Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

OMB No. 1545-0047

2011

Open to Public Inspection

A For the 2011 calendar year, or tax year beginning 07/01, **2011, and ending** 06/30, **20** 12

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

C Name of organization
FRANKLIN SQUARE HOSPITAL CENTER INC.
Doing Business As MEDSTAR FRANKLIN SQUARE MEDICAL CTR

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
9000 FRANKLIN SQUARE DRIVE

City or town, state or country, and ZIP + 4
BALTIMORE, MD 21237

D Employer identification number
52-0608007

E Telephone number
(410) 772-6719

G Gross receipts $ 480,983,815.

F Name and address of principal officer: SAMUEL MOSKOWITZ
9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237

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

H(b) Are all affiliates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

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

J Website: ▶ WWW.FRANKLINSQUARE.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶ | **L** Year of formation: 1898 | **M** State of legal domicile: MD

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
MEDSTAR FRANKLIN SQUARE MEDICAL CENTER, A MEMBER OF MEDSTAR HEALTH, PROVIDES THE HIGHEST QUALITY HEALTHCARE AND EDUCATION TO OUR COMMUNITIES.

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	20.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	14.
5	Total number of individuals employed in calendar year 2011 (Part V, line 2a)	5	4,224.
6	Total number of volunteers (estimate if necessary)	6	400.
7a	Total gross unrelated business revenue from Part VIII, column (C), line 12	7a	0
b	Net unrelated business taxable income from Form 990-T, line 34	7b	0

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	2,172,692.	1,554,945.
9	Program service revenue (Part VIII, line 2g)	447,746,775.	476,231,442.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	27,046.	12,182.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,973,353.	3,185,246.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	452,919,866.	480,983,815.
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)	218,337,018.	232,143,143.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24f)	216,493,339.	233,809,279.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	434,830,357.	465,952,422.
19	Revenue less expenses. Subtract line 18 from line 12	18,089,509.	15,031,393.

COPY FOR PUBLIC INSPECTION

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	310,161,018.	310,089,431.
21	Total liabilities (Part X, line 26)	73,232,767.	78,798,968.
22	Net assets or fund balances. Subtract line 21 from line 20	236,928,251.	231,290,463.

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 5/9/13

▶ MARC R. BERGER AVP, TAXATION
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed ▶ ☐	PTIN
SCOTT M. SHERMAN	Scott M Sh	5/8/13		P00451522

Firm's name ▶ KPMG LLP | EIN ▶ 13-5565207

Firm's address ▶ 440 MONTICELLO AVE, SUITE 1900 NORFOLK, VA 23510-2674 | Phone no. ▶ 757-616-7000

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2010)

JSA
1E1065 1.000

Cumulative e-File History 2011	
FED	
Locator:	32062H
Taxpayer Name:	FRANKLIN SQUARE HOSPITAL CENTER INC.
Return Type:	990, 990
Submitted Date:	05/10/2013 10:54:03
Acknowledgement Date:	05/10/2013 11:27:54
Status:	Accepted
Submission ID:	54027920131305000010

Form **8453-EO**

Exempt Organization Declaration and Signature for Electronic Filing

OMB No. 1545-1879

2011

For calendar year 2011, or tax year beginning 07/01, 2011, and ending 06/30, 20 12

For use with Forms 990, 990-EZ, 990-PF, 1120-POL, and 8868

▶ See instructions on back.

Department of the Treasury
Internal Revenue Service

Name of exempt organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number

52-0608007

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

Check the box for the type of return being filed with Form 8453-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 of 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-). If you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

1a	Form 990 check here ▶ [X]	b Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b 480983815.
2a	Form 990-EZ check here ▶ [ ]	b Total revenue, if any (Form 990-EZ, line 9)	2b
3a	Form 1120-POL check here ▶ [ ]	b Total tax (Form 1120-POL, line 22)	3b
4a	Form 990-PF check here ▶ [ ]	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b
5a	Form 8868 check here ▶ [ ]	b Balance due (Form 8868, Part I, line 3c or Part II, line 8c)	5b

Part II Declaration of Officer

6 [ ] I authorize the U.S. Treasury and its designated Financial Agent to initiate an Automated Clearing House (ACH) 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.

[ ] If a copy of this return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I certify that I executed the electronic disclosure consent contained within this return allowing disclosure by the IRS of this Form 990/990-EZ/990-PF (as specifically identified in Part I above) to the selected state agency(ies).

Under penalties of perjury, I declare that I am an officer of the above named organization and that I have examined a copy of the organization's 2011 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.

Sign Here ▶ Signature of officer | Date 5/8/13 | ▶ AVP, TAXATION/FINANCIAL Title

Part III Declaration of Electronic Return Originator (ERO) and Paid Preparer (see instructions)

I declare that I have reviewed the above organization's return and that the entries on Form 8453-EO are complete and correct to the best of my knowledge. If I am only a collector, I am not responsible for reviewing the return and only declare that this form accurately reflects the data on the return. The organization officer will have signed this form before I submit the return. I will give the officer a copy of all forms and information to be filed with the IRS, and have followed all other requirements in Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns. If I am also the Paid Preparer, under penalties of perjury I declare that I have examined the above organization's return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. This Paid Preparer declaration is based on all information of which I have any knowledge.

ERO's Use Only

ERO's signature ▶ | Date 5/8/13 | Check if also paid preparer [X] | Check if self-employed [ ] | ERO's SSN or PTIN P00451522

Firm's name (or yours if self-employed), address, and ZIP code ▶ KPMG LLP | EIN 13-5565207

440 MONTICELLO AVE, SUITE 1900

NORFOLK VA 23510-2674 | Phone no. 757-616-7000

Under penalties of perjury, I declare that I have examined the above return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer is based on all information of which the preparer has any knowledge.

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [ ] if self-employed	PTIN
Firm's name ▶			Firm's EIN ▶	
Firm's address ▶			Phone no.	

For Privacy Act and Paperwork Reduction Act Notice, see back of form.

Form **8453-EO** (2011)

JSA
1E1675 1.000

Form **8868**
(Rev. January 2012)
Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File an Exempt Organization Return

▶ File a separate application for each return.

OMB No. 1545-1709

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

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

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

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

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

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

Type or print
File by the due date for filing your return. See instructions.

Name of exempt organization or other filer, see instructions.	Enter filer's identifying number, see instructions Employer identification number (EIN) or
FRANKLIN SQUARE HOSPITAL CENTER INC.	X 52-0608007
Number, street, and room or suite no. If a P.O. box, see instructions. 9000 FRANKLIN SQUARE DRIVE	Social security number (SSN)
City, town or post office, state, and ZIP code. For a foreign address, see instructions. BALTIMORE, MD 21237	

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

Application Is For	Return Code	Application Is For	Return Code
Form 990	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 990-EZ	01	Form 4720	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

- The books are in the care of ▶ MARC BERGER

Telephone No. ▶ 410 772-6719 FAX No. ▶

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

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 02/15, 20 13, to file the exempt organization return for the organization named above. The extension is for the organization's return for:
▶ ☐ calendar year 20____ or
▶ X tax year beginning 07/01, 2011, and ending 06/30, 20 12.

