

Cumulative e-File History 2010	
FED	
Locator:	4228CV
Taxpayer Name:	SHORE HEALTH SYSTEM, INC.
Return Type:	990
Submitted Date:	05/14/2012 11:09:41
Acknowledgement Date:	05/14/2012 11:27:15
Status:	Accepted
Submission ID:	23695320121355000017

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

For calendar year 2010, or fiscal year beginning 07/01, 2010, and ending 06/30, 2011

2010

Department of the Treasury
Internal Revenue Service

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

Name of exempt organization

Employer identification number

SHORE HEALTE SYSTEM, INC.

52-0610538

Name and title of officer

WALTER ZAJAC, 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>232591942.</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 2010 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 24351 as my signature

ERO firm name

Enter five numbers, but do not enter all zeros

on the organization's tax year 2010 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 2010 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶

Date ▶

5/10/11

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.

54681436465

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2010 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 ▶

Date ▶

5/11/2012

ERO Must Retain This Form - See Instructions

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

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 2010 calendar year, or tax year beginning 07/01, 2010, and ending 06/30, 2011

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 SHORE HEALTH SYSTEM, INC.			D Employer identification number 52-0610538	
	Doing Business As			E Telephone number (410) 822-1000 EXT 5672	
	Number and street (or P.O. box if mail is not delivered to street address)		Room/suite		
	219 SOUTH WASHINGTON ST.				
City or town, state or country, and ZIP + 4 EASTON, MD 21601			G Gross receipts \$ 232,754,368.		
F Name and address of principal officer: KENNETH KOZEL 219 SOUTH WASHINGTON ST. EASTON, MD 21601			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			H(c) Group exemption number ▶		
J Website: ▶ WWW.SHOREHEALTH.ORG					
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			L Year of formation: 1906 M State of legal domicile: MD		

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: SHORE HEALTH SYSTEM IS A REGIONAL, NOT-FOR-PROFIT NETWORK OF INPATIENT AND OUTPATIENT SERVICES WITH FACILITIES IN TALBOT, DORCHESTER, CAROLINE, AND QUEEN ANNE'S COUNTIES.		
	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	18.
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	15.
	5 Total number of individuals employed in calendar year 2010 (Part V, line 2a)	5	2,003.
	6 Total number of volunteers (estimate if necessary)	6	612.
	7a Total gross unrelated business revenue from Part VIII, column (C), line 12	7a	6,721,509.
b Net unrelated business taxable income from Form 990-T, line 34	7b	-1,029,692.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	1,581,438.	1,135,148.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	206,968,617.	223,957,928.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	4,227,065.	7,209,286.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	220,992.	289,580.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	212,998,112.	232,591,942.
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)	103,071,337.	105,263,166.
	16 a 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-24f)	98,324,795.	104,117,804.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	201,396,132.	209,380,970.	
19 Revenue less expenses. Subtract line 18 from line 12	11,601,980.	23,210,972.	
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)	284,794,015.	304,359,977.
	22 Net assets or fund balances. Subtract line 21 from line 20	133,987,549.	124,473,468.
		150,806,466.	179,886,509.

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			
	▶ WALTER ZAJAC CFO				
Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN
	Firm's name ▶ GRANT THORNTON LLP				P00511122
	Firm's address ▶ 2001 MARKET STREET, SUITE 3100 PHILADELPHIA, PA 19103			Firm's EIN ▶ 36-6055558	Phone no. 215-561-4200
May the IRS discuss this return with the preparer shown above? (see instructions)					<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

For Paperwork Reduction Act Notice, see the separate instructions.

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:
TO EXCEL IN QUALITY CARE AND PATIENT SATISFACTION.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? Yes No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? Yes No
If "Yes," describe these changes on Schedule O.

4 Describe the exempt purpose achievements for each of the organization's three largest program services by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code: _____) (Expenses \$ 183,471,083. including grants of \$ _____) (Revenue \$ 223,957,928.)
ATTACHMENT 1

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 ▶ 183,471,083.

Part IV Checklist of Required Schedules

Table with 3 columns: Question number, Yes, No. Rows include questions 1 through 20b regarding organizational requirements and reporting.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question number, Question text, and Yes/No response boxes. Rows include questions 21 through 38 regarding grants, compensation, tax-exempt bonds, 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.

		Yes	No
1 a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable 1a 578		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable 1b 0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? 1c	X	
2 a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return 2a 2,003		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to <i>e-file</i> . (see instructions)	X	
3 a	Did the organization have unrelated business gross income of \$1,000 or more during the year? 3a	X	
b	If "Yes," has it filed a Form 990-T for this year? <i>If "No," provide an explanation in Schedule O</i> 3b	X	
4 a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? 4a		X
b	If "Yes," enter the name of the foreign country: <input type="text"/> See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.		
5 a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? 5a		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? 5b		X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T? 5c		
6 a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible? 6a		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? 6b		
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? 7a	X	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided? 7b	X	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? 7c		X
d	If "Yes," indicate the number of Forms 8282 filed during the year 7d		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? 7e		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? 7f		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? 7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? 7h		
8	Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations. Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year? 8		
9	Sponsoring organizations maintaining donor advised funds.		
a	Did the organization make any taxable distributions under section 4966? 9a		
b	Did the organization make a distribution to a donor, donor advisor, or related person? 9b		
10	Section 501(c)(7) organizations. Enter:		
a	Initiation fees and capital contributions included on Part VIII, line 12 10a		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities 10b		
11	Section 501(c)(12) organizations. Enter:		
a	Gross income from members or shareholders 11a		
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) 11b		
12 a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? 12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year 12b		
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? 13a		
	Note. See the instructions for additional information the organization must report on Schedule O.		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans 13b		
c	Enter the amount of reserves on hand 13c		
14 a	Did the organization receive any payments for indoor tanning services during the tax year? 14a		X
b	If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation in Schedule O</i> 14b		

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year (18); 1b Enter the number of voting members included in line 1a, above, who are independent (15); 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? (X); 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? (X); 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? (X); 5 Did the organization become aware during the year of a significant diversion of the organization's assets? (X); 6 Does the organization have members or stockholders? (X); 7a Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body? (X); 7b Are any decisions of the governing body subject to approval by members, stockholders, or other persons? (X); 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body? (X); b Each committee with authority to act on behalf of the governing body? (X); 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O (X).

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Does the organization have local chapters, branches, or affiliates? (X); 10b If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization?; 11a Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form? (X); 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990.; 12a Does the organization have a written conflict of interest policy? If "No," go to line 13 (X); 12b Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (X); 12c Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done (X); 13 Does the organization have a written whistleblower policy? (X); 14 Does the organization have a written document retention and destruction policy? (X); 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? a The organization's CEO, Executive Director, or top management official (X); b Other officers or key employees of the organization (X); If "Yes" to line 15a or 15b, describe the process in Schedule O. (See instructions.); 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? (X); 16b If "Yes," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken steps to safeguard the organization's exempt status with respect to such arrangements? (X).

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD;
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply. [] Own website [] Another's website [X] Upon request
19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: WALTER ZAJAC, CFO 219 SOUTH WASHINGTON ST. EASTON, MD 21601 410-822-1000

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.

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 (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
ATTACHMENT 3										
(1) ROBERT CHRENCIK UMMS PRESIDENT/CEO	1.00	X					0.	1,654,567.	198,781.	
(2) JOHN DILLON BOARD CHAIRMAN	1.00	X		X			0.	0.	0.	
(3) RICHARD LOEFFLER BOARD VICE CHAIRMAN	1.00	X		X			0.	0.	0.	
(4) CHARLES LEA BOARD VICE CHAIRMAN	1.00	X		X			0.	0.	0.	
(5) GERARD WALSH INTERIM PRES/CEO	40.00	X		X			296,737.	0.	22,573.	
(6) MARTHA RUSSELL BOARD TREASURER	1.00	X		X			0.	0.	0.	
(7) WALTER ZAJAC SVP/CFO-BOARD TREASURER	40.00	X		X			237,732.	0.	19,970.	
(8) STUART BOUNDS BOARD SECRETARY	1.00	X		X			0.	0.	0.	
(9) PHYLLIS MATTHAI BOARD ASSISTANT SECRETARY	40.00	X		X			66,858.	0.	15,605.	
(10) ROBERT CARMEAN BOARD MEMBER	1.00	X					0.	0.	0.	
(11) LUDWIG EGLSEDER, III, MD BOARD MEMBER	1.00	X					48,000.	0.	0.	
(12) MARLENE FELDMAN BOARD MEMBER	1.00	X					0.	0.	0.	
(13) MICHAEL JOYCE, MD BOARD MEMBER	1.00	X					0.	0.	0.	
(14) KEITH MCMAHAN BOARD MEMBER	1.00	X					0.	0.	0.	
(15) DAVID MILLIGAN BOARD MEMBER	1.00	X					0.	0.	0.	
(16) MICHAEL MORAN BOARD MEMBER	1.00	X					0.	0.	0.	

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

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(17) JOHN ASHWORTH, III BOARD MEMBER	1.00	X					0.	587,447.	24,957.	
(18) NEIL MUFSON BOARD MEMBER	1.00	X					0.	0.	0.	
(19) JAMES PETERSON BOARD MEMBER	1.00	X					0.	0.	0.	
(20) JACK STOLZ BOARD MEMBER	1.00	X					0.	0.	0.	
(21) JOSEPH ROSS PRESIDENT/CEO	40.00			X			601,804.	0.	24,480.	
(22) MICHAEL TOOKE, MD SVP/CMO	40.00				X		349,655.	0.	50,874.	
(23) CHRISTOPHER PARKER INTERIM COO	40.00				X		272,820.	0.	19,604.	
(24) MICHAEL ZIMMERMAN VP/HR	40.00				X		234,031.	0.	21,892.	
(25) MICHAEL SILGEN VP/MARKETING	40.00				X		175,134.	0.	21,099.	
(26) JONATHAN COOK VP/PHYSICIAN SERVICES	40.00				X	X	201,240.	0.	30,976.	
(27) JOHN SAWYER LEAD MEDICAL PHYSICIST	40.00					X	176,741.	0.	6,320.	
(28) CATHERINE FERARA CLINICAL PHARMIST	40.00					X	148,973.	0.	11,320.	
1b Sub-total							2,809,725.	2,242,014.	468,451.	
c Total from continuation sheets to Part VII, Section A ATTACHMENT 2							407,681.	0.	46,511.	
d Total (add lines 1b and 1c)							3,217,406.	2,242,014.	514,962.	

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 in reportable compensation from the organization **77**

	Yes	No
3 Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>		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? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such person</i>		X

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 4		

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 **29**

Part VIII Statement of Revenue

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c	71,899.			
	d	Related organizations	1d	777,496.			
	e	Government grants (contributions)	1e	139,515.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	146,238.			
	g	Noncash contributions included in lines 1a-1f: \$ _____					
	h	Total. Add lines 1a-1f ▶		1,135,148.			
Program Service Revenue				Business Code			
	2a	PATIENT SERVICE REVENUE		621500	217,703,694.	210,982,185.	6,721,509.
	b	OTHER OPERATING REVENUE		900099	6,254,234.	6,254,234.	
	c						
	d						
	e						
	f	All other program service revenue					
g	Total. Add lines 2a-2f ▶			223,957,928.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) ▶			5,702,384.		5,702,384.
	4	Income from investment of tax-exempt bond proceeds . . . ▶			0.		
	5	Royalties ▶			0.		
			(i) Real	(ii) Personal			
	6a	Gross Rents	403,328.				
	b	Less: rental expenses	136,059.				
	c	Rental income or (loss)	267,269.				
	d	Net rental income or (loss) ▶			267,269.		267,269.
			(i) Securities	(ii) Other			
	7a	Gross amount from sales of assets other than inventory	1,863,147.	-356,245.			
	b	Less: cost or other basis and sales expenses					
	c	Gain or (loss)	1,863,147.	-356,245.			
	d	Net gain or (loss) ▶			1,506,902.		1,863,147.
	8a	Gross income from fundraising events (not including \$ <u>71,899.</u> of contributions reported on line 1c). See Part IV, line 18 a		13,770.			
	b	Less: direct expenses b		26,367.			
c	Net income or (loss) from fundraising events ▶			-12,597.		-12,597.	
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	JOINT VENTURE REVENUE		900099	34,908.	34,908.		
b							
c							
d	All other revenue						
e	Total. Add lines 11a-11d ▶			34,908.			
12	Total revenue. See instructions ▶			232,591,942.	217,271,327.	6,721,509.	7,820,203.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns.

