORATE RIDGE, SUITE 400 MCLEAN, VA 22102 — Phone no. 703-847-7500

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2014)

JSA
4E1065 1.000

Form **8868**
(Rev. January 2014)
Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File an Exempt Organization Return

▶ **File a separate application for each return.**
▶ **Information about Form 8868 and its instructions is at *www.irs.gov/form8868.***

OMB No. 1545-1709

- If you are filing for an **Automatic 3-Month Extension, complete only Part I** and check this box . . . . . ▶ [X]
- If you are filing for an **Additional (Not Automatic) 3-Month Extension, complete only Part II** (on page 2 of this form).

Do not complete Part II unless you have already been granted an automatic 3-month extension on a previously filed Form 8868.

Electronic filing *(e-file)*. You can electronically file Form 8868 if you need a 3-month automatic extension of time to file (6 months for a corporation required to file Form 990-T), or an additional (not automatic) 3-month extension of time. You can electronically file Form 8868 to request an extension of time to file any of the forms listed in Part I or Part II with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, which must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit *www.irs.gov/efile* and click on *e-file for Charities & Nonprofits*.

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

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

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

Enter filer's identifying number, see instructions

Type or print	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
File by the due date for filing your return. See instructions.	PENINSULA REGIONAL MEDICAL CENTER	52-0591628
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	100 EAST CARROLL STREET	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
	SALISBURY, MD 21801	

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 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

- The books are in the care of ▶ JIM GREGORY, 100 EAST CARROLL ST SALISBURY, MD 21801

Telephone No. ▶ 410 912-4979 FAX No. ▶ 410 543-7449

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

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 02/15, 20 16, to file the exempt organization return for the organization named above. The extension is for the organization's return for:
▶ [ ] calendar year 20 ____ or
▶ [X] tax year beginning 07/01, 20 14, and ending 06/30, 20 15.

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

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

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

Cumulative e-File History 2014	
FED	
Locator:	5490IC
Taxpayer Name:	PENINSULA REGIONAL MEDICAL CENTER
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	10/05/2015 16:37:52
Acknowledgement Date:	10/05/2015 16:57:19
Status:	Accepted
Submission ID:	54681420152785000010

- If you are filing for an **Additional (Not Automatic) 3-Month Extension, complete only Part II** and check this box . . . . . ▶ X

Note. Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.

- If you are filing for an **Automatic 3-Month Extension, complete only Part I** (on page 1).

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

Enter filer's identifying number, see instructions

Type or print	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
	PENINSULA REGIONAL MEDICAL CENTER	52-0591628
File by the due date for filing your return. See instructions.	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	100 EAST CARROLL STREET	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
	SALISBURY, MD 21801	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

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

- The books are in the care of ▶ JIM GREGORY, 100 EAST CARROLL ST SALISBURY, MD 21801
  Telephone No. ▶ 410 912-4979 Fax No. ▶ 410 543-7449
- If the organization does not have an office or place of business in the United States, check this box . . . . . ▶ ☐
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box . . . . . ▶ ☐. If it is for part of the group, check this box . . . . . ▶ ☐ and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until 05/15, 20 16.

5 For calendar year _____, or other tax year beginning 07/01, 20 14, and ending 06/30, 20 15.

6 If the tax year entered in line 5 is for less than 12 months, check reason: ☐ Initial return ☐ Final return
☐ Change in accounting period

7 State in detail why you need the extension ADDITIONAL TIME IS NEEDED TO GATHER INFORMATION NECESSARY TO FILE A COMPLETE AND ACCURATE RETURN.

8a	If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	**8a**	$ 0
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 and any amount paid previously with Form 8868.	**8b**	$ 0
c	**Balance Due.** Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	**8c**	$ 0

Signature and Verification must be completed for Part II only.

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

Signature ▶ Mary O'Loretto Title ▶ TAX SENIOR MANAGER Date ▶ 01/28/2016

Cumulative e-File History 2014	
FED	
Locator:	5490IC
Taxpayer Name:	Peninsula Regional Medical Center
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	01/28/2016 20:12:10
Acknowledgement Date:	01/28/2016 20:26:39
Status:	Rejected
Submission ID:	54681420160285000021
Submitted Date:	01/29/2016 17:08:21
Acknowledgement Date:	01/29/2016 17:28:31
Status:	Accepted
Submission ID:	54681420160295000009

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:

IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE.

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 $ 340,928,826. including grants of $ _____) (Revenue $ 403,525,988.)

SEE SCHEDULE O

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

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

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

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

4e Total program service expenses ▶ 340,928,826.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	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 Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	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? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	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? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	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.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
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? *If "Yes," complete Schedule D, Part VII*	11b		X
c	Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	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)? *If "Yes," complete Schedule D, Part X*	11f		X
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a	X	
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? *If "Yes," complete Schedule F, Parts I and IV*	14b	X	
15	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? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	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? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	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? *If "Yes," complete Schedule G, Part I* (see instructions)	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	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? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV.*	28c	X	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	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
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	218		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	3,332		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)	2b		X	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a		X	
b	If "Yes," enter the name of the foreign country: ▶ CAYMAN ISLANDS See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	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?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?	9a			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O.	13a			
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	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

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

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a 16		
	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 in Schedule O.			
b	Enter the number of voting members included in line 1a, above, who are independent	1b 13		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? . .	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6	X	
7a	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	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	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9		X

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

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
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		
11a	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	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	X	
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 ▶ CA, MD, NC,

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records: ▶

JIM GREGORY 100 EAST CARROLL STREET SALISBURY, MD 21801 410-912-4979

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) MARGARET NALEPPA	40.00									
PRESIDENT/CEO	1.00	X		X				937,492.	0	131,496.
(2) WILLIAM R. MCCAIN	1.00									
CHAIRMAN	2.00	X		X				31,204.	0	0
(3) MONTY SAYLER	1.00									
VICE CHAIRMAN	1.00	X		X				0	0	0
(4) DEBORAH ABBOTT	1.00									
SECRETARY	1.00	X		X				0	0	0
(5) HERBERT J. GEARY III	1.00									
TREASURER	1.00	X		X				0	0	0
(6) TIMOTHY BENNING, M.D.	1.00									
BOARD MEMBER	1.00	X						0	0	0
(7) THOMAS COATES	1.00									
BOARD MEMBER	1.00	X						0	0	0
(8) MARK HIGDON	1.00									
BOARD MEMBER	1.00	X						0	0	0
(9) MURRAY K. HOY	1.00									
BOARD MEMBER	1.00	X						0	0	0
(10) CHRISTJON J. HUDDLESTON, M.D.	1.00									
BOARD MEMBER -TERM ENDED 10/14	1.00	X						0	0	51,320.
(11) MARION KEENAN	1.00									
BOARD MEMBER	1.00	X						0	0	0
(12) RYAN MCLAUGHLIN	1.00									
BOARD MEMBER	1.00	X						0	0	0
(13) VEL NATESAN, M.D.	1.00									
BOARD MEMBER	1.00	X						0	0	15,125.
(14) MARTIN NEAT	10.00									
BOARD MEMBER	1.00	X						0	0	0

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) THOMAS RICCIO, M.D.	1.00									
BOARD MEMBER	1.00	X						0	0	0
(16) DAVID ROMMEL	1.00									
BOARD MEMBER	2.00	X						0	0	0
(17) WILLIAM TODD, M.D.	1.00									
BOARD MEMBER	2.00	X						0	0	0
(18) LURA LUNSFORD	40.00									
VP OF OPERATIONS	1.00			X				460,307.	0	92,050.
(19) BRUCE I. RITCHIE	40.00									
CFO	0			X				534,496.	0	115,052.
(20) CHARLES SILVIA JR., M.D.	40.00									
VP - CHIEF MEDICAL OFFICER	0			X				449,007.	0	58,224.
(21) MARY BETH D'AMICO	40.00									
VP PATIENT CARE SERVICES	0				X			224,442.	0	38,576.
(22) SARA SCOTT	40.00									
VP PEOPLE & ORGANIZATION DEV.	0				X			208,286.	0	51,749.
(23) STEVEN LEONARD	40.00									
VP OPERATION OPTIMIZATION & IN	0				X			252,167.	0	84,514.
(24) KAREN POISKER	40.00									
VP POPULATION HEALTH	0				X			284,211.	0	113,907.
(25) DANIEL MULVANNY	40.00									
VP - GENERAL COUNSEL	0				X			367,931.	0	55,583.
1b Sub-total ▶								968,696.	0	197,941.
c Total from continuation sheets to Part VII, Section A ▶								6,632,706.	0	869,545.
d Total (add lines 1b and 1c) ▶								7,601,402.	0	1,067,486.

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 ▶ 219

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 1		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 91

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) ANDY PIERRE, M.D.	40.00									
PHYSICIAN	0					X		768,859.	0	34,241.
(27) JACEK MALIK, M.D.	40.00									
PHYSICIAN	0					X		783,013.	0	33,644.
(28) HALIM CHARBEL, M.D.	40.00									
PHYSICIAN	0					X		789,206.	0	14,389.
(29) JAMES TODD. M.D.	40.00									
PHYSICIAN	0					X		756,090.	0	90,582.
(30) KURT WEHBERG, M.D.	40.00									
PHYSICIAN	0					X		754,691.	0	87,034.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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 ▶ 219

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

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. 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

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

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
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d	334,585.			
	e	Government grants (contributions)	1e				
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	304,466.			
	g	Noncash contributions included in lines 1a-1f: $					
	h	**Total.** Add lines 1a-1f ▶		639,051.			
Program Service Revenue			**Business Code**				
	2a	NET PATIENT SERVICES	621500	399,347,426.	398,643,139.	704,287.	
	b	AMBULATORY PHARMACY	900099	3,996,644.		3,996,644.	
	c	INVESTMENT IN PREMIER	900099	616,016.	600,722.	15,294.	
	d						
	e						
	f	All other program service revenue					
	g	**Total.** Add lines 2a-2f ▶		403,960,086.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) ▶		5,991,069.			5,991,069.
	4	Income from investment of tax-exempt bond proceeds ▶		0			
	5	Royalties ▶		0			
			(i) Real	(ii) Personal			
	6a	Gross rents	219,421.				
	b	Less: rental expenses	386,519.				
	c	Rental income or (loss)	-167,098.				
	d	Net rental income or (loss) ▶		-167,098.			-167,098.
			(i) Securities	(ii) Other			
	7a	Gross amount from sales of assets other than inventory	141,761,145.	14,020.			
	b	Less: cost or other basis and sales expenses	129,452,361.				
	c	Gain or (loss)	12,308,784.	14,020.			
	d	Net gain or (loss) ▶		12,322,804.			12,322,804.
	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18 a					
	b	Less: direct expenses b					
	c	Net income or (loss) from fundraising events ▶		0			
	9a	Gross income from gaming activities. See Part IV, line 19 a					
	b	Less: direct expenses b					
	c	Net income or (loss) from gaming activities ▶		0			
	10a	Gross sales of inventory, less returns and allowances a					
	b	Less: cost of goods sold b					
	c	Net income or (loss) from sales of inventory ▶		0			
		Miscellaneous Revenue	**Business Code**				
	11a	CAFETERIA	722514	741,397.			741,397.
	b	PARTNERSHIP INCOME	900099	159.		159.	
	c	MANAGEMENT FEES	561000	200,000.		200,000.	
	d	All other revenue	900099	104.			104.
	e	**Total.** Add lines 11a-11d ▶		941,660.			
	12	**Total revenue.** See instructions ▶		423,687,572.	399,243,861.	4,916,384.	18,888,276.

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 . . . . . ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	0			
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	4,151,133.	3,752,458.	390,767.	7,908.
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	151,939,462.	137,347,167.	14,302,839.	289,456.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	4,213,743.	3,809,055.	396,661.	8,027.
9 Other employee benefits	17,095,590.	15,443,768.	1,619,144.	32,678.
10 Payroll taxes	10,134,843.	9,266,645.	852,231.	15,967.
11 Fees for services (non-employees):				
a Management	0			
b Legal	1,179,544.	1,202.	1,178,342.	
c Accounting	208,482.		208,482.	
d Lobbying	0			
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	1,428,570.		1,428,570.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.) ATCH 2	42,591,245.	29,578,994.	12,996,993.	15,258.
12 Advertising and promotion	527,635.	476,961.	49,669.	1,005.
13 Office expenses	106,980,467.	102,647,601.	4,292,501.	40,365.
14 Information technology	893,308.	866,756.	26,059.	493.
15 Royalties	0			
16 Occupancy	4,294,921.	4,286,828.	8,093.	
17 Travel	395,945.	288,849.	96,964.	10,132.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	26,375.		26,375.	
20 Interest	6,048,606.		6,048,606.	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	22,250,844.	22,204,178.	46,666.	
23 Insurance	4,797,328.	16,482.	4,780,846.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a BAD DEBTS	10,729,288.	10,729,288.		
b DUES	564,668.	212,594.	351,427.	647.
c BOND REFINANCING	7,308,928.		7,308,928.	
d				
e All other expenses				
25 **Total functional expenses.** Add lines 1 through 24e	397,760,925.	340,928,826.	56,410,163.	421,936.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	1,991,438.	1	1,605,466.
	2	Savings and temporary cash investments	25,272,529.	2	44,566,906.
	3	Pledges and grants receivable, net	0	3	0
	4	Accounts receivable, net	38,407,998.	4	38,694,139.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0	6	0
	7	Notes and loans receivable, net	0	7	0
	8	Inventories for sale or use	9,208,496.	8	10,189,320.
	9	Prepaid expenses and deferred charges	5,234,547.	9	4,921,805.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 488,817,735.			
	b	Less: accumulated depreciation — 10b: 286,484,419.	203,336,346.	10c	202,333,316.
	11	Investments - publicly traded securities	209,601,997.	11	232,783,197.
	12	Investments - other securities. See Part IV, line 11	0	12	0
	13	Investments - program-related. See Part IV, line 11	0	13	0
	14	Intangible assets	0	14	0
	15	Other assets. See Part IV, line 11	92,822,538.	15	106,479,816.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	585,875,889.	16	641,573,965.
Liabilities	17	Accounts payable and accrued expenses	16,261,817.	17	17,577,598.
	18	Grants payable	0	18	0
	19	Deferred revenue	0	19	0
	20	Tax-exempt bond liabilities	124,686,859.	20	146,651,280.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties	0	23	0
	24	Unsecured notes and loans payable to unrelated third parties	15,000.	24	0
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	41,305,959.	25	48,247,559.
	26	**Total liabilities.** Add lines 17 through 25	182,269,635.	26	212,476,437.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	375,152,248.	27	397,331,967.
	28	Temporarily restricted net assets	20,361,044.	28	23,519,520.
	29	Permanently restricted net assets	8,092,962.	29	8,246,041.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	403,606,254.	33	429,097,528.
	34	Total liabilities and net assets/fund balances	585,875,889.	34	641,573,965.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	423,687,572.
2	Total expenses (must equal Part IX, column (A), line 25)	2	397,760,925.
3	Revenue less expenses. Subtract line 2 from line 1	3	25,926,647.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	403,606,254.
5	Net unrealized gains (losses) on investments	5	189,641.
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-625,014.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	429,097,528.