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

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

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

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

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

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

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

Type or print / File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.	Enter filer's identifying number, see instructions: Employer identification number (EIN) or
	FRANKLIN SQUARE HOSPITAL CENTER INC.	[X] 52-0608007
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	9000 FRANKLIN SQUARE DRIVE	[ ]
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
	BALTIMORE, MD 21237	

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

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

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

- The books are in the care of ▶ MARC BERGER,
  Telephone No. ▶ 410 772-6719 FAX No. ▶
- If the organization does not have an office or place of business in the United States, check this box . . . . . ▶ [ ]
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box . . . . . ▶ [ ]. If it is for part of the group, check this box . . . . . ▶ [ ] and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until 05/15, 20 13.

5 For calendar year _____, or other tax year beginning 07/01, 20 11, and ending 06/30, 20 12.

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

7 State in detail why you need the extension INFORMATION NECESSARY TO PREPARE A COMPLETE AND ACCURATE RETURN IS NOT YET AVAILABLE.

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

Signature and Verification must be completed for Part II only.

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

Signature ▶ Title ▶ CPA Date ▶ 2/7/13

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

ATTACHMENT 1

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

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

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

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations 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 $ 371,551,652. including grants of $ 0) (Revenue $ 459,152,894.)

MEDSTAR FRANKLIN SQUARE MEDICAL CENTER'S LARGEST PROGRAM IS ACCESS TO AND THE PROVISION OF ACUTE HOSPITAL SERVICES TO THE COMMUNITIES OF EASTERN BALTIMORE COUNTY, MARYLAND AND THE SURROUNDING AREAS. IN ADDITION TO THE PROGRAM SERVICE EXPENSES LISTED ABOVE, MFSMC INCURRED $57.7M OF MANAGEMENT AND GENERAL EXPENSES IN PROVIDING SERVICES TO ITS COMMUNITIES. MFSMC OFFERS CLINICAL SERVICES IN MEDICINE, SURGERY, ONCOLOGY, OBSTETRICS, CARDIOLOGY (INCLUDING ANGIOPLASTY), PEDIATRICS, GYNECOLOGY, AND PSYCHIATRY. FOR ADDITIONAL INFORMATION, SEE SCHEDULE O.

4b (Code:) (Expenses $ 21,496,191. including grants of $ 0) (Revenue $ 17,078,548.)

MEDSTAR FRANKLIN SQUARE MEDICAL CENTER PROVIDED $21.5M IN SUBSIDIZED (MISSION DRIVEN) HEALTH SERVICES IN FISCAL YEAR 2012. THESE CRITICAL SERVICES, WHICH ARE DRIVEN BY COMMUNITY NEEDS, OPERATE AT A LOSS. THEY ADDRESS PRIORITIES PRIMARILY THROUGH DISEASE PREVENTION AND IMPROVEMENT OF HEALTH STATUS. SERVICES INCLUDE OPERATION AND MANAGEMENT OF THE FAMILY HEALTH CENTER, HOMELESS HEALTH SERVICES, PRIMARY CARE SERVICES, HOSPITALISTS, AND EMERGENCY AND TRAUMA SERVICES.

4c (Code:) (Expenses $ 15,155,932. including grants of $ 0) (Revenue $ 0)

MEDSTAR FRANKLIN SQUARE MEDICAL CENTER PROVIDED $15.2M IN HEALTH PROFESSIONS EDUCATION IN FISCAL YEAR 2012. THIS CATEGORY INCLUDES TRAINING IN GRADUATE MEDICAL EDUCATION, AND EDUCATION FOR PHYSICIANS, MEDICAL STUDENTS, NURSES, AND OTHER HEALTH PROFESSIONS.

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

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

4e Total program service expenses ▶ 408,203,775.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2		X
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4		X
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		X
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		X
c	Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI, XII, and XIII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants and other assistance to any government or organization in the United States on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24 a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25*	24a		X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25 a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c	X	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	X	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1*	34	X	
35 a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? **Note.** All Form 990 filers are required to complete Schedule O.	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	0		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?			1c	X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return .	2a	4,224			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?			2b	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)					
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?			3a		X
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*			3b		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?			4a		X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.					
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?			5a		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			5b		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?			5c		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible?			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				
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b				
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**					
a	Is the organization licensed to issue qualified health plans in more than one state?			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				
14a	Did the organization receive any payments for indoor tanning services during the tax year?			14a		X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*			14b		

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

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

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year. If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.	1a 20		
b	Enter the number of voting members included in line 1a, above, who are independent	1b 14		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4	X	
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6	X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9		X

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

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

Section C. Disclosure

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

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

☐ Own website ☐ Another's website ☒ Upon request

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

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶ MARC BERGER, 5565 STERRETT PLACE, 5TH FLOOR, COLUMBIA, MD 21044 410-772-6719

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
ATTACHMENT 2										
(1) MOHAMAD M ALABRASH MD DIRECTOR	1.00	X						35,000.	0	0
(2) WILLIAM D MCLAUGHLIN DIRECTOR	1.00	X						0	0	0
(3) SAMUEL MOSKOWITZ PRESIDENT/DIRECTOR	1.00	X						0	0	0
(4) KENNETH A SAMET DIRECTOR	1.00	X						0	6,126,151.	183,379.
(5) HATEM ABDO MD DIRECTOR	1.00	X						0	0	0
(6) KHALID AL-TALIB MD DIRECTOR	1.00	X						1,844.	0	0
(7) IRA GUBERNICK MD DIRECTOR	1.00	X						0	0	0
(8) GEORGE J JABAJI MD DIRECTOR	1.00	X						38,709.	0	0
(9) VINCENT MARTORANA DPM DIRECTOR	1.00	X						0	0	0
(10) MICHAEL D SUTER M.D. DIRECTOR	1.00	X						0	0	0
(11) DEBRA B DOYLE DIRECTOR	1.00	X						0	0	0
(12) MICHAEL L DIETRICH DIRECTOR	1.00	X						0	0	0
(13) ELIZABETH S GLENN DIRECTOR	1.00	X						0	0	0
(14) BISHOP CLIFFORD M JOHNSON, JR. DIRECTOR	1.00	X						0	0	0

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

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) COLLEEN LOPRESTO DIRECTOR	1.00	X						0	0	0
(16) PATRICIA R NORMAN DIRECTOR	1.00	X						0	0	0
(17) CHARLES PICCININI DIRECTOR	1.00	X						0	0	0
(18) RICHARD W SINGLE SR DIRECTOR	1.00	X						0	0	0
(19) DEBORAH M TURNER DIRECTOR	1.00	X						0	0	0
(20) THOMAS S WINTZ DIRECTOR	1.00	X						0	0	0
(21) JOHN B FRANZONE DIRECTOR	1.00	X						0	0	0
(22) G SCOTT BARHIGHT DIRECTOR	1.00	X						0	0	0
(23) DENNIS RASMUSSEN DIRECTOR	1.00	X						0	0	0
(24) CARL J SCHINDELAR PRESIDENT/DIRECTOR	1.00	X		X				0	1,080,736.	46,584.
(25) ADRIENNE KIRBY PRESIDENT/DIRECTOR	40.00	X		X				675,122.	0	8,985.
1b Sub-total ▶								75,553.	6,126,151.	183,379.
c Total from continuation sheets to Part VII, Section A ▶								4,341,131.	1,080,736.	219,831.
d Total (add lines 1b and 1c) ▶								4,416,684.	7,206,887.	403,210.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 265