All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21	0.			
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22	0.			
3 Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	2,659,085.	2,576,622.	82,463.	
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	78,894,501.	70,273,864.	8,620,637.	
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	2,109,773.	1,911,053.	198,720.	
9 Other employee benefits	15,638,053.	14,024,811.	1,613,242.	
10 Payroll taxes	5,961,754.	5,326,139.	635,615.	
11 Fees for services (non-employees):				
a Management	0.			
b Legal	15.		15.	
c Accounting	1,374,813.		1,374,813.	
d Lobbying	19,651.	19,651.		
e Professional fundraising services. See Part IV, line 17	0.			
f Investment management fees	0.			
g Other	22,076,133.	17,559,390.	4,516,743.	
12 Advertising and promotion	764,344.	764,344.		
13 Office expenses	10,146,091.	10,076,721.	69,370.	
14 Information technology	5,961,222.	151,257.	5,809,965.	
15 Royalties	0.			
16 Occupancy	4,606,197.	4,606,197.		
17 Travel	468,840.	355,258.	113,582.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	0.			
20 Interest	3,260,295.	3,011,832.	248,463.	
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	14,433,650.	13,333,680.	1,099,970.	
23 Insurance	78,207.	73,147.	5,060.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24f. If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O.)				
a <u>BAD DEBT</u>	8,434,519.	8,434,519.		
b <u>COST OF GOODS SOLD</u>	23,035,962.	23,035,962.		
c <u>RECRUITMENT</u>	596,052.	536,209.	59,843.	
d <u>EXPENDITURES FOR FUND PURPOS</u>	158,123.	158,123.		
e <u>EQUIPMENT RENTAL AND MAINTEN</u>	7,004,426.	6,694,816.	309,610.	
f All other expenses	1,699,264.	547,488.	1,151,776.	
25 Total functional expenses. Add lines 1 through 24f	209,380,970.	183,471,083.	25,909,887.	0.
26 Joint Costs. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720). Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X Balance Sheet

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	17,006,323.	1	13,584,502.
	2 Savings and temporary cash investments		2	
	3 Pledges and grants receivable, net	24,320,533.	3	26,391,398.
	4 Accounts receivable, net		4	
	5 Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6 Receivables from other disqualified persons (as defined under section 4958(f)(1)), 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)		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	3,784,925.	8	3,773,781.
	9 Prepaid expenses and deferred charges	679,587.	9	940,539.
	10 a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 244,872,559.		
	b Less: accumulated depreciation	10b 132,036,384.	114,587,824.	10c 112,836,175.
	11 Investments - publicly traded securities	21,525,350.	11	30,162,177.
	12 Investments - other securities. See Part IV, line 11	25,000,000.	12	25,000,000.
	13 Investments - program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	77,889,473.	15	91,671,405.
16 Total assets. Add lines 1 through 15 (must equal line 34)	284,794,015.	16	304,359,977.	
Liabilities	17 Accounts payable and accrued expenses	22,207,419.	17	18,424,310.
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties	2,683,338.	23	1,676,876.
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities. Complete Part X of Schedule D	109,096,792.	25	104,372,282.
	26 Total liabilities. Add lines 17 through 25	133,987,549.	26	124,473,468.
Net Assets or Fund Balances	Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	130,502,765.	27	155,505,594.
	28 Temporarily restricted net assets	9,220,722.	28	12,196,575.
	29 Permanently restricted net assets	11,082,979.	29	12,184,340.
	Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
33 Total net assets or fund balances	150,806,466.	33	179,886,509.	
34 Total liabilities and net assets/fund balances	284,794,015.	34	304,359,977.	

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	232,591,942.
2 Total expenses (must equal Part IX, column (A), line 25)	2	209,380,970.
3 Revenue less expenses. Subtract line 2 from line 1	3	23,210,972.
4 Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	150,806,466.
5 Other changes in net assets or fund balances (explain in Schedule O)	5	5,869,071.
6 Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	179,886,509.

Part XII Financial Statements and Reporting

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

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

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

2010

Open to Public Inspection

Name of the organization SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
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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 - Other

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?

	Yes	No
(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?	11g(i)	
(ii) A family member of a person described in (i) above?	11g(ii)	
(iii) A 35% controlled entity of a person described in (i) or (ii) above?	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 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) 2010

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) 2006, (b) 2007, (c) 2008, (d) 2009, (e) 2010, (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) 2006, (b) 2007, (c) 2008, (d) 2009, (e) 2010, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2010; 15 Public support percentage from 2009 Schedule A, Part II, line 14; 16a 33 1/3 % support test - 2010; b 33 1/3 % support test - 2009; 17a 10%-facts-and-circumstances test - 2010; b 10%-facts-and-circumstances test - 2009; 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

Table with 7 columns: (a) 2006, (b) 2007, (c) 2008, (d) 2009, (e) 2010, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Gross receipts from admissions, merchandise sold or services performed; 3 Gross receipts from activities that are not an unrelated trade or business; 4 Tax revenues levied for the organization's benefit; 5 The value of services or facilities furnished by a governmental unit; 6 Total; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 7c Add lines 7a and 7b; 8 Public support (Subtract line 7c from line 6).

Section B. Total Support

Table with 7 columns: (a) 2006, (b) 2007, (c) 2008, (d) 2009, (e) 2010, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 10b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975; 10c Add lines 10a and 10b; 11 Net income from unrelated business activities not included in line 10b; 12 Other income. Do not include gain or loss from the sale of capital assets; 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

Table with 3 columns: Description, Line Number, Percentage. Rows include: 15 Public support percentage for 2010 (line 8, column (f) divided by line 13, column (f)) - 15 %; 16 Public support percentage from 2009 Schedule A, Part III, line 15 - 16 %

Section D. Computation of Investment Income Percentage

Table with 3 columns: Description, Line Number, Percentage. Rows include: 17 Investment income percentage for 2010 (line 10c, column (f) divided by line 13, column (f)) - 17 %; 18 Investment income percentage from 2009 Schedule A, Part III, line 17 - 18 %

- 19a 33 1/3 % support tests - 2010. 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 - 2009. 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; or Part III, line 12. Also complete this part for any additional information. (See instructions).

Schedule of Contributors

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

2010

Name of the organization SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
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Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

501(c)(3) (enter number) organization

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

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

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

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

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

Name of organization SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

Part I Contributors (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
1	MARYLAND AFFILIATE OF SUSAN G. KOMEN BRE 200 E JOPPA RD, SUITE 407 TOWSON, MD 21286	\$ 114,584.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
2	MARYLAND INSTITUTE OF EMERGENCY MEDICAL 653 W PRATT ST BALTIMORE, MD 21201	\$ 53,440.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
3	MARYLAND HOSPITAL ASSOCIATION 6820 DEERPATH ROAD ELKRIDGE, MD 21075	\$ 60,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
4	DORCHESTER GENERAL HOSPITAL FOUNDATION, PO BOX 939 CAMBRIDGE, MD 21613	\$ 95,570.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
5	MEMORIAL HOSPITAL FOUNDATION, INC. PO BOX 1846 EASTON, MD 21601	\$ 701,926.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
6	MARYLAND DEPARTMENT OF HEALTH AND MENTAL 201 W PRESTON ST BALTIMORE, MD 21201	\$ 26,075.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

Part I Contributors (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
7	MEDICAL STAFF OF SHORE HEALTH SYSTEM 219 S WASHINGTON ST EASTON, MD 21601	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
8	JAMES P. THOMPSON, MD, PA 8420 OCEAN GATEWAY EASTON, MD 21601	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
9	THE GEORGE M. NEALL, II AND CLARA B. NEA 2071 CHAIN BRIDGE ROAD, #20 VIENNA, VA 22182	\$ 10,096.	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.)

SCHEDULE C
(Form 990 or 990-EZ)

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

OMB No. 1545-0047

2010

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

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

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

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

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

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

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

Name of organization SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities on behalf of or in opposition to candidates for public office 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 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.
- 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="text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="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) 2007	(b) 2008	(c) 2009	(d) 2010	(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)).

Table with columns (a) Yes/No and (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation...; a Volunteers?; b Paid staff or management...; c Media advertisements?; d Mailings to members...; e Publications...; f Grants to other organizations...; g Direct contact with legislators...; h Rallies, demonstrations...; i Other activities?; j Total...; 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?; b If "Yes," enter the amount of any tax incurred under section 4912; c If "Yes," enter the amount of any tax incurred by organization managers under section 4912; d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?.

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

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

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

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

Part IV Supplemental Information

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

SEE PAGE 4

Horizontal dashed lines for supplemental information input.

Part IV Supplemental Information (continued)

OTHER ACTIVITIES

SCHEDULE C, PART II-B, LINE 1I

THE ORGANIZATION DOES NOT ENGAGE IN ANY DIRECT LOBBYING ACTIVITIES. THE ORGANIZATION PAYS MEMBERSHIP DUES TO THE MARYLAND HOSPITAL ASSOCIATION (MHA) AND THE AMERICAN HOSPITAL ASSOCIATION (AHA). MHA AND AHA ENGAGE IN MANY SUPPORT ACTIVITIES INCLUDING LOBBYING AND ADVOCATING FOR THEIR MEMBER HOSPITALS. THE MHA AND AHA REPORTED THAT 8.65% AND 24.42% RESPECTIVELY OF MEMBER DUES WERE USED FOR LOBBYING PURPOSES AND AS SUCH, THE ORGANIZATION HAS REPORTED THIS AMOUNT ON SCHEDULE C PART II-B LINE 1I AS LOBBYING ACTIVITIES.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2010

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990. See separate instructions.

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

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

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

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply): Preservation of land for public use, Protection of natural habitat, Preservation of open space, Preservation of an historically important land area, Preservation of a certified historic structure; 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year; 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 170(h)(4)(B)(ii)? (Yes/No); 9 In Part XIV, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

Table with 2 columns: Amounts. Rows include: 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 XIV, 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) 2010

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

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

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

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

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

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

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

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

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

2a Did the organization include an amount on Form 990, Part X, line 21? Yes No

b If "Yes," explain the arrangement in Part XI V.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	2,404,542.	2,404,542.	2,404,542.		
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	2,404,542.	2,404,542.	2,404,542.		

2 Provide the estimated percentage of the year end balance held as:

- a Board designated or quasi-endowment _____ %
- b Permanent endowment 100.0000 %
- c Term endowment _____ %

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

	Yes	No
3a(i)		X
3a(ii)		X
3b		

b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?

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

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

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		3,154,541.		3,154,541.
b Buildings		114,910,609.	39,579,739.	75,330,870.
c Leasehold improvements				
d Equipment		126,401,340.	92,456,645.	33,944,695.
e Other		406,069.		406,069.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				112,836,175.

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) RELATED TO AFFILIATION AGMT	25,000,000.	FMV
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
(I)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.)	25,000,000.	

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 WHOSE USE IS LIMITED	18,854,737.
(2) OTHER RECEIVABLES	4,274,639.
(3) ECONOMIC INTERESTS IN NET	
(4) ASSETS OF RELATED ORGANIZATION	59,272,171.
(5) INVESTMENT IN SUBSIDIARIES AND	
(6) OTHER ASSETS	8,798,858.
(7) SELF-INSURANCE TRUST	
(8) CURRENT POSITION	471,000.
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.)	91,671,405.

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

1. (a) Description of liability	(b) Amount
(1) Federal income taxes	
(2) ADVANCES FROM 3RD PARTY PAYORS	5,287,050.
(3) OTHER LIABILITIES	11,357,260.
(4) DUE TO UMMS	87,727,972.
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	104,372,282.

2. FIN 48 (ASC 740) Footnote. In Part XIV, 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).

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

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

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

Part XIV Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

SEE PAGE 5

Part XIV Supplemental Information (continued)

INTENDED USES OF ENDOWMENT FUNDS

SCHEDULE D, PART V, LINE 4

ENDOWMENT FUNDS ARE USED TO SUPPORT THE HEALTHCARE MISSION OF SHORE HEALTH SYSTEM. INVESTMENT EARNINGS ON THE ENDOWMENT FUND ARE TRANSFERED TO RESTRICTED AND UNRESTRICTED FUNDS IN SUPPORT OF THE ORGANIZATION'S TAX EXEMPT MISSION.

LIABILITY FOR UNCERTAIN TAX POSITION (ASC 740)

SCHEDULE D, PART X, LINE 2

THE ORGANIZATION IS A SUBSIDIARY OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (THE CORPORATION). THE CORPORATION ADOPTED THE PROVISIONS OF ASC 740, ACCOUNTING FOR UNCERTAINTY IN THE INCOME TAXES (FIN 48) ON JULY 1, 2007. THE FOOTNOTE RELATED TO ASC 740 IN THE CORPORATION'S AUDITED FINANCIAL STATEMENTS IS AS FOLLOWS: THE CORPORATION FOLLOWS A THRESHOLD OF MORE-LIKELY-THAN-NOT FOR RECOGNITION AND DERECOGNITION OF TAX POSITIONS TAKEN OR EXPECTED TO BE TAKEN IN A TAX RETURN. MANAGEMENT DOES NOT BELIEVE THAT THERE ARE ANY UNRECOGNIZED TAX BENEFITS THAT SHOULD BE RECOGNIZED.