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis	2a		X
b	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis	2b	X	
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	X	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	3b		

Form **990** (2014)

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

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

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

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization	**Employer identification number**
PENINSULA REGIONAL MEDICAL CENTER	52-0591628

Part I **Reason for Public Charity Status** (All organizations must complete this part.) See instructions.

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

1 [ ] A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 [ ] A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 [X] A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 [ ] A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:

5 [ ] An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 [ ] A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 [ ] An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 [ ] A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 [ ] An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 [ ] An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 [ ] An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.

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).

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

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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 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)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) **12**

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2014 (line 6, column (f) divided by line 11, column (f)) **14** %

15 Public support percentage from 2013 Schedule A, Part II, line 14 **15** %

16a **33 1/3% support test - 2014.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test - 2013.** 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 **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10%-facts-and-circumstances test - 2014.** 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 **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10%-facts-and-circumstances test - 2013.** 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 **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2014 (line 8, column (f) divided by line 13, column (f))	15	%
16	Public support percentage from 2013 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2014** (line 10c, column (f) divided by line 13, column (f))	17	%
18	Investment income percentage from **2013** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2014.** 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 - 2013.** 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 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? *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.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
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)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* ***Part VI*** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *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.*	4b		
c	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)? *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.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) 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).*	5a		
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations; (b) individuals that are part of the charitable class benefited by one or more of its supported organizations; or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in* ***Part VI.***	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990).*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990).*	8		
9a	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))? *If "Yes," provide detail in* ***Part VI.***	9a		
b	Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* ***Part VI.***	9b		
c	Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* ***Part VI.***	9c		
10a	Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer (b) below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)*	10b		

Part IV Supporting Organizations *(continued)*

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

Section B. Type I Supporting Organizations

			Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *If "No," describe in* ***Part VI*** *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 directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.*	1		
2	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* ***Part VI*** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.*	2		

Section C. Type II Supporting Organizations

			Yes	No
1	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* ***Part VI*** *how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).*	1		

Section D. All Type III Supporting Organizations

			Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	1		
2	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* ***Part VI*** *how the organization maintained a close and continuous working relationship with the supported organization(s).*	2		
3	By reason of the relationship described in (2), 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* ***Part VI*** *the role the organization's supported organizations played in this regard.*	3		

Section E. Type III Functionally-Integrated Supporting Organizations

1 *Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (****see instructions****):*

a ☐ The organization satisfied the Activities Test. *Complete* **line 2** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* ***line 3*** *below.*

c ☐ The organization supported a governmental entity. *Describe in Part VI how you supported a government entity (see instructions).*

			Yes	No
2	Activities Test. ***Answer (a) and (b) below.***			
a	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* ***Part VI 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.*	2a		
b	Did the activities described in (a) 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* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	2b		
3	Parent of Supported Organizations. ***Answer (a) and (b) below.***			
a	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? *Provide details in* ***Part VI.***	3a		
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* ***Part VI*** *the role played by the organization in this regard.*	3b		

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. **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 Adjusted Net Income (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 Total (add lines 1a, 1b, and 1c)	**1d**		
e Discount claimed for blockage or other factors (explain in detail in **Part VI**):			
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 1-1/2% 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 .035	**6**		
7 Recoveries of prior-year distributions	**7**		
8 Minimum Asset Amount (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 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 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	**6**		

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	
4	Amounts paid to acquire exempt-use assets	
5	Qualified set-aside amounts (prior IRS approval required)	
6	Other distributions (describe in **Part VI**). See instructions.	
7	**Total annual distributions.** Add lines 1 through 6.	
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions.	
9	Distributable amount for 2014 from Section C, line 6	
10	Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2014	(iii) Distributable Amount for 2014
1	Distributable amount for 2014 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2014 (reasonable cause required-see instructions)			
3	Excess distributions carryover, if any, to 2014:			
a				
b				
c				
d				
e	From 2013			
f	**Total** of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2014 distributable amount			
i	Carryover from 2009 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2014 from Section D, line 7: $			
a	Applied to underdistributions of prior years			
b	Applied to 2014 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2014, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6	Remaining underdistributions for 2014. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7	**Excess distributions carryover to 2015**. Add lines 3j and 4c.			
8	Breakdown of line 7:			
a				
b				
c				
d	Excess from 2013			
e	Excess from 2014			

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

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2014

Name of the organization
PENINSULA REGIONAL MEDICAL CENTER

Employer identification number
52-0591628

Organization type (check one):

Filers of:	**Section:**
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] 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 or 990-EZ), 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 the prevention of cruelty to children or animals. Complete Parts I, 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. Do not 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 is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization PENINSULA REGIONAL MEDICAL CENTER | **Employer identification number** 52-0591628

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		$ 20,435.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 250,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 334,585.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4		$ 19,566.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
5		$ 14,465.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization PENINSULA REGIONAL MEDICAL CENTER

Employer identification number 52-0591628

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

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

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

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

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

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

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

Name of organization PENINSULA REGIONAL MEDICAL CENTER

Employer identification number 52-0591628

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 information once. See instructions.) ▶ $ ____________

Use duplicate copies of Part III if additional space is needed.

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.***

OMB No. 1545-0047

2014

Open to Public Inspection

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

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

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

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

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

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

Name of organization	Employer identification number
PENINSULA REGIONAL MEDICAL CENTER	52-0591628

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.

2 Political expenditures . . . . . ▶ $

3 Volunteer hours . . . . . .

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 . . . . . ▶ $

2 Enter the amount of any excise tax incurred by organization managers under section 4955 . . ▶ $

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? . . . . . ☐ Yes ☐ No

4a Was a correction made? . . . . . ☐ Yes ☐ No

b If "Yes," describe in Part IV.

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities . . . . . ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities . . . . . ▶ $

3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b . . . . . ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? . . . . . ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

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

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	**(a)** 2011	**(b)** 2012	**(c)** 2013	**(d)** 2014	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		23,205.
j Total. Add lines 1c through 1i			23,205.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	**1**		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	**2**		
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?	**3**		

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

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

Part IV Supplemental Information

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

SEE PAGE 4

Part IV **Supplemental Information** *(continued)*

OTHER ACTIVITIES

PENINSULA REGIONAL MEDICAL CENTER DOES NOT ENGAGE IN ANY DIRECT LOBBYING ACTIVITIES. THE ORGANIZATION DOES NOT ENGAGE IN ANY DIRECT LOBBYING ACTIVITIES. THE ORGANIZATION PAYS MEMBERSHIP DUES TO MARYLAND HOSPITAL ASSOCIATION (MHA) AND THE AMERICAN HOSPITAL ASSOCIATION (AHA). MHA AND AHA ENGAGE IN MANY SUPPORT ACTIVITIES INCLUDING LOBBYING AND ADVOCATING FOR THEIR MEMBER HOSPITALS. THE MHA AND AHA REPORTED THAT 4.80% AND 22.80% OF MEMBER DUES WERE USED FOR LOBBYING PURPOSES AND SUCH, THE ORGANIZATION HAS REPORTED THIS AMOUNT ON SCHEDULE C PART IV AS LOBBYING ACTIVITIES.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization

PENINSULA REGIONAL MEDICAL CENTER

Employer identification number

52-0591628

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

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

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate 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? ☐ Yes ☐ 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? ☐ Yes ☐ No

Part II Conservation Easements.

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

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

☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of a historically important land area
☐ Preservation of a certified historic structure

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 in (a)	2c
d	Number of conservation easements included in (c) acquired after 8/17/06, 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, and enforcing conservation easements during the year ▶ _____

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

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

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

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenue included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenue included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $

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

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

- a ☐ Public exhibition
- b ☐ Scholarly research
- c ☐ Preservation for future generations
- d ☐ Loan or exchange programs
- e ☐ Other _____

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

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

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

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

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

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21, 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" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	45,972,891.	39,054,428.	34,734,107.	34,191,392.	28,295,999.
b Contributions	647,931.	500,000.	6,448.	12,685.	105,500.
c Net investment earnings, gains, and losses	3,765,292.	6,781,222.	4,624,939.	801,060.	6,047,698.
d Grants or scholarships					
e Other expenditures for facilities and programs		41,210.			
f Administrative expenses	341,503.	321,549.	311,066.	271,030.	257,805.
g End of year balance	50,044,611.	45,972,891.	39,054,428.	34,734,107.	34,191,392.

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

- a Board designated or quasi-endowment ▶ 50.7231 %
- b Permanent endowment ▶ .1529 %
- c Temporarily restricted endowment ▶ 49.1240 %

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

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

		Yes	No
(i) unrelated organizations	3a(i)		X
(ii) related organizations	3a(ii)		X
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b		

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		10,636,389.		10,636,389.
b Buildings		232,038,282.	83,336,401.	148,701,881.
c Leasehold improvements				
d Equipment		232,285,782.	195,904,660.	36,381,122.
e Other		13,857,282.	7,243,358.	6,613,924.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				202,333,316.

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

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

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

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

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

(a) Description	(b) Book value
(1) INVESTMENT IN PARTNERSHIPS	2,898,942.
(2) UNAMORTIZED FINANCING COSTS	1,355,560.
(3) OTHER ASSETS	7,989,237.
(4) CONSTRUCTION FUND	18,863,488.
(5) DONOR RESTRICTED FUND	31,921,944.
(6) SELF INSURANCE FUND	19,292,994.
(7) BOARD DESIGNATED INVESTMENTS	23,962,536.
(8) INTERCOMPANY RECEIVABLES	195,115.
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	106,479,816.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ADVANCES FROM THIRD PARTY PAYORS	9,845,839.
(3) ACCRUED SELF INSURANCE LIABILITY	14,995,754.
(4) OTHER LIABILITIES	4,640,176.
(5) EMPLOYEE COMPENSATION RELATED PAYRO	18,765,790.
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	48,247,559.

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

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	409,704,908.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains (losses) on investments	2a	189,641.		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d	-10,116,249.		
e	Add lines **2a** through **2d**			2e	-9,926,608.
3	Subtract line **2e** from line **1**			3	419,631,516.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	1,428,570.		
b	Other (Describe in Part XIII.)	4b	2,627,486.		
c	Add lines **4a** and **4b**			4c	4,056,056.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	423,687,572.

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	385,636,919.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d	386,519.		
e	Add lines **2a** through **2d**			2e	386,519.
3	Subtract line **2e** from line **1**			3	385,250,400.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	1,428,570.		
b	Other (Describe in Part XIII.)	4b	11,081,955.		
c	Add lines **4a** and **4b**			4c	12,510,525.
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	397,760,925.

Part XIII Supplemental Information.

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

SEE PAGE 5

Part XIII Supplemental Information *(continued)*

INTENDED USE OF ENDOWMENT FUNDS

SCHEDULE D, PART V, LINE 4

THE ORGANIZATION'S ENDOWMENT FUNDS ARE USED FOR CAPITAL, PATIENT SERVICES OR EDUCATIONAL PURPOSES.

RECONCILIATION OF REVENUE AND EXPENSES TO AUDITED FINANCIAL STATEMENTS

SCHEDULE D, PART XI, LINE 2D

BAD DEBT EXPENSES	($10,729,288)
RENT EXPENSES	$386,519
PARTNERSHIP K-1 INCOME - TAX DIFFERENCES	$226,520
	($10,116,249)

SCHEDULE D, PART XI, LINE 4B

MANAGEMENT FEES RECLASSED FROM EXPENSES	$200,000
FOUNDATION CONTRIBUTIONS	$334,585
PARTNERSHIP K-1 INCOME	$627,387
TEMPORARY RESTRICTED INCOME	$1,439,630
PERMANENTLY RESTRICTED INCOME	$23,410
MISC. INCOME	$2,474
	$2,627,486

Part XIII Supplemental Information *(continued)*

SCHEDULE D, PART XII, LINE 2D

RENT EXPENSES	$386,519

SCHEDULE D, PART XII, LINE 4B

RECLASS OF BAD DEBT EXPENSES	$10,729,288
MANAGEMENT FEES RECLASSED FROM EXPENSES	$200,000
FOUNDATION CONTRIBUTIONS	$152,667
	$11,081,955

SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 14b, 15, or 16.**
▶ **Attach to Form 990.**
▶ **Information about Schedule F (Form 990) and its instructions is at *www.irs.gov/form990*.**

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization

PENINSULA REGIONAL MEDICAL CENTER

Employer identification number

52-0591628

Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

1 **For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☐ **Yes** ☐ **No**

2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.

3 Activities per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

	(a) Region	**(b)** Number of offices in the region	**(c)** Number of employees, agents, and independent contractors in region	**(d)** Activities conducted in region (by type) (e.g., fundraising, program services, investments, grants to recipients located in the region)	**(e)** If activity listed in (d) is a program service, describe specific type of service(s) in region	**(f)** Total expenditures for and investments in region
(1)	CENTRAL AMERICA/CARIBBEAN	1.	1.	INVESTMENTS	CAPTIVE INSURANCE CO.	1,151,487.
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						
(11)						
(12)						
(13)						
(14)						
(15)						
(16)						
(17)						
3a	Sub-total	1.	1.			1,151,487.
b	Total from continuation sheets to Part I					
c	**Totals** (add lines 3a and 3b)	1.	1.			1,151,487.

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than $5,000. Part II can be duplicated if additional space is needed.

1	(a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
(11)									
(12)									
(13)									
(14)									
(15)									
(16)									

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter . . . . . ▶

3 Enter total number of other organizations or entities . . . . . ▶

Schedule F (Form 990) 2014

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16. Part III can be duplicated if additional space is needed.

	(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								
(13)								
(14)								
(15)								
(16)								
(17)								
(18)								

Part IV Foreign Forms

1	Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	[X] Yes	[ ] No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; do not file with Form 990)*	[ ] Yes	[X] No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations (see Instructions for Form 5471)*	[X] Yes	[ ] No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)*	[ ] Yes	[X] No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons With Respect To Certain Foreign Partnerships (see Instructions for Form 8865)*	[ ] Yes	[X] No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to file Form 5713, International Boycott Report (see Instructions for Form 5713; do not file with Form 990)*	[ ] Yes	[X] No

Part V **Supplemental Information**

Complete this part to provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information (see instructions).