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 3		

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 ▶ 41

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 (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) ANTHONY SCALMA VICE PRESIDENT	40.00			X				519,089.	0	32,776.
(27) ROBERT LALLY VICE PRESIDENT	40.00			X				342,671.	0	45,142.
(28) LAWRENCE STRASSNER VICE PRESIDENT	40.00				X			308,036.	0	19,787.
(29) GLENN VISBEEN SENIOR VP	40.00				X			312,064.	0	12,596.
(30) KAMYUN AUYEUNG CHIEF	40.00					X		426,957.	0	9,013.
(31) WILLIAM MCGUIRE PHYSICIAN DIR SERVICE LINE FSH	40.00					X		471,085.	0	1,053.
(32) WILLIAM WATERFIELD CHIEF	40.00					X		420,940.	0	12,225.
(33) ALBERT FLEISHER MEDICAL DIRECTOR	40.00					X		430,852.	0	16,338.
(34) JEROLD FLEISHMAN PHYSICIAN	40.00					X		434,315.	0	15,332.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 265

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

Section B. Independent Contractors

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

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

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

Part VIII Statement of Revenue

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d				
	e Government grants (contributions)	1e				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	1,554,945.			
	g Noncash contributions included in lines 1a-1f: $					
	h Total. Add lines 1a-1f		1,554,945.			
Program Service Revenue		Business Code				
	2a NET PATIENT SERVICE REVENUE	621300	472,121,680.	472,121,680.		
	b PHARMACY	900099	4,048,021.	4,048,021.		
	c HEALTH EDUCATION	900099	61,741.	61,741.		
	d					
	e					
	f All other program service revenue					
	g Total. Add lines 2a-2f		476,231,442.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		9,742.			9,742.
	4 Income from investment of tax-exempt bond proceeds		0			
	5 Royalties		0			
		(i) Real	(ii) Personal			
	6a Gross rents	362,278.				
	b Less: rental expenses					
	c Rental income or (loss)	362,278.				
	d Net rental income or (loss)		362,278.			362,278.
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory	2,440.				
	b Less: cost or other basis and sales expenses					
	c Gain or (loss)	2,440.				
	d Net gain or (loss)		2,440.			2,440.
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18 a					
	b Less: direct expenses b					
	c Net income or (loss) from fundraising events		0			
	9a Gross income from gaming activities. See Part IV, line 19 a					
	b Less: direct expenses b					
	c Net income or (loss) from gaming activities		0			
	10a Gross sales of inventory, less returns and allowances a					
	b Less: cost of goods sold b					
	c Net income or (loss) from sales of inventory		0			
	Miscellaneous Revenue	Business Code				
	11a REBATE INCOME	900099	1,391,082.			1,391,082.
	b PARKING LOT REVENUE	812930	94,545.			94,545.
	c NSABP REVENUE	900099	41,378.			41,378.
	d All other revenue	900099	1,295,963.			1,295,963.
	e Total. Add lines 11a-11d		2,822,968.			
	12 Total revenue. See instructions		480,983,815.	476,231,442.		3,197,428.

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).

Check if Schedule O contains a response to any question in this Part IX . . . . . ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21	0			
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	0			
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	2,276,268.	2,057,678.	218,590.	
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	188,946,161.	170,801,674.	18,144,487.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	4,171,525.	3,770,934.	400,591.	
9 Other employee benefits	23,164,917.	20,940,392.	2,224,525.	
10 Payroll taxes	13,584,272.	11,905,634.	1,678,638.	
11 Fees for services (non-employees):				
a Management	26,680,737.	32,197.	26,648,540.	
b Legal	17,770.	15,000.	2,770.	
c Accounting	0			
d Lobbying	0			
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	0			
g Other	44,678,806.	41,769,054.	2,909,752.	
12 Advertising and promotion	929,070.	58,742.	870,328.	
13 Office expenses	3,363,061.	2,167,401.	1,195,660.	
14 Information technology	83,622.	77,866.	5,756.	
15 Royalties	0			
16 Occupancy	1,767,471.	1,775,198.	-7,727.	
17 Travel	513,283.	429,292.	83,991.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	43,626.	31,413.	12,213.	
19 Conferences, conventions, and meetings	0			
20 Interest	11,137,867.	11,137,867.		
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	22,750,609.	22,750,609.		
23 Insurance	8,947,832.	8,545,699.	402,133.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a DRUGS/PHARMACY	29,386,768.	29,350,387.	36,381.	
b MEDICAL/SURGICAL SUPPLIES	26,710,769.	26,674,147.	36,622.	
c BAD DEBTS	23,112,824.	23,112,824.		
d IMPLANTS/PROST.	9,222,327.	9,222,327.		
e All other expenses	24,462,837.	21,577,440.	2,885,397.	
25 Total functional expenses. Add lines 1 through 24e	465,952,422.	408,203,775.	57,748,647.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

				(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing		6,428.	1	6,828.
	2	Savings and temporary cash investments		194,039.	2	349,327.
	3	Pledges and grants receivable, net		0	3	0
	4	Accounts receivable, net		61,540,128.	4	72,880,403.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		0	5	0
	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)		0	6	0
	7	Notes and loans receivable, net		0	7	0
	8	Inventories for sale or use		6,680,009.	8	5,919,485.
	9	Prepaid expenses and deferred charges		931,948.	9	1,453,322.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 452,764,967.			
	b	Less: accumulated depreciation	10b 225,024,602.	238,588,889.	10c	227,740,365.
	11	Investments - publicly traded securities		0	11	0
	12	Investments - other securities. See Part IV, line 11		485,215.	12	451,916.
	13	Investments - program-related. See Part IV, line 11		0	13	0
	14	Intangible assets		0	14	0
	15	Other assets. See Part IV, line 11		1,734,362.	15	1,287,785.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		310,161,018.	16	310,089,431.
Liabilities	17	Accounts payable and accrued expenses		40,284,965.	17	42,397,495.
	18	Grants payable		0	18	0
	19	Deferred revenue		323,611.	19	221,279.
	20	Tax-exempt bond liabilities		0	20	0
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		0	21	0
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		0	22	0
	23	Secured mortgages and notes payable to unrelated third parties		0	23	0
	24	Unsecured notes and loans payable to unrelated third parties		0	24	0
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		32,624,191.	25	36,180,194.
	26	**Total liabilities.** Add lines 17 through 25		73,232,767.	26	78,798,968.
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		236,443,036.	27	230,838,547.
	28	Temporarily restricted net assets		485,215.	28	451,916.
	29	Permanently restricted net assets		0	29	0
		Organizations that do not follow SFAS 117, check here ▶ [ ] and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building, or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		236,928,251.	33	231,290,463.
	34	Total liabilities and net assets/fund balances		310,161,018.	34	310,089,431.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	480,983,815.
2	Total expenses (must equal Part IX, column (A), line 25)	2	465,952,422.
3	Revenue less expenses. Subtract line 2 from line 1	3	15,031,393.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	236,928,251.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-20,669,181.
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	231,290,463.

