

Cumulative e-File History 2012	
FED	
Locator:	3956AU
Taxpayer Name:	HARFORD MEMORIAL HOSPITAL, INC.
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	11/15/2013 11:45:57
Acknowledgement Date:	11/15/2013 11:59:21
Status:	Accepted
Submission ID:	23695320133195000013

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

For calendar year 2012, or fiscal year beginning _____, 2012, and ending _____, 20_____

2012

Department of the Treasury
Internal Revenue Service

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

Name of exempt organization HARFORD MEMORIAL HOSPITAL, INC. Employer identification number 52-0591484

Name and title of officer JOSEPH E. HOFFMAN III, CFO

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

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

1a	Form 990 check here ▶ <input checked="" type="checkbox"/>	b	Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	<u>98803113.</u>
2a	Form 990-EZ check here ▶ <input type="checkbox"/>	b	Total revenue, if any (Form 990-EZ, line 9)	2b	_____
3a	Form 1120-POL check here ▶ <input type="checkbox"/>	b	Total tax (Form 1120-POL, line 22)	3b	_____
4a	Form 990-PF check here ▶ <input type="checkbox"/>	b	Tax based on investment income (Form 990-PF, Part VI, line 5).	4b	_____
5a	Form 8868 check here ▶ <input type="checkbox"/>	b	Balance Due (Form 8868, 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 2012 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

I authorize GRANT THORNTON LLP to enter my PIN 1 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 2012 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 2012 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 *Joseph E. Hoffman III* Date 11/14/13

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. 2 3 6 9 5 3 3 6 6 0 5
do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2012 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 *Frank D. ...* Date 11/11/2013

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

For Paperwork Reduction Act Notice, see back of form. Form **8879-EO** (2012)

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

Department of the Treasury
Internal Revenue Service

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

A For the 2012 calendar year, or tax year beginning , 2012, and ending , 20

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization HARFORD MEMORIAL HOSPITAL, INC. Doing Business As			D Employer identification number 52-0591484
	Number and street (or P.O. box if mail is not delivered to street address) 501 SOUTH UNION AVENUE		Room/suite	E Telephone number (410) 877-3700
	City, town or post office, state, and ZIP code HAVRE DE GRACE, MD 21078			G Gross receipts \$ 128,998,832.
	F Name and address of principal officer: LYLE E SHELDON 520 UPPER CHESAPEAKE DR., STE. 405 BEL AIR, MD 21014			H(a) Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		J Website: ▶ WWW.UCHS.ORG		H(c) Group exemption number ▶
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			L Year of formation: 1911	M State of legal domicile: MD

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: ACUTE HOSPITAL CARE		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	16.
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	9.
	5 Total number of individuals employed in calendar year 2012 (Part V, line 2a)	5	981.
	6 Total number of volunteers (estimate if necessary)	6	198.
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
b Net unrelated business taxable income from Form 990-T, line 34	7b	0	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	2,654,016.	1,230,777.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	89,832,620.	92,270,172.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,914,077.	2,687,565.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	756,424.	2,614,599.
		97,157,137.	98,803,113.
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)	44,484,696.	47,052,185.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	b Total fundraising expenses (Part IX, column (D), line 25) ▶	0	
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	44,695,764.	45,160,194.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	89,180,460.	92,212,379.	
19 Revenue less expenses. Subtract line 18 from line 12	7,976,677.	6,590,734.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21 Total liabilities (Part X, line 26)	118,861,732.	127,058,074.
	22 Net assets or fund balances. Subtract line 21 from line 20	93,889,059.	92,881,646.
	24,972,673.	34,176,428.	

Part II Signature Block

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

Sign Here	▶ Signature of officer	Date			
	▶ Type or print name and title				
Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN P00288383
	Firm's name ▶ GRANT THORNTON LLP	Firm's EIN ▶ 36-6055558			
	Firm's address ▶ 2001 MARKET STREET, SUITE 3100 PHILADELPHIA, PA 19103	Phone no. 215-561-4200			

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

For Paperwork Reduction Act Notice, see the separate instructions.

Application for Extension of Time To File an Exempt Organization Return

▶ **File a separate application for each return.**

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

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

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 File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions. HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number (EIN) or 52-0591484
	Number, street, and room or suite no. If a P.O. box, see instructions. 501 SOUTH UNION AVENUE	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. HAVRE DE GRACE, MD 21078	

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

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	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 ▶ JOSEPH E. HOFFMAN

Telephone No. ▶ 443 643-3340 FAX No. ▶ _____

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

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 08/15, 2013, to file the exempt organization return for the organization named above. The extension is for the organization's return for:
 ▶ calendar year 2012 or
 ▶ tax year beginning _____, 20____, and ending _____, 20____.

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	\$
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	\$
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	\$

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

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

Cumulative e-File History 2012	
FED - EXT	
Locator:	3956AU
Taxpayer Name:	HARFORD MEMORIAL HOSPITAL, INC.
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	05/08/2013 16:19:58
Acknowledgement Date:	05/08/2013 16:28:07
Status:	Accepted
Submission ID:	23695320131285000020

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

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

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

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

Type or print <small>File by the due date for filing your return. See instructions.</small>	Enter filer's identifying number, see instructions	
	Name of exempt organization or other filer, see instructions. HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number (EIN) or 52-0591484
	Number, street, and room or suite no. If a P.O. box, see instructions. 501 SOUTH UNION AVENUE	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. HAVRE DE GRACE, MD 21078	

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	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 JOSEPH E. HOFFMAN
Telephone No. 443 643-3340 FAX No.

• If the organization does not have an office or place of business in the United States, check this box

• If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until 11/15, 2013 .

5 For calendar year 2012, or other tax year beginning _____, 20____, and ending _____, 20____ .

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 IN ORDER TO FILE A COMPLETE AND ACCURATE TAX RETURN.

8a 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.	8a	\$
b If this application is for Form 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	8b	\$
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 Busslee Armstrong Title CPA Date 8/12/13

Cumulative E-File History 2012

FED - EXT

Locator: 3956AU
Taxpayer Name: HARFORD MEMORIAL HOSPITAL, INC.
Return Type: 990, 990

Submitted Date 8/12/2013 3:03:22 PM
Acknowledgement Date 8/12/2013 3:31:15 PM
Status Accepted
Submission ID 23695320132245000023

Print

Close

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III Yes No

1 Briefly describe the organization's mission:

ATTACHMENT 1

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

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

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

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

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

4a (Code:) (Expenses \$ 63,454,347. including grants of \$) (Revenue \$ 94,153,949.)

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 63,454,347.

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	X	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I		X
4 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	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		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		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III		X
9 Did the organization report an amount in Part X, line 21, 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		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		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	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		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		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	X	
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	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		X
12 a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII		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	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E		X
14 a Did the organization maintain an office, employees, or agents outside of the United States?		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		X
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the United States? If "Yes," complete Schedule F, Parts II and IV		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the United States? If "Yes," complete Schedule F, Parts III and IV		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)		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II		X
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III		X
20 a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include questions 21 through 38 regarding grants, compensation, tax-exempt bonds, excess benefit transactions, and controlled entities.

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response to any question in this Part V

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 1a through 14b regarding IRS filings and tax compliance.

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

Check if Schedule O contains a response to any question in this Part VI. [X]

Section A. Governing Body and Management

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 1a, 1b, 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, and 9.

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

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, and 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: JOSEPH E. HOFFMAN 520 UPPER CHESAPEAKE DRIVE, STE 405 BEL AIR, MD 21014 443-643-3340

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

Check if Schedule O contains a response to any question 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) H. WILLIAM ACKER VICE CHAIR/DIRECTOR	5.00	X		X				0	0	0
(2) JASON M. BIRNBAUM, M.D. DIRECTOR	1.00	X						0	0	0
(3) STEVEN M. BENTMAN DIRECTOR	1.00	X						0	22,917.	0
(4) JOHN H. CAIN DIRECTOR	1.00	X						0	0	0
(5) MELINDA L. CRAIG DIRECTOR	1.00	X						0	0	0
(6) DIANE K. FORD DIRECTOR	1.00	X						0	0	0
(7) M. SCOT KAUFMAN SECRETARY/DIRECTOR	5.00	X		X				0	0	0
(8) ANDREW KLEIN DIRECTOR	1.00	X						0	0	0
(9) JAMES LAMBDIN DIRECTOR	1.00	X						0	0	0
(10) ANTHONY J. MEOLI TREASURER/DIRECTOR	5.00	X		X				0	0	0
(11) ROGER E. SCHNEIDER, M.D. CHAIRMAN/DIRECTOR	5.00	X		X				0	0	0
(12) LYLE E. SHELDON PRESIDENT & CEO/DIRECTOR	5.00	X		X				0	2,674,235.	79,823.
(13) RICHARD P. STRETT JR, V.M.D. DIRECTOR	1.00	X						0	0	0
(14) ADELE A. WILZACK, R.N., M.S. DIRECTOR	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) ALBERT J. A. YOUNG DIRECTOR	1.00	X					0	0	0	
16) FAHEEM YOUNUS, M.D. DIRECTOR	1.00	X					0	165,000.	0	
17) JOYCE FOX VP - PATIENT SVCS/CNO	20.00				X		245,318.	0	47,696.	
18) JOSEPH E. HOFFMAN III SR VP/CFO	5.00				X		0	724,598.	77,334.	
19) JAMES J. HURSEY SR VP/COO	5.00				X		0	276,141.	56,414.	
20) DEAN C. KASTER SR VP - CORP STRATEGY/PLANNING	5.00				X		0	499,354.	63,620.	
21) MARGARET M. VAUGHAN SR VP - MEDICAL AFFAIRS	5.00				X		0	828,477.	28,762.	
22) E. SCOTT CONOVER SR VP/GENERAL COUNSEL	5.00				X		0	456,107.	43,977.	
23) TONI M. SHIVERY VP - HUMAN RESOURCES	5.00				X		0	214,360.	64,712.	
24) EUGENE CURROTTO VP - OPERATIONS	40.00					X	179,736.	0	57,597.	
25) RICHARD CASTEEL VP - MIS	40.00					X	187,226.	0	31,837.	
1b Sub-total							0	2,697,152.	79,823.	
c Total from continuation sheets to Part VII, Section A							982,036.	3,164,037.	584,959.	
d Total (add lines 1b and 1c)							982,036.	5,861,189.	664,782.	