ACTIVITIES PER REGION

SCHEDULE F, PART IV

THE AMOUNTS IN COLUMN F WERE DETERMINED USING AN ACCRUAL METHOD OF

ACCOUNTING. THE ENTIRE $1,151,487 REPRESENTS A CAPTIVE INSURANCE

INVESTMENT.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization
PENINSULA REGIONAL MEDICAL CENTER

Employer identification number
52-0591628

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	3a	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☒ 300% ☐ 350% ☐ 400% ☐ Other _____%	3b	X	
c	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.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			10,195,082.		10,195,082.	2.68
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			10,195,082.		10,195,082.	2.68
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		46517	2,005,862.	279,108.	1,726,754.	.45
f Health professions education (from Worksheet 5)		584	653,908.	38,755.	615,153.	.16
g Subsidized health services (from Worksheet 6)		85185	40,663,870.	18,033,378.	22,630,492.	5.96
h Research (from Worksheet 7)			535.		535.	
i Cash and in-kind contributions for community benefit (from Worksheet 8)		2106	100,489.		100,489.	.03
j **Total.** Other Benefits		134392	43,424,664.	18,351,241.	25,073,423.	6.60
k **Total.** Add lines 7d and 7j		134392	53,619,746.	18,351,241.	35,268,505.	9.28

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development			25,260.		25,260.	.01
3 Community support			34,976.		34,976.	.01
4 Environmental improvements			115,415.		115,415.	.03
5 Leadership development and training for community members						
6 Coalition building			294,938.	350.	294,588.	.08
7 Community health improvement advocacy						
8 Workforce development			1,020.		1,020.	.12
9 Other						
10 Total			471,609.	350.	471,259.	.25

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

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount 2 10,729,288.			
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. 3			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	238,652,107.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	225,032,100.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	13,620,007.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other		

Section C. Collection Practices

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

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

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

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest - see instructions)

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

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 PENINSULA REGIONAL MEDICAL CENTER 100 E. CARROLL STREET SALISBURY MD 21801 WWW.PENINSULA.ORG	X	X					X			
2										
3										
4										
5										
6										
7										
8										
9										
10										

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 PENINSULA REGIONAL MEDICAL CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

			Yes	No
Community Health Needs Assessment				
1	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?	1		X
2	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	2		X
3	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	3	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[ ] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[ ] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[ ] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 13			
5	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	5	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		X
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	6b		X
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): WWW.PENINSULA.ORG			
b	[ ] Other website (list url):			
c	[X] Made a paper copy available for public inspection without charge at the hospital facility			
d	[X] Other (describe in Section C)			
8	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	8	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 2013			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): WWW.PENINSULA.ORG			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		X
11	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.			
12a	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)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	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 PENINSULA REGIONAL MEDICAL CENTER

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	X	
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 300 %			
b	[X] Income level other than FPG (describe in Section C)			
c	[X] Asset level			
d	[X] Medical indigency			
e	[ ] Insurance status			
f	[ ] Underinsurance status			
g	[ ] Residency			
h	[X] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	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	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[X] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[X] Other (describe in Section C)			
16	Included measures to publicize the policy within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): WWW.PENINSULA.ORG			
b	[X] The FAP application form was widely available on a website (list url): WWW.PENINSULA.ORG			
c	[X] A plain language summary of the FAP was widely available on a website (list url): WWW.PENINSULA.ORG			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] 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	[X] Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h	[ ] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[ ] Other (describe in Section C)			
Billing and Collections				
17	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 non-payment?	17	X	
18	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	[ ] Reporting to credit agency(ies)			
b	[ ] Selling an individual's debt to another party			
c	[ ] Actions that require a legal or judicial process			
d	[ ] Other similar actions (describe in Section C)			
e	[X] None of these actions or other similar actions were permitted			

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

Name of hospital facility or letter of facility reporting group PENINSULA REGIONAL MEDICAL CENTER

			Yes	No
19	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?	19		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Actions that require a legal or judicial process			
d	☐ Other similar actions (describe in Section C)			
20	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	☒ Notified individuals of the financial assistance policy on admission			
b	☐ Notified individuals of the financial assistance policy prior to discharge			
c	☒ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills			
d	☒ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy			
e	☐ Other (describe in Section C)			
f	☐ None of these efforts were made			

Policy Relating to Emergency Medical Care

21	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?	21	X	
	If "No," indicate why:			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ Other (describe in Section C)			

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b	☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c	☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d	☒ Other (describe in Section C)			
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?	23		X
	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?	24		X
	If "Yes," explain in Section C.			

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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

CONSULTING A REPRESENTATIVE OF THE COMMUNITY SERVED BY THE HOSPITAL

SCHEDULE H, PART V, LINE 5

PENINSULA REGIONAL MEDICAL CENTER CONDUCTED A COMMUNITY NEEDS ASSESSMENT SURVEY OF 335 INDIVIDUALS. THESE INDIVIDUALS WERE BOARD MEMBERS, THE EXECUTIVE TEAM, PENINSULA PARTNERS (A COMMUNITY SENIOR GROUP), CHURCHES, THE LIONS AND ROTARY CLUBS AND COMMUNITY WELLNESS AND SCREENING EVENTS. IN ADDITION THE SURVEY WAS POSTED ON OUR WEBSITE, FACEBOOK AND BLOG.

OTHER WAYS THE HOSPITAL MAKES ITS CHNA REPORT AVAILABLE THE PUBLIC

SCHEDULE H, PART V, LINE 7D

PENINSULA REGIONAL'S CHNA PLAN IS AVAILABLE TO THE PUBLIC, THROUGH OUR WEBSITE UNDER QUICK LINKS - CREATING HEALTH COMMUNITIES AT (WWW.PENINSULA.ORG/CHC). AVAILABLE TO THE PUBLIC IS THE CURRENT AND COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT AND THE IMPLEMENTATION STRATEGY. IN ADDITION, THERE IS A COMMUNITY HEALTH DATA AND RESOURCES SECTION THAN CAN BE ACCESSED BY THE PUBLIC, COLLABORATION BETWEEN PENINSULA REGIONAL MEDICAL CENTER, WICOMICO COUNTY; ATLANTIC GENERAL, WORCESTER COUNTY; AND EDWARD MCCREADY MEMORIAL HOSPITAL, SOMERSET COUNTY. AS PART OF THIS CREATING HEALTHY COMMUNITIES MODULE AVAILABLE TO THE PUBLIC IS DISPARITY DASHBOARD, DEMOGRAPHICS, HEALTHY PEOPLE 2020 TRACKER, MARYLAND SHIP TRACKER AND PROMISING.

NEEDS NOT ADDRESSED BY THE MOST RECENT CHNA

SCHEDULE H, PART V, LINE 11

BASED ON THE SIGNIFICANT NEEDS IDENTIFIED IN THE COMMUNITY HEALTH NEEDS

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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

ASSESSMENT, THE FOLLOWING IMPLEMENTATION INITIATIVES WERE DEVELOPED AND OUTLINED BELOW:

1) REDUCE DIABETES COMPLICATIONS:

A. PROVIDE AWARENESS, EDUCATION AND DIABETES MANAGEMENT TO THE COMMUNITY.

I. CONTINUE TO CREATE GENERAL PUBLIC AWARENESS AROUND THE HIGH PREVALENCE OF DIABETES IN THIS REGION.

II. CREATE AND CONTINUE A "DIABETES SUPPORT GROUP FOR TEENS AND KIDS" THAT MEETS THE MEDICAL, EDUCATIONAL AND SOCIAL NEEDS OF THIS GROUP.

III. "EDUCATING THE EDUCATORS." WORK WITH MULTIPLE EDUCATORS TO PROMOTE ADOLESCENT AND ADULT DIABETES AWARENESS.

IV. SUPPORT AND PARTNER WITH THE TRI-COUNTY DIABETES ALLIANCE TO CREATE AWARENESS, EDUCATION AND MANAGEMENT OF THE DIABETES POPULATION IN THE LOWER THREE COUNTIES.

V. DISEASE SELF- MANAGEMENT PROGRAM. PARTNER WITH MAINTAINING ACTIVE CITIZENS IN THE STATEWIDE LICENSE FOR CHRONIC DISEASE SELF-MANAGEMENT EDUCATION. THE PRIMARY OBJECTIVE IS TO DELIVER CHRONIC DISEASE SELF-MANAGEMENT SERVICES TO COMMUNITY RESIDENTS. THE PROGRAM WILL PROMOTE INCREASED PATIENT COMPETENCE AND COPING THROUGH TREATMENT PLANS THAT INCLUDE EDUCATION AND REFERRALS TO NECESSARY RESOURCES, PROVIDE COMPREHENSIVE ASSESSMENTS AND HELP THE PATIENT UTILIZE THE HEALTH SYSTEM APPROPRIATELY. HEALTHY LIVING WITH DIABETES. A DIABETES SELF-MANAGEMENT EDUCATION PROGRAM AT MAC. HEALTHY LIVING WITH DIABETES IS A 6-8 WEEK WORKSHOP DEVELOPED AT STANFORD UNIVERSITY, BASED ON SELF-MANAGEMENT.

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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

VI. PARTNER WITH LOCAL HEALTH DEPARTMENTS UNDER THE 1422 GRANT TO PREVENT OBESITY AND DIABETES.

2) REDUCE OBESITY:

A. REDUCE THE NUMBER OF CHILD AND ADOLESCENTS IN WICOMICO, WORCESTER AND SOMERSET COUNTIES WHO ARE CONSIDERED OVERWEIGHT.

B. DEVELOP EDUCATIONAL MODULES AND INCREASE EDUCATIONAL AWARENESS AROUND CHILDHOOD AND ADOLESCENT OBESITY TO REDUCE THE TOTAL NUMBER OF CHILDREN WHO ARE OVERWEIGHT.

C. THE PRIMARY OBJECTIVE IS TO EDUCATE OUR CHILDREN ON HOW TO MAKE BETTER HEALTHY LIFESTYLE CHOICES AT A YOUNG AGE, AND TO INVOLVE THE PARENTS IN HEALTHY LIFESTYLE ACTIVITIES SO THEY WILL START TO COMMIT TO A HEALTHIER LIFESTYLE AND REINFORCE THIS WITH THEIR CHILDREN.

D. CREATE DIABETES COMMUNITY AWARENESS AND PROVIDE EDUCATION REGARDING HEALTHY LIFESTYLES WITHIN THE TRI-COUNTY REGION (WICOMICO, WORCESTER & SOMERSET).

E. PROVIDE SCREENINGS AND EDUCATION FOR UNDERSERVED AND UNINSURED MEMBERS OF THE COMMUNITY THROUGH HEALTHFEST, AN ANNUAL HEALTH EXPO.

F. PROVIDE PEDIATRIC OBESITY SCREENINGS AND EDUCATION FOR UNDER AND UNINSURED COMMUNITY MEMBERS. INCREASE BREAST FEEDING RATES TO HELP LOWER PEDIATRIC OBESITY. PROMOTE PHYSICAL ACTIVITY.

G. PROVIDE HEALTHY HEART SCREENINGS TO RESIDENTS OF DELMARVA USING A MOBILE VAN TO REACH COMMUNITIES THAT HAVE LIMITED ACCESS TO HEALTHCARE. THE TWO HEALTHY HEART INITIATIVES INCLUDE:

- CCC- COASTAL CARDIAC CHECKS
- WOMEN'S HEART SCREENINGS

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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

OBESITY COMPONENT

AN INTEGRAL COMPONENT OF THESE HEART SCREENINGS INCLUDES AN EDUCATIONAL SESSION THAT HIGHLIGHTS REDUCING OBESITY, EXERCISING AND HEALTHY FOOD CHOICES -ALL OF WHICH CONTRIBUTE TO A HEALTHY HEART.

- OBESITY SCREENING COMPONENT INCLUDES:
- HEIGHT
- WEIGHT
- BMI
- BODY FAT %
- EDUCATIONAL SESSION ON NUTRITION AND HEALTHY LIFESTYLES
- RESOURCES AVAILABLE
- POTENTIAL REFERRAL IF NEEDED

NEEDS NOT ADDRESSED BY THE MOST RECENT CHNA

SCHEDULE H, PART V, LINE 11

PENINSULA REGIONAL MEDICAL CENTER HAS A FIXED VALUE OF RESOURCES AVAILABLE AND THE HOSPITAL FOCUSES THOSE RESOURCES TO THE AREAS WITH THE GREATEST IMPACT, THERFORE NOT ALL NEEDS IDENTIFIED IN THE CHNA WERE ABLE TO BE ADDRESSED TO DATE.

ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE

SCHEDULE H, PART V, LINE 13

PENINSULA REGIONAL MEDICAL CENTER OFFERS FINANCIAL ASSISTANCE TO PATIENTS WHOSE INCOME IS AT OR BELOW 200% OF THE FEDERAL POVERTY GUIDELINES. PRMC

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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

ALSO PROVIDES FINANCIAL ASSISTANCE BASED UPON SEVERAL SPECIAL

EXCEPTIONS:

1) FINANCIAL ASSISTANCE WILL BE CONSIDERED IF PATIENT IS OVER INCOME

CRITERION, BUT HAVE A FINANCIAL HARDSHIP. A FINANCIAL HARDSHIP EXISTS

WHEN THE AMOUNT OF MEDICAL DEBT AT PENINSULA REGIONAL MEDICAL CENTER

EXCEEDS 25% OF THE FAMILY'S INCOME IN A YEAR.

2) A PATIENT THAT HAS QUALIFIED FOR MARYLAND MEDICAL ASSISTANCE IS DEEMED

TO AUTOMATICALLY QUALIFY FOR PRMC'S FINANCIAL ASSISTANCE PROGRAM. THE

AMOUNT DUE FROM A PATIENT ON THESE ACCOUNTS MAY BE WRITTEN OFF TO

FINANCIAL ASSISTANCE WITH VERIFICATION OF MEDICAID ELIGIBILITY. NORMAL

DOCUMENTATION REQUIREMENTS ARE WAIVED FOR FINANCIAL ASSISTANCE GRANTED

UPON THE BASIS OF MARYLAND MEDICAL ASSISTANCE ELIGIBILITY.