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: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	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: ☐ Separate basis ☒ Consolidated basis ☐ 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		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b		

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

2011

Open to Public Inspection

Name of the organization	**Employer identification number**
FRANKLIN SQUARE HOSPITAL CENTER INC.	52-0608007

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									

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2011 (line 6, column (f) divided by line 11, column (f)) . . . . . 14 %

15 Public support percentage from 2010 Schedule A, Part II, line 14 . . . . . 15 %

16a **33 1/3% support test - 2011.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support test - 2010.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test - 2011.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2010.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organzation meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2011 (line 8, column (f) divided by line 13, column (f))	15	%
16	Public support percentage from 2010 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2011** (line 10c, column (f) divided by line 13, column (f))	17	%
18	Investment income percentage from **2010** Schedule A, Part III, line 17	18	%

19a **331/3% support tests - 2011.** If the organization did not check the box on line 14, and line 15 is more than 331/3%, and line 17 is not more than 331/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ▶ ☐

b **331/3% support tests - 2010.** If the organization did not check a box on line **14** or line 19a, and line 16 is more than 331/3%, and line 18 is not more than 331/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ▶ ☐

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

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

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number
52-0608007

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

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

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

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

☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of 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.

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

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

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

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

9 In Part 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.

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 ▶ $

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 XIV and complete the following table:

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

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

b If "Yes," explain the arrangement in Part XIV.

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

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

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

a Board designated or quasi-endowment ▶ _____ %
b Permanent endowment ▶ _____ %
c Temporarily restricted endowment ▶ _____ %

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

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

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

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 property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		386,702.		386,702.
b Buildings		158,606,037.	75,383,287.	83,222,750.
c Leasehold improvements		2,673,466.	1,460,201.	1,213,265.
d Equipment		260,975,043.	141,721,479.	119,253,564.
e Other		30,123,718.	6,459,634.	23,664,084.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				227,740,365.

Part VII Investments - Other Securities. See Form 990, Part X, line 12.

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

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

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

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

	(a) Description	(b) Book value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶		

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

1.	(a) Description of liability	(b) Book value
(1)	Federal income taxes	
(2)	ADVANCED FROM 3RD PARTY PAYORS	14,633,643.
(3)	WORKERS COMPENSATION	5,431,422.
(4)	STOCK OPTION PLAN	605,182.
(5)	ASBESTOS ABATEMENT LIABILITY	198,124.
(6)	OTHER LIABILITY	15,311,823.
(7)		
(8)		
(9)		
(10)		
(11)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶		36,180,194.

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)*

FIN 48 FOOTNOTE

SCHEDULE D, PART X

INCOME TAXES ARE ACCOUNTED FOR UNDER THE ASSET AND LIABILITY METHOD. DEFERRED TAX ASSETS AND LIABILITIES ARE RECOGNIZED FOR THE FUTURE TAX CONSEQUENCES ATTRIBUTABLE TO DIFFERENCES BETWEEN THE FINANCIAL STATEMENT CARRYING AMOUNTS OF EXISTING ASSETS AND LIABILITIES AND THEIR RESPECTIVE TAX BASES AND OPERATING LOSS AND TAX CREDIT CARRYFORWARDS. DEFERRED TAX ASSETS AND LIABILITIES ARE MEASURED USING ENACTED TAX RATES EXPECTED TO APPLY TO TAXABLE INCOME IN THE YEARS IN WHICH THOSE TEMPORARY DIFFERENCES ARE EXPECTED TO BE RECOVERED OR SETTLED. THE EFFECT ON DEFERRED TAX ASSETS AND LIABILITIES OF A CHANGE IN TAX RATES IS RECOGNIZED IN THE PERIOD THAT INCLUDES THE ENACTMENT DATE. ANY CHANGES TO THE VALUATION ALLOWANCE ON THE DEFERRED TAX ASSET ARE REFLECTED IN THE YEAR OF CHANGE. THE CORPORATION ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH THE FASB ACCOUNTING STANDARDS CODIFICATION (ASC) TOPIC 740, INCOME TAXES. THERE WAS NO LIABILITY RECORDED FOR UNCERTAIN TAX POSITIONS AS OF JUNE 30, 2012.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number

52-0608007

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. [X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities [ ] Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a	Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: [ ] 100% [ ] 150% [X] 200% [ ] Other _____ %	X	
b	Did the organization use FPG to determine eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: [ ] 200% [ ] 250% [ ] 300% [ ] 350% [X] 400% [ ] 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?	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		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	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			10,008,413.		10,008,413.	2.15
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			10,008,413.		10,008,413.	2.15
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	140	276227	1,930,455.	154,919.	1,775,536.	.38
f Health professions education (from Worksheet 5)	14	1390	15,155,932.		15,155,932.	3.25
g Subsidized health services (from Worksheet 6)	5	394	21,496,191.	17,078,548.	4,417,643.	.95
h Research (from Worksheet 7)	1		24,385.		24,385.	.01
i Cash and in-kind contributions for community benefit (from Worksheet 8)	9	270	242,856.	795.	242,061.	.05
j Total. Other Benefits	169	278281	38,849,819.	17,234,262.	21,615,557.	4.64
k Total. Add lines 7d and 7j	169	278281	48,858,232.	17,234,262.	31,623,970.	6.79

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	3	39	45,870.		45,870.	.01
4 Environmental improvements						
5 Leadership development and training for community members	1	34	2,130.		2,130.	
6 Coalition building						
7 Community health improvement advocacy	4	68	33,854.		33,854.	.01
8 Workforce development						
9 Other						
10 Total	8	141	81,854.		81,854.	.02

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2	Enter the amount of the organization's bad debt expense 2 23,112,824.			
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy 3			
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 as community benefit.			

Section B. Medicare

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

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures (see instructions)

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

Part V Facility Information

Section A. Hospital Facilities

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

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

Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1 FRANKLIN SQUARE HOSPITAL CENTER 9000 FRANKLIN SQUARE DRIVE BALTIMORE MD 21237-3901	X	X		X		X	X	X	FAST TRACK ER
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									

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: FRANKLIN SQUARE HOSPITAL CENTER

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 tax year 2011)				
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	1	X	
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 1 2			
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	X	
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		X
5	Did the hospital facility make its Needs Assessment widely available to the public?	5	X	
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a	[X] Hospital facility's website			
b	[X] Available upon request from the hospital facility			
c	[ ] 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	[X] Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b	[X] Execution of the implementation strategy			
c	[X] Participation in the development of a community-wide community benefit plan			
d	[X] Participation in the execution of a community-wide community benefit plan			
e	[X] Inclusion of a community benefit section in operational plans			
f	[X] Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] 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 *free* care?	9	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 2 0 0 %			
	If "No," explain in Part VI the criteria the hospital facility used.			