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 ▶ 47

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

Section B. Independent Contractors

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

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ▶ 13

Part VIII Statement of Revenue

Check if Schedule O contains a response to any question 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, 513, or 514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a						
	b Membership dues	1b						
	c Fundraising events	1c						
	d Related organizations	1d	303,864.					
	e Government grants (contributions) . .	1e	919,263.					
	f All other contributions, gifts, grants, and similar amounts not included above .	1f	7,650.					
	g Noncash contributions included in lines 1a-1f: \$							
	h Total. Add lines 1a-1f			1,230,777.				
Program Service Revenue	Business Code							
	2a NET PATIENT SERVICE REVENUE		621400	92,197,285.	92,197,285.			
	b BARIATRIC PROGRAM		621400	72,887.	72,887.			
	c							
	d							
	e							
	f All other program service revenue							
	g Total. Add lines 2a-2f			92,270,172.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			924,868.			924,868.	
	4 Income from investment of tax-exempt bond proceeds . . .			0				
	5 Royalties			0				
	6a Gross rents	(i) Real	655,203.					
		(ii) Personal						
		b Less: rental expenses	716,450.					
		c Rental income or (loss)	-61,247.					
	d Net rental income or (loss)			-61,247.			-61,247.	
	7a Gross amount from sales of assets other than inventory	(i) Securities	31,182,620.	13,355.				
		(ii) Other						
		b Less: cost or other basis and sales expenses	29,479,269.					
		c Gain or (loss)	1,703,351.	13,355.				
	d Net gain or (loss)			1,762,697.			1,762,697.	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a						
	b Less: direct expenses	b						
c Net income or (loss) from fundraising events				0				
9a Gross income from gaming activities. See Part IV, line 19	a							
b Less: direct expenses	b							
c Net income or (loss) from gaming activities				0				
10a Gross sales of inventory, less returns and allowances	a							
b Less: cost of goods sold	b							
c Net income or (loss) from sales of inventory				0				
Miscellaneous Revenue			Business Code					
11a INCENTIVE PMTS-ELECTRONIC HLTH RECORDS		900099	1,883,777.	1,883,777.				
b CAFETERIA SALES/VENDING		900099	477,784.			477,784.		
c INTEREST INCOME - ACCTS RECEIVABLE		900099	14,084.			14,084.		
d All other revenue		900099	300,201.			300,201.		
e Total. Add lines 11a-11d			2,675,846.					
12 Total revenue. See instructions			98,803,113.	94,153,949.			3,418,387.	

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 to any question 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 governments and organizations in the United States. See Part IV, line 21 .	0			
2	Grants and other assistance to individuals in the United States. See Part IV, line 22	0			
3	Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16	0			
4	Benefits paid to or for members	0			
5	Compensation of current officers, directors, trustees, and key employees	0			
6	Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7	Other salaries and wages	37,742,679.	27,499,644.	10,243,035.	
8	Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	0			
9	Other employee benefits	6,440,229.	4,692,407.	1,747,822.	
10	Payroll taxes	2,869,277.	2,090,580.	778,697.	
11	Fees for services (non-employees):				
a	Management	0			
b	Legal	336.		336.	
c	Accounting	362,244.		362,244.	
d	Lobbying	0			
e	Professional fundraising services. See Part IV, line 17	0			
f	Investment management fees	290,410.		290,410.	
g	Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	3,495,069.	2,528,254.	966,815.	
12	Advertising and promotion	134.	114.	20.	
13	Office expenses	767,469.	1,087.	766,382.	
14	Information technology	0			
15	Royalties	0			
16	Occupancy	1,451,080.	31,828.	1,419,252.	
17	Travel	43,387.	9,076.	34,311.	
18	Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19	Conferences, conventions, and meetings	76,095.	6,837.	69,258.	
20	Interest	1,407,952.	1,025,846.	382,106.	
21	Payments to affiliates	0			
22	Depreciation, depletion, and amortization	4,019,253.	2,928,463.	1,090,790.	
23	Insurance	1,568,916.	1,143,126.	425,790.	
24	Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a	<u>MEDICAL SUPPLIES</u>	10,133,136.	9,437,473.	695,663.	
b	<u>PROVISION FOR BAD DEBT</u>	9,109,252.	9,109,252.		
c	<u>MAINTENANCE CONTRACT</u>	3,812,673.	86,741.	3,725,932.	
d	<u>CORPORATE FEES</u>	4,096,310.		4,096,310.	
e	All other expenses	4,526,478.	2,863,619.	1,662,859.	
25	Total functional expenses. Add lines 1 through 24e	92,212,379.	63,454,347.	28,758,032.	
26	Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

Check if Schedule O contains a response to any question in this Part X

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	17,883,662.	1	18,485,374.
	2 Savings and temporary cash investments	0	2	0
	3 Pledges and grants receivable, net	0	3	0
	4 Accounts receivable, net	12,170,923.	4	12,721,993.
	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	0	8	0
	9 Prepaid expenses and deferred charges	4,198,677.	9	3,896,879.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 110,465,263.		
	b Less: accumulated depreciation	10b 73,357,922.	36,040,357.	10c 37,107,341.
	11 Investments - publicly traded securities	43,904,062.	11	0
	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	4,664,051.	15	54,846,487.
16 Total assets. Add lines 1 through 15 (must equal line 34)	118,861,732.	16	127,058,074.	
Liabilities	17 Accounts payable and accrued expenses	22,801,306.	17	18,459,175.
	18 Grants payable	0	18	0
	19 Deferred revenue	0	19	0
	20 Tax-exempt bond liabilities	27,396,955.	20	26,959,326.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23 Secured mortgages and notes payable to unrelated third parties	0	23	0
	24 Unsecured notes and loans payable to unrelated third parties	0	24	0
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	43,690,798.	25	47,463,145.
	26 Total liabilities. Add lines 17 through 25	93,889,059.	26	92,881,646.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	24,972,673.	27	34,176,428.
	28 Temporarily restricted net assets	0	28	0
	29 Permanently restricted net assets	0	29	0
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
33 Total net assets or fund balances	24,972,673.	33	34,176,428.	
34 Total liabilities and net assets/fund balances	118,861,732.	34	127,058,074.	

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI

1	Total revenue (must equal Part VIII, column (A), line 12)	1	98,803,113.
2	Total expenses (must equal Part IX, column (A), line 25)	2	92,212,379.
3	Revenue less expenses. Subtract line 2 from line 1	3	6,590,734.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	24,972,673.
5	Net unrealized gains (losses) on investments	5	2,899,913.
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	-286,892.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	34,176,428.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question in this Part XII

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

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

SCHEDULE A
(Form 990 or 990-EZ)

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. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
--	---

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

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

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

	Yes	No
11g(i)		
 - (ii) A family member of a person described in (i) above?

	Yes	No
11g(ii)		
 - (iii) A 35% controlled entity of a person described in (i) or (ii) above?

	Yes	No
11g(iii)		
- h 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 in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of monetary support
			Yes	No	Yes	No	Yes	No	
(A)									
(B)									
(C)									
(D)									
(E)									
Total									

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

Schedule A (Form 990 or 990-EZ) 2012

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

Section A. Public Support

Table with 7 columns: (a) 2008, (b) 2009, (c) 2010, (d) 2011, (e) 2012, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2008, (b) 2009, (c) 2010, (d) 2011, (e) 2012, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities; 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 2 columns: Percentage, %. Rows include: 14 Public support percentage for 2012; 15 Public support percentage from 2011 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2012; b 33 1/3% support test - 2011; 17a 10%-facts-and-circumstances test - 2012; b 10%-facts-and-circumstances test - 2011; 18 Private foundation.

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(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) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
9 Amounts from line 6.						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2012 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2011 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2012 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2011 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2012. 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 - 2011. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

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

Schedule of Contributors

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

2012

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
--	---

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

501(c)(03) (enter number) organization

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

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

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

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

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

Name of organization HARFORD MEMORIAL HOSPITAL, INC.

Employer identification number

52-0591484

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	UPPER CHESAPEAKE HEALTH FOUNDATION, INC. 520 UPPER CHESAPEAKE DRIVE, SUITE 405 BEL AIR, MD 21014	\$ 303,864.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
---	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
---	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
---	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
---	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
---	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization **HARFORD MEMORIAL HOSPITAL, INC.**

Employer identification number

52-0591484

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
-----	----- ----- -----	\$-----	-----
-----	----- ----- -----	\$-----	-----
-----	----- ----- -----	\$-----	-----
-----	----- ----- -----	\$-----	-----
-----	----- ----- -----	\$-----	-----
-----	----- ----- -----	\$-----	-----
-----	----- ----- -----	\$-----	-----
-----	----- ----- -----	\$-----	-----
-----	----- ----- -----	\$-----	-----

Name of organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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Part III **Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than \$1,000 for the year.** Complete columns (a) through (e) and the following line entry.
 For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this information once. See instructions.) ► \$ _____
 Use duplicate copies of Part III if additional space is needed.