3) PATIENTS WHO ARE BENEFICIARIES/RECIPIENTS OF CERTAIN MEANS-TESTED

SOCIAL SERVICES PROGRAMS ADMINISTERED BY THE STATE OF MARYLAND ARE DEEMED

TO HAVE PRESUMPTIVE ELIGIBILITY FOR PRMC'S FINANCIAL ASSISTANCE PROGRAM.

THE AMOUNT DUE FROM A PATIENT ON THESE ACCOUNTS MAY BE WRITTEN OFF TO

FINANCIAL ASSISTANCE WITH VERIFICATION OF ELIGIBILITY FOR ONE OF THESE

PROGRAMS. NORMAL DOCUMENTATION REQUIREMENTS ARE WAIVED FOR FINANCIAL

ASSISTANCE GRANTED UPON THE BASIS OF PRESUMPTIVE ELIGIBILITY. IT IS THE

RESPONSIBILITY OF PATIENTS TO NOTIFY THE HOSPITAL THEY ARE IN A MEANS

TESTED PROGRAM AND PROVIDE THE DOCUMENTATION.

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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

PUBLICIZING THE FINANCIAL ASSISTANCE POLICY

SCHEDULE H, PART V, LINE 15

IF A PATIENT IS UNABLE TO PAY DUE TO FINANCIAL RESOURCES, ALL EFFORTS WILL BE MADE TO HELP THE PATIENT OBTAIN ASSISTANCE THROUGH APPROPRIATE AGENCIES. IN THE EVENT THAT THE PATIENT HAS APPLIED FOR AND KEPT ALL NECESSARY APPOINTMENTS AND THIRD PARTY ASSISTANCE IS NOT AVAILABLE, PENINSULA REGIONAL MEDICAL CENTER WILL PROVIDE CARE AT REDUCED OR ZERO COST.

WHEN NO THIRD PARTY ASSISTANCE IS AVAILABLE TO COVER THE TOTAL BILL AND THE PATIENT INDICATES THAT THEY HAVE INSUFFICIENT FUNDS, THE FOLLOWING PROCEDURE WILL OCCUR:

1) THE MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION SHOULD BE REVIEWED BY STAFF, IN CONSULTATION WITH THE PATIENT, TO MAKE INITIAL ASSESSMENT OF ELIGIBILITY.

2) COMPARE PATIENT'S INCOME TO CURRENT FEDERAL POVERTY GUIDELINES.

3) IF PRELIMINARILY ELIGIBLE PER GUIDELINES, SEND MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION TO PATIENT/GUARANTOR FOR COMPLETION AND SIGNATURE. PATIENT SHOULD ATTACH APPROPRIATE DOCUMENTATION AND RETURN TO REPRESENTATIVE WITHIN 10 DAYS.

UPON RECEIPT OF THE FINANCIAL ASSISTANCE REQUEST, THE REPRESENTATIVE WILL

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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

REVIEW INCOME AND ALL DOCUMENTATION. THE PATIENT MUST BE NOTIFIED WITHIN TWO BUSINESS DAYS OF THEIR PROBABLE ELIGIBILITY AND INFORMED THAT THE FINAL DETERMINATION WILL BE MADE ONCE THE COMPLETED FORM AND ALL SUPPORTING DOCUMENTS ARE RECEIVED, REVIEWED, AND THE INFORMATION VERIFIED. INCOME INFORMATION WILL BE VERIFIED USING THE DOCUMENTATION PROVIDED BY THE PATIENT AND EXTERNAL RESOURCES WHEN AVAILABLE. A FINANCIAL ASSISTANCE DISCOUNT WILL BE APPLIED TO THE PATIENT'S RESPONSIBILITY IN ACCORDINGLY.

4) IF INELIGIBLE, THE REPRESENTATIVE WILL NOTIFY THE PATIENT AND RESUME NORMAL DUNNING PROCESS AND FILE DENIAL WITH THE ACCOUNT. THE DENIALS WILL BE KEPT ON FILE IN THE COLLECTION OFFICE. ALL DENIALS WILL BE REVIEWED BY THE COLLECTION COORDINATOR LEVEL OR ABOVE.

THE PATIENT MAY REQUEST RECONSIDERATION BY SUBMITTING A LETTER TO THE DIRECTOR OF PATIENT FINANCIAL SERVICES INDICATING THE REASON FOR THE REQUEST.

ONLY INCOME AND FAMILY SIZE WILL BE CONSIDERED IN APPROVING APPLICATIONS FOR FINANCIAL ASSISTANCE UNLESS ONE OF THE FOLLOWING THREE SCENARIOS OCCURS:

- THE AMOUNT REQUESTED IS GREATER THAN $50,000.
- THE TAX RETURN SHOWS A SIGNIFICANT AMOUNT OF INTEREST INCOME, OR THE PATIENT STATES THEY HAVE BEEN LIVING OFF OF THEIR SAVINGS ACCOUNTS.

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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

- DOCUMENTATION INDICATES SIGNIFICANT WEALTH.

IF ONE OF THE ABOVE THREE SCENARIOS ARE APPLICABLE IN THE APPLICATION,

LIQUID ASSETS MAY BE CONSIDERED INCLUDING: CHECKING AND SAVINGS

ACCOUNTS, STOCKS, BONDS, CD'S, MONEY MARKET OR ANY OTHER ACCOUNTS FOR THE

PAST THREE MONTHS ALONG WITH THE PAST YEAR'S TAX RETURN, AND A CREDIT

REPORT MAY BE REVIEWED. THE FOLLOWING ASSETS ARE EXCLUDED:

- THE FIRST $10,000 OF MONETARY ASSETS.

- UP TO $150,000 IN A PRIMARY RESIDENCE.

CERTAIN RETIREMENT BENEFITS (SUCH AS A 401-K WHERE THE IRS HAS GRANTED

PREFERENTIAL TAX TREATMENT AS A RETIREMENT ACCOUNT INCLUDING BUT NOT

LIMITED TO DEFERRED-COMPENSATION PLANS QUALIFIED UNDER THE INTERNAL

REVENUE CODE, OR NONQUALIFIED DEFERRED-COMPENSATION PLANS) WHERE THE

PATIENT POTENTIALLY COULD PAY TAXES AND/OR PENALTIES BY CASHING IN THE

BENEFIT.

IF THE BALANCE DUE IS SUFFICIENT TO WARRANT IT AND THE ASSETS ARE

SUITABLE, A LIEN WILL BE PLACED ON THE ASSETS FOR THE AMOUNT OF THE BILL.

COLLECTION EFFORTS WILL CONSIST OF PLACEMENT OF THE LIEN WHICH WILL

RESULT IN PAYMENT TO THE HOSPITAL UPON SALE OR TRANSFER OF THE ASSET.

REFER ACCOUNT TO COLLECTION COORDINATOR FOR FILING A LIEN.

5) COLLECTION COORDINATOR WILL REVIEW DOCUMENTATION.

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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

IF ELIGIBLE, THE ACCOUNT WILL BE WRITTEN OFF TO FINANCIAL ASSISTANCE AND THE "REQUEST FOR FINANCIAL ASSISTANCE" FORM FINALIZED. A COPY IS RETAINED IN THE PATIENT'S FILE. THE REPRESENTATIVE WILL CALL THE PATIENT AND NOTIFY HIM/HER OF THE FINAL DETERMINATION OF ELIGIBILITY.

6) PENINSULA REGIONAL MEDICAL CENTER WILL REVIEW ONLY THOSE ACCOUNTS WHERE THE PATIENT OR GUARANTOR INQUIRE ABOUT FINANCIAL ASSISTANCE, MAILS IN AN APPLICATION, OR IN THE NORMAL WORKING OF THE ACCOUNT THERE IS INDICATION THAT THE PATIENT MAY BE ELIGIBLE. ANY PATIENT/CUSTOMER SERVICE REPRESENTATIVE, FINANCIAL COUNSELOR, OR COLLECTION REPRESENTATIVE MAY BEGIN THE REQUEST PROCESS.

PRE-PLANNED SERVICE MAY ONLY BE CONSIDERED FOR FINANCIAL ASSISTANCE WHEN THE SERVICE IS MEDICALLY NECESSARY. FOR EXAMPLE, NO COSMETIC SURGERY WILL BE ELIGIBLE.

INPATIENT, OUTPATIENT, EMERGENCY, AND PENINSULA REGIONAL MEDICAL GROUP PHYSICIAN CHARGES ARE ALL ELIGIBLE.

MAXIMUM CHARGE AMOUNTS FOR FAP-ELIGIBLE INDIVIDUALS

SCHEDULE H, PART V, LINE 22E

PENINSULA REGIONAL MEDICAL CENTER IS A MARYLAND HOSPITAL. AS SUCH PATIENTS AND ALL INSURANCE COMPANIES, INCLUDING MEDICARE & MEDICAID, PAY THE SAME RATE. THIS RATE IS DETERMINED BY THE STATE AGENCY, THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION.

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

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

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

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

OTHER METHOD USED IN DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE

SCHEDULE H, PART I, LINE 3C

N/A - PENINSULA REGIONAL MEDICAL CENTER USES THE FPG IN DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE. FINANCIAL ASSISTANCE IS ALSO CONSIDERED IF A PATIENT IS OVER INCOME CRITERION BUT HAS FINANCIAL HARDSHIP BASED ON MEDICAL DEBT. PATIENTS WHO ARE BENEFICIARIES/RECIPIENTS OF CERTAIN MEANS-TESTED SOCIAL SERVICES PROGRAM ADMINISTERED BY THE STATE OF MARYLAND ARE DEEMED TO HAVE PRESUMPTIVE ELEGIBILITY FOR PRMC'S FA PROGRAM.

COMMUNITY BENEFIT REPORT

SCHEDULE H, PART I, LINE 6A

PENINSULA REGIONAL MEDICAL CENTER FUNCTIONS AS THE PRIMARY HOSPITAL PROVIDER FOR THE RURAL SOUTHERNMOST THREE COUNTIES OF THE EASTERN SHORE OF MARYLAND, WHICH INCLUDES WICOMICO, WORCESTER AND SOMERSET. IN FY 2015, APPROXIMATELY 77% OF THE PATIENTS DISCHARGED FROM THE MEDICAL CENTER WERE RESIDENTS OF THE PRIMARY SERVICE AREA, WHICH HAD AN ESTIMATED POPULATION OF APPROXIMATELY 179,605 IN 2015 AND IS EXPECTED TO INCREASE TO 183,893

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

IN 2020, OR BY 2.4%. THE PRIMARY SERVICE AREA POPULATION HAS GROWN BY AN

ESTIMATED 10% SINCE 2000.

THE SECONDARY SERVICE AREA, ACCOUNTING FOR 20.6% OF PENINSULA REGIONAL'S

FY 2015 DISCHARGES, CONSISTS OF THE SOUTHERN PORTION OF SUSSEX COUNTY,

DELAWARE AND THE NORTHERN PORTION OF ACCOMACK COUNTY, VIRGINIA AND PARTS

OF DORCHESTER COUNTY, MARYLAND. THESE COUNTIES HAD A POPULATION OF

APPROXIMATELY 285,978 IN 2015 AND ARE PROJECTED TO GROW TO 301,015 IN

2020, A GROWTH RATE OF 5.3%. THE PRIMARY AND SECONDARY SERVICE AREAS

COMBINED ACCOUNTED FOR 98% OF PENINSULA REGIONAL'S TOTAL PATIENTS.

IN THE PAST PENINSULA REGIONAL'S APPROACH TO RURAL POPULATION HEALTH AND

COMMUNITY BENEFITS WAS GENERALIZED AND CONSISTED OF TOUCHING OUR THREE

PRIMARY COUNTIES: WICOMICO, WORCESTER AND SOMERSET. HOWEVER, THERE ARE

EXAMPLES WHERE PENINSULA REGIONAL HAS PARTICIPATED WITH OUR NEIGHBORS IN

DELAWARE AND VIRGINIA ON URGENT COMMUNITY HEALTHCARE NEEDS. MANY OF THE

SOCIAL DETERMINANTS OF RURAL HEALTH IN OUR THREE COUNTY AREA SPILL OVER

STATE LINES CREATING SIMILAR ISSUES IN OUR NEIGHBORING STATES AND

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

ALLOWING US TO WORK TOGETHER.

UNTIL NOW, MOST OF PRMC'S INITIATIVES HAVE BEEN "REACTIVE," ACTIVATED BY PATIENTS PRESENTING IN THE EMERGENCY ROOM OR AS INPATIENTS. PRMC NOW SEEKS TO DEPLOY RESOURCES AND EMBED CARE MANAGEMENT FUNCTIONS WITHIN PRIMARY CARE PRACTICES TO ADDRESS SOME OF THE DETERMINANTS (OR ROOT CAUSES) OF HIGH UTILIZATION. BY MOVING CARE BACK OUT INTO THE COMMUNITY WITH PCPS AND CARE MANAGERS EMBEDDED WITHIN THOSE PCPS, THE RIGHT CARE WILL DELIVERED, REDUCING THE NEED FOR INPATIENT HOSPITAL ADMISSIONS AND READMISSIONS.

OVER THE NEXT SEVERAL YEARS, PENINSULA REGIONAL WILL BE IN A TRANSITIONAL PERIOD WHERE SPECIFIED "SUPER UTILIZERS" WITHIN OUR CBSA WILL BE IDENTIFIED, CATEGORIZED AND TARGETED FOR POPULATION HEALTH MANAGEMENT.

O DEMOGRAPHICS (BLOCK GROUPS, ZIP CODES)

O RACE/ETHNICITY

O AGE-COHORTS

O CHRONIC CONDITIONS

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

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THE TARGET POPULATION INCLUDES PATIENTS THAT HAVE CHRONIC CONDITIONS WHO

HAVE DEMONSTRATED TO HAVE BEEN HIGH UTILIZERS AT PRMC, OR ARE IDENTIFIED

AS BEING AT RISK OF HIGH UTILIZATION BASED ON HIS/HER CHRONIC CONDITIONS

AND PATTERNS OF CARE.

PENINSULA REGIONAL MEDICAL CENTER FILES ANNUALLY A COMMUNITY BENEFIT

REPORT WITH THE STATE OF MARYLAND. THE REPORT IS FILED WITH THE HSCRC

(HEALTH SERVICES COST REVIEW COMMISSION).

FINANCIAL ASSISTANCE AND CERTAIN OTHER COMMUNITY BENEFITS AT COST

SCHEDULE H, PART I, LINE 7

THE AMOUNT OF BAD DEBT EXPENSE EXCLUDED FROM THE DENOMINATOR IN THE

COLUMN (F) PERCENTAGES IS $10,729,228. LINE 7B COLUMN (C) & (F)-

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL

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

COST REVIEW COMMISSION, (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING

PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME

AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S

Part VI Supplemental Information

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UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY DIRECTED 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.