Part V Facility Information *(continued)* FRANKLIN SQUARE HOSPITAL CENTER

			Yes	No
10	Used FPG to determine eligibility for providing *discounted* care?	10	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
	If "No," explain in Part VI the criteria the hospital facility used.			
11	Explained the basis for calculating amounts charged to patients?	11	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[X] Asset level			
c	[X] Medical indigency			
d	[X] Insurance status			
e	[X] Uninsured discount			
f	[X] Medicaid/Medicare			
g	[ ] State regulation			
h	[ ] Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12	X	
13	Included measures to publicize the policy within the community served by the hospital facility?	13	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[ ] The policy was posted on the hospital facility's website			
b	[ ] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[X] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[ ] 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 (FAP) that explained actions the hospital facility may take upon non-payment?	14	X	
15	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			
16	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	16		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			
17	Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):			
a	[ ] Notified patients of the financial assistance policy on admission			
b	[ ] Notified patients of the financial assistance policy prior to discharge			
c	[ ] Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	[ ] Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy			
e	[ ] Other (describe in Part VI)			

Part V Facility Information *(continued)* FRANKLIN SQUARE HOSPITAL CENTER

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

Individuals Eligible for Financial Assistance

19	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a	☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b	☒ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c	☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d	☐ Other (describe in Part VI)			
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?	20		X
	If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient?	21		X
	If "Yes," explain in Part VI.			

Part V Facility Information *(continued)*

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

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

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

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

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 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.

CHARITY CARE AT COST

PART I, LINE 7A

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

UNREIMBURSED MEDICAID

PART I, LINE 7B

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

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, 9, 10, 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.

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

HEALTH PROFESSIONS EDUCATION

PART I, LINE 7F

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S

Part VI Supplemental Information

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, 9, 10, 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.

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.

PERCENT OF TOTAL EXPENSE

PART I, LINE 7, COLUMN(F)

BAD DEBT EXPENSE OF $23,112,824 HAS BEEN REMOVED FROM TOTAL EXPENSE TO CALCULATE THE PERCENTAGES IN COLUMN (F).

BAD DEBT

PART III, LINE 4

MEDSTAR HEALTH AND ITS AFFILIATED ORGANIZATIONS REPORT BAD DEBT EXPENSE IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES (GAAP) AND HFMA 15. AMOUNTS THAT ARE NOT EXPECTED TO BE COLLECTED, FOR PATIENTS QUALIFYING UNDER MEDSTAR HEALTH'S FINANCIAL ASSISTANCE POLICY, ARE WRITTEN OFF TO CHARITY CARE AND REPORTED AS A REDUCTION

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, 9, 10, 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.

TO REVENUE. BAD DEBT EXPENSE RESULTS FROM MANAGEMENT'S INABILITY TO COLLECT REVENUES THAT MEET THE GAAP CRITERIA FOR REVENUE RECOGNITION. BAD DEBT REPRESENTS AN OPERATING EXPENSE AND IS REFLECTED AS A SEPARATE LINE ITEM ON THE ORGANIZATION'S STATEMENT OF OPERATIONS. HOWEVER, MEDSTAR AND ITS AFFILIATED ENTITIES DO NOT MAKE A DETERMINATION AS TO WHETHER SELF PAY AMOUNTS ARE COLLECTIBLE IN DETERMINING REVENUE RECOGNITION. RESERVE MODELS, WHICH HAVE BEEN DEVELOPED BASED ON HISTORICAL COLLECTION RESULTS AND WHICH ARE ADJUSTED PERIODICALLY BASED ON ACTUAL COLLECTIONS EXPERIENCE, ARE USED TO ESTIMATE UNCOLLECTIBLE AMOUNTS ACROSS ALL PAYORS INCLUDING SELF PAY. BAD DEBT DETERMINATIONS ARE MADE ONLY AFTER SUFFICIENT EVIDENCE IS OBTAINED TO SUPPORT THAT AN AMOUNT IS NOT COLLECTIBLE.

MEDICARE

PART III, LINE 8

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH

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, 9, 10, 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.

SERVICES COST REVIEW COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. AS SUCH, THE NET EFFECT FOR MEDICARE EXPENSES AND REVENUES IN MARYLAND IS ZERO.

NEEDS ASSESSMENT

PART V, SECTION B, LINE 7

THE IMPLEMENTATION STRATEGIES SERVE AS A ROADMAP FOR HOW COMMUNITY BENEFIT RESOURCES WILL BE ALLOCATED AND DEPLOYED. MEDSTAR'S HOSPITALS WILL BE ABLE TO MEASURE OUR CONTRIBUTION TO IMPROVING THE HEALTH OF UNDERSERVED AND VULNERABLE POPULATIONS IN THE REGIONS WE SERVE. THREE-YEAR IMPLEMENTATION STRATEGIES WITH MEASURABLE OBJECTIVES WERE DEVELOPED FOR EACH HOSPITAL'S COMMUNITY BENEFIT SERVICE AREA - A SPECIFIC

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, 9, 10, 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.

COMMUNITY OR TARGET POPULATION OF FOCUS. PRIORITIES WERE BASED ON COMMUNITY NEED AS DETERMINED BY QUANTITATIVE DATA AND COMMUNITY INPUT, AS WELL AS ON HOSPITAL EXPERTISE, RESOURCES, STRENGTHS OF EXISTING PROGRAMMING AND PARTNERSHIPS, AND ALIGNMENT WITH NATIONAL, STATE, AND LOCAL HEALTH GOALS. THE MEDSTAR HEALTH CORPORATE COMMUNITY HEALTH DEPARTMENT WILL PROVIDE SYSTEM-WIDE COORDINATION AND OVERSIGHT OF COMMUNITY BENEFIT PROGRAMMING.

PART VI, LINE 2

IN FY12, MEDSTAR FRANKLIN SQUARE MEDICAL CENTER CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN ACCORDANCE WITH THE GUIDELINES ESTABLISHED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE INTERNAL REVENUE SERVICE.

THE HOSPITAL'S CHNA WAS LED BY 14 ADVISORY TASK FORCE (ATF) MEMBERS, WHICH WAS COMPRISED OF A DIVERSE GROUP OF INDIVIDUALS, INCLUDING COMMUNITY RESIDENTS, HOSPITAL REPRESENTATIVES, PUBLIC HEALTH LEADERS, AND

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, 9, 10, 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.

OTHER STAKEHOLDER ORGANIZATIONS, SUCH AS REPRESENTATIVES FROM LOCAL HEALTH DEPARTMENTS. THE ATF REVIEWED QUANTITATIVE AND QUALITATIVE COMMUNITY HEALTH DATA, AS WELL AS LOCAL, REGIONAL AND NATIONAL HEALTH GOALS.

BASED ON THEIR FINDINGS, ATF MEMBERS DESIGNED A SURVEY TO IDENTIFY TRENDS IN HOW PARTICIPANTS PERCEIVED THE SEVERITY OF KEY HEALTH ISSUES IN THE FOLLOWING CATEGORIES: WELLNESS AND PREVENTION, ACCESS TO CARE, QUALITY OF LIFE, AND ENVIRONMENT. COMMUNITY MEMBERS RESPONDED TO THE SURVEY BY ATTENDING A COMMUNITY INPUT SESSION OR COMPLETING IT ONLINE OR VIA HARDCOPY.