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

**Supplemental Information Regarding
Fundraising or Gaming Activities**

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

2010

**Open To Public
Inspection**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

Part I

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

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

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

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? **Yes** **No**

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

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col. (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Total						

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

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

		(a) Event #1	(b) Event #2	(c) Other Events	(d) Total events
		DINNER/DANCE (event type)	(event type)	0. (total number)	(add col. (a) through col. (c))
Revenue	1 Gross receipts	85,669.			85,669.
	2 Less: Charitable contributions	71,899.			71,899.
	3 Gross income (line 1 minus line 2)	13,770.			13,770.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs				
	7 Food and beverages	10,672.			10,672.
	8 Entertainment	3,000.			3,000.
	9 Other direct expenses	12,695.			12,695.
	10 Direct expense summary. Add lines 4 through 9 in column (d)				(26,367.)
	11 Net income summary. Combine line 3, column (d), and line 10				-12,597.

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

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

9 Enter the state(s) in which the organization operates gaming activities: _____

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

b If "No," explain: _____

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

b If "Yes," explain: _____

- 11 Does the organization operate gaming activities with nonmembers? Yes No
- 12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? Yes No
- 13 Indicate the percentage of gaming activity operated in:

a The organization's facility	13a	%
b An outside facility	13b	%

14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

- 15 a Does the organization have a contract with a third party from whom the organization receives gaming revenue? Yes No
- b If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ _____ and the amount of gaming revenue retained by the third party ▶ \$ _____.
- c If "Yes," enter name and address of the third party:

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ \$ _____

Description of services provided ▶ _____

Director/officer Employee Independent contractor

17 Mandatory distributions:

- a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? Yes No
- b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ _____

Part IV **Supplemental Information.** Complete this part to provide the explanation required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2010

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 SHORE HEALTH SYSTEM, INC. **Employer identification number** 52-0610538

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	
b 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) to determine eligibility for providing <i>free</i> care to low income individuals? 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 to determine eligibility for providing <i>discounted</i> care to low income individuals? 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 did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, to determine 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?		
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?	X	X
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	

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheets 1 and 2)			4,961,775.		4,961,775.	2.37
b Unreimbursed Medicaid (from Worksheet 3, column a)						
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			4,961,775.		4,961,775.	2.37
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		10150	1,230,361.	157,176.	1,073,185.	.51
f Health professions education (from Worksheet 5)		226	1,200,892.		1,200,892.	.57
g Subsidized health services (from Worksheet 6)		57559	3,669,045.	119,513.	3,549,532.	1.70
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)			82,400.		82,400.	.04
j Total Other Benefits		67935	6,182,698.	276,689.	5,906,009.	2.82
k Total . Add lines 7d and 7j		67935	11,144,473.	276,689.	10,867,784.	5.19

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

Schedule H (Form 990) 2010

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						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building		1000	2,042.		2,042.	
7 Community health improvement advocacy		10	3,150.		3,150.	
8 Workforce development		3697	18,807.		18,807.	.01
9 Other						
10 Total		4707	23,999.		23,999.	.01

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

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

Section B. Medicare

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

Section C. Collection Practices

- 9a Does the organization have a written debt collection policy during the tax year?
- 9b 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

Part IV Management Companies and Joint Ventures

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

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 2

Name and address

1 THE MEMORIAL HOSPITAL AT EASTON
219 S. WASHINGTON STREET
EASTON MD 21601

2 DORCHESTER GENERAL HOSPITAL
300 BYRN STREET
CAMBRIDGE MD 21613

3

4

5

6

7

8

9

10

11

12

13

14

15

16

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
	X	X					X		
	X	X					X		

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of Hospital Facility: THE MEMORIAL HOSPITAL AT EASTON

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8 If "Yes," indicate what the Needs Assessment describes (check all that apply):	1	
a	<input type="checkbox"/> A definition of the community served by the hospital facility		
b	<input type="checkbox"/> Demographics of the community		
c	<input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input type="checkbox"/> How data was obtained		
e	<input type="checkbox"/> The health needs of the community		
f	<input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs		
j	<input type="checkbox"/> Other (describe in Part VI)		
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 <u> </u> <u> </u>		
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	
5	Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):	5	
a	<input type="checkbox"/> Hospital facility's website		
b	<input type="checkbox"/> Available upon request from the hospital facility		
c	<input type="checkbox"/> Other (describe in Part VI)		
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):		
a	<input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b	<input type="checkbox"/> Execution of the implementation strategy		
c	<input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d	<input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e	<input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f	<input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g	<input type="checkbox"/> Prioritization of health needs in its community		
h	<input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i	<input type="checkbox"/> Other (describe in Part VI)		
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7	
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X
9	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for free care: <u> </u> <u> </u> <u> </u> %	9	X

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of Hospital Facility: DORCHESTER GENERAL HOSPITAL

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 2

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8 If "Yes," indicate what the Needs Assessment describes (check all that apply):	1	
a	<input type="checkbox"/> A definition of the community served by the hospital facility		
b	<input type="checkbox"/> Demographics of the community		
c	<input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input type="checkbox"/> How data was obtained		
e	<input type="checkbox"/> The health needs of the community		
f	<input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs		
j	<input type="checkbox"/> Other (describe in Part VI)		
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 <u> </u> <u> </u>		
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	
5	Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):	5	
a	<input type="checkbox"/> Hospital facility's website		
b	<input type="checkbox"/> Available upon request from the hospital facility		
c	<input type="checkbox"/> Other (describe in Part VI)		
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):		
a	<input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b	<input type="checkbox"/> Execution of the implementation strategy		
c	<input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d	<input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e	<input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f	<input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g	<input type="checkbox"/> Prioritization of health needs in its community		
h	<input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i	<input type="checkbox"/> Other (describe in Part VI)		
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7	
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X
9	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for free care: <u>200</u> %	9	X

Part V Facility Information (continued) THE MEMORIAL HOSPITAL AT EASTON

		Yes	No
10	Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>3</u> <u>0</u> <u>0</u> %	X	
11	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 checked="" type="checkbox"/> Insurance status		
e	<input type="checkbox"/> Uninsured discount		
f	<input type="checkbox"/> Medicaid/Medicare		
g	<input type="checkbox"/> State regulation		
h	<input type="checkbox"/> Other (describe in Part VI)		
12	Explained the method for applying for financial assistance?	X	
13	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 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

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	X	
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:		
a	<input checked="" 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 type="checkbox"/> Other actions (describe in Part VI)		
16	Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year? If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):	X	
a	<input checked="" 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 type="checkbox"/> Other actions (describe in Part VI)		
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply):		
a	<input checked="" type="checkbox"/> Notified patients of the financial assistance policy on admission		
b	<input checked="" type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c	<input checked="" type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d	<input checked="" type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance		
e	<input type="checkbox"/> Other (describe in Part VI)		

Part V Facility Information (continued) DORCHESTER GENERAL HOSPITAL

		Yes	No
10	Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>3</u> <u>0</u> <u>0</u> %	X	
11	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 checked="" type="checkbox"/> Insurance status		
e	<input type="checkbox"/> Uninsured discount		
f	<input type="checkbox"/> Medicaid/Medicare		
g	<input type="checkbox"/> State regulation		
h	<input type="checkbox"/> Other (describe in Part VI)		
12	Explained the method for applying for financial assistance?	X	
13	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 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

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	X	
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:		
a	<input checked="" 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 type="checkbox"/> Other actions (describe in Part VI)		
16	Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year? If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):	X	
a	<input checked="" 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 type="checkbox"/> Other actions (describe in Part VI)		
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply):		
a	<input checked="" type="checkbox"/> Notified patients of the financial assistance policy on admission		
b	<input checked="" type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c	<input checked="" type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d	<input checked="" type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance		
e	<input type="checkbox"/> Other (describe in Part VI)		

Part V Facility Information (continued) THE MEMORIAL HOSPITAL AT EASTON

Policy Relating to Emergency Medical Care

		Yes	No
18	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?	X	
If "No," indicate the reasons why (check all that apply):			
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):		
a	<input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility		
b	<input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility		
c	<input type="checkbox"/> The hospital facility used the Medicare rate for those services		
d	<input checked="" type="checkbox"/> Other (describe in Part VI)		
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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?		X
If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient?	X	
If "Yes," explain in Part VI.			

Part V Facility Information (continued) DORCHESTER GENERAL HOSPITAL

Policy Relating to Emergency Medical Care

		Yes	No
18	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?	X	
If "No," indicate the reasons why (check all that apply):			
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):		
a	<input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility		
b	<input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility		
c	<input type="checkbox"/> The hospital facility used the Medicare rate for those services		
d	<input checked="" type="checkbox"/> Other (describe in Part VI)		
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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?		X
If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient?	X	
If "Yes," explain in Part VI.			

Part V Facility Information (continued)**Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many non-hospital facilities did the organization operate during the tax year? 10

Name and address	Type of Facility (describe)
1 REQUARD CANCER CENTER 509 IDLEWILD AVENUE EASTON MD 21601	ONCOLOGY SERVICES
2 DIGESTIVE DISEASE CENTER 5111 IDLEWILD AVENUE EASTON MD 21601	DIGESTIVE HEALTH
3 DIAGNOSTIC CENTER 10 MARTIN COURT EASTON MD 21601	DIAGNOSTIC & REHAB
4 SHORE HEALTH SYSTEM SURGERY CENTER 6 CAULK LANE EASTON MD 21601	AMBULATORY SURGERY
5 CENTREVILLE DIAGNOSTIC CENTER 2540 CENTREVILLE ROAD CENTREVILLE MD 21617	DIAGNOSTIC
6 SUNBURST CENTER ROUTE 50 CAMBRIDGE MD 21613	REHAB SERVICES
7 INTEGRATIVE MEDICINE 607 DUTCHMANS LANE EASTON MD 21601	ALTERNATIVE MEDICINE
8 SHOREWORKS BYRN STREET CAMBRIDGE MD 21658	EMPLOYER HEALTH
9 QUEEN ANNE EMERGENCY CENTER 115 SHOREWAY DRIVE QUEENSTOWN MD 21658	24-HOUR ER
10 DENTON DIAGNOSTIC CENTER 920 MARKET ST DENTON MD 21601	DIAGNOSTIC & REHAB

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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; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 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.

CRITERIA FOR FREE OR DISCOUNTED CARE

SCHEDULE H, PART I, LINE 3C

SHORE HEALTH SYSTEM WILL PROVIDE FINANCIAL ASSISTANCE TO PERSONS WHO HAVE HEALTHCARE NEEDS AND ARE UNINSURED, UNDERINSURED, INELIGIBLE FOR A GOVERNMENT PROGRAM, OR OTHERWISE UNABLE TO PAY FOR MEDICALLY NECESSARY CARE BASED ON THEIR INDIVIDUAL FINANCIAL SITUATION, FOR RELATED SYSTEM HOSPITALS, FINANCIAL ASSISTANCE IS BASED ON INDIGENCE OR HIGH MEDICAL EXPENSE FOR PATIENTS WHO MEET SPECIFIED FINANCIAL CRITERIA, REQUEST ASSISTANCE, AND PROVIDE ADEQUATE EVIDENCE OF SUCH NEED AND ELIGIBILITY. ELIGIBILITY INCLUDES INCOME, PRESUMPTIVE FINANCIAL ASSISTANCE ELIGIBILITY, AND MEDICAL HARDSHIP CRITERIA, WHICH MAY INCLUDE ASSET CONSIDERATION.

RELATED ORGANIZATION REPORT

SCHEDULE H, PART I, LINE 6A

SHORE HEALTH SYSTEM, IS AN AFFILIATE OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM. THE COMMUNITY BENEFIT REPORT IS PREPARED SEPARATELY.

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; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 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.
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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.

COST ATTRIBUTABLE TO A PHYSICAL CLINIC

SCHEDULE H, PART I, LINE 7G

SUBSIDIZED COSTS ARE NOT ATTRIBUTED TO A PHYSICIAN CLINIC, BUT ANESTHESIA
AND EMERGENCY HOSPITAL SERVICES.

COSTING METHODOLOGY

SCHEDULE H, PART I, LINE 7

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

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL

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

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

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

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

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

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

HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED

CARE.

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; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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LINE 7B, COLUMNS (C) THROUGH (F)

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL
 PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES
 COST REVIEW COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A RATE SETTING
 PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME
 AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S
 UNIQUE ALL PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED
 CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO
 BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. COMMUNITY
 BENEFIT EXPENSES ARE EQUAL TO MEDICAID REVENUES IN MARYLAND, AS SUCH, THE
 NET EFFECT IS ZERO. ADDITIONALLY, NET REVENUES FOR MEDICAID SHOULD
 REFLECT THE FULL IMPACT ON THE HOSPITAL OF ITS SHARE OF THE MEDICAID
 ASSESSMENT.

Part VI Supplemental Information

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COMMUNITY BUILDING ACTIVITIES

SCHEDULE H, PART II

COMMUNITY BUILDING ACTIVITIES PROVIDE NEED ASSESSMENT AND IDENTIFICATION

OF INITIATIVES THE SYSTEM CAN ADDRESS AND POSITIVELY IMPACT THAT NEED.