THE COST METHODOLOGY FOR CHARITY CARE AND CERTAIN OTHER COMMUNITY BENEFITS IS THE COST-TO-CHARGE RATIO USED FOR THE CHARITY CARE PROGRAMS AND DIRECT COST METHOD FOR THE OTHER BENEFITS/PROGRAMS.

METHODOLOGY USED TO ESIMATED BAD DEBT EXPENSE

SCHEDULE H, PART III, LINES 2 AND 3

SEE RESPONSE BELOW TO LINE 4 REGARDING THE METHODOLOGY USED BY THE ORGANIZATION REGARDING BAD DEBT.

Part VI Supplemental Information

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BAD DEBT FOOTNOTE IN THE AUDITED FINANCIAL STATEMENTS

SCHEDULE H, PART III, LINE 4

THE HOSPITAL PROVIDES SERVICES TO PATIENTS IN THE EASTERN SHORE AREA OF MARYLAND, DELAWARE AND VIRGINIA, THE MAJORITY OF WHOM ARE COVERED BY THIRD-PARTY HEALTH INSURANCE. THE HOSPITAL BILLS THE INSURER DIRECTLY FOR SERVICES PROVIDED.

INSURANCE COVERAGE AND FINANCIAL INFORMATION IS OBTAINED FROM PATIENTS UPON ADMISSION WHEN AVAILABLE. THE HOSPITAL'S POLICY IS TO PERFORM IN-HOUSE COLLECTION PROCEDURES FOR APPROXIMATELY 85 DAYS. A DETERMINATION IS MADE AT THAT TIME AS TO WHAT ADDITIONAL COLLECTION EFFORTS TO PURSUE. A PROVISION FOR UNCOLLECTIBLE ACCOUNTS IS RECORDED FOR AMOUNTS NOT YET WRITTEN OFF, WHICH ARE EXPECTED TO BECOME UNCOLLECTIBLE.

DISCOUNTS RANGING FROM 2% TO 6% OF CHARGES ARE GIVEN TO MEDICARE, MEDICAID AND CERTAIN APPROVED COMMERCIAL HEALTH INSURANCE AND HEALTH MAINTENANCE ORGANIZATION PROGRAMS FOR REGULATED SERVICES. DISCOUNTS IN VARYING PERCENTAGES ARE GIVEN FOR CERTAIN UNREGULATED SERVICES. THESE

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MAJOR PAYORS ROUTINELY REVIEW PATIENT BILLINGS AND DENY PAYMENT FOR CERTAIN CHARGES AS MEDICALLY UNNECESSARY OR AS PERFORMED WITHOUT APPROPRIATE PREAUTHORIZATION. DISCOUNTS AND DENIALS ARE RECORDED AS REDUCTIONS OF NET PATIENT SERVICE REVENUE. ACCOUNTS RECEIVABLE FROM THESE THIRD-PARTY PAYORS HAVE BEEN ADJUSTED TO REFLECT THE DIFFERENCE BETWEEN CHARGES AND THE ESTIMATED REIMBURSABLE AMOUNTS.

APPROXIMATELY 38% AND 39%, RESPECTIVELY, OF ACCOUNTS RECEIVABLE WERE DUE FROM THE MEDICARE PROGRAM AS OF JUNE 30, 2015 AND 2014, RESPECTIVELY.

THE MEDICARE AND MEDICAID REIMBURSEMENT PROGRAMS REPRESENT A SUBSTANTIAL PORTION OF THE HOSPITAL'S REVENUES. THE HOSPITAL'S OPERATIONS ARE SUBJECT TO NUMEROUS LAWS AND REGULATIONS OF FEDERAL, STATE AND LOCAL GOVERNMENTS. THESE LAWS AND REGULATIONS INCLUDE, BUT ARE NOT NECESSARILY LIMITED TO, MATTERS SUCH AS LICENSURE, ACCREDITATION, GOVERNMENT HEALTH CARE PROGRAM PARTICIPATION REQUIREMENTS, REIMBURSEMENT FOR PATIENT SERVICES AND MEDICARE AND MEDICAID FRAUD AND ABUSE.

Part VI Supplemental Information

Provide the following information.

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MEDICARE COSTING METHODOLOGY

SCHEDULE H, PART III, LINE 8

MEDICARE ALLOWABLE COSTS WERE CALCULATED USING A COST TO CHARGE RATIO.

PENINSULA REGIONAL MEDICAL CENTER PROVIDES QUALITY MEDICAL SERVICES TO

ALL PATIENTS REGARDLESS OF WHAT INSURANCE THEY HAVE. APPROXIMATELY, 49%

OF THE MEDICAL CENTER'S NET PATIENT REVENUE REVENUE IS ATTRIBUTABLE TO

MEDICARE PATIENTS DURING THE YEAR ENDED JUNE 30, 2015.

COLLECTION POLICY

SCHEDULE H, PART III, LINE 9B

COLLECTION POLICIES ARE THE SAME FOR ALL PATIENTS. IF A PATIENT NOTIFIES

THE MEDICAL CENTER ABOUT THEIR INABILITY TO PAY, THE MEDICAL CENTER WILL

SEND THEM THE CHARITY CARE AND FINANCIAL ASSISTANCE FORMS TO FILL OUT.

ONCE THE FORMS ARE COMPLETE AND RETURNED TO THE MEDICAL CENTER AND THE

PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE, THEN THE PATIENT'S ACCOUNT

WILL BE REMOVED FROM COLLECTIONS AND THE ACCOUNT WILL BE WRITTEN OFF.

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NEEDS ASSESSMENT - PROMOTION OF COMMUNITY HEALTH

SCHEDULE H, PART VI, LINE 2

PENINSULA REGIONAL MEDICAL CENTER IN COOPERATION WITH THE WICOMICO, WORCESTER AND SOMERSET COUNTIES, HEALTH DEPARTMENTS, THE ATLANTIC GENERAL HOSPITAL AND THE EDWARD W. MCCREADY MEMORIAL HOSPITAL, HAS BEEN CONDUCTING COMMUNITY HEALTH SURVEYS OF THE TRI-COUNTY AREA SINCE 1995. THESE SURVEYS, ADMINISTERED BY PROFESSIONAL RESEARCH CONSULTANTS (PRC) OF OMAHA, NEBRASKA WERE ADMINISTERED IN 1995, 2000, 2004,2009 AND 2013. IN ADDITION TO THESE ADULT SURVEYS, A SEPARATE ADOLESCENT SURVEY WAS CONDUCTED IN 2000, 2005, AND 2010.

RESULTS OF THESE SURVEYS ARE USED BY THE PARTICIPANTS TO ASSESS COMMUNITY HEALTH NEEDS AND PLAN FUTURE SERVICES. OF PARTICULAR NOTE WAS THE DEVELOPMENT OF THE TRI-COUNTY DIABETES ALLIANCE, WHICH IS A COOPERATIVE VENTURE BETWEEN ALL THE PARTNERS AND COMMUNITY AGENCIES TO REDUCE THE INCIDENCES OF DIABETES IN THE TRI-COUNTY AREA. OTHER OUTCOMES RESULTING FROM THE SURVEY FINDINGS INCLUDE SMOKING CESSATION PROGRAMS, OTHER EARLY DETECTION AND SCREENING PROGRAMS FOR HEART AND CANCER, AS WELL AS HEALTH

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PROMOTION AND EDUCATION WITH A FOCUS ON PREVENTION.

THE PRC COMMUNITY HEALTH ASSESSMENT IS A SYSTEMATIC, DATA-DRIVEN APPROACH TO DETERMINING THE HEALTH STATUS, BEHAVIORS AND NEEDS OF OUR COMMUNITY RESIDENTS. SURVEY RESULTS ARE SHARED WITH THE COMMUNITY AND ARE POSTED TO THE PARTICIPANTS WEBSITES. THIS COMMUNITY HEALTH ASSESSMENT SERVES AS A TOOL TOWARDS REACHING THE FOLLOWING THREE GOALS:

1. TO IMPROVE RESIDENTS' HEALTH STATUS, INCREASE THEIR LIFE SPANS, AND ELEVATE THEIR OVERALL QUALITY OF LIFE.

2. REDUCE THE HEALTH DISPARITIES AMONG RESIDENTS BY GATHERING DEMOGRAPHIC INFORMATION ALONG WITH HEALTH STATUS AND BEHAVIOR DATA.

3. TO INCREASE ACCESSIBILITY TO PREVENTIVE SERVICES FOR ALL COMMUNITY RESIDENTS.

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

SCHEDULE H, PART VI, LINE 3

PENINSULA REGIONAL MEDICAL CENTER MAKES AVAILABLE TO ALL PATIENTS THE HIGHEST QUALITY OF MEDICAL CARE POSSIBLE WITHIN THE RESOURCES AVAILABLE.

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IF A PATIENT IS UNABLE TO PAY DUE TO FINANCIAL RESOURCES, ALL EFFORTS WILL BE MADE TO HELP THE PATIENT OBTAIN ASSISTANCE THROUGH APPROPRIATE AGENCIES, OR, IF HELP IS NOT AVAILABLE, TO PROVIDE CARE AT REDUCED OR ZERO COST. ONE OF PENINSULA REGIONAL'S OVERALL GUIDING PRINCIPLES IS THAT CONCERN OVER A HOSPITAL BILL SHOULD NEVER PREVENT ANY INDIVIDUAL FROM RECEIVING EMERGENCY HEALTH SERVICES. THE MEDICAL CENTER WILL COMMUNICATE THIS MESSAGE CLEARLY TO PROSPECTIVE PATIENTS AND TO LOCAL COMMUNITY SERVICE AGENCIES AND MAKE IT CLEAR THAT EMERGENCY SERVICES WILL BE PROVIDED WITHOUT REGARD TO ABILITY TO PAY. THE MEDICAL CENTER WILL ENSURE THAT AN EMERGENCY ADMISSION OR TREATMENT IS NOT DELAYED OR DENIED PENDING DETERMINATION OF COVERAGE OR REQUIREMENT FOR PREPAYMENT OR DEPOSIT. THE MEDICAL CENTER WILL POST ADEQUATE NOTICE OF THE AVAILABILITY OF MEDICAL SERVICES, AND THE GENERAL OBLIGATION OF THE HOSPITAL TO PROVIDE CHARITY CARE. PENINSULA REGIONAL'S "FINANCIAL ASSISTANCE POLICY" INCLUDES THE REQUIRED LANGUAGE OF DETERMINATION OF PROBABLE ELIGIBILITY WITHIN TWO BUSINESS DAYS. ON PAGE 2, THE "FINANCIAL ASSISTANCE POLICY" STATES THAT UPON RECEIPT OF THE FINANCIAL ASSISTANCE REQUEST, THE REPRESENTATIVE WILL REVIEW INCOME AND ALL DOCUMENTATION. THE PATIENT MUST BE NOTIFIED WITHIN

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TWO BUSINESS DAYS OF THEIR PROBABLE ELIGIBILITY. IN ACCORDANCE WITH

SECTION 1, 2 AND 3, PENINSULA REGIONAL PROVIDES PUBLIC NOTICE AND

INFORMATION REGARDING ITS CHARITY CARE POLICY IN DELMARVA'S LARGEST PAPER

"THE DAILY TIMES", POSTED SIGNS IN THE ADMISSION, BUSINESS OFFICE

EMERGENCY ROOM AND OTHER MAJOR SERVICE AREAS OF THE MEDICAL CENTER;

ADDITIONALLY, INDIVIDUAL NOTICE IS PROVIDED TO EACH PERSON WHO SEEKS

SERVICES IN THE MEDICAL CENTER AT THE TIME OF PRE-ADMISSION OR ADMISSION.

COMMUNITY INFORMATION

SCHEDULE H, PART VI, LINE 4

PENINSULA REGIONAL IS LOCATED IN SALISBURY, MARYLAND . THE HOSPITAL'S

SERVICE AREA IS PREDOMINATELY RURAL AND COVERS 6 COUNTIES LOCATED IN

THREE DIFFERENT STATES: MARYLAND, DELAWARE AND VIRGINIA. SOME OF THE

UNIQUE HEALTHCARE CHARACTERISTICS OF THESE COUNTIES INCLUDE A HIGH

PREVALENCE OF DIABETES WHICH IS APPROXIMATELY TWICE THAT OF THE STATE OF

MARYLAND. THERE IS A HIGHER INCIDENCE OF SKIN CANCER AND THE INCIDENCE

RATE FOR HEART DISEASE IS STATISTICALLY SIGNIFICANTLY HIGHER THAN

MARYLAND. IN ADDITION, THE MEDIAN INCOME IS LOWER THAN THAT OF MARYLAND

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AND EDUCATIONAL ATTAINMENT LAGS BEHIND THE STATES AVERAGE. THE MEDICAL CENTER'S PRIMARY SERVICE AREA IS COMPRISED OF THE MAJORITY OF ZIP CODES IN WICOMICO, WORCESTER, AND SOMERSET COUNTIES. AS OF JUNE 30, 2015 THESE COUNTIES CONTRIBUTED APPROXIMATELY 75 PERCENT OF PENINSULA REGIONAL'S TOTAL DISCHARGES. THE MEDICAL CENTER ALSO SERVICES DORCHESTER COUNTY, MARYLAND, THE SOUTHERN PORTION OF SUSSEX COUNTY, DELAWARE AND THE NORTHERN PORTION OF ACCOMACK COUNTY, VIRGINIA. THESE COUNTIES COMPRISED AN ADDITIONAL 21 PERCENT OF THE MEDICAL CENTER'S TOTAL DISCHARGES DURING THE SAME TIME PERIOD.

PATIENTS DISCHARGED FROM THE FOLLOWING GEOGRAPHICAL AREAS:

AREA	2015 DISCHARGES	%
WICOMICO	9,746	50.0%
WORCESTER	3,261	16.7%
SOMERSET	1,999	10.3%
DORCHESTER, TALBOT,CAROLINE	691	3.6%
DELAWARE	2,186	11.2%

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VIRGINIA	1,120	5.8%
ALL OTHERS	474	2.4%
	------	------
TOTAL	19,477	100.0%

SOURCE: PENINSULA REGIONAL MEDICAL CENTER, FINANCIAL AND STATISTICAL REPORT, JUNE 30, 2015. BETWEEN 2009 AND 2014, THE MEDICAL CENTER'S PRIMARY SERVICE AREA (WICOMICO, WORCESTER AND SOMERSET COUNTIES, MARYLAND) HAD AN ESTIMATEDPOPULATION OF 179,605 IN 2013 AND IS EXPECTED TO INCREASE TO 183,893 IN 2020, OR BY 2.4%. IN THE MEDICAL CENTER'S SECONDARY SERVICE AREA (DORCHESTER COUNTY, MARYLAND, SUSSEX COUNTY, DELAWARE, AND ACCOMACK COUNTY, VIRGINIA) THE POPULATION WAS ESTIMATED AT 177,422 IN 2013, AND IS EXPECTED TO INCREASE TO 179,814 IN 2017.