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

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

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

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

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

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

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

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

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

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

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

▶ **See separate instructions.**

2012

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Department of the Treasury
Internal Revenue Service

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

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

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

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

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

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

Name of organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
--	---

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												
1 a	Total lobbying expenditures to influence public opinion (grass roots lobbying)														
b	Total lobbying expenditures to influence a legislative body (direct lobbying)														
c	Total lobbying expenditures (add lines 1a and 1b)														
d	Other exempt purpose expenditures														
e	Total exempt purpose expenditures (add lines 1c and 1d)														
f	Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width: 50%; text-align: left;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
g	Grassroots nontaxable amount (enter 25% of line 1f)														
h	Subtract line 1g from line 1a. If zero or less, enter -0-														
i	Subtract line 1f from line 1c. If zero or less, enter -0-														
j	If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes <input type="checkbox"/> No												

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) Total
2 a 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)		(b)
	Yes	No	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		4,521.
j Total. Add lines 1c through 1i			4,521.
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

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

LOBBYING ACTIVITIES

SCHEDULE, C, PART II-B, LINE 1I

LOBBYING EXPENSES IN THE AMOUNT OF \$4,521 FOR 12/31/12 REPRESENT A

PORTION OF THE DUES PAID TO MARYLAND HOSPITAL ASSOCIATION. THIS

ASSOCIATION ALLOCATES A PORTION OF MEMBER DUES TO LOBBYING ACTIVITY.

Part IV Supplemental Information *(continued)*

**SCHEDULE D
(Form 990)**

Supplemental Financial Statements

OMB No. 1545-0047

2012

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

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

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

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

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

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

	Held at the End of the 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) Revenues included in Form 990, Part VIII, line 1 ▶ \$ _____

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

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

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

b Assets included in Form 990, Part X ▶ \$ _____

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule D (Form 990) 2012

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?

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?
b If "Yes," explain the arrangement in Part XIII and complete the following table:
Table with columns: Amount, 1c Beginning balance, 1d Additions during the year, 1e Distributions during the year, 1f Ending balance
2a Did the organization include an amount on Form 990, Part X, line 21?
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.

Table with 6 columns: (a) Current year, (b) Prior year, (c) Two years back, (d) Three years back, (e) Four years back. Rows include: 1a Beginning of year balance, b Contributions, c Net investment earnings, gains, and losses, d Grants or scholarships, e Other expenditures for facilities and programs, f Administrative expenses, g End of year balance.

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
a Board designated or quasi-endowment %
b Permanent endowment %
c Temporarily restricted endowment %
The percentages in lines 2a, 2b, and 2c should equal 100%.
3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
(i) unrelated organizations
(ii) related organizations
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?
4 Describe in Part XIII the intended uses of the organization's endowment funds.

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

Table with 5 columns: (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows include: 1a Land, b Buildings, c Leasehold improvements, d Equipment, e Other, Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c)).

Part VII Investments - Other Securities. 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) _____		
(I) _____		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶		

Part VIII Investments - Program Related. See Form 990, Part X, line 13.

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

Part IX Other Assets. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) ASSETS LIMITED TO USE	49,678,197.
(2) DEFERRED FINANCING COSTS	116,301.
(3) DUE FROM AFFILIATES	4,405,000.
(4) TRUSTEE HELD FUNDS	646,989.
(5) _____	
(6) _____	
(7) _____	
(8) _____	
(9) _____	
(10) _____	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	54,846,487.

Part X Other Liabilities. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value	
(1) Federal income taxes		
(2) ADVANCES FROM THIRD PARTIES	1,728,394.	
(3) DUE TO AFFILIATES	37,550,291.	
(4) LIABILITY FOR ASBESTOS REMOVAL	5,273,550.	
(5) ACCRUED PENSION OBLIGATION	2,910,910.	
(6) _____		
(7) _____		
(8) _____		
(9) _____		
(10) _____		
(11) _____		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	47,463,145.	

2. FIN 48 (ASC 740) Footnote. 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

1	Total revenue, gains, and other support per audited financial statements		1	92,733,387.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
a	Net unrealized gains on investments	2a	2,899,913.	
b	Donated services and use of facilities	2b		
c	Recoveries of prior year grants	2c		
d	Other (Describe in Part XIII.)	2d	-9,686,089.	
e	Add lines 2a through 2d		2e	-6,786,176.
3	Subtract line 2e from line 1		3	99,519,563.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:			
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a		
b	Other (Describe in Part XIII.)	4b	-716,450.	
c	Add lines 4a and 4b		4c	-716,450.
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)		5	98,803,113.

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

1	Total expenses and losses per audited financial statements		1	83,529,167.
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	716,450.	
e	Add lines 2a through 2d		2e	716,450.
3	Subtract line 2e from line 1		3	82,812,717.
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	290,410.	
b	Other (Describe in Part XIII.)	4b	9,109,252.	
c	Add lines 4a and 4b		4c	9,399,662.
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)		5	92,212,379.

Part XIII Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, 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)

INCOME TAXES (FIN 48)

PART X, QUESTION 2

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

RECONCILIATION OF REVENUE

SCHEDULE D, PART XI

LINE 2D - OTHER REVENUE ON BOOKS NOT ON RETURN

MINIMUM PENSION LIABILITY	\$ (286,427)
RECLASS- INVESTMENT EXPENSE	\$ (290,410)
RECLASS - PROVISIONS FOR BAD DEBTS	\$(9,109,252)

	\$(9,686,089)

LINE 4B - OTHER REVENUE ON RETURN NOT ON BOOKS

RECLASS - RENTAL EXPENSE	\$ (716,450)
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Part XIII Supplemental Information (continued)

RECONCILIATION OF EXPENSE

SCHEDULE D, PART XII

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

RECLASS - RENTAL EXPENSE \$716,450

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

RECLASS - PROVISION FOR BAD DEBTS \$9,109,252

SCHEDULE H
(Form 990)

Hospitals

OMB No. 1545-0047

2012

Open to Public Inspection

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

Department of the Treasury
Internal Revenue Service

Name of the organization

HARFORD MEMORIAL HOSPITAL, INC.

Employer identification number

52-0591484

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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)			6,985,632.		6,985,632.	8.00
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			6,985,632.		6,985,632.	8.00
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			917,054.	41,767.	875,287.	1.00
f Health professions education (from Worksheet 5)			224,864.		224,864.	.24
g Subsidized health services (from Worksheet 6)			2,223,973.		2,223,973.	3.00
h Research (from Worksheet 7)			9,443.		9,443.	.01
i Cash and in-kind contributions for community benefit (from Worksheet 8)			87,603.		87,603.	.10
j Total. Other Benefits			3,462,937.	41,767.	3,421,170.	4.35
k Total. Add lines 7d and 7j.			10,448,569.	41,767.	10,406,802.	12.35

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

Schedule H (Form 990) 2012

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support			104,209.		104,209.	
4 Environmental improvements						
5 Leadership development and training for community members	12	14	1,542.		1,542.	
6 Coalition building	76		6,827.		6,827.	
7 Community health improvement advocacy						
8 Workforce development	36		2,687.		2,687.	
9 Other						
10 Total	124	14	115,265.		115,265.	

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		
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	36,867,593.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	37,063,332.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-195,739.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other		

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year?	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 (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group HARFORD MEMORIAL HOSPITAL

For single facility filers only: line number of hospital facility (from Schedule H, Part V, Section A) 1

Table with 3 columns: Question, Yes, No. Rows include Community Health Needs Assessment questions 1 through 8c.

Part V Facility Information (continued)

Financial Assistance Policy HARFORD MEMORIAL HOSPITAL		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate the FPG family income limit for eligibility for free care: <u>2</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	X	
11	Used FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>3</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	X	
12	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply):	X	
a	<input checked="" type="checkbox"/> Income level		
b	<input checked="" type="checkbox"/> Asset level		
c	<input checked="" type="checkbox"/> Medical indigency		
d	<input type="checkbox"/> Insurance status		
e	<input type="checkbox"/> Uninsured discount		
f	<input type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input type="checkbox"/> Other (describe in Part VI)		
13	Explained the method for applying for financial assistance?	X	
14	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input checked="" type="checkbox"/> The policy was attached to billing invoices		
c	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Part VI)		
Billing and Collections			
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency		
b	<input checked="" type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input checked="" type="checkbox"/> Other similar actions (describe in Part VI)		
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged:	X	
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input checked="" type="checkbox"/> Other similar actions (describe in Part VI)		

Part V Facility Information (continued) HARFORD MEMORIAL HOSPITAL

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a Notified individuals of the financial assistance policy on admission
- b Notified individuals of the financial assistance policy prior to discharge
- c Notified individuals of the financial assistance policy in communications with the patients regarding the patients' bills
- d Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy
- e Other (describe in Part VI)

Policy Relating to Emergency Medical Care

19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?
If "No," indicate why:

- 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 Part VI)
- d Other (describe in Part VI)

	Yes	No
19	X	

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

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

- a 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 Part VI)

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

If "Yes," explain in Part VI.

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

If "Yes," explain in Part VI.

22	X	
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Part V Facility Information (continued)

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

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

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

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

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART III, SECTION A, LINE 4

BAD DEBT EXPENSE

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

PART III, SECTION C, LINE 9B

COLLECTION PRACTICES

IT IS THE POLICY OF HARFORD MEMORIAL HOSPITAL ("HMH") TO ATTEMPT TO COLLECT PAYMENT FOR ALL SERVICES RENDERED TO PATIENTS IN THE MOST EFFICIENT AND PATIENT FRIENDLY MANNER. HMH WILL FIRST ATTEMPT TO COLLECT PAYMENT FROM THE PATIENT'S INSURANCE COMPANY. IN THE EVENT THE PATIENT HAS NO INSURANCE OR LIMITED INSURANCE COVERAGE, HMH WILL ATTEMPT TO QUALIFY THE PATIENT FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND/OR

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

HMH'S FINANCIAL ASSISTANCE POLICY.