BAD DEBT EXPENSE

SCHEDULE H, PART III, LINE 4

REVENUE IS REDUCED FOR ANTICIPATED DISCOUNTS UNDER

CONTRACTUAL ARRANGEMENTS AND FOR CHARITY CARE. AN ESTIMATED PROVISION FOR

BAD DEBTS IS RECORDED IN THE PERIOD THE RELATED SERVICES ARE

PROVIDED BASED UPON ANTICIPATED UNCOMPENSATED CARE, AND IS ADJUSTED

AS ADDITIONAL INFORMATION BECOMES AVAILABLE. THE PROVISION FOR BAD DEBTS

IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET

COLLECTIONS CONSIDERING HISTORICAL BUSINESS AND ECONOMIC CONDITIONS,

TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS.

PERIODICALLY THROUGHOUT THE YEAR, MANAGEMENT ASSESSES THE ADEQUACY OF THE

ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED UPON HISTORICAL WRITE-OFF

EXPERIENCE BY PAYOR CATEGORY. THE RESULTS OF THIS REVIEW ARE THEN USED TO

Part VI Supplemental Information

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MAKE MODIFICATIONS TO THE PROVISION FOR BAD DEBTS AND TO ESTABLISH
 AN ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES. AFTER COLLECTION OF
 AMOUNTS DUE FROM INSURERS, THE CORPORATION FOLLOWS INTERNAL GUIDELINES
 FOR PLACING CERTAIN PAST DUE BALANCES WITH COLLECTION AGENCIES.

MEDICARE COST REPORT
 SCHEDULE H, PART III, LINE 8
 ALLOWABLE COSTS ARE ESTIMATED RATIO OF COST TO CHARGE APPLIED TO GROSS
 CHARGES.

COLLECTION PRACTICES
 SCHEDULE H, PART III, LINE 9B

APPENDIX 1: DESCRIBE YOUR CHARITY CARE POLICY
 A. DESCRIBE HOW THE HOSPITAL INFORMS PATIENTS AND PERSON WHO WOULD
 OTHERWISE BE BILLED FOR SERVICES ABOUT THEIR ELIGIBILITY FOR ASSISTANCE
 UNDER FEDERAL, STATE OR LOCAL GOVERNMENT PROGRAMS OR UNDER THE HOSPITALS
 CHARITY CARE POLICY.

Part VI Supplemental Information

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IT IS THE POLICY OF SHORE HEALTH SYSTEM TO WORK WITH OUR PATIENTS TO
 IDENTIFY AVAILABLE RESOURCES TO PAY FOR THEIR CARE. ALL PATIENTS
 PRESENTING AS SELF PAY AND REQUESTING CHARITY RELIEF FROM THEIR BILL WILL
 BE SCREENED AT ALL POINTS OF ENTRY, FOR POSSIBLE COVERAGE THROUGH STATE
 PROGRAMS AND A PROBABLE DETERMINATION FOR COVERAGE FOR EITHER MEDICAL
 ASSISTANCE OR FINANCIAL ASSISTANCE (CHARITY CARE) FROM THE HOSPITAL IS
 IMMEDIATELY GIVEN TO THE PATIENT. THE PROCESS IS RESOURCE INTENSIVE AND
 TIME CONSUMING FOR PATIENTS AND THE HOSPITAL; HOWEVER, IF PATIENTS
 QUALIFY FOR ONE OF THESE PROGRAMS, THEN THEY WILL HAVE HEALTH BENEFITS
 THAT THEY WILL CARRY WITH THEM BEYOND THEIR CURRENT HOSPITAL BILLS, AND
 ALLOW THEM TO ACCESS PREVENTIVE CARE SERVICES AS WELL. SHORE HEALTH
 SYSTEM WORKS WITH A BUSINESS PARTNER WHO WILL WORK WITH OUR PATIENTS TO
 ASSIST THEM WITH THE STATE ASSISTANCE PROGRAMS, WHICH IS FREE TO OUR
 PATIENTS. IF A PATIENT DOES NOT QUALIFY FOR MEDICAID OR ANOTHER PROGRAM,
 SHORE HEALTH SYSTEM OFFERS OUR FINANCIAL ASSISTANCE PROGRAM. SHORE HEALTH
 SYSTEM POSTS NOTICES OF OUR POLICY IN CONSPICUOUS PLACES THROUGHOUT THE
 HOSPITALS, HAS INFORMATION WITHIN OUR HOSPITAL BILLING BROCHURE, EDUCATES
 ALL NEW EMPLOYEES THOROUGHLY ON THE PROCESS DURING ORIENTATION, AND DOES

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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A YEARLY RE-EDUCATION TO ALL EXISTING STAFF. ALL STAFF HAVE COPIES OF THE
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 TO PATIENTS WHO WE DEEM, AFTER SCREENING, TO HAVE A NEED FOR ASSISTANCE.
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 WITH OUR PATIENTS TO ASSIST THEM WITH THIS PROCESS AND EXPEDITE THE
 DECISION PROCESS.

THE MEMORIAL HOSPITAL AT EASTON 1
 SCHEDULE H, PART V, SECTION B

LINE 19D - CALCULATES AN APPROVED % OF FINANCIAL ASSISTANCE BASED ON
 INCOME AND % OF FEDERAL POVERTY LEVEL INCOME. THE PATIENT IS BILLED THE
 CHARGES LESS THE % OF FINANCIAL ASSISTANCE DETERMINED.

LINE 21 - GROSS CHARGES FOR SERVICES ARE ALWAYS CHARGED AT THE SAME RATE
 WITHOUT DISCRIMINATION. GROSS CHARGES FOR SERVICES ARE ALWAYS BILLED, ANY
 ADJUSTMENT SUCH AS FINANCIAL ASSISTANCE IS APPLIED TO RESULT IN THE
 BALANCE DUE FOR PAYMENT.

Part VI Supplemental Information

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DORCHESTER GENERAL HOSPITAL 2

SCHEDULE H, PART V, SECTION B

LINE 19D - CALCULATES AN APPROVED % OF FINANCIAL ASSISTANCE BASED ON INCOME AND % OF FEDERAL POVERTY LEVEL INCOME. THE PATIENT IS BILLED THE CHARGES LESS THE % OF FINANCIAL ASSISTANCE DETERMINED.

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COMMUNITY HEALTH CARE NEEDS ASSESSMENT

SCHEDULE H, PART VI, LINE 2

PART VI SUPPLEMENTAL INFORMATION 2010 SHORE HEALTH SYSTEM

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.

Part VI Supplemental Information

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SHORE HEALTH DID NOT PERFORM A COMMUNITY HEALTH NEEDS ASSESSMENT AS

DEFINED BY THE FEDERAL REFORM BILL IN FY11. SUCH AN ASSESSMENT IS

CURRENTLY BEING CONDUCTED IN FY12 AND WILL BE FULLY IMPLEMENTED IN FY13.

THE INFORMATION INCLUDED BELOW REFLECTS THE STANDARD ASSESSMENT PROCESS

WHICH SHORE HEALTH SYSTEM HAS TYPICALLY CONDUCTED EACH YEAR AS PART OF

STRATEGIC PLANNING.

SHORE HEALTH IDENTIFIES COMMUNITY NEEDS THROUGH ANALYSIS OF THE CURRENT

NEEDS ASSESSMENTS AND HEALTH PLANS DEVELOPED BY THE LOCAL HEALTH

DEPARTMENTS FOR TALBOT, DORCHESTER, CAROLINE, AND QUEEN ANNE'S COUNTIES.

THE NEEDS ASSESSMENTS INCLUDE DATA COMPILED BY COUNTY, STATE, AND FEDERAL

GOVERNMENT AND IDENTIFIES HEALTH NEEDS BY COUNTY.

ADDITIONAL RESOURCES REVIEWED IN FY11 TO IDENTIFY COMMUNITY NEEDS: THE

HEALTHY PEOPLE 2020 GUIDELINES ESTABLISHED BY THE MARYLAND DHHS AND THE

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE'S STATE IMPROVEMENT PLAN

(SHIP, [HTTP://DHMH.MARYLAND.GOV./SHIP](http://DHMH.MARYLAND.GOV./SHIP)). THESE COMPREHENSIVE SETS OF HEALTH

OBJECTIVES SERVE AS THE FRAMEWORK TO DEVELOP COMMUNITY HEALTH INITIATIVES

Part VI Supplemental Information

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AND ACTIVITIES THAT ADDRESS MAJOR PUBLIC HEALTH CONCERN

CURRENTLY SHS USES STATISTICAL DATA GATHERED BY LOCAL HEALTH DEPARTMENTS

ALONG WITH INTERNAL DOCUMENTATION/EVALUATION TO ASSESS EFFECTIVENESS OF

COMMUNITY BENEFIT INITIATIVES. SHS TRACKS ENCOUNTERS FOR ALL HEALTH

SCREENINGS, COMMUNITY OUTREACH PROGRAMS, AND EDUCATIONAL BASED PROGRAMS

OFFERED. THE PROGRAM INITIATIVES ARE EVALUATED TO ENSURE THE GOALS OF THE

PROGRAM ARE MET. THOROUGH DOCUMENTATION AND TRACKING IS ACCOMPLISHED

THROUGH COMPLETION OF: ACTIVITY FORMS; OCCURRENCE FORMS; OUTCOMES FORMS;

AND LEADERSHIP JOURNAL FORMS FOR ALL COMMUNITY BENEFIT ACTIVITIES. THIS

TRACKING SYSTEM PROVIDES THE STAKEHOLDERS WITH THE ABILITY TO DETERMINE

THE EFFECTIVENESS OF INDIVIDUAL ACTIVITIES AND FOR YEAR-TO-YEAR

COMPARISON ANALYSIS.

SHS IS CONTINUING TO WORK TOWARDS THE INCORPORATION OF AN ELECTRONIC DATA

COLLECTION PROCESS TO IMPROVE TRACKING EFFECTIVENESS OF ACTIVITIES.

SHORE HEALTH MAINTAINS OPEN COMMUNICATION WITH THE LOCAL HEALTH

Part VI Supplemental Information

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DEPARTMENTS FOR TALBOT, DORCHESTER, CAROLINE, AND QUEEN ANNE'S COUNTIES;

PUBLIC SCHOOL SYSTEMS AND CHURCH LEADERS. SHORE HEALTH SYSTEM PROGRAMS

SERVE THE NEEDS OF A DIVERSE POPULATION THROUGH SENIOR CENTERS, SCHOOLS,

CHURCHES, AND COMMUNITY CENTERS THROUGHOUT THE MID SHORE. LEADERSHIP OF

SHORE HEALTH ARE MEMBERS OF COMMITTEES, ADVISORY BOARDS, COMMUNITY

WORKGROUPS IDENTIFYING THE REGION'S HEALTH CARE NEEDS. MANY FACTORS, SUCH

AS POPULATION GROWTH PROJECTIONS, THE AGING OF THE REGIONAL POPULATION,

EMERGING TRENDS IN HEALTH CARE DELIVERY, PHYSICIAN RECRUITMENT NEEDS,

CHANGES IN THE REGION'S TRANSPORTATION NETWORK ARE EXAMINED.

ELIGIBILITY EDUCATION

SCHEDULE H, PART VI, LINE 3

PART VI SUPPLEMENTAL INFORMATION 2010 SHORE HEALTH SYSTEM

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

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ASSISTANCE POLICY.

IT IS THE POLICY OF SHORE HEALTH SYSTEM TO WORK WITH OUR PATIENTS TO IDENTIFY AVAILABLE RESOURCES TO PAY FOR THEIR CARE. ALL PATIENTS PRESENTING AS SELF PAY AND REQUESTING CHARITY RELIEF FROM THEIR BILL WILL BE SCREENED AT ALL POINTS OF ENTRY, FOR POSSIBLE COVERAGE THROUGH STATE PROGRAMS AND A PROBABLE DETERMINATION FOR COVERAGE FOR EITHER MEDICAL ASSISTANCE OR FINANCIAL ASSISTANCE (CHARITY CARE) FROM THE HOSPITAL IS IMMEDIATELY GIVEN TO THE PATIENT. THE PROCESS IS RESOURCE INTENSIVE AND TIME CONSUMING FOR PATIENTS AND THE HOSPITAL; HOWEVER, IF PATIENTS QUALIFY FOR ONE OF THESE PROGRAMS, THEN THEY WILL HAVE HEALTH BENEFITS THAT THEY WILL CARRY WITH THEM BEYOND THEIR CURRENT HOSPITAL BILLS, AND ALLOW THEM TO ACCESS PREVENTIVE CARE SERVICES AS WELL. SHORE HEALTH SYSTEM WORKS WITH A BUSINESS PARTNER WHO WILL WORK WITH OUR PATIENTS TO ASSIST THEM WITH THE STATE ASSISTANCE PROGRAMS, WHICH IS FREE TO OUR PATIENTS.