PROMOTION OF COMMUNITY HEALTH

SCHEDULE H, PART VI, LINE 5

PENINSULA REGIONAL MEDICAL CENTER IS COMMITTED TO THE HEALTH OF THE RURAL COMMUNITIES IT SERVES. IN FY 2015, THE HOSPITAL'S CHARITY CARE WAS

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$9,408,499; COMBINED CHARITY AND BAD DEBT FOR FY 2015 WAS $20,137,787. AS PART OF PENINSULA REGIONAL'S ONGOING COMMITMENT AND MISSION STATEMENT "TO IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE, WE CONTINUE TO ASSESS THE HEALTH NEEDS OF THE COMMUNITY. WE ATTEND TRI-COUNTY COMMUNITY HEALTH IMPROVEMENT (T-CHIP)PROCESS MEETINGS. THESE MEETINGS ARE MADE UP OF WICOMICO, WORCESTER AND SOMERSET'S HEALTH DEPARTMENT, LOCAL HOSPITALS, LOCAL AND NATIONAL COMMUNITY HEALTH ORGANIZATIONS AND OTHER LOCAL HEALTHY LIFESTYLE PROGRAMS. WE SYNERGIZE AS A GROUP WORKING TOWARD OUR IDENTIFIED SHIP (STATE HEALTH IMPROVEMENT PROCESS INITIATIVES) IN ADDTION TO SHARING WITH EACH OTHER OUR PROGRAM SUCCESSES AND SOMETIMES FAILURES. THE DIVERSITY OF THE PARTICIPANTS AND THE DYNAMICS OF THIS PARTICULAR GROUP ALLOW US TO KEEP A BETTER PULSE PN THE NEEDS OF THE COMMUNITY WITH CONTRIBUTES TO PLANNING AND FORMULATION OF TACTICS TO MEET LOCAL HEALTH OBJECTIVES. PENINSULA REGIONAL CLINICIANS AND EXECUTIVES ATTEND VARIOUS PUBLIC MEETINS AS REQUESTED BY EITHER ENTITY AS WE EXCHANGE COMMUNITY HEALTH IDEAS, DATA OR BRING RESOURCES TO BARE THAT BOTH PARTIES CAN BENEFIT FROM.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

COMMUNITY BENEFITS IS WOVEN THROUGHOUT PENINSULA REGIONAL'S STRATEGIC

PLAN AND IS AN INTEGRAL PART OF EACH ONE OF OUR STRATEGIC TENETS WHICH

ENCOMPASSES THE FOLLOWING THEMES:

PATIENT CENTERED CARE, POPULATION HEALTH MANAGEMENT AND EXPANDING ACCESS

THROUGH GROWTH OF AN AMBULATORY PRESENCE. THE STRATEGIC PLAN IS A LIVING

DOCUMENT THAT INTERFACES WITH COMMUNITY BENEFIT INITIATIVES, THE

STRATEGIC TRANSFORMATION PLAN, LOCAL COUNTY HEALTH DEPARTMENTS, AND

DOVETAILS THE STATE HEALTH IMPROVEMENT PLAN (SHIP) GOALS. IN ADDITION,

COLLABORATION AND PARTNERSHIPS WITH LOCAL CIVIC ORGANIZATIONS, FAITH

BASED INSTITUTIONS AND COMMUNITY PROVIDERS LIKE THE YMCA AND MAC, ETC.,

ARE NOW THE NORM INSTEAD OF THE EXCEPTION.

AS PART OF THE PRECEDING STRATEGIC TENET, PENINSULA REGIONAL CONTINUES TO

BUILD THE FUTURE CARE INFRASTRUCTURE FOR ONGOING COMMUNITY HEALTH

BENEFITS BY INVESTING IN PATIENT- CENTERED CARE, PROVIDER/CARE TEAM

INNOVATIONS, HEALTH INFORMATION SYSTEMS REINVESTMENT AND EMPLOYEE/

FAMILY, "LIVE WELL" INITIATIVES. THE SYNERGY CREATED BY THESE INCREMENTAL

HEALTH BUILDING BLOCKS HAS PROVIDED ACCESS TO THOSE MOST IN NEED OF

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.

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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.

HEALTH RESOURCES AND CHRONIC DISEASE MANAGEMENT IN OUR COMMUNITY.

PATIENT CENTERED CARE-SAMPLING

O DEVELOPED A BEHAVIORAL HEALTH "PARTIAL HOSPITALIZATION PROGRAM" IN

PARTNERSHIP WITH ADVENTIST SECONDARY TO A COMMUNITY ASSESSMENT FOR GAPS

IN SERVICE FOR THE REGION.

O PROVISION OF MEDICATION FOR INDIGENT POPULATION TO PAY FOR MEDS TO HELP

PREVENT READMISSIONS AND DEVELOP A HEALTHIER COMMUNITY.

O PALLIATIVE CARE WHOSE FOCUS ON PATIENT WITH COMPLEX CHRONIC DISEASE

STATES WITH SPECIALIZED CARE REVOLVING AROUND SYMPTOM CONTROL,

COUNSELING, FAMILY SUPPORT AND EDUCATION/ASSISTANCE WITH END OF LIFE

DECISION MAKING.

O RN COORDINATORS TO IMPROVE ACCESS TO PRIMARY CARE APPOINTMENTS WITHIN

72 HOURS OF DISCHARGE.

O ADDITIONAL SOCIAL WORKER TO CONNECT ED HIGH UTILIZERS WITH COMMUNITY

SERVICES, PRIMARY CARE PHYSICIANS INCLUDING HELPING TO PROVIDE

TRANSPORTATION.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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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.

PROVIDER CARE TEAMS-SAMPLING

O HEALTH COACHES AT PENINSULA HOME CARE FOCUS ON HEART FAILURE AND

CHRONIC KIDNEY DISEASE PATIENTS PROVIDING ASSISTANCE WITH IMPROVING

COMPLIANCE WITH DIETARY AND MEDICATION MANAGEMENT ETC.

O ENDOCRINOLOGY: IMPLEMENTATION OF TELEMEDICINE/DIABETES CLINIC FOR

PEDIATRIC PATIENTS WITH A FOCUS ON ACCURATE DIAGNOSIS/ TREATMENT USING

FAMILY SUPPORT AND SCHOOL NURSE.

O CONTINUED RECRUITMENT OF PRIMARY CARE PHYSICIANS THAT DEVELOP CARE

MODELS TARGETING HIGH RISK PATIENTS ASSIGNING THEM TO SPECIFIC CARE PLANS

AND CARE PLAN COORDINATORS.

HEALTH INFORMATION SYSTEMS

HEALTH INFORMATION TECHNOLOGY IMPLEMENTED TO SUPPORT PREDICTIVE ANALYTIC

MODELING SOFTWARE TO DETERMINE HIGH RISK RENAL PATIENTS AND ENGAGING

PHYSICIANS AND CAREGIVERS IN PARTICIPATING IN THE PATIENT'S SELF-CARE

REGIMEN COMPLIANCE. DEVELOPMENT OF PROCESSES USED TO IDENTIFY HIGH RISK

PATIENTS FOR CARE, IDENTIFICATION OF QUALITY CARE ISSUES AND IMPROVEMENTS

TO PREVENT COMPLICATIONS AND READMISSIONS.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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EMPLOYEE FAMILY "LIVE WELL" CAMPAIGN

BUILDING ON THE EXTERNALLY FOCUSED "LIVE WELL" MARKETING EFFORTS,

PENINSULA REGIONAL TURNED THAT INWARD TO THE NEW "LIVE WELL" CAMPAIGN

THAT IS DIRECTED AT EMPLOYEES AND THEIR FAMILIES. THIS CAMPAIGN

ENCOURAGES/PROMOTES HEALTHY LIFESTYLES THROUGH EDUCATION, FINANCIAL

BENEFITS, HEALTH CARE ASSESSMENTS, CHRONIC DISEASE MANAGEMENT AND OTHER

COLLECTIVE HEALTH ACTIVITIES.

A SPECIFIC MODULE ASSOCIATED WITH THE "LIVE WELL" CAMPAIGN FOCUSES ON

EMPLOYEES WITH DIABETES AS A DIAGNOSIS, THE PRIMARY OBJECTIVE IS TO

IMPROVE DIABETES CONTROL AND REDUCE A1C FOR INDIVIDUALS OVER TIME.

EMPLOYEES PARTICIPATING IN THE PROGRAM RECEIVE A REDUCTION IN COST FOR

THEIR HEALTH CARE BENEFIT AND RECEIVE FREE TESTING AND MEDICATIONS FOR

THEIR DIABETES CARE.

IN ADDITION, PRMC IS CURRENTLY DEVELOPING A PLAYBOOK TO BUILD WAYS TO

ENGAGE ITS EMPLOYEES AND THEIR FAMILIES IN A COMPREHENSIVE "LIVE WELL"

Part VI Supplemental Information

Provide the following information.

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LIFESTYLE.

POPULATION HEALTH

OVER THE LAST FEW YEARS POPULATION HEALTH ACTIVITIES ARE BASED UPON

COMMUNITY AND REGIONAL NEEDS. PRMC'S OVERARCHING GOALS HAVE BEEN TO

PROVIDE CARE WITHIN THE COMMUNITY TO IMPROVE THE OVERALL QUALITY OF LIFE,

REDUCE HEALTH DISPARITIES, WORK WITH COMMUNITY ORGANIZATION AND COUNTY

HEALTH DEPARTMENTS THAT IMPACT THE POPULATION ON A DAILY BASIS, AND TO

INCREASE ACCESS TO CARE OUTSIDE OF THE ACUTE CARE SETTING. THE COMMUNITY

HEALTH BENEFITS REPORT DETAILS EFFORTS AROUND DIABETES, AND OBESITY

HOWEVER PRMC HAS BEEN WORKING TO FURTHER POPULATION HEALTH EFFORTS.

FUTURE COMMUNITY BENEFIT INTENT:

PRMC HAS DETERMINED THAT THERE IS A GREAT NEED TO FOCUS ACTIVITIES IN THE

COMMUNITY WITH CARE MANAGERS LOCATED IN PRIMARY CARE OFFICES TO ASSIST

PRIMARY CARE PHYSICIANS IN CARING FOR PATIENTS WITH MULTIPLE

ADMISSIONS/EMERGENCY ROOM VISITS AND WITH MULTIPLE CHRONIC CONDITIONS.

FURTHER, THERE IS A NEED TO ACCESS TO CARE FOR THOSE PATIENTS WHO DO NOT

Part VI Supplemental Information

Provide the following information.

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HAVE A PRIMARY CARE PHYSICIAN BY ASSISTING PATIENTS WITHIN A BRIDGE

CLINIC. ACTION PLANS ARE BEING DEVELOPED TO ASSIST PATIENTS BY PROVIDING

A MOBILE VAN TO ADDRESS RURAL DISPARITIES IN ACCESSING HEALTH.

CHRONIC DISEASE MANAGEMENT:

HEARTLINE, A DATA COLLECTION SOURCE, AND HEALTH COACHES WHO UTILIZE THE

INFORMATION TO ASSIST PATIENTS IN BETTER MANAGING CHRONIC DISEASE. WE ARE

ALSO DEVELOPING CARE MANAGERS TO ASSIST PRIMARY CARE PRACTITIONERS,

PATIENTS AND THEIR FAMILIES TO MAKE PALLIATIVE CARE AND HOSPITAL

REFERRALS FOR OUTPATIENT SYMPTOM CONTROL AND COUNSELING AS WELL AS

IN-HOME SERVICES. FINALLY IN COLLABORATION WITH MULTIPLE PARTNERS SUCH AS

ATLANTIC GENERAL, MCCREADY HOSPITAL, CRISFIELD CLINIC AND MULTIPLE

SNF'S/REHAB, PRMC SEEKS TO PREVENT AVOIDABLE ADMISSIONS BY ADDRESSING

BEHAVIORAL/CHRONIC HEALTH NEEDS AND CHRONIC DISEASE MANAGEMENT.

AMBULATORY ACCESS

PRMC IS COMMITTED TO BEING AN INTEGRATOR OF HEALTH SERVICES, AS AN

INTEGRATOR WE MUST PROVIDE APPROPRIATE ACCESS TO SERVICE FOR THE

Part VI Supplemental Information

Provide the following information.

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POPULATIONS WE SEEK TO SERVE ACROSS THE ENTIRE CONTINUUM. THE RANGE OF

SERVICES THAT POPULATIONS REQUIRE IS BROAD AND INCLUDES:

O FACILITY-BASED SERVICES SUCH AS HOSPITALS, FREE-STANDING URGENT CARE

CENTERS, CLINICS AND OTHER ESSENTIAL AMBULATORY NETWORKS

O NON-FACILITY-BASED SERVICES

O NEW PARTNERSHIPS, RELATIONSHIPS, AFFILIATIONS AND PATHWAYS TO DRIVE

INTEGRATION AND INNOVATION.

O HEALTH PROFESSIONAL SERVICES SUCH AS PHYSICIANS, NURSE PRACTITIONERS

AND PHYSICIAN ASSISTANTS

IN THE LAST SEVERAL YEARS PENINSULA REGIONAL HAS OPENED SEVERAL HEALTH

PAVILIONS WITHIN THE COMMUNITY, ONE IN MILLSBORO, DELAWARE AND ONE IN

OCEAN PINES, MARYLAND. AS PART OF OUR PLAN TO EXPAND HEALTH SERVICES

OUTSIDE THE HOSPITAL WALLS AND INTO COMMUNITIES THE STRATEGY PROVIDES

EASE OF ACCESS AND PROMOTES CONTINUITY OF PRIMARY AND POPULATION HEALTH

SERVICES. THESE HEALTH PAVILIONS PROVIDE PRIMARY CARE PHYSICIANS, A

PHARMACY, REHAB, MEDICAL IMAGING, AND PARTNERSHIPS THAT PROVIDE SPECIALTY

Part VI Supplemental Information

Provide the following information.