PART V, LINES 15E/16E/19D/21

BILLING AND COLLECTIONS:

LINE 15E

PATIENTS WHO ARE LEFT WITH A BALANCE AFTER ALL INSURANCES HAVE BEEN PURSUED AND FINANCIAL ASSISTANCE HAS BEEN OFFERED WILL BE FORWARDED TO A COLLECTION AGENCY AS A LAST RESORT TO OBTAIN PAYMENT FROM THE PATIENT.

LINE 16E

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

CHARGES FOR MEDICAL CARE:

LINES 19D & 21

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

THE STATE OF MARYLAND HEALTH SERVICES COST REVIEW COMMISSION SETS RATES FOR ALL HOSPITALS IN THE STATE. THOSE RATES ARE APPLIED UNIFORMLY TO ALL PATIENTS. GROSS CHARGES MAY NOT BE DISCOUNTED OUTSIDE OF STATE-ACCEPTED DISCOUNTS FOR PROMPT PAYMENT AND ADVANCE FUNDING. IF A PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE, A PERCENTAGE OF THE GROSS CHARGES ARE THEN WRITTEN-OFF TO CHARITY CARE.

PART VI, SUPPLEMENTAL INFORMATION

NEEDS ASSESSMENT

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

PART VI, SUPPLEMENTAL INFORMATION

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

THE HOSPITAL DISPLAYS SIGNS AT EVERY REGISTRATION POINT INFORMING THE

PATIENTS ABOUT THE AVAILABILITY OF THE VARIOUS FINANCIAL AND MEDICAL

ASSISTANCE PROGRAMS.

THE HOSPITAL OFFERS EVERY SELF-PAY PATIENT OR ANY PATIENT WHO INQUIRES,

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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THE FINANCIAL ASSISTANCE INFORMATIONAL PACKET AND APPLICATION. THE COVER SHEET FOR THE FINANCIAL ASSISTANCE PACKET ALSO INCLUDES INFORMATION ON OBTAINING MEDICAL ASSISTANCE.

IN ADDITION, THE HOSPITAL HAS A FINANCIAL COUNSELOR THAT VISITS THE SELF-PAY PATIENT IN THE EMERGENCY DEPARTMENT OR IN THE PATIENT'S ROOM TO DISCUSS WHAT IS AVAILABLE TO THEM.

THE HOSPITAL ALSO EMPLOYS A MEDICAL ASSISTANCE ADVOCACY COMPANY TO ASSIST THE HOSPITAL'S PATIENTS GET MEDICAL ASSISTANCE.

THE HOSPITAL ALSO PROVIDES INFORMATION ABOUT THE PROGRAMS IN EACH BILLING STATEMENT.

PART VI, SUPPLEMENTAL INFORMATION

COMMUNITY INFORMATION

THE SERVICE AREA OF THE UPPER CHESAPEAKE HEALTH SYSTEM, WHICH INCLUDES HARFORD MEMORIAL HOSPITAL, CONSISTS OF THE NORTHEAST PART OF MARYLAND, INCLUDING HARFORD COUNTY, WESTERN CECIL COUNTY AND PORTION OF BALTIMORE COUNTY. THIS SERVICE AREA IS LOCATED AT THE APEX OF THE CHESAPEAKE BAY

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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AND IS SPREAD ACROSS 536 SQUARE MILES. IT CONTAINS, AMONG OTHERS, THE CITIES AND TOWNS OF HAVRE DE GRACE, ABERDEEN, BEL AIR, FALLSTON, AND EDGEWOOD. THE SERVICE AREA ENJOYS A DIVERSE ECONOMIC BASE, RANGING FROM CONCENTRATIONS IN SERVICE, MANUFACTURING, DISTRIBUTION, AND RETAIL, TO FEDERAL GOVERNMENT EMPLOYMENT. HARFORD COMMUNITY COLLEGE PROVIDES A LOCAL VENUE FOR ADVANCED EDUCATION AND HARFORD COUNTY'S PROXIMITY TO BALTIMORE GIVES IT ACCESS TO NATIONALLY RECOGNIZED UNIVERSITIES WHICH HELP PROVIDE A SKILLED WORKFORCE. THE SERVICE AREA IS SERVED BY INTERSTATE 95, AMTRAK AND FREIGHT RAIL LINES ALONG THE BUSY EAST-COAST TRANSPORTATION CORRIDOR BETWEEN NEW YORK AND WASHINGTON, DC. IN 2007, THE SERVICE AREA HAD A TOTAL POPULATION OF 276,500 PEOPLE WITH HISTORICAL ANNUAL GROWTH RATES OF APPROXIMATELY 1.8% PER YEAR. THIS GROWTH HAS BEEN CHARACTERIZED BY AN INFLUX OF YOUNG FAMILIES SEEKING SUBURBAN ENVIRONMENT IN WHICH TO LIVE AND IS COMPLEMENTED BY A GROWTH IN BUSINESSES AND OTHER SERVICES THAT FOLLOW YOUNG, MIDDLE CLASS FAMILIES. IN 2007, THE SERVICE AREA HAD AN ESTIMATED 101,930 HOUSEHOLDS WITH A MEDIAN FAMILY INCOME OF \$67,300 AND AN AVERAGE HOUSEHOLD INCOME OF \$81,000. 87% OF THE SERVICE

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

AREA'S ADULTS OVER THE AGE OF 25 ARE HIGH SCHOOL GRADUATES OR HIGHER; 27%

ACHIEVED BACHELOR'S DEGREES OR HIGHER. THE SERVICE AREA'S GROWTH AND

GEOGRAPHIC LOCATION EXPLAIN ITS ABILITY TO ATTRACT MAJOR EAST-COAST

DISTRIBUTION CENTER AND INDUSTRY, WHICH HAVE PROVIDED ADDITIONAL

EMPLOYMENT OPPORTUNITIES IN THE SERVICE AREA. IN DECEMBER 2007, THE

SERVICE AREA HAD A WORK FORCE OF APPROXIMATELY 142,829.

PLEASE SEE SCHEDULE O FOR MORE INFORMATION.

PART VI, SUPPLEMENTAL INFORMATION

PROMOTION OF COMMUNITY HEALTH

MONIES SPENT FOR HOSPITAL AND COMMUNITY PREPAREDNESS FOR HAZARDOUS

ACCIDENTS, NATURAL DISASTERS, AND COALITION BUILDING IN THE COMMUNITY.

PART VI, SUPPLEMENTAL INFORMATION

AFFILIATED HEALTH CARE SYSTEM

HARFORD MEMORIAL HOSPITAL, INC. (HMH) IS ONE HOSPITAL IN AN "AFFILIATED

HEALTH CARE SYSTEM" THAT INCLUDES A SECOND HOSPITAL, UPPER CHESAPEAKE

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

MEDICAL CENTER, INC. (UCMC), A PHYSICIAN SERVICES ORGANIZATION (UPPER CHESAPEAKE MEDICAL SERVICES, INC.), A PROPERTY HOLDING COMPANY (UPPER CHESAPEAKE PROPERTIES, INC.), A HOSPICE RESIDENCE (UPPER CHESAPEAKE RESIDENTIAL HOSPICE HOUSE, INC. & HOSPICE OF HARFORD COUNTY LLC) AND A FOR-PROFIT VENTURE WITH INVESTMENTS IN PRIVATE IMAGING SERVICES (UPPER CHESAPEAKE HEALTH VENTURES, INC.).

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

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

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART VI, SUPPLEMENTAL INFORMATION

STATE FILING OF COMMUNITY BENEFIT REPORT

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

SUPPLEMENTAL INFORMATION

HARFORD MEMORIAL HOSPITAL EXPECTS ITS COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN TO BE COMPLETED BY THE END OF TAX YEAR 2013 IN ACCORDANCE WITH THE AFFORDABLE CARE ACT.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

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

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2012

**Open to Public
Inspection**

Name of the organization

HARFORD MEMORIAL HOSPITAL, INC.

Employer identification number

52-0591484

Part I Questions Regarding Compensation

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

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

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

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

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

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

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

- a** Receive a severance payment or change-of-control payment? **4a** Yes No
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b** Yes No
- c** Participate in, or receive payment from, an equity-based compensation arrangement? **4c** Yes No
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

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

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

- a** The organization? **5a** Yes No
- b** Any related organization? **5b** Yes No
- 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** Yes No
- b** Any related organization? **6b** Yes No
- 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** Yes No

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** Yes No

9 If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? **9** Yes No

	Yes	No
1a		
1b		
2		
3		
4a		X
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7		X
8		X
9		X