IF A PATIENT DOES NOT QUALIFY FOR MEDICAID OR ANOTHER PROGRAM, SHORE

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HEALTH SYSTEM OFFERS OUR FINANCIAL ASSISTANCE PROGRAM. SHORE HEALTH
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 WITH OUR PATIENTS TO ASSIST THEM WITH THIS PROCESS AND EXPEDITE THE
 DECISION PROCESS.

SHORE HEALTH NOTIFIES PATIENTS OF AVAILABILITY OF FINANCIAL ASSISTANCE
 FUNDS PRIOR TO SERVICE DURING OUR CALLS TO PATIENTS, THROUGH SIGNAGE AT
 ALL OF OUR REGISTRATION LOCATIONS, THROUGH OUR PATIENT BILLING BROCHURE
 AND THROUGH OUR DISCUSSIONS WITH PATIENTS DURING REGISTRATION. IN
 ADDITION, THE INFORMATION SHEET IS MAILED TO PATIENTS WITH ALL STATEMENTS
 AND/OR HANDED TO THEM IF NEEDED. NOTICES ARE SENT REGARDING OUR HILL
 BURTON PROGRAM YEARLY AS WELL.

Part VI Supplemental Information

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DESCRIPTION OF COMMUNITY SERVED

SCHEDULE H, PART VI, LINE 4

PART VI SUPPLEMENTAL INFORMATION 2010 SHORE HEALTH SYSTEM

4. COMMUNITY INFORMATION. DESCRIBE THE COMMUNITY THE ORGANIZATION SERVES, TAKING INTO ACCOUNT THE GEOGRAPHIC AREA AND DEMOGRAPHIC CONSTITUENTS IT SERVES.

MARYLAND POSTAL ZIP CODE AREAS FROM WHICH THE FIRST 60 PERCENT OF A HOSPITAL'S PATIENT DISCHARGES ORIGINATE DURING THE MOST RECENT 12 MONTH PERIOD AVAILABLE, WHERE THE DISCHARGES FROM EACH ZIP CODE ARE ORDERED FROM LARGEST TO SMALLEST NUMBER OF DISCHARGES.

DESCRIPTION OF THE COMMUNITY SHORE HEALTH SYSTEM SERVES:
SITUATED ON MARYLAND'S EASTERN SHORE, SHORE HEALTH SYSTEM'S TWO

Part VI Supplemental Information

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HOSPITALS, THE MEMORIAL HOSPITAL AT EASTON AND DORCHESTER GENERAL
 HOSPITAL IN CAMBRIDGE, ARE NOT FOR PROFIT HOSPITALS OFFERING A COMPLETE
 RANGE OF INPATIENT AND OUTPATIENT SERVICES TO OVER 170,000 PEOPLE
 THROUGHOUT THE MID-SHORE OF MARYLAND. SHORE HEALTH SYSTEM'S SERVICE AREA
 IS DEFINED AS THE MARYLAND COUNTIES OF CAROLINE, DORCHESTER, TALBOT
 (PRIMARY SERVICE AREA); QUEEN ANNE'S AND KENT (SECONDARY SERVICE AREA).

MEMORIAL HOSPITAL AT EASTON IS SITUATED AT THE CENTER OF THE MID-SHORE
 AREA AND THUS SERVES A LARGE GEOGRAPHICAL AREA. MHE IS A SINGLE
 JURISDICTION HOSPITAL LOCATED IN A RURAL AREA. DORCHESTER GENERAL
 HOSPITAL, ALSO A SINGLE JURISDICTION HOSPITAL, IS LOCATED APPROXIMATELY
 18 MILES FROM MHE. MHE IS LOCATED APPROXIMATELY 44 MILES FROM CHESTER
 RIVER HOSPITAL AND APPROXIMATELY 42 MILES FROM ANNE ARUNDEL MEDICAL
 CENTER.

MEMORIAL HOSPITAL'S SERVICE AREA HAS A HIGHER PERCENTAGE OF POPULATION
 AGED 65 AND OLDER AS COMPARED TO MARYLAND OVERALL. TALBOT COUNTY HAS A
 20.4 PERCENT RATE FOR THIS AGE GROUP. THIS CONCENTRATION IS DUE MAINLY TO

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INFLUX OF RETIREES.

THE FIVE COUNTIES OF THE MID-SHORE COMPRISE 20% OF THE LANDMASS OF THE
STATE OF MARYLAND AND 2% OF THE POPULATION. THE POPULATION OF THE FIVE
COUNTIES IS JUST OVER 170,000 -- 16,485 ADULTS HAVE LESS THAN A 9TH GRADE
EDUCATION AND 16,356 HAVE EDUCATION AT THE 9TH -12TH GRADE LEVEL BUT DO
NOT HAVE A HIGH SCHOOL DIPLOMA.

*SOURCE: 2000 CENSUS DATA.

** SOURCE: U. S. CENSUS BUREAU, SMALL AREA INCOME & POVERTY ESTIMATES FOR
STATES AND COUNTIES (2009)

THE ENTIRE REGION HAS OVER 4,400 EMPLOYERS WITH NEARLY 45,000 WORKERS.
ONLY 50 OF THOSE EMPLOYERS EMPLOY 100 OR MORE WORKERS. ALMOST 85% OF
EMPLOYERS IN THIS RURAL REGION ARE MANUFACTURING FIRMS, WHICH REQUIRE
WORKERS WITH HIGH-LEVEL TECHNOLOGY SKILLS AS WELL AS LOW-SKILLED WORKERS.
THE SERVICE INDUSTRY IS GROWING RAPIDLY AS THE LOCAL POPULATION SHIFTS TO
INCLUDE MORE SENIOR ADULTS WHO RETIRE TO THIS BEAUTIFUL AREA OF THE

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STATE. ALTHOUGH THE SEAFOOD INDUSTRY CONTINUES TO BE IMPORTANT TO THE
 REGION IT IS FAST BECOMING AN ENDANGERED SPECIES.

IN THE PAST YEAR, THE MID-SHORE REGION, HAS SIGNIFICANTLY HIGHER
 UNEMPLOYMENT RATES AS COMPARED TO STATE AND NATIONAL LEVELS. LIKE MANY
 OTHER RURAL COMMUNITIES IN THE COUNTRY, THE AREA HAS SUFFERED A
 SIGNIFICANT LOSS OF JOBS. MANUFACTURERS SUCH AS AIRPAX, BLACK & DECKER
 AND HI-TECH PLASTICS HAVE MOVED PRODUCTION WORK OUT OF THE COUNTRY,
 LEAVING LOCAL RESIDENTS WITH FEW OPTIONS. WELL OVER 1,000
 WORKERS HAVE BEEN DISLOCATED AND OFTEN NEED TO UPGRADE THEIR SKILLS IN
 ORDER TO FIND WORK IN MORE TECHNICAL FIELDS OR EVEN JUST TO DO THE JOBS
 NOW AVAILABLE IN THE WORKPLACE.

SOURCE: MID SHORE COMPREHENSIVE ECONOMIC DEVELOPMENT STRATEGY CEDS
[HTTP://WWW.MIDSHORE.ORG/REPORTS/CEDS%20FULL%20DOCUMENT%20UPDATE%202-18-11%
 20-%20FINAL.PDF](http://www.midshore.org/reports/ceds%20full%20document%20update%202-18-11%20-%20final.pdf)

ALTHOUGH MINORITY POPULATIONS ARE SIGNIFICANT THROUGHOUT THE EASTERN
 SHORE, DORCHESTER HAS THE HIGHEST PERCENTAGES OF AFRICAN-AMERICAN AND

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HISPANIC RESIDENTS AND THE HIGHEST LEVEL OF UNEMPLOYMENT AT 11%. OF THE

FIVE COUNTIES COMPRISING THE MID-SHORE, KENT, CAROLINE AND

DORCHESTER HAVE THE HIGHEST PERCENTAGE OF LOW-INCOME FAMILIES.

SOURCE: MARYLAND DEPARTMENT OF BUSINESS & ECONOMIC DEVELOPMENT

FURTHERMORE, THESE THREE COUNTIES ARE AMONG THE TOP QUARTILE OF

JURISDICTIONS IN MARYLAND WHERE SIGNIFICANT PERCENTAGES OF FAMILIES ARE

CONSIDERED AT-RISK. SOME EXAMPLES INCLUDE:

IN DORCHESTER COUNTY, THE

RATIO IS 75 OVER 1,000.

IN DORCHESTER COUNTY (5.2%).

SOURCE: CENSUS BUREAU AND MARYLAND VITAL STATISTICS MID SHORE CEDS 2011

PERCENTAGE OF HOUSEHOLDS WITH INCOMES BELOW THE FEDERAL POVERTY

GUIDELINES WITHIN THE CBSA

Part VI Supplemental Information

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TALBOT 8.80%

DORCHESTER 15.40%

CAROLINE 13.20%

QUEEN ANNE'S 7.30%

SOURCE: U. S. CENSUS BUREAU, SMALL AREA INCOME & POVERTY ESTIMATES FOR STATES AND COUNTIES (2009)

LIFE EXPECTANCY BY COUNTY WITHIN THE CBSA.

TALBOT 80.1

DORCHESTER 76.5

CAROLINE 75.7

QUEEN ANNE'S 80.1

SOURCE: MD ASSESSMENT TOOL FOR COMMUNITY HEALTH AND BUREAU OF LABOR STATISTICS

MORTALITY RATES BY COUNTY WITHIN THE CBSA.

TALBOT 1,213.4 PER 1000,000

DORCHESTER 1,154.7 PER 1000,000

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CAROLINE 983 PER 1000,000

QUEEN ANNE'S 715.2 PER 1000,000

SOURCE: MD ASSESSMENT TOOL FOR COMMUNITY HEALTH AND BUREAU OF LABOR

STATISTICS

PROMOTING THE HEALTH OF THE COMMUNITY

SCHEDULE H, PART VI, LINE 5

PART VI SUPPLEMENTAL INFORMATION 2010 SHORE HEALTH SYSTEM

5. PROMOTION OF COMMUNITY HEALTH. PROVIDE ANY OTHER INFORMATION

IMPORTANT TO DESCRIBING HOW THE ORGANIZATION'S HOSPITAL FACILITIES OR

OTHER HEALTH CARE FACILITIES FURTHER ITS EXEMPT PURPOSE BY PROMOTING THE

HEALTH OF THE COMMUNITY (E.G., OPEN MEDICAL STAFF, COMMUNITY BOARD, USE

OF SURPLUS FUNDS, ETC.).

MAJOR NEEDS IDENTIFIED:

THE TOP TEN AREAS/NEEDS THAT HAVE THE GREATEST IMPACT ON OVERALL HEALTH

IN OUR COMMUNITIES ARE:

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- ACCESS TO QUALITY HEALTH SERVICES
- CANCER
- HEART DISEASE AND STROKE
- PHYSICAL ACTIVITY AND FITNESS
- EDUCATIONAL & COMMUNITY-BASED PROGRAMS
- DIABETES
- MATERNAL, INFANT AND CHILD HEALTH
- NUTRITION AND OBESITY
- MENTAL HEALTH AND MENTAL DISORDERS
- ENVIRONMENTAL HEALTH

NEEDS IDENTIFIED NOT ADDRESSED:

- ENVIRONMENTAL HEALTH REQUIRES EXPERTISE AND RESOURCES BEYOND THE CAPABILITIES OF SHORE HEALTH SYSTEM.
- MENTAL HEALTH AND MENTAL DISORDERS IS BEING ADDRESSED THROUGH THE MID-SHORE MENTAL HEALTH SYSTEMS, INC., A PRIVATE NOT FOR PROFIT 501(C)(3) ORGANIZATION, SERVING CAROLINE, DORCHESTER, KENT, QUEEN ANNE'S AND TALBOT COUNTIES. THE MISSION OF MSMHS IS TO CONTINUALLY IMPROVE THE PROVISION OF

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MENTAL HEALTH SERVICES FOR RESIDENTS OF THE MID-SHORE THROUGH EFFECTIVE
 COORDINATION OF SERVICES IN COLLABORATION WITH CONSUMERS, FAMILY MEMBERS,
 PROVIDERS AND COMMUNITY LEADERS.