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SERVICES SUCH AS CARDIOLOGY AND ORTHOPEDICS. EACH PAVILION HAS AN

EDUCATIONAL ROOM THAT CAN BE UTILIZED BY THE PUBLIC AND OTHER COMMUNITY

HEALTH PROVIDERS TO HOLD HEALTH SEMINARS AND EDUCATIONAL SESSIONS. PRMC

CONTINUES TO DEVELOP ITS AMBULATORY CARE PRESENCE IN ADDITION TO

AFFILIATIONS AND PARTNERSHIPS AS WE REVIEW THE EXTERNAL ENVIRONMENT'S

SOCIO-DEMOGRAPHICS, GAPS IN HEALTH SERVICES AND ACCESS NEEDS.

AFFILIATED HEALTH CARE SYSTEM ROLES

SCHEDULE H, PART VI, LINE 6

PENINSULA REGIONAL MEDICAL CENTER IS PART OF THE PENINSULA REGIONAL

HEALTH SYSTEM. THE SYSTEM INCLUDES A FOUNDATION AND FOR-PROFIT ENTITIES

WITH INTERESTS IN VARIOUS HEALTH CARE JOINT VENTURES. IN ADDITION TO THE

COMMUNITY BENEFITS PROVIDED BY THE MEDICAL CENTER, THE HEALTH SYSTEM

EVALUATES THE NEEDS OF THE COMMUNITY AND WILL PARTICIPATE IN COMMUNITY

BENEFIT PROGRAMS AS NEEDED.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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COMMUNITY BENEFIT REPORT STATE FILINGS

SCHEDULE H, PART VI, LINE 7

STATE(S) WITH WHICH THE ORGANIZATION FILES A COMMUNITY BENEFIT REPORT:

MARYLAND

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

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization: PENINSULA REGIONAL MEDICAL CENTER

Employer identification number: 52-0591628

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☒ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**	X	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?	**2**	X	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☒ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		X
	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 in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**		X
b	Any related organization?	**5b**		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**	X	
b	Any related organization?	**6b**	X	
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**	X	
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

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

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

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
	MARGARET NALEPPA	(i)	706,910.	214,403.	16,179.	117,641.	13,855.	1,068,988.	0
1	PRESIDENT/CEO	(ii)	0	0	0	0	0	0	0
	LURA LUNSFORD	(i)	369,983.	81,839.	8,485.	78,195.	13,855.	552,357.	0
2	VP OF OPERATIONS	(ii)	0	0	0	0	0	0	0
	BRUCE I. RITCHIE	(i)	404,966.	128,265.	1,265.	92,796.	22,256.	649,548.	0
3	CFO	(ii)	0	0	0	0	0	0	0
	CHARLES SILVIA JR., M.D	(i)	391,525.	56,217.	1,265.	34,838.	23,386.	507,231.	0
4	VP - CHIEF MEDICAL OFFICER	(ii)	0	0	0	0	0	0	0
	MARY BETH D'AMICO	(i)	202,560.	20,617.	1,265.	15,190.	23,386.	263,018.	0
5	VP PATIENT CARE SERVICES	(ii)	0	0	0	0	0	0	0
	SARA SCOTT	(i)	187,187.	19,834.	1,265.	31,443.	20,306.	260,035.	
6	VP PEOPLE & ORGANIZATION DEV.	(ii)	0	0	0	0	0	0	0
	STEVEN LEONARD	(i)	226,267.	24,635.	1,265.	58,628.	25,886.	336,681.	0
7	VP OPERATION OPTIMIZATION & IN	(ii)	0	0	0	0	0	0	0
	KAREN POISKER	(i)	255,045.	27,901.	1,265.	97,552.	16,355.	398,118.	0
8	VP POPULATION HEALTH	(ii)	0	0	0	0	0	0	0
	DANIEL MULVANNY	(i)	345,369.	22,000.	562.	37,857.	17,726.	423,514.	0
9	VP - GENERAL COUNSEL	(ii)	0	0	0	0	0	0	0
	ANDY PIERRE, M.D.	(i)	666,344.	70,000.	32,515.	18,522.	15,719.	803,100.	0
10	PHYSICIAN	(ii)	0	0	0	0	0	0	0
	JACEK MALIK, M.D.	(i)	672,748.	109,000.	1,265.	22,710.	10,934.	816,657.	0
11	PHYSICIAN	(ii)	0	0	0	0	0	0	0
	HALIM CHARBEL, M.D.	(i)	482,910.	293,853.	12,443.	14,171.	218.	803,595.	0
12	PHYSICIAN	(ii)	0	0	0	0	0	0	0
	JAMES TODD. M.D.	(i)	721,491.	33,334.	1,265.	72,990.	17,592.	846,672.	0
13	PHYSICIAN	(ii)	0	0	0	0	0	0	0
	KURT WEHBERG, M.D.	(i)	720,092.	33,334.	1,265.	68,402.	18,632.	841,725.	0
14	PHYSICIAN	(ii)	0	0	0	0	0	0	0
		(i)							
15		(ii)							
		(i)							
16		(ii)							

Part III Supplemental Information

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

SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN

SCHEDULE J, PART I, LINE 4B

PRMC HAS A NON-QUALIFIED SUPPLEMENTAL RETIREMENT PLAN (UNDER SECTION 457 (F)). THIS PLAN WASAPPROVED BY THE COMPENSATION COMMITTEE OF THE PRMC BOARD OF DIRECTORS TO SUPPLEMENT THE EXECUTIVE'S RETIREMENT INCOME. THE SUPPLEMENTAL RETIREMENT PLAN WAS DEVELOPED BASED ON AN INDEPENDENT CONSULTANT REPORT ON MARKET-BASED PRACTICES FOR SUPPLEMENTAL RETIREMENT PLANS. THE PERCENTAGE OF FINAL AVERAGE PAY, THE REQUIREMENTS FOR VESTING, PARTICIPANTS, AND PAY-OUT PROVISIONS WERE ESTABLISHED, REVIEWED, AND APPROVED BY THE COMPENSATION COMMITTEE. THE CONTRIBUTIONS TO THE SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN ARE INCLUDED IN SCHEDULE J, PART II, COLUMN C OR IN SCHEDULE J, PART II, COLUMN B(III) AS PART OF DEFERRED COMPENSATION.

THE FOLLOWING INDIVIDUALS PARTICIPATED IN THIS SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN:

MARGARET NALEPPA	76,923
LURA LUNSFORD	40,000

Part III Supplemental Information

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

BRUCE I. RITCHIE 40,000

STEVEN LEONARD 40,000

JAMES TODD, M.D. 50,000

KURT WEHBERG, M.D. 50,000

CONTINGENT COMPENSATION

SCHEDULE J, PART I, LINE 6A & 6B

OFFICERS AND KEY EMPLOYEES OF PENINSULA REGIONAL MEDICAL CENTER ARE PAID COMPENSATION DETERMINED BY A NUMBER OF VARIABLES INCLUDING BUT NOT LIMITED TO INDIVIDUAL GOALS AS WELL AS ORGANIZATION OPERATIONAL ACHIEVEMENTS IN SERVICE, QUALITY, SAFETY, EMPLOYEE SATISFACTION, AND COST. THE FINAL DETERMINATION OF THE CONTIGENT COMPENSATION AMOUNT IS DETERMINED AND APPROVED BY THE BOARD AS PART OF THE OVERALL COMPENSATION REVIEW OF OFFICERS AND KEY EMPLOYEES.

DURING CALENDAR YEAR 2014, THE FOLLOWING BONUSES WERE PAID:

MARGARET NALEPPA 214,403

LURA LUNSFORD 81,839

BRUCE I. RITCHIE 128,265

Part III Supplemental Information

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

MARY BETH D'AMICO	20,617
SARA SCOTT	19,834
STEVEN LEONARD	24,635
KAREN POISKER	27,901
DANIEL MULVANNY	22,000
CHARLES SILVIA JR, M.D.	56,217
ANDY PIERRE, M.D.	20,000
JACEK MALIK, M.D.	59,000
JAMES TODD, M.D.	33,334
KURT WEHBERG, M.D.	33,334

NON FIXED PAYMENTS

SCHEDULE J, PART I, LINE 7

DURING CALENDAR YEAR 2014, THE FOLLOWING PRODUCTIVITY BONUSES WERE PAID:

ANDY PIERRE, M.D.	50,000
JACEK MALIK, M.D.	50,000
HALIM CHARBEL, M.D.	293,853

SCHEDULE K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization

PENINSULA REGIONAL MEDICAL CENTER

Employer identification number

52-0591628

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	MARYLAND HEALTH & HIGHER EDUCATION FACILITES	52-0936091	574218UF8	02/05/2015	122,212,727.	REFER TO PART VI	X			X		X
B	MARYLAND HEALTH & HIGHER EDUCATION FACILITES	52-0936091	574218UF8	02/05/2015	25,222,024.	REFER TO PART VI	X			X		X
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	122,212,727.	25,222,024.		
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows	121,024,047.			
7	Issuance costs from proceeds	1,188,680.	222,024.		
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds		6,156,857.		
11	Other spent proceeds				
12	Other unspent proceeds		18,843,143.		
13	Year of substantial completion				

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X		X				
15	Were the bonds issued as part of an advance refunding issue?	X			X				
16	Has the final allocation of proceeds been made?	X			X				
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

Part III Private Business Use

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

Part III Private Business Use *(Continued)* MARYLAND HEALTH & HIGHER EDUCATION FACILITES

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X					
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?		X		X				
c Are there any research agreements that may result in private business use of bond-financed property?	X		X					
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?	X		X					
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	.9000 %		.9000 %		%		%	
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	.4400 %		.4400 %		%		%	
6 Total of lines 4 and 5	1.3400 %		1.3400 %		%		%	
7 Does the bond issue meet the private security or payment test?								
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X					

Part IV Arbitrage

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

Part IV **Arbitrage** *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X				
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X				
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X					

Part V **Procedures To Undertake Corrective Action**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?								

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

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

DESCRIPTION OF PURPOSE

SCHEDULE K, PART I, COLUMN F

PROCEEDS OF PUBLICLY-OFFERED, FIXED RATE SERIES 2015 BONDS, TOGETHER WITH FUNDS HELD IN AN EXISTING DEBT SERVICE RESERVE FUND ACCOUNT AND THE EXISTING PRINCIPAL AND INTEREST ACCOUNTS, HAVE BEEN USED TO 1) ADVANCE REFUND ALL OF PENINSULA REGIONAL MEDICAL CENTER'S ("PRMC") OUTSTANDING SERIES 2006 BONDS (ISSUED 2/09/06) FOR SAVINGS, 2) FUND VARIOUS CAPITAL EXPENDITURES (INCLUDING EQUIPMENT PURCHASES) (THE "PROJECT"), AND 3) PAY ALL BOND ISSUANCE EXPENSES.

SCHEDULE K, PART I, LINE A (F)

REFUNDING OF BONDS ISSUED ON 02/09/2006

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

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

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

OMB No. 1545-0047

2014

Open To Public Inspection

Name of the organization

PENINSULA REGIONAL MEDICAL CENTER

Employer identification number

52-0591628

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 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? To	From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	No	(h) Approved by board or committee? Yes	No	(i) Written agreement? 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)					

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	(e) Sharing of organization's revenues? No
(1)	WILLIAM TODD, M.D.	TRUSTEE	112,254.	MEDICAL STAFF FEES		X
(2)	WILLIAM TODD, M.D.	TRUSTEE	206,562.	EMERGENCY ROOM SERVICES		X
(3)	DAVID ROMMEL	TRUSTEE	697,217.	ELECTRICAL/MECHANICAL SERVICES		X
(4)	TIMOTHY BENNING	TRUSTEE	462,000.	PATHOLOGY SERVICES		X
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

Part V Supplemental Information

Provide additional information for responses to questions on Schedule L (see instructions).

SCHEDULE L, PART IV

DESCRIPTION OF TRANSACTIONS WITH INTERESTED PERSONS

EACH OF THE ABOVE-NAMED TRUSTEES ARE OWNERS OF BUSINESSES WHICH PROVIDE SERVICES TO PRMC. THE SERVICES PROVIDED WERE APPROVED BY INDEPENDENT MEMBERS OF THE GOVERNING BODY AND ARE CHARGED AT FAIR MARKET VALUE RATES.

SCHEDULE O
(Form 990 or 990-EZ)

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 990-EZ.

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization
PENINSULA REGIONAL MEDICAL CENTER

Employer identification number
52-0591628

STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS

FORM 990, PART III, LINE 4

PENINSULA REGIONAL MEDICAL CENTER IS A NOT-FOR-PROFIT 501(C)(3) NON-STOCK CORPORATION FOUNDED IN 1897 TO SERVE THE HEALTH CARE NEEDS OF THE COMMUNITY. THE HOSPITAL'S PRIMARY PURPOSE IS TO PROVIDE THE HIGHEST PRIMARY, SECONDARY, AND SELECTED TERTIARY HEALTH CARE SERVICES TO RESIDENTS OF AND VISITORS TO THE MID-DELMARVA PENINSULA IN A COMPETENT, COMPASSIONATE, AND COST-EFFECTIVE MANNER DESIGNED TO ELICIT A HIGH DEGREE OF CUSTOMER SATISFACTION. THE HOSPITAL'S MISSION IS TO IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE BY PROVIDING QUALITY MEDICAL CARE REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, HANDICAP, OR AGE. IF A PATIENT IS UNABLE TO PAY DUE TO FINANCIAL RESOURCES, EFFORTS WILL BE TAKEN TO ASSURE CARE AT AN AFFORDABLE COST, OR OBTAINED ASSISTANCE THROUGH APPROPRIATE AGENCIES ON THE PATIENT'S BEHALF. EMERGENCY SERVICES CARE WILL BE PROVIDED TO EVERYONE REGARDLESS OF ABILITY TO PAY.

PENINSULA REGIONAL MEDICAL CENTER SERVED OVER 19,000 INPATIENTS AND PROVIDED MORE THAN 540,000 OUTPATIENT SERVICES DURING FISCAL 2015. FOOD SERVICE PROVIDED MORE THAN 400,000 MEALS TO PATIENTS AND EMPLOYEES.