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

Schedule J (Form 990) 2012

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 LYLE E. SHELDON PRESIDENT & CEO/DIRECTOR	(i)	0	0	0			
	(ii)	506,583.	249,752.	1,917,900.	54,500.	25,323.	2,754,058.
2 FAHEEM YOUNUS, M.D. DIRECTOR	(i)	0	0	0			
	(ii)	165,000.	0	0			165,000.
3 JOYCE FOX VP - PATIENT SVCS/CNO	(i)	189,669.	48,561.	7,088.	44,119.	3,577.	293,014.
	(ii)	0	0	0			
4 JOSEPH E. HOFFMAN III SR VP/CFO	(i)	0	0	0			
	(ii)	296,238.	119,391.	308,969.	51,500.	25,834.	801,932.
5 JAMES J. HURSEY SR VP/COO	(i)	0	0	0			
	(ii)	269,587.	0	6,554.	46,037.	10,377.	332,555.
6 DEAN C. KASTER SR VP - CORP STRATEGY/PLANNING	(i)	0	0	0			
	(ii)	223,452.	89,174.	186,728.	32,438.	31,182.	562,974.
7 MARGARET M. VAUGHAN SR VP - MEDICAL AFFAIRS	(i)	0	0	0			
	(ii)	308,514.	125,000.	394,963.	0	28,762.	857,239.
8 E. SCOTT CONOVER SR VP/GENERAL COUNSEL	(i)	0	0	0			
	(ii)	308,389.	102,030.	45,688.	41,500.	2,477.	500,084.
9 TONI M. SHIVERY VP - HUMAN RESOURCES	(i)	0	0	0			
	(ii)	169,792.	44,298.	270.	37,747.	26,965.	279,072.
10 EUGENE CURROTTO VP - OPERATIONS	(i)	142,531.	33,113.	4,092.	30,628.	26,969.	237,333.
	(ii)	0	0	0			
11 RICHARD CASTEEL VP - MIS	(i)	161,608.	23,190.	2,428.	16,941.	14,896.	219,063.
	(ii)	0	0	0			
12 STEPHEN LOW DIR - PHARMACEUTICAL SERVICES	(i)	124,336.	13,217.	103.	6,899.	24,048.	168,603.
	(ii)	0	0	0			
13 STEVEN D. BOWMAN DIR - FINANCIAL ACCT/BUDGET	(i)	107,194.	11,843.	2,590.	17,639.	24,322.	163,588.
	(ii)	0	0	0			
14 SHERRY S. ROBERTS DIR - IMAGING SERVICES	(i)	83,757.	10,991.	15,725.	20,533.	19,569.	150,575.
	(ii)	0	0	0			
15	(i)						
	(ii)						
16	(i)						
	(ii)						

Part III Supplemental Information

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

SCHEDULE J, PART I, QUESTION 3

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

UPPER CHESAPEAKE HEALTH SYSTEM UNDERTAKES A THOROUGH PROCESS TO ENSURE THAT THE EXECUTIVE COMPENSATION IT PAYS TO ITS TOP MANAGEMENT OFFICIALS IS REASONABLE GIVEN THE MARKET IN WHICH THE ORGANIZATION OPERATES.

UPPER CHESAPEAKE HEALTH SYSTEM CHECKS THE FOLLOWING BOXES FOR SCHEDULE J, PART I, QUESTION 3 ON ITS FORM 990:

COMPENSATION COMMITTEE

WRITTEN EMPLOYMENT CONTRACT

INDEPENDENT COMPENSATION CONSULTANT

COMPENSATION SURVEY OR STUDY

APPROVAL BY THE BOARD OF COMPENSATION COMMITTEE

Part III Supplemental Information

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

SCHEDULE J, PART I, QUESTION 4B

AN ORGANIZATION RELATED TO THIS FILING ORGANIZATION MADE SPLIT DOLLAR LIFE INSURANCE PLAN CONTRIBUTIONS TO THE FOLLOWING MEMBERS OF SENIOR LEADERSHIP WHO ARE LISTED ON THIS FILING ORGANIZATION'S FORM 990, PART VII, SECTION A, LINE 1A:

LYLE E. SHELDON	\$29,885
MARGARET M. VAUGHAN	\$ 8,562
JOSEPH E. HOFFMAN III	\$ 8,481
DEAN C. KASTER	\$ 6,489

LYLE E. SHELDON	\$29,885
MARGARET M. VAUGHAN	\$ 8,562
JOSEPH E. HOFFMAN III	\$ 8,481
DEAN C. KASTER	\$ 6,489

SCHEDULE J, SUPPLEMENTAL INFORMATION

EFFECTIVE IN CALENDAR YEAR 2012, UPPER CHESAPEAKE HEALTH SYSTEM, INC., TERMINATED THEIR SECURED EXECUTIVE BENEFIT PLAN (SERP). AS A RESULT OF THE SERP'S TERMINATION, THE PLAN PARTICIPANTS: LYLE SHELDON, JOSEPH

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.

HOFFMAN, DEAN CASTER AND MARGARET VAUGHAN RECOGNIZED ADDITIONAL TAXABLE
COMPENSATION (SUBJECT TO EMPLOYMENT TAX WITHHOLDING) IN TAX YEAR 2012.
THIS ADDITIONAL COMPENSATION IS REFLECTED IN SCHEDULE J - PART II -
COLUMN B(III).

**SCHEDULE K
(Form 990)**

Supplemental Information on Tax-Exempt Bonds

OMB No. 1545-0047

2012

**Open to Public
Inspection**

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

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

Department of the Treasury
Internal Revenue Service

Name of the organization
HARFORD MEMORIAL HOSPITAL, INC.

Employer identification number
52-0591484

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A MARYLAND HEALTH & HIGHER ED FACILITIES AUTHORITY	52-0936091	5742172P9	08/08/2008	19,856,000.	REFI EXISTING DEBT-SERIES 2008C		X		X		X
B MARYLAND HEALTH & HIGHER ED FACILITIES AUTHORITY	52-0936091	5742172P9	08/08/2008	8,852,000.	REFI EXISTING DEBT-SERIES 2008C		X		X		X
C MARYLAND HEALTH & HIGHER ED FACILITIES AUTHORITY	52-0936091		10/01/2011	8,000,000.	CAPITAL PROJECTS-SERIES 2011A		X		X		X
D MARYLAND HEALTH & HIGHER ED FACILITIES AUTHORITY	52-0936091		12/01/2011	9,476,000.	REFI EXISTING DEBT-SERIES 2011B		X		X		X

Part II Proceeds

	A		B		C		D	
1 Amount of bonds retired	20,048,000.		8,660,000.					
2 Amount of bonds legally defeased								
3 Total proceeds of issue	20,796,800.		9,375,360.		8,000,000.		9,476,000.	
4 Gross proceeds in reserve funds			636,320.					
5 Capitalized interest from proceeds					55,281.			
6 Proceeds in refunding escrows	16,549,989.		6,739,878.					
7 Issuance costs from proceeds	117,276.		78,994.		181.			
8 Credit enhancement from proceeds	36,356.							
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds	595,200.							
11 Other spent proceeds								
12 Other unspent proceeds								
13 Year of substantial completion	2008		2008		2013		2000	
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?	X		X			X	X	
15 Were the bonds issued as part of an advance refunding issue?		X		X		X		X
16 Has the final allocation of proceeds been made?	X		X		X		X	
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III Private Business Use

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

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

Schedule K (Form 990) 2012

**SCHEDULE K
(Form 990)**

Supplemental Information on Tax-Exempt Bonds

OMB No. 1545-0047

2012

**Open to Public
Inspection**

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

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

Department of the Treasury
Internal Revenue Service

Name of the organization
HARFORD MEMORIAL HOSPITAL, INC.

Employer identification number
52-0591484

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 & HIGH ED FACILITIES AUTHORITY	52-0936091		12/01/2011	9,476,000.	REFINANCE EXISTING DEBT-SERIES 201		X		X		X
B											
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	9,476,000.							
4 Gross proceeds in reserve funds								
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows								
7 Issuance costs from proceeds								
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds								
11 Other spent proceeds								
12 Other unspent proceeds								
13 Year of substantial completion								
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?	X							
15 Were the bonds issued as part of an advance refunding issue?		X						
16 Has the final allocation of proceeds been made?	X							
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	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						
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X						

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

Schedule K (Form 990) 2012

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

Part IV Arbitrage								
	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T?		X		X		X		X
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?								
b Exception to rebate?		X						
c No rebate due?								
If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?	X			X		X		X
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X			X				
b Name of provider	BANK OF AMERICA							
c Term of hedge	35.000							
d Was the hedge superintegrated?		X						
e Was the hedge terminated?		X						

Part III Private Business Use (Continued)	TAX-EXEMPT BOND LIABILITIES							
	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X						
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							
c Are there any research agreements that may result in private business use of bond-financed property?		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							
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶							%	%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶							%	%
6 Total of lines 4 and 5							%	%
7 Does the bond issue meet the private security or payment test?		X						
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		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						

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

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

THE OBLIGATED GROUP ON THE BOND ISSUES IDENTIFIED IN SCHEDULE K INCLUDE

BOTH UPPER CHESAPEAKE MEDICAL CENTER, INC. (52-1253920) AND HARFORD

MEMORIAL HOSPITAL, INC. (52-0591484). THE ALLOCATION IS AS FOLLOWS:

UPPER CHESAPEAKE MEDICAL CENTER 84%; HARFORD MEMORIAL HOSPITAL 16%.

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

OMB No. 1545-0047

2012

Open To Public Inspection

Name of the organization

HARFORD MEMORIAL HOSPITAL, INC.

Employer identification number

52-0591484

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

- 2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ \$ _____
- 3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ \$ _____

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

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

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				

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

Schedule L (Form 990 or 990-EZ) 2012

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) ROGER E SCHNEIDER, MD	VASC SURG ASSOC PARTNER	435,044.	PHYSICIAN FEES PAID TO VSA LLC		X
(2) JOHN H CAIN	BB&T OFFICER	1,734,120.	INTEREST ON O/S DEBT		X
(3) RICHARD P STREETT, JR	ROCK GLENN COMM PARTNER	569,547.	LEASE PAYMENTS		X
(4) JASON M. BIRNBAUM, M.D.	PULMONARY CCA PARTNER	919,589.	PHYSICIAN FEES PAID TO PCCA		X
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

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

2012

**Open to Public
Inspection**

Name of the organization

HARFORD MEMORIAL HOSPITAL, INC.