PROVIDE CHILDREN AGES 8-13 WITH DIABETES AND/OR ASTHMA, ACCESS TO
 EDUCATORS AND RESOURCES TO MANAGE CHRONIC CONDITIONS

EDUCATE SENIORS ON DIABETES MANAGEMENT TO PREVENT ADVERSE OUTCOMES,
 REDUCTION OF HOSPITAL ENCOUNTERS RELATED TO OVER DIABETES

INCREASE KNOWLEDGE OF RISK FACTORS FOR HEART DISEASE AND STROKE AND HOW
 TO IMPROVE HEALTH WITH REGULAR EXERCISE

PARTICIPATE AND SPONSOR EVENT TO RAISE AWARENESS OF ORIGINS AND SYMPTOMS
 OF HEART DISEASE AND STROKE

PROVIDE NUTRITION RECOMMENDATIONS AS PART OF LIFE STYLE CHANGES NECESSARY
 TO MAINTAIN HEALTHY WEIGHT

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EDUCATE CHILDREN AND WOMEN ON HEALTHY EATING TO IMPROVE OVERALL HEALTH
AND REDUCE OBESITY

EDUCATE INDIVIDUALS AT RISK FOR DIABETES PROVIDING INFORMATION ON HOW TO
PREVENT AND/OR DELAY THE ONSET OF TYPE 2 DIABETES

INCREASE THE NUMBER OF WOMEN SURVIVING BREAST CANCER BY DIAGNOSING THEM
AT AN EARLIER STAGE THROUGH EDUCATION AND PROMOTION OF PREVENTATIVE
MEASURES AND EARLY DETECTION.

DIAGNOSE AFRICAN AMERICAN WOMEN AT EARLIER STAGES OF BREAST CANCER,
EQUIVALENT TO CAUCASIAN WOMEN.

EDUCATE LATINA WOMEN IN BREAST SELF EXAMINATION WITH THE ASSISTANCE OF A
TRANSLATOR.

INCREASE BREAST CANCER SCREENING LEVELS AMONG UNINSURED AND UNDERINSURED

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WOMEN

PROVIDE FOLLOWUP DIAGNOSIS TREATMENT WHEN NEEDED

PROVIDE EDUCATION WITH A FOCUS ON UNDERSERVED WOMEN

PROVIDE MEN IN THE MID SHORE, THE OPPORTUNITY TO OBTAIN A FREE PROSTATE
CANCER SCREENING WHICH INCLUDES BLOOD TEST AND EXAM BY A COMPETENT
PHYSICIAN.

PROVIDE SERVICES BY SOCIAL WORKERS AT NO COST, INCLUDING CRISIS
INTERVENTION, LINKING TO RESOURCES, COUNSELING AND ADVOCACY, AND PUBLIC
EDUCATION.

PROVIDE ANTICOAGULATED PATIENTS (NO CHARGE) WITH CLOSE MONITORING,
EDUCATIONAL RESOURCES AND DEDICATED EXPERTISE TO PREVENT ADVERSE
OUTCOMES, REDUCTION OF HOSPITAL ENCOUNTERS RELATED TO OVER
ANTICOAGULATION OR UNDER ANTICOAGULATION

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PROVIDE CONTINUED PATIENT CARE FOR UNINSURED. PROGRAM DESIGNED TO REDUCE
 READMISSIONS TO ER FOR SAME/LIKE ILLNESSES DUE TO LACK OF FOLLOWUP CARE.

STROKE AWARENESS AND PREVENTION PROGRAM IS DESIGNED TO RAISE AWARENESS OF
 RISK FACTORS, AND WARNING SIGNS OF STROKE -ALONG WITH EMS ACTIVATION IN
 AN EFFORT TO DECREASE THE INCIDENCE OF STROKE

EDUCATE STROKE SURVIVORS OR RECOVERY AND HEALTH MAINTENANCE TO REDUCE
 RISK OF RECURRENT STROKE

PROVIDE SUPPORT BY BUILDING RELATIONSHIPS AND EMOTIONAL SUPPORT FOR
 SURVIVORS AND CAREGIVERS

WELL PARTNERS IS A UNIQUE PROGRAM THAT PROVIDES A CONTINUUM OF CARE,
 FOCUSING ON PREVENTIVE CARE TO IMPROVE THE ABILITY OF PATIENTS AND
 FAMILIES TO WORK TOGETHER TO MANAGE CHRONIC DISEASE. DESIGNED FOR AT-RISK
 FAMILIES AND INDIVIDUALS WHO DON'T HAVE SUFFICIENT RESOURCES AND ARE NOT

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- 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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- 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.

ELIGIBLE FOR OTHER IN-HOME SERVICES. WELLNESS PARTNERS HELPS PATIENTS
 WITH DISEASE MANAGEMENT AND LIFE SKILLS SO THAT THEY CAN CONTINUE TO LIVE
 IN THEIR OWN HOMES. THE SERVICE IS PROVIDED BY SHORE HEALTH SYSTEM AT NO
 CHARGE FOR THOSE WHO QUALIFY.

OBJECTIVES:

- MANAGING PHYSICAL HEALTH PROBLEMS
- CONNECTION WITH OTHER COMMUNITY SERVICES
- DIETARY EDUCATION
- HOME SAFETY EVALUATIONS
- SAFE MEDICINE USE
- EDUCATION ON SPECIFIC ILLNESS AND TREATMENTS
- EMOTIONAL SUPPORT
- MONITORING CLIENT PROGRESS THROUGH HOME VISITS OR PHONE CALLS.

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; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 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.

AFFILIATED HEALTH CARE SYSTEM ROLES

SCHEDULE H, PART VI, LINE 6

SHORE HEALTH SYSTEM, AN AFFILIATE OF THE UNIVERSITY OF MARYLAND MEDICAL

SYSTEM, IS CURRENTLY LICENSED TO OPERATE 217 BEDS COMBINED. THE GOVERNING

BODY INCLUDES THE BOARD OF SHORE HEALTH SYSTEM WHOSE MEMBERS RESIDE IN THE

PRIMARY SERVICE AREA AS PER BELOW: SHORE HEALTH SYSTEM PRIMARILY

DETERMINES ITS ROLE AS AN ORGANIZATION IN PROMOTING HEALTH OF ITS

COMMUNITY. DESCRIPTION OF THE COMMUNITY SHORE HEALTH SYSTEM SERVES: THE

MEMORIAL HOSPITAL AT EASTON AND DORCHESTER GENERAL HOSPITAL IN CAMBRIDGE

ARE PRIVATE, NOT FOR PROFIT HOSPITALS OFFERING A COMPLETE RANGE OF

INPATIENT AND OUTPATIENT SERVICES TO OVER 150,000 PEOPLE THROUGHOUT THE

MID-SHORE OF MARYLAND. SITUATED ON MARYLAND'S EASTERN SHORE, SHORE HEALTH

SYSTEM SERVICES A FOUR COUNTY AREA, COVERING CAROLINE, DORCHESTER, QUEEN

ANNE, AND TALBOT COUNTIES.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

SHORE HEALTH SYSTEM, INC.

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

2010

Open to Public Inspection

Employer identification number

52-0610538

Part I Questions Regarding Compensation

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

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

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

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

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

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

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

- a** Receive a severance payment or change-of-control payment from the organization or a related organization? **4a**
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b**
- c** Participate in, or receive payment from, an equity-based compensation arrangement? **4c**
- 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**
- b** Any related organization? **5b**
- 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**
- b** Any related organization? **6b**
- If "Yes" to line 6a or 6b, describe in Part III.

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

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

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

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

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

Schedule J (Form 990) 2010

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) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a.

(A) Name	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 ROBERT CHRENCIK	(i)	0.	0.	0.	0.	0.	0.
	(ii)	986,285.	659,250.	9,032.	179,013.	19,768.	1,853,348.
2 JOSEPH ROSS	(i)	397,367.	108,365.	96,072.	8,801.	15,679.	626,284.
	(ii)	0.	0.	0.	0.	0.	0.
3 GERARD WALSH	(i)	219,695.	50,023.	27,019.	8,367.	14,206.	319,310.
	(ii)	0.	0.	0.	0.	0.	0.
4 WALTER ZAJAC	(i)	180,528.	36,645.	20,559.	7,043.	12,927.	257,702.
	(ii)	0.	0.	0.	0.	0.	0.
5 JOHN ASHWORTH, III	(i)	0.	0.	0.	0.	0.	0.
	(ii)	345,255.	120,341.	121,851.	8,928.	16,029.	612,404.
6 MICHAEL TOOKE, MD	(i)	266,621.	74,168.	8,866.	37,527.	13,347.	400,529.
	(ii)	0.	0.	0.	0.	0.	0.
7 CHRISTOPHER PARKER	(i)	187,982.	55,109.	29,729.	7,093.	12,511.	292,424.
	(ii)	0.	0.	0.	0.	0.	0.
8 MICHAEL ZIMMERMAN	(i)	169,399.	41,219.	23,413.	6,623.	15,269.	255,923.
	(ii)	0.	0.	0.	0.	0.	0.
9 MICHAEL SILGEN	(i)	146,713.	26,471.	1,950.	15,884.	5,215.	196,233.
	(ii)	0.	0.	0.	0.	0.	0.
10 JOHN SAWYER	(i)	176,396.	0.	345.	6,105.	215.	183,061.
	(ii)	0.	0.	0.	0.	0.	0.
11 CATHERINE FERARA	(i)	148,932.	0.	41.	5,668.	5,652.	160,293.
	(ii)	0.	0.	0.	0.	0.	0.
12 SUSAN SIFORD	(i)	131,877.	7,233.	146.	5,265.	14,073.	158,594.
	(ii)	0.	0.	0.	0.	0.	0.
13 PATTI WILLIS	(i)	103,019.	19,637.	11,242.	4,057.	12,393.	150,348.
	(ii)	0.	0.	0.	0.	0.	0.
14 JONATHAN COOK	(i)	156,044.	43,608.	1,588.	17,406.	13,570.	232,216.
	(ii)	0.	0.	0.	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, 4c, 5a, 5b, 6a, 6b, 7, and 8. Also complete this part for any additional information.

HEALTH OR SOCIAL CLUB DUES OR INITIATION FEES

SCHEDULE J, PART I, LINE 1A

UMMS EXECUTIVES RECEIVE A BENEFIT PACKAGE WHICH MAY BE USED TOWARDS HEALTH CLUB DUES OR OTHER HEALTH MAINTENANCE PROGRAMS. SUCH BENEFITS ARE CAPPED AT \$7,000 OR \$3,000 DEPENDING ON JOB TITLE AS DESCRIBED IN THE PROGRAM DOCUMENTS.

SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN

SCHEDULE J, PART I, LINE 4B

DURING THE FISCAL YEAR END JUNE 30, 2011, THE CERTAIN OFFICERS AND KEY EMPLOYEES PARTICIPATED IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) SUPPLEMENTAL NONQUALIFIED PLAN. THE INDIVIDUALS, LISTED BELOW HAVE NOT VESTED IN THE PLAN THEREFORE THE ACCRUED CONTRIBUTION TO THE PLAN FOR THE FISCAL YEAR IS REPORTED ON SCHEDULE J PART II COLUMN (C), RETIREMENT AND OTHER DEFERRED COMPENSATION:

JOSEPH P ROSS TERM 4/1/11

WALTER J ZAJAC

ROBERT CRENCIK

GERARD M WALSH

Part III Supplemental Information

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

JOHN ASHWORTH

MICHAEL C TOOKE MD

JONATHAN COOK MD CHRISTOPHER

PARKER MICHAEL SILGEN

PATTI WILLIS

MICHAEL ZIMMERMANIN

DURING THE FISCAL YEAR END JUNE 30, 2011, THE CERTAIN OFFICERS AND KEY EMPLOYEES PARTICIPATED IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) SUPPLEMENTAL NONQUALIFIED PLAN. THE OFFICERS AND KEY EMPLOYEES LISTED BELOW HAVE VESTED IN THE PLAN IN A PRIOR YEAR, THEREFORE THE CONTRIBUTION TO THE PLAN FOR THE FISCAL YEAR IS REPORTED AS TAXABLE COMPENSATION AND REPORTED ON SCHEDULE J, PART II, COLUMN (BIII), OTHER REPORTABLE COMPENSATION:

MICHAEL ZIMMERMAN

PATTI WILLIS

JOSEPH P ROSS

JOHN ASHWORTH

Part III Supplemental Information

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

WALTER ZAJAC

GERARD M WALSH

CHRISTOPHER PARKER

DURING THE FISCAL YEAR END JUNE 30, 2011, THE CERTAIN OFFICERS AND KEY EMPLOYEES PARTICIPATED IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) SUPPLEMENTAL NONQUALIFIED PLAN. THE OFFICERS AND KEY EMPLOYEES LISTED BELOW HAVE VESTED IN THE PLAN IN THE REPORTING TAX YEAR, THEREFORE THE FULL VALUE OF THE PLAN, INCLUDING ANY CONTRIBUTION TO THE PLAN FOR THE CURRENT FISCAL YEAR, IS REPORTED AS TAXABLE COMPENSATION AND REPORTED ON SCHEDULE J, PART II, COLUMN (BIII), OTHER REPORTABLE COMPENSATION. PRIOR YEAR CONTRIBUTIONS TO THE PLAN WERE PREVIOUSLY REPORTED ON FORM 990 AND ARE INDICATED ON SCHEDULE J, PART II, COLUMN (F).

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

2010

**Open to Public
Inspection**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

MEMBERS OR STOCKHOLDERS

FORM 990, PART VI, LINE 6, 7A, AND 7B

THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION IS A MEMBER OF SHORE HEALTH SYSTEM, INC. UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION MAY ELECT MEMBERS AND APPROVE DECISIONS OF THE SHORE HEALTH SYSTEM BOARD.