ALTHOUGH REIMBURSEMENT FOR SERVICES RENDERED IS CRITICAL TO THE OPERATION AND STABILITY OF PENINSULA REGIONAL MEDICAL CENTER, IT IS RECOGNIZED THAT NOT ALL INDIVIDUALS POSSESS THE ABILITY TO PAY FOR ESSENTIAL MEDICAL SERVICES. THE HOSPITAL, IN KEEPING WITH THE COMMITMENT TO SERVE ALL

Name of the organization: PENINSULA REGIONAL MEDICAL CENTER

Employer identification number: 52-0591628

MEMBERS OF THE COMMUNITY, DURING FISCAL 2015 PROVIDED:

-CHARITY AND OTHER ALLOWANCES TOTALING $40,255,085

-DISCOUNTS TO THIRD PARTY PAYORS INCLUDING GOVERNMENT PROGRAMS SUCH AS

-MEDICARE AND MEDICAID $53,492,511

-WRITE-OFF OF UNCOLLECTIBLE ACCOUNTS $10,729,288

-THE TOTAL UNREIMBURSED VALUE OF PROVIDING CARE TO THESE PATIENTS IS

$104,476,884

ALSO PROVIDED ARE MANY WELLNESS PROGRAMS, COMMUNITY EDUCATION AND FREE PROGRAMS OFFERED THROUGHOUT THE YEAR BASED UPON ACTIVITIES AND SERVICES THAT PENINSULA REGIONAL MEDICAL CENTER BELIEVES WILL SERVE A BONA FIDE COMMUNITY HEALTH NEED. SOME OF THE PROGRAMS ARE AS FOLLOWS:

-A VARIETY OF BROCHURES ARE DISPLAYED IN ALL HOSPITAL WAITING AREAS TO EDUCATE MEMBERS OF THE COMMUNITY REGARDING PROGRAMS AND SERVICES.

-PARTICIPATION IN HEALTH FAIRS DURING FY 2015 IN ORDER TO FOSTER HEALTH EDUCATION IN THE COMMUNITY.

-BEING CALLED UPON TO SPEAK BEFORE COMMUNITY ORGANIZATIONS ON A VARIETY OF HEALTHCARE TOPICS. WE PROVIDE CHILDBIRTH PREPARATION CLASSES, EXERCISE CLASSES FOR PRENATAL AND POSTPARTUM WOMEN AND CPR CLASSES.

-WE PROVIDE ASSISTANCE TO EDUCATORS THROUGH OUR WORK WITH STUDENT NURSES, RADIOLOGY, RESPIRATORY AND LABORATORY TECHNICIANS.

DURING FY 2015, PENINSULA REGIONAL MEDICAL CENTER VOLUNTEERS CONTRIBUTED

Name of the organization	Employer identification number
PENINSULA REGIONAL MEDICAL CENTER	52-0591628

OVER 35,000 HOURS TOWARD THE COMMON PURPOSE OF SERVICING THE HEALTH CARE OF THE COMMUNITY.

DURING FY 2015, PENINSULA REGIONAL MEDICAL CENTER PERFORMED OVER 450 COMMUNITY OUTREACH ACTIVITIES. SPECIFIC EXAMPLES OF EDUCATION AND OUTREACH PROGRAMS, SUPPORT GROUPS, COMMUNITY HEALTH SCREENINGS, AND FITNESS AND WELLNESS ACTIVITIES SUPPORTED BY PENINSULA REGIONAL MEDICAL CENTER ARE AS FOLLOWS:

COMMUNITY EDUCATIONAL AND OUTREACH PROGRAMS:

- LABOR & DELIVERY TOURS (EXCLUSIVE OF CHILDBIRTH CLASS TOURS)
- CPR
- CHILDBIRTH PREPARATION CLASSES
- REFRESHER COURSE - CHILDBIRTH
- INFANT CARE CLASSES
- GRANDPARENT CLASSES
- SAFE SITTER PROGRAM
- WOMEN'S HEALTH EDUCATION

SUPPORT GROUPS:

- DIABETES SUPPORT GROUPS
- STROKE SUPPORT GROUP
- HEAD AND NECK CANCER SUPPORT GROUP

EVENTS:

Name of the organization: PENINSULA REGIONAL MEDICAL CENTER

Employer identification number: 52-0591628

COMMUNITY SCREENINGS:

- HEIGHT/WEIGHT, BLOOD PRESSURE
- SKIN CANCER SCREENINGS
- ORAL, HEAD AND NECK CANCER SCREENINGS
- HEARING SCREENINGS
- FLU CLINIC
- EDUCATIONAL EXHIBITS TO PROMOTE HEALTHY LIFESTYLES

BENEFITS:

- UNITED WAY
- HEALTHFEST

FITNESS/EXERCISE PROGRAMMING:

- CARDIAC REHABILITATION
- INDOOR CYCLING AND WEIGHTS

BUSINESS RELATIONSHIPS
FORM 990, PART VI, LINE 2

MARGARET NALEPPA, MARTIN NEAT, WILLIAM MCCAIN AND MONTY SAYLER ARE MEMBERS OF THE BOARD OF DIRECTORS OF PENINSULA HEALTH VENTURES, A WHOLLY-OWNED TAXABLE SUBSIDIARY OF PENINSULA REGIONAL HEALTH SYSTEM. BRUCE I. RITCHIE, PRMC'S CFO, ALSO SERVES AS SECRETARY / TREASURER OF PENINSULA HEALTH VENTURES.

MEMBERS OR STOCKHOLDERS
FORM 990, PART VI, LINE 6

Name of the organization: PENINSULA REGIONAL MEDICAL CENTER

Employer identification number: 52-0591628

PENINSULA REGIONAL HEALTH SYSTEM IS THE SOLE CORPORATE MEMBER OF THE MEDICAL CENTER.

MEMBERS OR STOCKHOLDERS WHO MAY ELECT
FORM 990, PART VI, LINE 7A

AS THE SOLE CORPORATE MEMBER OF THE MEDICAL CENTER, PENINSULA REGIONAL HEALTH SYSTEM HAS THE ABILITY TO ELECT MEMBERS OF THE MEDICAL CENTER'S GOVERNING BODY.

DECISIONS SUBJECT TO APPROVAL
FORM 990, PART VI, LINE 7B

AS THE SOLE CORPORATE MEMBER, PENINSULA REGIONAL HEALTH SYSTEM HAS THE ABILITY TO APPROVE MAJOR EXPENDITURES AND LONG TERM BORROWINGS OF THE MEDICAL CENTER.

FORM 990 REVIEW PROCESS
FORM 990, PART VI, LINE 11B

OVERSIGHT OF THE COMPLETION OF THE ORGANIZATION'S FORM 990 HAS BEEN DELEGATED TO THE CHIEF FINANCIAL OFFICER OF PENINSULA REGIONAL MEDICAL CENTER BY THE PRESIDENT OF THE ORGANIZATION. ONCE THE FORM 990 AND ALL SCHEDULES HAVE BEEN PREPARED BY THE ORGANIZATION'S INDEPENDENT TAX SERVICES PROVIDER, THEY ARE REVIEWED BY THE PRESIDENT PRIOR TO FILING. THE RETURN IS PRESENTED TO THE BOARD OF TRUSTEES BY THE ORGANIZATION'S INDEPENDENT TAX ADVISORS FROM GRANT THORNTON LLP AND APPROVED FOR SUBMISSION.

Name of the organization: PENINSULA REGIONAL MEDICAL CENTER

Employer identification number: 52-0591628

CONFLICT OF INTEREST POLICY MONITORING & ENFORCEMENT

FORM 990, PART VI, LINE 12C

THE BOARD OF TRUSTEES ARE REQUIRED TO DISCLOSE ANNUALLY, IN WRITING, ANY AND ALL INTEREST WHICH THEY OR ANY IMMEDIATE MEMBER OF THEIR FAMILY MAY HAVE IN ANY BUSINESS ENTITY WHICH HAS OR SEEKS A CONTRACTUAL OR COMPETITIVE RELATIONSHIP WITH THE ORGANIZATION. THE BOARD HAS THE AUTHORITY TO DETERMINE IF A VIOLATION HAS OCCURED AND WHETHER ANY INTEREST WHICH SHOULD BE DISCLOSED SHOULD DISQUALIFY A DIRECTOR FROM PARTICIPATING IN ANY SPECIFIC BOARD DISCUSSION OR BOARD MEMBERSHIP. ALL DISCLOSURES ARE REVIEWED BY THE ORGANIZATION'S CHIEF COMPLIANCE OFFICER. ANY CONFLICTS ARE PRESENTED TO THE BOARD. IF A PERSON IS CONFLICTED, THEY WILL RECUSE THEMSELVES FROM ALL DISCUSSIONS AND DELIBERATIONS TO WHICH THEY WOULD APPEAR TO BE CONFLICTED.

PROCESS FOR DETERMINING COMPENSATION

FORM 990, PART VI, LINE 15A & 15B

THE ORGANIZATION USES A COMPENSATION COMMITTEE TO DETERMINE THE COMPENSATION OF THE CEO/EXECUTIVE DIRECTOR AND OTHER KEY EMPLOYEES. THE CEO OF THE ORGANIZATION HAS A WRITTEN EMPLOYMENT CONTRACT. THE COMPENSATION COMMITTEE USES AN INDEPENDENT CONSULTANT, COMPENSATION SURVEYS AND OTHER ORGANIZATION'S FORM 990 IN THE DETERMINATION PROCESS.

THE MEMBERS OF THE COMPENSATION COMMITTEE ARE INDEPENDENT AND RELY ON THIS COMPARABILITY DATA WHEN THEY DISCUSS AND DETERMINE THE INDIVIDUAL'S COMPENSATION. CONTEMPORANEOUS MINUTES OF SUCH DISCUSSIONS ARE KEPT AND MAINTAINED IN THE ORGANIZATION'S FILES.

Name of the organization: PENINSULA REGIONAL MEDICAL CENTER

Employer identification number: 52-0591628

HOW DOCUMENTS ARE MADE AVAILABLE TO THE PUBLIC

FORM 990, PART VI, LINE 19

THE ORGANIZATION'S GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST TO THE PUBLIC INFORMATION OFFICE OF PENINSULA REGIONAL MEDICAL CENTER AT 100 EAST CARROLL STREET, SALISBURY, MD 21801

OTHER CHANGES IN NET ASSETS

FORM 990, PART XI, LINE 9

PENSION ADJUSTMENT - FAS 158	$ (2,713,764)
NET ASSETS RELEASED FROM RESTRICTION	978,127
FOUNDATION TRANSFER - CAPITAL RESTRICTED	48,450
CHANGE IN NET ASSETS ENDOWMENT	1,463,040
PARTNERSHIP K-1 INCOME NOT ON BOOKS	(400,867)
TOTAL	$ (625,014)

ATTACHMENT 1

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
HORIZON CSA, LLC 265 PIT RD. MOORESVLLE, NC 28115	BIOMEDICAL SERVICES	5,281,313.
SHERIDAN ANESTHESIA OF MD P.O. BOX 452197 SUNRISE, FL 33323-2197	ANESTHESIA SERVICES	3,385,917.
SLEEP WAVES, INC. 873 E. BALTIMORE PIKE, STE. 345 KENNETT SQUARE, PA 19348	SLEEP LAB SERVICES	2,564,000.
FOCUSONE SOLUTIONS, LLC	CONTRACTED SERVICES	1,769,179.

Name of the organization: PENINSULA REGIONAL MEDICAL CENTER

Employer identification number: 52-0591628

ATTACHMENT 1 (CONT'D)

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
P.O. BOX 3037 OMAHA, NE 68103-0037		
MAYO COLLABORATIVE SERVICES P.O. BOX 9146 MINNEAPOLIS, MN 55480-9146	MEDICAL SERVICES	1,443,327.

ATTACHMENT 2

FORM 990, PART IX - OTHER FEES

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
TECHNICAL PROFESSIONAL FEES	5,372,533.		5,372,533.	
REFERENCE LAB WORK	1,869,201.	1,869,201.		
MEDICAL STAFF ADMINISTRATION	75,000.		75,000.	
CONTRACTED SERVICES	20,230,924.	12,866,898.	7,348,768.	15,258.
LICENSES TAXES	177,816.	177,816.		
COLLECTION FEES	847,782.	847,782.		
TEMPORARY LABOR	4,016,525.	4,016,525.		
PEST CONTROL	35,005.	35,005.		
TRASH PICKUP	288,907.	288,907.		
CANDIDATE EXPENSE	180,321.		180,321.	
EMPLOYEE MOVING EXPENSE	20,371.		20,371.	
PHYSICIAN CONTRACTED SERVICES	9,476,860.	9,476,860.		
TOTALS	42,591,245.	29,578,994.	12,996,993.	15,258.

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.**

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

OMB No. 1545-0047

2014

Open to Public Inspection

Name of the organization

PENINSULA REGIONAL MEDICAL CENTER

Employer identification number

52-0591628

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) PENINSULA REGIONAL MEDICAL CENTER FDN 52-1851935 100 EAST CARROLL STREET SALISBURY, MD 21801	FUNDRAISING	MD	501(C)(3)	11 TYPE I	PRHS		X
(2) PENINSULA REGIONAL HEALTH SYSTEM (PRHS) 52-2132761 100 EAST CARROLL STREET SALISBURY, MD 21801	PARENT	MD	501(C)(3)	11-II	N/A		X
(3) PENINSULA GENERAL HOSPITAL INS TRUST 52-6321234 100 EAST CARROLL STREET SALISBURY, MD 21801	INSURANCE	MD	501(C)(3)	11 TYPE III	PRHS		X
(4)							
(5)							
(6)							
(7)							

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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) DELMARVA SURG CTR 52-2251436 641 S SALISBURY	HEALTHCARE	MD	PHV		0	0						
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1) PENINSULA HEALTH VENTURES (PHV) 52-2250012 100 EAST CARROLL STREET SALISBURY, MD 21801	P'SHIP INV	MD	PRHS	C CORP	0	0			X
(2) PRLTC INC 52-2190588 100 EAST CARROLL STREET SALISBURY, MD 21801	LT CARE	MD	PHV	C CORP	0	0			X
(3) DELMARVA PENINSULA INSURANCE COMPANY 98-1110617 P.O. BOX 1159 KY1-1102 GRAND CAYMAN, CJ	INSURANCE		PRMC	C CORP			100.0000	X	
(4)									
(5)									
(6)									
(7)									

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

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

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

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	PENINSULA REGIONAL MEDICAL CENTER FOUNDATION	M,S,C	334,585.	FMV
(2)	PENINSULA REGIONAL MEDICAL CENTER FOUNDATION	N,O,Q	375,053.	FMV
(3)	DELMARVA PENINSULA INSURANCE COMPANY	R	1,151,487.	FMV
(4)	PENINSULA HEALTH VENTURES (PHV)	L	200,000.	FMV
(5)				
(6)				

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

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

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

Part VII **Supplemental Information**

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