BASED ON THE ATF'S RECOMMENDATION, THE HOSPITAL IDENTIFIED SOUTHEAST BALTIMORE COUNTY AS ITS COMMUNITY BENEFIT SERVICE AREA (CBSA) - A GEOGRAPHY WITH A HIGH DENSITY OF LOW-INCOME OR VULNERABLE RESIDENTS WITHIN CLOSE PROXIMITY OF THE HOSPITAL. HEALTH PRIORITIES FOR THE CBSA INCLUDE HEART DISEASE, SUBSTANCE ABUSE, AND ASTHMA.

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, 9, 10, 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.

THE HOSPITAL'S FY12 CHNA AND 3-YEAR IMPLEMENTATION STRATEGIES WERE ENDORSED BY MEDSTAR FRANKLIN SQUARE'S BOARD OF DIRECTORS AND APPROVED BY THE MEDSTAR HEALTH BOARD OF DIRECTORS. THE DOCUMENT BECAME AVAILABLE ON THE HOSPITAL'S WEBSITE ON JUNE 30, 2012.

AS A PROUD MEMBER OF MEDSTAR HEALTH, REPRESENTATIVES FROM MEDSTAR FRANKLIN SQUARE ROUTINELY PARTICIPATE IN THE MEDSTAR HEALTH COMMUNITY BENEFIT WORKGROUP. THE WORKGROUP IS COMPRISED OF COMMUNITY HEALTH PROFESSIONALS WHO REPRESENT ALL NINE MEDSTAR HOSPITALS. THE TEAM ANALYZES LOCAL AND REGIONAL COMMUNITY HEALTH DATA, ESTABLISHES SYSTEM-WIDE COMMUNITY HEALTH PROGRAMMING PERFORMANCE AND EVALUATION MEASURES AND SHARES BEST PRACTICES.

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

AS ONE OF THE REGION'S LEADING NOT-FOR-PROFIT HEALTHCARE SYSTEMS, MEDSTAR HEALTH IS COMMITTED TO ENSURING THAT UNINSURED PATIENTS WITHIN THE COMMUNITIES WE SERVE WHO LACK FINANCIAL RESOURCES HAVE ACCESS TO

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, 9, 10, 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.

NECESSARY HOSPITAL SERVICES. MEDSTAR HEALTH AND ITS HEALTHCARE FACILITIES WILL:

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

" SERVE THE EMERGENCY HEALTH CARE NEEDS OF EVERYONE WHO PRESENTS AT OUR FACILITIES REGARDLESS OF A PATIENT'S ABILITY TO PAY FOR CARE.

" ASSIST THOSE PATIENTS WHO ARE ADMITTED THROUGH OUR ADMISSIONS PROCESS FOR NON-URGENT, MEDICALLY NECESSARY CARE WHO CANNOT PAY FOR PART OF ALL OF THE CARE THEY RECEIVE.

" BALANCE NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH BROADER FISCAL RESPONSIBILITIES IN ORDER TO KEEP ITS HOSPITALS' DOORS OPEN FOR ALL WHO MAY NEED CARE IN THE COMMUNITY.

IN MEETING ITS COMMITMENTS, MEDSTAR HEALTH'S FACILITIES WILL WORK WITH THEIR UNINSURED PATIENTS TO GAIN AN UNDERSTANDING OF EACH PATIENT'S FINANCIAL RESOURCES PRIOR TO ADMISSION (FOR SCHEDULED SERVICES) OR PRIOR TO BILLING (FOR EMERGENCY SERVICES). BASED ON THIS INFORMATION AND

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, 9, 10, 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.

PATIENT ELIGIBILITY, MEDSTAR HEALTH'S FACILITIES WILL ASSIST UNINSURED PATIENTS WHO RESIDE WITHIN THE COMMUNITIES WE SERVE IN ONE OR MORE OF THE FOLLOWING WAYS:

" ASSIST WITH ENROLLMENT IN PUBLICLY-FUNDED ENTITLEMENT PROGRAMS (E.G., MEDICAID).

" ASSIST WITH CONSIDERATION OF FUNDING THAT MAY BE AVAILABLE FROM OTHER CHARITABLE ORGANIZATIONS.

" PROVIDE CHARITY CARE AND FINANCIAL ASSISTANCE ACCORDING TO APPLICABLE GUIDELINES.

" PROVIDE FINANCIAL ASSISTANCE FOR PAYMENT OF FACILITY CHARGES USING A SLIDING SCALE BASED ON PATIENT FAMILY INCOME AND FINANCIAL RESOURCES.

" OFFER PERIODIC PAYMENT PLANS TO ASSIST PATIENTS WITH FINANCING THEIR HEALTHCARE SERVICES.

EACH FACILITY WILL POST THE POLICY, INCLUDING A DESCRIPTION OF THE APPLICABLE COMMUNITIES IT SERVES, IN EACH MAJOR PATIENT REGISTRATION AREA AND IN ANY OTHER AREAS REQUIRED BY APPLICABLE REGULATIONS, WILL

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, 9, 10, 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.

COMMUNICATE THE INFORMATION TO PATIENTS AS REQUIRED BY THIS POLICY AND APPLICABLE REGULATIONS AND WILL MAKE A COPY OF THE POLICY AVAILABLE TO ALL PATIENTS. ADDITIONALLY, THE MARYLAND PATIENT INFORMATION SHEET/MEDSTAR'S PATIENT INFORMATION SHEET WILL BE PROVIDED TO INPATIENTS ON ADMISSION AND AT TIME OF FINAL ACCOUNT BILLING.

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

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

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, 9, 10, 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.

AVAILABILITY OF FINANCIAL ASSISTANCE.

" WORKING WITH THE FACILITY'S FINANCIAL COUNSELORS AND OTHER FINANCIAL SERVICES STAFF TO ENSURE THERE IS A COMPLETE UNDERSTANDING OF THE PATIENT'S FINANCIAL SITUATION AND CONSTRAINTS.

" COMPLETING APPROPRIATE APPLICATIONS FOR PUBLICLY-FUNDED HEALTHCARE PROGRAMS. THIS RESPONSIBILITY INCLUDES RESPONDING IN A TIMELY FASHION TO REQUESTS FOR DOCUMENTATION TO SUPPORT ELIGIBILITY.

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

" PROVIDING UPDATED FINANCIAL INFORMATION TO THE FACILITY'S FINANCIAL COUNSELORS ON A TIMELY BASIS AS THE PATIENT'S CIRCUMSTANCES MAY CHANGE.

" IT IS THE RESPONSIBILITY OF THE PATIENT TO INFORM THE MEDSTAR HOSPITAL OF THEIR EXISTING ELIGIBILITY UNDER A MEDICAL HARDSHIP DURING THE 12 MONTH PERIOD.

UNINSURED PATIENTS OF MEDSTAR HEALTH'S FACILITIES MAY BE ELIGIBLE FOR CHARITY CARE OR SLIDING-SCALE FINANCIAL ASSISTANCE UNDER THIS POLICY.

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, 9, 10, 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.