Employer identification number

52-0591484

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

FAMILY OR BUSINESS RELATIONSHIP

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

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

EXISTENCE OF MEMBERS

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

PART VI, SECTION B, POLICIES QUESTION 11B

ORGANIZATIONAL REVIEW OF FORM 990

THE BOARD OF UPPER CHESAPEAKE HEALTH SYSTEM, INC. ("HEALTH SYSTEM") HAS ASSIGNED THE EXECUTIVE COMMITTEE OF THE HEALTH SYSTEM'S BOARD TO REVIEW AND APPROVE ALL CONTENTS OF FORM 990 ON BEHALF OF THE BOARDS OF ALL HEALTH SYSTEM'S TAX-EXEMPT AFFILIATES. IN TURN, ONCE THE FORM 990 HAS

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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BEEN APPROVED BY HEALTH SYSTEM'S EXECUTIVE COMMITTEE, A FINAL VERSION OF THE FORM 990 WILL BE MADE AVAILABLE TO ALL BOARD MEMBERS OF THE RESPECTIVE HEALTH SYSTEM'S TAX-EXEMPT AFFILIATES. FORMAL NOTIFICATION OF THE FINAL AND APPROVED FORM 990 FOR EACH OF THE HEALTH SYSTEM'S AFFILIATES AS WELL AS ITS AVAILABILITY WILL BE COMMUNICATED TO THE APPLICABLE BOARD MEMBERS ON OR BEFORE THE FILING OF THE FORM 990.

PART VI, SECTION B, POLICIES QUESTION 12C

CONFLICT OF INTEREST POLICY

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

PART VI, SECTION B, POLICIES QUESTION 15

PROCESS FOR DETERMINING COMPENSATION

THE EXECUTIVE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS APPROVES

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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COMPENSATION FOR THE CHIEF EXECUTIVE OFFICER, CHIEF OPERATING OFFICER, CHIEF FINANCIAL OFFICER, AND ALL KEY EMPLOYEES. THE EXECUTIVE COMPENSATION COMMITTEE UTILIZES BUT IS NOT LIMITED TO THE FOLLOWING RESOURCES IN EVALUATING AND ESTABLISHING REASONABLE COMPENSATION: INDEPENDENT COMPENSATION CONSULTANTS, COMPENSATION SURVEYS AND COMPENSATION STUDIES. THIS ORGANIZATION AND ITS TAX-EXEMPT AFFILIATES STRIVE TO MAINTAIN AN ARM'S LENGTH RELATIONSHIP BETWEEN ITSELF AND ITS EMPLOYEES. IT IS THE GOAL OF THE EXECUTIVE COMPENSATION COMMITTEE TO ENSURE THAT TOTAL COMPENSATION (COMPENSATION AND BENEFITS) PAID TO ITS EMPLOYEES IS FAIR AND REASONABLE. FINALLY, THE PROCESS OF SETTING AND APPROVING SUCH COMPENSATION IS PERFORMED ANNUALLY BY THE BOARD'S EXECUTIVE COMPENSATION COMMITTEE.

PART VI, SECTION C, DISCLOSURE QUESTION 19

DOCUMENTS AVAILABLE TO THE PUBLIC

THE ORGANIZATION WILL MAKE THE FOLLOWING DOCUMENTS AVAILABLE TO THE PUBLIC UPON REQUEST: ARTICLES OF INCORPORATION, BYLAWS, CONFLICT OF INTEREST POLICY, AND AUDITED FINANCIAL STATEMENTS (HARFORD MEMORIAL HOSPITAL, INC. AND UPPER CHESAPEAKE MEDICAL CENTER, INC.).

PART VIII STATEMENT OF REVENUE

LINE 2A - PROGRAM SERVICE REVENUE

GROSS PATIENT REVENUE..... \$ 104,936,444

LESS: ALLOWANCES & CHARITY POLICIES... (12,739,159)

NET PATIENT REVENUE..... \$ 92,197,285

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
---	--

RECONCILIATION OF NET ASSETS

PART XI, LINE 5

MINIMUM PENSION PLAN LIABILITY.... \$(286,427)

ROUNDING..... (465)

TOTAL..... \$(286,892)

PART III, PROGRAM SERVICE ACCOMPLISHMENTS

TO PROVIDE HEALTHCARE SERVICES TO PATIENTS REGARDLESS OF THEIR ABILITY TO PAY FOR SUCH SERVICES.

FOR MORE THAN 90 YEARS, UPPER CHESAPEAKE HEALTH HAS BEEN PROVIDING COMPREHENSIVE, HIGH QUALITY HEALTH CARE. ITS TWO HOSPITALS, HARFORD MEMORIAL HOSPITAL AND UPPER CHESAPEAKE MEDICAL CENTER OFFER SOME OF THE AREA'S MOST ADVANCED INPATIENT AND OUTPATIENT SERVICES SO THAT PATIENTS CAN ENJOY THE SUPERIOR WELLNESS RESOURCES A HEALTHY LIFESTYLE NEEDS, WITHOUT LEAVING THEIR NEIGHBORHOOD. UPPER CHESAPEAKE HEALTH SYSTEM IS A COMMUNITY-BASED, NON-PROFIT HEALTH SYSTEM LOCATED IN HARFORD COUNTY, MARYLAND. OUR VISION IS BASED ON CREATING THE HEALTHIEST COMMUNITY IN MARYLAND. BUILDING ON THAT VISION, WE HAVE A STRONG COMMITMENT TO SERVICE EXCELLENCE. SO MUCH SO THAT IT HAS BECOME PART OF THE FABRIC OF THE HEALTHCARE EXPERIENCE AT UPPER CHESAPEAKE HEALTH. UPPER CHESAPEAKE HEALTH SYSTEM HAS OVER 2,500 PHYSICIANS AND HEALTHCARE PROFESSIONALS WHO ARE DELIVERING CARE FOR THE MIND, BODY AND SPIRIT IN SETTINGS FROM OFFICES, TO OUTPATIENT CENTERS, TO HOSPITALS, TO SHOPPING CENTERS, TO BUSINESSES AND HOMES. HARFORD MEMORIAL HOSPITAL IS A MEMBER OF THE UPPER

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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CHESAPEAKE HEALTH SYSTEM. HARFORD MEMORIAL HOSPITAL IS AN ACUTE CARE, NON-PROFIT FACILITY OFFERING A FULL COMPLEMENT OF MEDICAL, DIAGNOSTIC AND EMERGENCY CARE SERVICES. THE HOSPITAL IS FULLY ACCREDITED BY THE JOINT COMMISSION ON THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO). IN ADDITION TO MEDICAL/SURGICAL ACUTE CARE BEDS, THE HOSPITAL HAS A STATE-OF-THE-ART ICU/PCU AND A BUSY EMERGENCY DEPARTMENT THAT CARES FOR OVER 35,000 PATIENTS EACH YEAR. HARFORD MEMORIAL OFFERS VERY SPECIALIZED, ONE OF A KIND, HOSPITAL BASED SERVICES, INCLUDING A JOINT CENTER FOR PATIENTS UNDERGOING HIP OR KNEE JOINT REPLACEMENT SURGERY, A SLEEP DISORDER CENTER FOR THE DIAGNOSIS AND TREATMENT OF SLEEP DISORDERS, AND INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES.

HARFORD MEMORIAL AND UPPER CHESAPEAKE MEDICAL CENTER MAINTAIN CHARITY CARE PROGRAMS AND, IN ADDITION, CONDUCT MANY COMMUNITY OUTREACH AND COMMUNITY BUILDING ACTIVITIES, INCLUDING:

- COMMUNITY HEALTH EDUCATION PROGRAMS WHICH INCLUDE NEWBORN BABY CARE, SITTER SAFETY PROGRAM, INFANT CPR, INFANT SAFETY, STOP SMOKING CLASS, KIDS SAFETY CLASS, AND PRENATAL BREAST FEEDING CLASS

- SUPPORT GROUPS INCLUDING BREAST FEEDING SUPPORT, BREAST CANCER AWARENESS GROUPS, PERINATAL BEREAVEMENT, ASTHMA SUPPORT GROUP, WIDOW AND WIDOWERS SUPPORT GROUP, GRIEF SUPPORT GROUP, PROSTATE CANCER SUPPORT GROUP, AMPUTEE NETWORK, BRAIN INJURY SUPPORT GROUP, STROKE CLUB, LUPUS SUPPORT GROUP, AND OTHERS

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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- HEALTH SCREENINGS INCLUDING SCREENINGS FOR OSTEOPOROSIS, CARDIAC PROBLEMS, BLOOD PRESSURE, AND OTHER ISSUES

- FREE AND MOBILE CLINICS

A NUMERICAL SUMMARY OF COMMUNITY ACTIVITIES FOR UPPER CHESAPEAKE MEDICAL CENTER IS AS FOLLOWS:

	# OF STAFF HOURS	# OF ENCOUNTERS
COMMUNITY HEALTH SERVICES	644	7,554
HEALTH PROFESSIONS EDUCATION	6,352	175
MISSION DRIVEN HEALTHCARE SVCS	0	0
RESEARCH	92	5
FINANCIAL CONTRIBUTIONS	138	8
COMMUNITY BENEFIT OPERATIONS	124	14

TOTAL HOSPITAL COMMUNITY	7,350	7,756

	DIRECT COST (\$)	INDIRECT COST (\$)
COMMUNITY HEALTH SERVICES	\$ 547,789	\$ 369,265
HEALTH PROFESSIONS EDUCATION	224,864	0
MISSION DRIVEN HEALTHCARE SVCS	2,223,973	0
RESEARCH	9,443	0
FINANCIAL CONTRIBUTIONS	87,603	0

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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COMMUNITY BUILDING ACTIVITIES	68,852	46,413
FOUNDATION FUNDED COMM. BENEFIT	47,681	0
MEDICAID ASSESSMENTS	2,550,165	0