FORM 990 REVIEW PROCESS

FORM 990, PART VI, LINE 11B

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

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

UPON COMPLETION OF THE IN-HOUSE REVIEW, GRANT THORNTON IS INSTRUCTED TO MAKE ANY NECESSARY CHANGES AND TO PREPARE THE FINAL TAX RETURN. THE

Name of the organization SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
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FINAL RETURN UNDERGOES ANOTHER REVIEW BY THE ACCOUNTING STAFF AT FINANCE SHARED SERVICES AND IS ALSO REVIEWED BY THE ACCOUNTING MANAGER, THE DIRECTOR OF FINANCIAL REPORTING, THE VICE PRESIDENT OF FINANCE AND THE CFO, WHO SIGNS THE RETURN.

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

CONFLICT OF INTEREST POLICY MONITORING & ENFORCEMENT

FORM 990, PART VI, LINE 12C

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

A QUESTIONNAIRE WHICH DISCLOSES POTENTIAL CONFLICTS OF INTEREST IS DISTRIBUTED ANNUALLY TO ALL OFFICERS, DIRECTORS AND KEY EMPLOYEES. THE

Name of the organization SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
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GENERAL COUNSEL OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (UMMSC) REVIEWS THE RESPONSES FOR UMMSC, UNIVERSITY SPECIALTY HOSPITAL AND JAMES LAWRENCE KERNAN HOSPITAL. THE CEO OR CFO OF EACH OF THE OTHER ENTITIES IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM REVIEWS THE RESPONSES FOR THOSE ENTITIES.

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

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

ALL INVITATIONS FOR BIDS, PROPOSALS OR SOLICITATIONS FOR OFFERS INCLUDE THE FOLLOWING PROVISION: ANY VENDOR, SUPPLIER OR CONTRACTOR MUST DISCLOSE ANY ACTUAL OR POTENTIAL TRANSACTION WITH ANY ORGANIZATION OFFICER, DIRECTOR, EMPLOYEE OR MEMBER OF THE MEDICAL STAFF, INCLUDING

Name of the organization SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
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FAMILY MEMBERS WITHIN FIVE DAYS OF THE TRANSACTION. FAILURE TO COMPLY WITH THIS PROVISION IS A MATERIAL BREACH OF AGREEMENT. IN ADDITION, A BOARD DISCLOSURE REPORT IS FILED WITH THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION ON AN ANNUAL BASIS SHOWING ANY BUSINESS TRANSACTIONS BETWEEN THE BOARD MEMBERS AND THE ORGANIZATION.

PROCESS FOR DETERMINING COMPENSATION

FORM 990, PART VI, LINES 15A, 15B

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

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

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

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

THE COMMITTEE SEEKS AN OPINION OF COUNSEL THAT IT HAS MET THE REQUIREMENTS OF THE IRS INTERMEDIATE SANCTIONS REGULATIONS.

Name of the organization SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
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THIS PROCESS IS USED TO DETERMINE THE COMPENSATION PACKAGES FOR ALL MANAGEMENT EMPLOYEES FROM THE VICE PRESIDENT LEVEL AND UP.

HOW DOCUMENTS ARE MADE AVAILABLE TO THE PUBLIC

FORM 990, PART VI, LINE 19

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

REQUESTS FOR FORM 990 AND FORM 1023: A REQUESTOR SEEKING TO REVIEW AND/OR OBTAIN A COPY OF THE ORGANIZATION'S IRS FORM 990 OR FORM 1023 AS FILED WITH THE INTERNAL REVENUE SERVICE, INCLUDING ALL SCHEDULES AND ATTACHMENTS, MAY APPEAR IN PERSON OR SUBMIT A WRITTEN REQUEST. THE MOST RECENT THREE YEARS OF IRS FORM 990 MAY BE REQUESTED. IF THE REQUESTER APPEARS IN PERSON, THE INDIVIDUAL IS DIRECTED TO THE OFFICE OF THE CHIEF FINANCIAL OFFICER FOR THE ORGANIZATION AND THE FORM 990 AND/OR FORM 1023 ARE MADE AVAILABLE FOR INSPECTION. THE INDIVIDUAL IS PERMITTED TO REVIEW THE RETURN, TAKE NOTES AND REQUEST A COPY. IF REQUESTED, A COPY IS PROVIDED ON THE SAME DAY. A NOMINAL FEE IS CHARGED FOR MAKING THE COPIES. THE ORGANIZATION MAY HAVE AN EMPLOYEE PRESENT DURING THE PUBLIC INSPECTION OF THE DOCUMENT. WRITTEN REQUESTS FOR AN ENTITY'S FORM 990 OR FORM 1023 ARE DIRECTED IMMEDIATELY TO THE OFFICE OF THE CHIEF FINANCIAL OFFICER FOR THE ORGANIZATION. THE REQUESTED COPIES ARE MAILED WITHIN 30 DAYS OF THE REQUEST. REPRODUCTION FEES AND MAILING COSTS ARE

Name of the organization SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
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CHARGED TO THE REQUESTOR.

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

CHANGES IN NET ASSETS

FORM 990, PART XI, LINE 5

THE FOLLOWING ARE THE OTHER CHANGES IN NET ASSETS:

TRANSFER OF CNES/CENT ACTIVITIES TO

SHORE CLINICAL FOUNDATION \$ (1,889,689)

INTERCOMPANY TRANSACTIONS ELIMINATION (8,149,700)

CHANGE IN BENEFICIARY INTEREST 9,154,564

CHANGE IN INVESTMENT OF SUBSIDIARY 6,430,573

ROUNDING 1,623

UNREALIAZED GAINS 321,700

TOTAL OTHER CHANGES IN NET ASSETS \$ 5,869,071

HOURS ON RELATED ENTITY

THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) IS A MULTI-ENTITY HEALTH CARE SYSTEM INCLUDING 8 ACUTE CARE HOSPITALS AND VARIOUS SUPPORTING ENTITIES. A NUMBER OF INDIVIDUALS PROVIDE SERVICES TO VARIOUS ENTITIES

Name of the organization SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
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WITHIN THE SYSTEM. IN GENERAL, THE OFFICERS AND KEY EMPLOYEES OF UMMS AVERAGE IN EXCESS OF 40 HOURS PER WEEK SERVING THE DIFFERENT ENTITIES THAT COMPRISE UMMS.

TAX EXEMPT BONDS

PURSUANT TO A MASTER LOAN AGREEMENT DATED JUNE 20, 1991 (THE "MASTER LOAN AGREEMENT"), AS AMENDED, THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (THE "CORPORATION") AND SEVERAL OF ITS SUBSIDIARIES HAVE ISSUED DEBT THROUGH THE MARYLAND HEALTH AND HIGHER EDUCATION FACILITY AUTHORITY (THE "AUTHORITY") AS SECURITY FOR THE PERFORMANCE OF THE BOND OBLIGATION. UNDER THE MASTER LOAN AGREEMENT, THE AUTHORITY MAINTAINS A SECURITY INTEREST IN THE REVENUE OF THE OBLIGORS. THE MASTER LOAN AGREEMENT CONTAINS CERTAIN RESTRICTIVE COVENANTS. THESE COVENANTS REQUIRE THAT RATES AND CHARGES BE SET AT CERTAIN LEVELS, LIMIT INCURRENCE OF ADDITIONAL DEBT, REQUIRE COMPLIANCE WITH CERTAIN OPERATING RATIOS AND RESTRICT THE DISPOSITION OF ASSETS. THE OBLIGATED GROUP UNDER THE MASTER LOAN AGREEMENT INCLUDES THE CORPORATION, UNIVERSITY SPECIALTY HOSPITAL, INC., THE JAMES LAWRENCE KERNAN HOSPITAL, INC., MARYLAND GENERAL HOSPITAL, INC, BALTIMORE WASHINGTON MEDICAL CENTER, INC., SHORE HEALTH SYSTEM, INC., CHESTER RIVER HEALTH SYSTEM, INC., AND THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM FOUNDATION, INC. EACH MEMBER OF THE OBLIGATED GROUP IS JOINTLY AND SEVERALLY LIABLE FOR THE REPAYMENT OF THE OBLIGATIONS UNDER THE MASTER LOAN AGREEMENT OF THE CORPORATION OF \$994,560,000 OF THE OUTSTANDING AUTHORITY BONDS ON JUNE 30, 2011. ALL OF THE BONDS WERE ISSUED IN THE NAME OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND ARE REPORTED ON SCHEDULE K OF ITS FORM 990.

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

ATTACHMENT 1

FORM 990, PART III - PROGRAM SERVICE, LINE 4A

SHORE HEALTH SYSTEM, INC. IS A 217 LICENSED BED COMMUNITY HOSPITAL PROVIDING A FULL RANGE OF INPATIENT AND OUTPATIENT CLINICAL SERVICES TO THE MARYLAND MID-SHORE AREA; INCLUDING GENERAL HOSPITAL, EMERGENCY, AND SPECIALIZED SERVICES AS WELL AS OUTPATIENT CENTERS FOR PRIMARY CARE, DIAGNOSTICS, TREATMENT, EDUCATION, AND REHABILITATION. THE SYSTEM OFFERS FREE EDUCATION PROGRAMS AND SERVICES TO PROMOTE HEALTH AWARENESS IN THE COMMUNITY. DURING FY 2011, THE SYSTEM PROVIDED CARE FOR 14,047 INPATIENTS RESULTING IN 51,231 DAYS OF PATIENT CARE, TREATED 66,509 PATIENTS IN THE ER, AND PERFORMED 15,618 SURGERIES IN THE OR. THE SYSTEM'S ANCILLARY SERVICE DEPARTMENTS REALIZED 413,138 OUTPATIENT ENCOUNTERS. HOME HEALTH/HOSPICE SERVICES WERE PROVIDED TO 1,686 PATIENTS IN 28,736 NURSING VISITS. THE SYSTEMS MISSION STATEMENT IS "TO EXCEL IN QUALITY CARE AND PATIENT SATISFACTION". ITS STRATEGIC PRINCIPLE IS "EXCEPTIONAL CARE, EVERY DAY", AND ITS VALUES STATEMENT IS "EVERY INTERACTION WITH ANOTHER IS AN OPPORTUNITY TO CARE". AS A PART OF ITS MISSION, THE SYSTEM PROVIDES CHARITY CARE TO PATIENTS UNABLE TO PAY, PROVIDING \$7.0 MILLION OF CHARITY CARE IN FY 2011.

ATTACHMENT 2

PART VII - CONTINUATION OF OFFICERS, DIRECTORS, TRUSTEES, KEY EMPLOYEES AND HIGHEST COMPENSATED EMPLOYEES

(1)=IND.TRUSTEE/DIR. (2)=INS.TRUSTEE (3)=OFFICER (4)=KEY EMP. (5)=HIGHEST COMP. (6)=FORMER

(A) NAME AND TITLE	(B) HOURS	(C) POSITION						COMPENSATION FROM		
		(1)	(2)	(3)	(4)	(5)	(6)	(D) ORG.	(E) REL. ORG.	(F) OTHER
29 SUSAN SIFORD PHARMACY DIRECTOR	40.00				X			139,256.	0.	19,338.
30 GEORGE SHOENER										

Name of the organization SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
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				<u>ATTACHMENT 2 (CONT'D)</u>	
FACILITIES DIRECTOR	40.00	X	134,527.	0.	10,723.
31 PATTI WILLIS					
VP PUBLIC REL/COMM	40.00	X	133,898.	0.	16,450.

ATTACHMENT 3FORM 990, PART VII, COLUMN B - ESTIMATED AVERAGE PER WEEK

NAME AND TITLE	HOURS DEVOTED FOR RELATED ORGANIZATION
ROBERT CHRENCIK UMMS PRESIDENT/CEO	40.00
GERARD WALSH INTERIM PRES/CEO	5.00
WALTER ZAJAC SVP/CFO-BOARD TREASURER	5.00
JOHN ASHWORTH, III BOARD MEMBER	40.00
JOSEPH ROSS PRESIDENT/CEO	5.00
MICHAEL TOOKE, MD SVP/CMO	5.00
CHRISTOPHER PARKER INTERIM COO	5.00
MICHAEL ZIMMERMAN VP/HR	5.00
MICHAEL SILGEN VP/MARKETING	5.00
JONATHAN COOK VP/PHYSICAN SERVICES	5.00

ATTACHMENT 4990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
EAGLE HOSPITAL PHYSICIANS, LLC 1600 N. DALLAS PARKWAY; SUITE 450 DALLAS, TX 75248	MGMT FEES	1,742,632.
TIDEWATER ANESTHESIA ASSOC. PA PO BOX 1208 EASTON, MD 21601	PROF. SERVICES	1,609,271.
WILLOW CONSTRUCTION, LLC	CONSTRUCTION	873,556.