THE FINANCIAL COUNSELORS AND FINANCIAL SERVICES STAFF WILL DETERMINE

ELIGIBILITY FOR CHARITY CARE AND SLIDING-SCALE FINANCIAL ASSISTANCE BASED

ON REVIEW OF INCOME FOR THE PATIENT AND THEIR FAMILY (HOUSEHOLD), OTHER

FINANCIAL RESOURCES AVAILABLE TO THE PATIENT'S FAMILY, FAMILY SIZE, AND

THE EXTENT OF THE MEDICAL COSTS TO BE INCURRED BY THE PATIENT.

COMMUNITY INFORMATION

PART VI, LINE 4

GEOGRAPHIC

LOCATED IN THE ROSEDALE SECTION OF EASTERN BALTIMORE COUNTY, MARYLAND,

MEDSTAR FRANKLIN SQUARE'S COMMUNITY BENEFIT SERVICE AREA (CBSA) INCLUDES

NEIGHBORHOODS IN SOUTHEASTERN BALTIMORE COUNTY AND ADJACENT TO THE

CHESAPEAKE BAY INCLUDING OVERLEA (21206), EDGEMERE (21219), MIDDLE RIVER

(21220), ESSEX (21221), DUNDALK (21222, 21224), ROSEDALE (21237),

NOTTINGHAM (21236) AND PERRY HALL (21128).

SIGNIFICANT DEMOGRAPHIC CHARACTERISTICS RELEVANT TO THE NEEDS THE

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, 9, 10, 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.

HOSPITAL SEEKS TO MEET

THIS AREA HAS A BASE POPULATION OF APPROXIMATELY 230,544 INDIVIDUALS. THE SERVICE AREA HAS BECOME A MUCH MORE DIVERSE COMMUNITY OVER THE PAST FEW DECADES. THE AREA, PARTICULARLY EASTERN BALTIMORE CITY AND EASTERN BALTIMORE COUNTY, CAN BE DESCRIBED AS BLUE-COLLAR, HIGH SCHOOL EDUCATED, AND ECONOMICALLY DEPRESSED, WITH A POPULATION CONSISTING OF CAUCASIANS (83.8%), AFRICAN-AMERICANS (11.8%), ASIAN/PACIFIC ISLANDERS (2.0%), HISPANICS/LATINOS (1.5%), AND AMERICAN INDIANS/ALASKA NATIVES (0.3%). OVER ONE-THIRD (36.6%) OF THE POPULATION IS EITHER VERY YOUNG OR ELDERLY, WITH 22.0% OF RESIDENTS UNDER THE AGE OF EIGHTEEN AND 14.6% OVER 65 YEARS OF AGE. POVERTY IS A SIGNIFICANT PROBLEM IN EASTERN BALTIMORE COUNTY. FORTY-SIX PERCENT (46%) OF THE RESIDENTS ABOVE 24 YEARS OF AGE HAVE A HIGH SCHOOL OR LOWER LEVEL OF EDUCATION. THE MEDIAN HOUSEHOLD INCOME IN THE ESSEX/MIDDLE RIVER/DUNDALK AREA OF APPROXIMATELY $49,200 IS MUCH LOWER THAN THE OVERALL COUNTY MEDIAN OF $74,750. BASED ON HOSPITAL UTILIZATION DATA, THE NUMBER OF INDIVIDUALS WHO ARE UNINSURED OR UNDERINSURED IN THE HOSPITAL'S CATCHMENT AREA IS ESTIMATED TO BE 38% AND GROWING. THIS IS A DIRECT RESULT OF THE DECLINE IN MANUFACTURING

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, 9, 10, 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.

INDUSTRIES IN THE REGION, WHICH ARE BEING REDUCED OR DECLARING BANKRUPTCY (E.G., GENERAL MOTORS OLDSMOBILE ASSEMBLY PLANT AND BETHLEHEM STEEL CORPORATION, BOTH OF WHOM WERE PREVIOUSLY MAJOR EMPLOYERS IN THE AREA). CURRENTLY, THE LARGEST EMPLOYER IN THE AREA IS THE HOSPITAL. THE INCREASING NUMBER OF FAMILIES AND INDIVIDUALS WITH EITHER NO HEALTH INSURANCE OR SEVERELY CURBED HEALTH INSURANCE REPRESENTS A SERIOUS CONCERN FOR THE HEALTHCARE COMMUNITY AND GOVERNMENT AGENCIES.

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

AS A COMMUNITY PARTNER, MEDSTAR FRANKLIN SQUARE ENGAGES IN A NUMBER OF COMMUNITY BENEFIT ACTIVITIES TO IMPROVE AND PROMOTE THE HEALTH AND WELLBEING OF THE COMMUNITY. FOR EXAMPLE, THE HOSPITAL PROVIDES ACCESS TO HIGH QUALITY HEALTH SERVICES FOR THE HOMELESS, AS WELL AS COMPREHENSIVE CHILD ABUSE SERVICES. IN PARTNERSHIP WITH THE BALTIMORE COUNTY DEPARTMENT OF HEALTH, THE BALTIMORE COUNTY DEPARTMENT OF SOCIAL SERVICES, AND HEALTHCARE FOR THE HOMELESS IN BALTIMORE CITY, MEDSTAR FRANKLIN SQUARE PROVIDES FINANCIAL AND IN-KIND SUPPORT TO ENSURE ACCESS TO PRIMARY 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, 9, 10, 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.

SERVICES FOR HOMELESS PERSONS. THE HOSPITAL ALSO PROVIDES STAFFING, IN-KIND SUPPORT FOR TECHNICAL ASSISTANCE, INFORMATION TECHNOLOGY, BUDGETING/BILLING, AND PUBLIC RELATIONS AND MARKETING. MEDSTAR FRANKLIN SQUARE ALSO UNDERWRITES EXPENSES FOR LABS AND SPECIALTY SERVICES.

MEDSTAR FRANKLIN SQUARE EVALUATES OVER 300 CHILDREN EACH YEAR WHO ARE SUSPECTED OF BEING ABUSED. IN RESPONSE TO THE HIGH INCIDENCE OF ABUSE, THE DEPARTMENT OF PEDIATRICS DEVELOPED A COMPREHENSIVE PROGRAM TO DIAGNOSE AND PREVENT CHILD ABUSE. THE MEDSTAR FRANKLIN SQUARE CHILD PROTECTION TEAM (CPT) BEGAN TO FUNCTION IN NOVEMBER, 2000. THE TEAM IS COMPRISED OF A SOCIAL WORKER COORDINATOR, MEDICAL DIRECTOR, AND ON-CALL SOCIAL WORK AND MEDICAL STAFF. THE TEAM PROVIDES 24/7 COVERAGE TO THE HOSPITAL AND EVALUATES ANY CHILD SUSPECTED OF BEING PHYSICALLY OR SEXUALLY ABUSED. THIS SERVICE HAS PROVEN TO BE A SIGNIFICANT CONTRIBUTION TO THE COMMUNITY - IMPACTING THOUSANDS OF PARENTS AND CHILDREN.