TOTAL HOSPITAL COMMUNITY BENEFIT	\$ 5,760,370	\$ 415,678

	OFFSETTING REVENUE (\$)	NET COMMUNITY BENEFIT (\$)
COMMUNITY HEALTH SERVICES	\$ 41,767	\$ 875,287
HEALTH PROFESSIONS EDUCATION	0	224,864
MISSION DRIVEN HEALTHCARE SVCS	0	2,223,973
RESEARCH	0	9,443
FINANCIAL CONTRIBUTIONS	0	87,603
COMMUNITY BUILDING ACTIVITIES	0	115,265
CHARITY CARE	0	3,051,400
FOUNDATION FUNDED COMM. BENEFIT	0	47,681
MEDICAID ASSESSMENTS	2,180,710	369,455

TOTAL HOSPITAL COMMUNITY BENEFIT	\$ 2,222,477	\$ 7,004,971

COMMUNITY OUTREACH

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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SCHEDULE H, PART VI

COMMUNITY OUTREACH

- IN 2012, HEALTHLINK HAD OVER 19,000 COMMUNITY-WIDE CONTACTS THROUGH THEIR SCREENING AND EDUCATIONAL PROGRAMS, FLU VACCINATION CLINICS, SUPPORT GROUPS AND HEALTHLINK PRIMARY CARE CLINIC VISITS. APPROXIMATELY, 4740 OF THESE CONTACTS WERE FOR HEALTH SCREENINGS (BLOOD PRESSURE, BODY FAT, CHOLESTEROL, OSTEOPOROSIS, STROKE, DIABETES RISK ASSESSMENTS, FOOT AND EYE SCREENINGS, AND CANCER SCREENINGS). THIS ALSO INCLUDES 4,689 CONTACTS THAT WERE REALIZED THROUGH THE HEALTHLINK PRIMARY CARE CLINIC. OVER 2,277 INFLUENZA VACCINATIONS WERE ADMINISTERED COUNTYWIDE. COMMUNITY OUTREACH ALSO PROVIDED LOCAL BUSINESSES WITH EMPLOYEE HEALTH SCREENINGS AND VACCINATIONS. AND MORE THAN 3000 HARFORD COUNTY CHILDREN RECEIVED HEALTH EDUCATION FROM UPPER CHESAPEAKE COMMUNITY OUTREACH.

SENIOR CENTER/SENIOR HOUSING/ASSISTED LIVING PROGRAMS

- COMMUNITY OUTREACH CONTINUED TO PROVIDE MONTHLY BLOOD PRESSURE SCREENINGS AT ALL SIX SENIOR CENTERS AND SENIOR HOUSING CENTERS INCLUDING WINDSOR VALLEY APARTMENTS, ABINGDON SENIOR HOUSING, FAIRBROOKE, ST. JOHNS COMMONS, ST. JOHNS TOWERS, ABERDEEN AND PERRYMAN STATION AS WELL AS BRIGHTVIEW AND AVONDALE ASSISTED LIVING FACILITIES. THROUGHOUT THE YEAR, MANY DIFFERENT HEALTH SCREENINGS WERE HELD DURING CERTAIN MONTHS AT EACH SENIOR LOCATION. DURING THE MONTH OF FEBRUARY, CHOLESTEROL SCREENINGS WERE PROVIDED TO 253 PARTICIPANTS AT ALL SIX SENIOR CENTERS. IN MARCH, A SCREENING FOR BODY COMPOSITION WAS PROVIDED TO 106 PARTICIPANTS AT THE SENIOR CENTERS. DURING THE MONTH OF MAY, A SCREENING FOR STROKE RISK ASSESSMENT WAS PROVIDED FOR 249 PARTICIPANTS AT ALL OF THE SENIOR CENTERS

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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AND SENIOR HOUSING CENTERS. IN SEPTEMBER, A HEARING AND VISION SCREENING WAS PROVIDED FOR THE FIRST TIME AT ALL SIX SENIOR CENTERS FOR 137 PARTICIPANTS. THEN IN OCTOBER, INFLUENZA VACCINATIONS WERE PROVIDED AT ALL OF THE SENIOR CENTERS, SENIOR HOUSING, AND ASSISTED LIVING PROGRAMS. THERE WAS ALSO A DIABETES RISK SCREENING PROVIDED IN NOVEMBER AT A FEW SENIOR CENTERS THAT 17 PARTICIPANTS ENGAGED IN.

CHILDREN'S PROGRAMS

- A TOTAL OF 291 CHILDREN WERE INVOLVED WITH OUR GLO GERM PROGRAM. THIS IS A PROGRAM THAT EMPHASIZES HOW INFECTION IS SPREAD AND THE IMPORTANCE OF GOOD HAND WASHING HABITS.

- APPROXIMATELY 588 CHILDREN WERE EXPOSED TO OUR KATU (KIDS AGAINST TOBACCO USE) PROGRAM AND SMOKING OUT THE TRUTH PROGRAMS. THESE PROGRAMS TEACH CHILDREN, ADOLESCENTS, AND TEENS ABOUT THE DANGERS ASSOCIATED WITH TOBACCO USE. TOXIC SOUP IS A PROGRAM THAT ADDRESSES THE EFFECTS OF SECONDHAND SMOKE WHICH IS A PROGRAM INCLUDED AT TIMES.

- THERE WERE APPROXIMATELY 1043 CHILDREN WHO ATTENDED OUR TEDDY BEAR CLINICS AT MANY OF THE HARFORD COUNTY ELEMENTARY PUBLIC SCHOOLS. THIS IS AN INTERACTIVE PROGRAM THAT FAMILIARIZES CHILDREN WITH THE HOSPITAL EXPERIENCE AND PRESENTS INFORMATION ON CHILD SAFETY.

- ANOTHER POPULAR PROGRAM TITLED HOW SWEET IT IS WAS TAKEN OUT INTO THE COMMUNITY AND OVER 2363 CHILDREN AND ADULTS WERE EXPOSED TO THIS PROGRAM. THE FOCUS OF THIS PROGRAM IS TO EDUCATE CHILDREN AND ADULTS ON THE SUGAR CONTENT IN MANY OF THEIR FAVORITE DRINKS INCLUDING JUICE BOXES, SPORTS

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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DRINKS, SODA, FLAVORED WATER, AND POPULAR COFFEE DRINKS.

- OVER 300 CHILDREN AND ADULTS WERE INVOLVED IN OUR SUN SENSE PROGRAM DURING THE YEAR. THIS PROGRAM EDUCATES CHILDREN, TEENS AND ADULTS ON THE HARMFUL EFFECTS OF THE SUN INCLUDING THE DANGERS OF TANNING BEDS. A SKIN ANALYZER MACHINE IS ALSO UTILIZED WITH THIS PROGRAM TO ALLOW INDIVIDUALS TO EXAMINE THEIR OWN SKIN AND REALIZE THE IMPACT THAT THE SUN HAS HAD ON THEIR SKIN.

- IN ADDITION TO THE ABOVE PROGRAMS, A NUTRITION PROGRAM TITLED MY PLATE WAS DEVELOPED GEARED TO CHILDREN, TEENS, ADULTS AND SENIORS. THIS PROGRAM FOCUSES ON MAKING HEALTHIER FOOD CHOICES AND BUILDING A HEALTHY PLATE.

NEW SCREENINGS AND NEW BUSINESSES

- IN 2012, NEW EQUIPMENT WAS OBTAINED TO BE ABLE TO PROVIDE HBA1C SCREENINGS FOR TEAM MEMBERS DETERMINED AT RISK FOR DIABETES AT THE WELLNESS WORKS PROGRAM HERE AT UCH. THIS SCREENING USES BLOOD FROM A FINGERSTICK TO DETERMINE A HBA1C LEVEL WHICH IS THE AVERAGE BLOOD GLUCOSE LEVEL IN THE BODY OVER A 2-3MONTH PERIOD. THE ABILITY TO USE THIS SCREENING TOOL IN THE COMMUNITY IS BEING EVALUATED.

- A NEW PARTNERSHIP WAS FORMED WITH THE HARFORD COUNTY SHERIFF'S OFFICE TO PROVIDE HEALTH FAIRS FOR THEIR EMPLOYEES. THE FIRST HEALTH FAIR WAS HELD AT THE HEAT CENTER IN ABERDEEN WITH OVER 25 PARTICIPANTS AT THIS EVENT. SOME OF THE HEALTH SCREENINGS AND PROGRAMS OFFERED WERE BLOOD PRESSURES, BODY COMPOSITION, HEALTH WHEEL, SLEEP ASSESSMENT, AND HOW SWEET IT IS. IN THE FALL, TWO HEALTH FAIRS WERE COORDINATED AT THE

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
---	--

NORTHERN AND SOUTHERN PRECINCTS TO CAPTURE AND IMPROVE ACCESSABILITY TO MORE EMPLOYEES. THERE WERE APPROXIMATELY 55 PARTICIPANTS AT THESE EVENTS. SOME OF THE SCREENINGS OFFERED IN THE FALL WERE CHOLESTEROL, BLOOD PRESSURE, BODY COMPOSITION, CO ASSESSMENT TO SCREEN FOR SMOKING, MY PLATE, HEALTH WHEEL, FLU SHOTS, AND HOW SWEET IT IS.

- COMMUNITY OUTREACH GOT INVOLVED WITH A NEW INITIATIVE BY THE HARFORD COUNTY PUBLIC SCHOOLS TO PROVIDE HEALTH SCREENINGS TO THEIR EMPLOYEES AT THREE DESIGNATED SCHOOLS DURING THE MONTH OF SEPTEMBER. MANY DIFFERENT HEALTH SCREENINGS WERE OFFERED INCLUDING CHOLESTEROL, BLOOD PRESSURES, BODY COMPOSITION, OSTEOPOROSIS, CARDIAC RISK ASSESSMENT, AND STROKE RISK ASSESSMENT.