Name of the organization SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
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ATTACHMENT 4 (CONT'D)

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

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
PO BOX 521 EASTON, MD 21601		
INNOVATIVE HEALTH SERVICES, LLC PO BOX 778 EASTON, MD 21601	MGMT FEES	739,108.
UNIVERSITY OF MD NEUROSURGERY ASSOC. 22 S. GREENE ST.; SUITE 212D BALTIMORE, MD 21201	PROF. SERVICES	524,230.
	TOTAL COMPENSATION	<u>5,488,797.</u>

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2010

**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

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) CHESAPEAKE EAR, NOSE, THROAT & SINUS 20-2995846 219 S WASHINGTON ST EASTON, MD 21601	HEALTHCARE	MD			SHS
(2) NHP, LLC 26-2178083 219 S WASHINGTON ST EASTON, MD 21601	REAL ESTATE	MD			SHS
(3) CHESAPEAKE NEUROLOGICAL SURGERY 20-2995904 219 S WASHINGTON ST EASTON, MD 21601	HEALTHCARE	MD			SHS
(4) -----					
(5) -----					
(6) -----					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) BALTIMORE WASHINGTON EMERGENCY PHYS INC 52-1756326 301 HOSPITAL DRIVE GLEN BURNDIE, MD 21061	HEALTH CARE	MD	501 (C) (3)	11	BWMS		X
(2) BALTIMORE WASHINGTON HEALTHCARE SVCS 52-1830243 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTH CARE	MD	501 (C) (3)	11	BWMS		X
(3) BALTIMORE WASHINGTON MEDICAL CENTER INC 52-0689917 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTH CARE	MD	501 (C) (3)	03	BWMS		X
(4) BALTIMORE WASHINGTON MEDICAL SYSTEM INC 52-1830242 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTH CARE	MD	501 (C) (3)	11	UMMSC		X
(5) BW MEDICAL CENTER FOUNDATION, INC. 52-1813656 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	FUNDRAISING	MD	501 (C) (3)	11	BWMS		X
(6) NORTH ARUNDEL DEVELOPMENT CORPORATION 52-1318404 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	REAL ESTATE	MD	501 (C) (2)		BWMS		X
(7) NORTH COUNTY CORPORATION 52-1591355 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	REAL ESTATE	MD	501 (C) (2)		BWMS		X

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

Schedule R (Form 990) 2010

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2010

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Department of the Treasury
Internal Revenue Service

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▶ **Attach to Form 990.**

▶ **See separate instructions.**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) CHESTER RIVER HEALTH FOUNDATION, INC. 52-1338861 100 BROWN STREET CHESTERTOWN, MD 21620	FUNDRAISING	MD	501 (C) (3)	11	CRHS		X
(2) CHESTER RIVER HEALTH SYSTEM, INC. 52-2046500 100 BROWN STREET CHESTERTOWN, MD 21620	HEALTH CARE	MD	501 (C) (3)	11	UMMSC		X
(3) CHESTER RIVER HOSPITAL CENTER, INC. 52-0679694 200 MORGNEC ROAD CHESTERTOWN, MD 21620	HEALTH CARE	MD	501 (C) (3)	03	CRHS		X
(4) CHESTER RIVER MANOR, INC. 52-6070333 200 MORGNEC ROAD CHESTERTOWN, MD 21620	HEALTH CARE	MD	501 (C) (3)	11	CRHS		X
(5) MARYLAND GENERAL CLINICAL PRACTICE GROUP 52-1566211 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTH CARE	MD	501 (C) (3)	11	MGHS		X
(6) MARYLAND GENERAL COMM HEALTH FOUNDATION 52-2147532 827 LINDEN AVENUE BALTIMORE, MD 21201	FUNDRAISING	MD	501 (C) (3)	11	MGHS		X
(7) MARYLAND GENERAL HEALTH SYSTEMS, INC. 52-1175337 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTH CARE	MD	501 (C) (3)	11	UMMSC		X

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Schedule R (Form 990) 2010

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

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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

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) CARE HEALTH SERVICES, INC. 52-1510269 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTH CARE	MD	501 (C) (3)	11	SHS	X	
(2) DORCHESTER GENERAL HOSPITAL FOUNDATION 52-1703242 219 SOUTH WASHINGTON STREET EASTON, MD 21601	FUNDRAISING	MD	501 (C) (3)	11	SHS		X
(3) MEMORIAL HOSPITAL FOUNDATION, INC. 52-1282080 219 SOUTH WASHINGTON STREET EASTON, MD 21601	FUNDRAISING	MD	501 (C) (3)	11	SHS	X	
(4) SHORE CLINICAL FOUNDATION, INC. 52-1874111 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTH CARE	MD	501 (C) (3)	11	SHS	X	
(5) MARYLAND GENERAL HOSPITAL INC 52-0591667 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTH CARE	MD	501 (C) (3)	03	MGHS		X
(6) JAMES LAWRENCE KERNAN HOSP ENDOW FD 23-7360743 2200 KERNAN DRIVE BALTIMORE, MD 21207	FUNDRAISING	MD	501 (C) (3)	11	UMMSC		X
(7) JAMES LAWRENCE KERNAN HOSPITAL, INC. 52-0591639 2200 KERNAN DRIVE BALTIMORE, MD 21207	HEALTH CARE	MD	501 (C) (3)	03	UMMSC		X

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

Schedule R (Form 990) 2010

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2010

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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

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) SHIPLEY'S CHOICE MEDICAL PARK, INC. 04-3643849 22 SOUTH GREENE STREET BALTIMORE, MD 21201	REAL ESTATE	MD	501 (C) (3)	11	UMMSC		X
(2) UMMS FOUNDATION, INC. 52-2238893 22 SOUTH GREENE STREET BALTIMORE, MD 21201	FUNDRAISING	MD	501 (C) (3)	11	UMMSC		X
(3) UNIVERSITY OF MD MEDICAL SYSTEM CORP 52-1362793 22 SOUTH GREENE STREET BALTIMORE, MD 21201	HEALTH CARE	MD	501 (C) (3)	03	UMMSC		X
(4) UNIVERSITY SPECIALTY HOSPITAL 52-0882914 611 SOUTH CHARLES STREET BALTIMORE, MD 21230	HEALTH CARE	MD	501 (C) (3)	03	UMMSC		X
(5) -----							
(6) -----							
(7) -----							

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

Schedule R (Form 990) 2010

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) ARUNDEL PHYSICIANS ASSOCIATES, 301 HOSPITAL DRIVE	HEALTH CARE	MD	APA, INC					X			X	
(2) CENTRAL MARYLAND RADIOLOGY ONC 10710 CHARTER DRIVE	HEALTH CARE	MD	UMMSC					X			X	
(3) CENTRAL MD REHABILITATION CENT 22 SOUTH GREENE STREET	HEALTH CARE	MD	UMMSC					X			X	
(4) HELEN P. DENIT CANCER TREATMEN 22 SOUTH GREENE STREET	HEALTH CARE	MD	UMMSC					X			X	
(5) INNOVATIVE HEALTH, LLC 52-1997 29165 CANVASBACK DRIVE, SUITE	BILLING	MD	SHS		34,908.	300,773.		X			X	
(6) NORTH ARUNDEL PET CENTER, LLC 301 HOSPITAL DRIVE	HEALTH CARE	MD	BWP. INC.					X			X	
(7) NORTH ARUNDEL SENIOR LIVING, L 301 HOSPITAL DRIVE	HEALTH CARE	MD	BWHE. INC.					X			X	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) ARUNDEL PHYSICIANS ASSOCIATES, INC. 52-1992649 301 HOSPITAL DRIVE GLEN BURNIE, MD 21601	HEALTH CARE	MD	BWHE	C CORP			
(2) BALTIMORE WASHINGTON HEALTH ENTERPRISES 52-1936656 301 HOSPITAL DRIVE GLEN BURNIE, MD 21601	HEALTH CARE	MD	BWMS	C CORP			
(3) BW PROFESSIONAL SERVICES, INC. 52-1655640 301 HOSPITAL DRIVE GLEN BURNIE, MD 21601	HEALTH CARE	MD	BWHE	C CORP			
(4) COUNCIL OF UNIT OWNERS OF MD GEN PC 52-1891126 827 LINDEN AVENUE BALTIMORE, MD 21601	REAL ESTATE	MD	MGHS	C CORP			
(5) SHORE HEALTH ENTERPRISES, INC. 52-1363201 219 SOUTH WASHINGTON STREET EASTON, MD 21601	REAL ESTATE	MD	SHS	C CORP	57,130.	749,470.	100.0000
(6) UNIVERSITY LITHOTRIPTER, INC. 52-1451021 22 SOUTH GREENE STREET BALTIMORE, MD 21201	HEALTH CARE	MD	UMSC	C CORP			
(7) UMMS SELF INSURANCE TRUST 52-6315433 23 SOUTH GREENE STREET BALTIMORE, MD 21201	INSURANCE	MD	UMSC	C CORP			

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) NAH/SUNRISE OF SEVERNA PARK, L 301 HOSPITAL DRIVE	HEALTH CARE	MD	BWHE. INC.					X			X	
(2) SHIPLEY'S IMAGING CENTER, LLC 22 SOUTH GREENE STREET	HEALTH CARE	MD	UMMSC					X			X	
(3) UNIVERSITYCARE, LLC 52-1914892 22 SOUTH GREENE STREET	HEALTH CARE	MD	UMMSC					X			X	
(4) -----												
(5) -----												
(6) -----												
(7) -----												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) TERRAPIN INSURANCE COMPANY ----- 98-0129232 P.O. BOX 1109 KY1-1102 GRAND CAYMAN, CAYMAN ISLANDS CJ	INSURANCE	CJ	UMSC	C CORP			
(2) NA EXECUTIVE BUILDING CONDO ASSN, INC. 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	REAL ESTATE	MD	UMSC	C CORP			
(3) -----							
(4) -----							
(5) -----							
(6) -----							
(7) -----							

Part V Transactions With Related Organizations (Complete if the organization answered "Yes" to Form 990, Part IV, line 34, 35, 35a, 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 other organization(s)	X	
c Gift, grant, or capital contribution from other organization(s)	X	
d Loans or loan guarantees to or for other organization(s)		X
e Loans or loan guarantees by other organization(s)	X	
f Sale of assets to other organization(s)		X
g Purchase of assets from other organization(s)		X
h Exchange of assets		X
i Lease of facilities, equipment, or other assets to other organization(s)		X
j Lease of facilities, equipment, or other assets from other organization(s)	X	
k Performance of services or membership or fundraising solicitations for other organization(s)	X	
l Performance of services or membership or fundraising solicitations by other organization(s)		X
m Sharing of facilities, equipment, mailing lists, or other assets		X
n Sharing of paid employees	X	
o Reimbursement paid to other organization for expenses	X	
p Reimbursement paid by other organization for expenses	X	
q Other transfer of cash or property to other organization(s)	X	
r Other transfer of cash or property from other 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-r)	(c) Amount involved	(d) Method of determining amount involved
(1) SHORE HEALTH ENTERPRISES	A	61,419.	
(2) SHORE HEALTH ENTERPRISES	J	57,000.	
(3) MEMORIAL HOSPITAL FOUNDATION, INC.	C	701,926.	
(4) DORCHESTER GENERAL HOSPITAL FOUNDATION, INC.	C	75,570.	
(5) CARE HEALTH SERVICES	N	581,900.	
(6) MEMORIAL HOSPITAL FOUNDATION	N	155,968.	

Part V Transactions With Related Organizations (Complete if the organization answered "Yes" to Form 990, Part IV, line 34, 35, 35a, 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	1a	
b Gift, grant, or capital contribution to other organization(s)	1b	
c Gift, grant, or capital contribution from other organization(s)	1c	
d Loans or loan guarantees to or for other organization(s)	1d	
e Loans or loan guarantees by other organization(s)	1e	
f Sale of assets to other organization(s)	1f	
g Purchase of assets from other organization(s)	1g	
h Exchange of assets	1h	
i Lease of facilities, equipment, or other assets to other organization(s)	1i	
j Lease of facilities, equipment, or other assets from other organization(s)	1j	
k Performance of services or membership or fundraising solicitations for other organization(s)	1k	
l Performance of services or membership or fundraising solicitations by other organization(s)	1l	
m Sharing of facilities, equipment, mailing lists, or other assets	1m	
n Sharing of paid employees	1n	
o Reimbursement paid to other organization for expenses	1o	
p Reimbursement paid by other organization for expenses	1p	
q Other transfer of cash or property to other organization(s)	1q	
r Other transfer of cash or property from other organization(s)	1r	

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

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(1) SHORE CLINICAL FOUNDATION	N	578,422.	
(2) SHORE CLINICAL FOUNDATION	A	89,312.	
(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) Are all partners section 501(c)(3) organizations?		(e) Share of end-of-year assets	(f) Disproportionate allocations?		(g) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(h) General or managing partner?	
			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).