VACCINES

SCHEDULE H, PART VI

- COMMUNITY OUTREACH ADMINISTERED APPROXIMATELY 2277 COMMUNITY FLU VACCINATIONS THROUGHOUT THE COUNTY IN 2012.

"DINING WITH DOCS" LECTURES AND COMMUNITY LECTURES

- IN 2012, THERE WERE SEVERAL "DINING WITH DOCS" LECTURES ABOUT CANCER AND THE ENVIRONMENT AND SLEEP DISORDERS THAT WERE HELD AT THE UPPER CHESAPEAKE MEDICAL CENTER. APPROXIMATELY 68 COMMUNITY RESIDENTS ATTENDED THESE LECTURES.

- THERE WERE MANY OTHER COMMUNITY LECTURES PROVIDED ON TOPICS REGARDING HEALTHY AGING, HEART HEALTH, AND NUTRITION HELD AT SEVERAL CHURCHES IN THE COUNTY. APPROXIMATELY 546 COMMUNITY RESIDENTS ATTENDED ONE OF THESE LECTURES.

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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- A SEMINAR ON HEART DISEASE AND ERECTILE DYSFUNCTION PRESENTED BY A CARDIOLOGIST AND UROLOGIST WAS COORDINATED WITH CHESAPEAKE UROLOGY ASSOCIATES AT THE RICHLIN BALLROOM IN EDGEWOOD. OVER 45 MEMBERS OF THE COMMUNITY ATTENDED THIS EVENT. A BLOOD PRESSURE SCREENING WAS ALSO PROVIDED.

HAVRE DE GRACE HEALTH-TACULAR

- THE SECOND ANNUAL HEALTH FAIR WAS HELD AT THE HAVRE DE GRACE ACTIVITY CENTER. HEALTHLINK WAS INVOLVED IN THE PLANNING OF THIS EVENT WITH MARKETING AND OTHER DEPARTMENTS ON THE COMMITTEE. THERE WERE MANY DIFFERENT SCREENINGS AND PROGRAMS OFFERED AT THIS EVENT INCLUDING CHOLESTEROL, BLOOD PRESSURE, BODY COMPOSITION, HEARING SCREENING, BREAST HEALTH, SKIN CANCER SCREENING, PROSTATE SCREENING, HEALTH WHEEL, HOW SWEET IT IS PROGRAM, AND FREE FLU VACCINATIONS. OVER 300 PEOPLE TOOK ADVANTAGE OF THESE SERVICES OFFERED.

HEALTHLINK COMMUNITY WELLNESS CENTER

- IN 2012, THE HEALTHLINK COMMUNITY WELLNESS CENTER WHICH OPERATES FROM THE HEALTHLINK MEDICAL MOBILE VAN HAD 84 RESIDENTS PARTICIPATE IN ONE OF THE AVAILABLE HEALTH SCREENINGS OFFERED THROUGHOUT THE YEAR. THE WELLNESS CENTERS ARE OFFERED MONTHLY AT TWO DIFFERENT LOCATIONS IN THE COUNTY.

PRIMARY CARE CLINIC

- THE HEALTHLINK PRIMARY CARE CLINIC (PCC) PROVIDED PRIMARY CARE ON A

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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SLIDING FEE SCALE TO LOW INCOME ADULTS AGE 19 AND ABOVE WHO ARE UNINSURED OR UNDERINSURED AND MEET SPECIFIC INCOME CRITERIA. IN 2012, THE PCC HAD APPROXIMATELY 4,689 PATIENT ENCOUNTERS.

HEALTHLINK CALL CENTER

- IN 2012, OUR HEALTHLINK CALL CENTER HANDLED APPROXIMATELY 6,334 CALLS. THIS INCLUDED ALMOST 387 PHYSICIAN REFERRALS, 2,784 PHYSICIAN RELATED CALLS AND 1,884 SERVICE CALLS.

SUPPORT GROUPS

- HEALTHLINK RNS FACILITATE COUNTYWIDE SUPPORT GROUPS FOR DIABETES. THE SUPPORT GROUPS MEET AT THE ABERDEEN SENIOR CENTER, EDGEWOOD SENIOR CENTER, PRIMARY CARE CLINIC, AND THE MCFAUL ACTIVITY CENTER. THESE GROUPS MEET MONTHLY AND SERVED APPROXIMATELY 180 PARTICIPANTS.

HEALTHLINK AND COMMUNITY HEALTH IMPROVEMENT COALITIONS AND COMMITTEES

- HARFORD COUNTY SCHOOL HEALTH BOARD
- HARFORD COUNTY TOBACCO COALITION
- HARFORD COUNTY CANCER COALITION
- OFFICE ON AGING ADVISORY BOARD
- HARFORD COUNTY HOMELESS ADVISORY BOARD
- GAIN COMMITTEE
- HEALTHY HARFORD

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.	Employer identification number 52-0591484
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ATTACHMENT 1FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

AN ACUTE CARE, NON-PROFIT HOSPITAL, HARFORD MEMORIAL HOSPITAL OFFERS A FULL COMPLEMENT OF MEDICAL, DIAGNOSTIC, AND EMERGENCY CARE SERVICES. THE HOSPITAL HAS A STATE-OF-THE-ART ICU/PCU AND A BUSY EMERGENCY DEPARTMENT THAT CARES FOR OVER 50,000 PATIENTS A YEAR. HARFORD MEMORIAL OFFERS SPECIALIZED, HOSPITAL-BASED SERVICES, INCLUDING A BARIATRIC SURGERY PROGRAM, ANTICOAGULATION MANAGEMENT, CENTER FOR WOUND CARE, INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES, JOINT CENTER FOR HIP AND KNEE REPLACEMENT, AND A SLEEP DISORDER CENTER.

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

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
NORTHERN CHESAPEAKE ANESTHESIA ASSOC P.O. BOX 89 BEL AIR, MD 21014	PHYSICIAN FEES	1,400,000.
VISION CONSULTING, LLC 3325 ASPEN GROVE DRIVE, SUITE 204 FRANKLIN, TN 37067	SOFTWARE CONSULTING	308,119.
CHESAPEAKE MEDICAL STAFFING 2401 YORK ROAD TIMONIUM, MD 21093	MEDICAL STAFF FEES	183,948.
KPMG, LLC 111 SOUTH CALVERT ST BALTIMORE, MD 21202	AUDIT FEES	169,484.
BRAIN AND SPINE SPECIALISTS PA 520 UPPER CHESAPEAKE DR., STE 211 BEL AIR, MD 21014	PHYSICIAN FEES	246,401.

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2012

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

Name of the organization

HARFORD MEMORIAL HOSPITAL, INC.

Employer identification number

52-0591484

Part I Identification of Disregarded Entities (Complete if the organization answered "Yes" to 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" to Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) UPPER CHESAPEAKE HEALTH FOUNDATION, INC. 52-1398507 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	FIN SUPPORT	MD	501(C)(3)	11A	N/A		X
(2) UPPER CHESAPEAKE MEDICAL SERVICES, INC. 52-1501734 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	PHYSICIAN SVC	MD	501(C)(3)	9	UCHS/UMMS VN		X
(3) UPPER CHESAPEAKE/ST. JOE'S HOME CARE, IN 52-1229742 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HOSPICE CARE	MD	501(C)(3)	9	UCHS/UMMS VN		X
(4) UPPER CHESAPEAKE MEDICAL CENTER, INC. 52-1253920 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HOSPITAL CARE	MD	501(C)(3)	3	UCHS/UMMS VN		X
(5) UPPER CHESAPEAKE PROPERTIES, INC. 52-1907237 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	TITLE HOLDING	MD	501(C)(3)	N/A	UCHS/UMMS VN		X
(6) UPPER CHESAPEAKE HEALTH SYSTEMS, INC. 52-1398513 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HLTHCARE SVCS	MD	501(C)(3)	11C; III-FI	UCHS/UMMS VN		X
(7) UPPER CHESAPKE RESIDENTIAL HOSPICE HOUSE 26-0737028 520 UPPER CHESAPEAKE DRIVE BEL AIR, MD 21014	HOSPICE CARE	MD	501(C)(3)	7	UCHS/UMMS VN		X

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

Schedule R (Form 990) 2012

SCHEDULE R (Form 990)

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2012

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Name of the organization HARFORD MEMORIAL HOSPITAL, INC.

Employer identification number 52-0591484

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

Table with 6 columns: (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. Rows 1-6 are empty.

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

Table with 9 columns: (a) Name, address, and EIN of related organization; (b) Primary activity; (c) Legal domicile (state or foreign country); (d) Exempt Code section; (e) Public charity status (if section 501(c)(3)); (f) Direct controlling entity; (g) Section 512(b)(13) controlled entity? (Yes/No). Row 1: HEALTHY HARFORD, INC. 52-1944325, 2027 PULASKI HWY, SUITE 215 HAVRE DE GRACE, MD 21078, HEALTH INITATV, MD, 501(C)(3), 7, N/A, No, X.

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

Schedule R (Form 990) 2012

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) UCHS/UMMS VENTURE LLC 52-21780 520 UPPER CHESAPEAKE DRIVE	MEDICAL SERVICES	MD	N/A									
(2) UCHS UMMS R/E TRUST 27-6803540 520 UPPER CHESAPEAKE DRIVE	HOLD LAND	MD	N/A									
(3) -----												
(4) -----												
(5) -----												
(6) -----												
(7) -----												

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

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

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

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

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

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

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

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

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

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

Part VII **Supplemental Information**

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