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, 9, 10, 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

PART VI, LINE 6

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR FRANKLIN SQUARE IS ABLE TO EXPAND ITS CAPACITY TO MEET THE NEEDS OF THE COMMUNITY BY PARTNERING WITH OTHER MEDSTAR HOSPITALS AND ASSOCIATED ENTITIES. MEDSTAR HEALTH RESOURCES ASSIST THE HOSPITAL IN COMMUNITY HEALTH PLANNING TO MEET THE NEEDS OF THE UNINSURED AND OTHER VULNERABLE POPULATIONS. THROUGH ITS COMMUNITY HEALTH FUNCTION, MEDSTAR HEALTH PROVIDES MEDSTAR FRANKLIN SQUARE WITH TECHNICAL SUPPORT TO ENHANCE COMMUNITY HEALTH PROGRAMMING AND EVALUATION. MEDSTAR'S CORPORATE PHILANTHROPY DEPARTMENT IDENTIFIES AND SEEKS PUBLIC AND PRIVATE FUNDING SOURCES TO ENSURE THE AVAILABILITY OF HIGH QUALITY HEALTH SERVICES, REGARDLESS OF ABILITY TO PAY.

STATE FILING OF COMMUNITY BENEFIT REPORT

Part VI 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, 9, 10, 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.

PART VI, LINE 7

THE COMMUNITY BENEFIT REPORT FOR MEDSTAR FRANKLIN SQUARE MEDICAL CENTER

IS FILED IN THE STATE OF MARYLAND.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

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

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number

52-0608007

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
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?	2		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director. Explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☒ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) 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		X
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a		X
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Schedule J (Form 990) 2011 Page 2

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

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

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

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 KENNETH A SAMET	(i)	0	0	0	0	0	0	0
	(ii)	1,166,887.	1,481,670.	3,477,594.	163,987.	19,392.	6,309,530.	0
2 CARL J SCHINDELAR	(i)	0	0	0	0	0	0	0
	(ii)	593,297.	487,439.	0	27,630.	18,954.	1,127,320.	0
3 ADRIENNE KIRBY	(i)	439,671.	235,451.	0	0	8,985.	684,107.	0
	(ii)	0	0	0	0	0	0	0
4 KAMYUN AUYEUNG	(i)	402,561.	24,396.	0	7,977.	1,036.	435,970.	0
	(ii)	0	0	0	0	0	0	0
5 WILLIAM MCGUIRE	(i)	424,739.	46,346.	0	0	1,053.	472,138.	0
	(ii)	0	0	0	0	0	0	0
6 WILLIAM WATERFIELD	(i)	379,173.	41,767.	0	0	12,225.	433,165.	0
	(ii)	0	0	0	0	0	0	0
7 ALBERT FLEISHER	(i)	396,620.	34,232.	0	0	16,338.	447,190.	0
	(ii)	0	0	0	0	0	0	0
8 JEROLD FLEISHMAN	(i)	396,894.	37,421.	0	0	15,332.	449,647.	0
	(ii)	0	0	0	0	0	0	0
9 ANTHONY SCALMA	(i)	355,415.	163,674.	0	11,042.	21,734.	551,865.	0
	(ii)	0	0	0	0	0	0	0
10 ROBERT LALLY	(i)	240,024.	100,589.	2,058.	25,067.	20,075.	387,813.	0
	(ii)	0	0	0	0	0	0	0
11 LAWRENCE STRASSNER	(i)	214,480.	93,556.	0	9,519.	10,268.	327,823.	0
	(ii)	0	0	0	0	0	0	0
12 GLENN VISBEEN	(i)	220,508.	76,000.	15,556.	0	12,596.	324,660.	0
	(ii)	0	0	0	0	0	0	0
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Schedule J (Form 990) 2011

JSA

1E1291 1.000

Part III Supplemental Information

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

OTHER REPORTABLE COMPENSATION

SCHEDULE J, PART I, LINE 4B

KENNETH SAMET

MR. SAMET'S OTHER REPORTABLE COMPENSATION IN PART II, COLUMN (B) (III) INCLUDES $3,465,504 REPRESENTING HIS ACCRUED BENEFIT IN A SUPPLEMENTAL RETIREMENT PLAN, WHICH WAS EARNED DURING THE PAST 23 YEARS OF SERVICE. THIS AMOUNT WAS NOT ACTUALLY PAID DURING THIS REPORTING PERIOD, BUT WAS REPORTED AS COMPENSATION UNDER FICA TAX-REPORTING RULES.

GLENN VISBEEN

GLENN VISBEEN'S OTHER REPORTABLE COMPENSATION IN PART II, COLUMN (B) (III) INCLUDES $8,654 REPRESENTING THE AMOUNT OF SEVERANCE PAYMENTS RECEIVED BY MR. VISBEEN.

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

OMB No. 1545-0047

2011

Open To Public Inspection

Name of the organization: FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer Identification number: 52-0608007

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

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

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

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

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

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 26, or Form 990-EZ, Part V, line 38a.

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

Part III Grants or Assistance Benefiting Interested Persons.

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

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

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

	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	(e) Sharing of organization's revenues? No
(1)	ORTHOPEDIC & HAND SURGERY ASSOCIATES, PA	SEE PART V	359,297.	ORTHOPEDIC SERVICES		X
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

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

BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

DR. IRA GUBERNICK, A BOARD MEMBER AT MEDSTAR FRANKLIN SQUARE MEDICAL CENTER, OWNS MORE THAN 5% OF ORTHOPEDIC & HAND SURGERY ASSOCIATES, P.A. (OHSA), WHICH PROVIDES MANAGEMENT AND SUPPORT SERVICES TO MEDSTAR FRANKLIN SQUARE MEDICAL CENTER'S ORTHOPEDIC, SPORTS MEDICINE, AND EMERGENCY DEPARTMENTS. OHSA'S GROSS REVENUES RECEIVED FROM THE HOSPITAL FOR THE YEAR WERE $0.4 MILLION.

Name of the organization
FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number
52-0608007

DESCRIPTION OF EXEMPT PURPOSE ACHIEVEMENTS

PART III, LINE 4A

MFSMC ATTAINED MAGNET RECOGNITION BY THE AMERICAN NURSES CREDENTIALING CENTER (ANCC) IN 2008 AND IS RECOGNIZED BY THE JOINT COMMISSION AS AN ADVANCED PRIMARY STROKE CENTER. US NEWS AND WORLD REPORT RECOGNIZED MFSMC AS A HIGH PERFORMING HOSPITAL IN GASTROENTEROLOGY, PULMONOLOGY, CANCER, DIABETES, ENDOCRINOLOGY, GYNECOLOGY, ORTHOPEDICS, NEPHROLOGY, NEUROLOGY, NEUROSURGERY, GERIATRICS AND UROLOGY. THE HOSPITAL WAS ALSO A FOURTH-TIME RECIPIENT OF THE DELMARVA FOUNDATION FOR MEDICAL CARE'S EXCELLENCE AWARD FOR QUALITY IMPROVEMENT IN HOSPITALS. MFSMC WAS ALSO RECOGNIZED BY HEALTHGRADES AS ONE OF THE NATION'S 50 BEST HOSPITALS FOR ITS CLINICAL EXCELLENCE.

BYLAWS REVISIONS - 2012 - MEDSTAR HEALTH, INC. AND AFFILIATED HOSPITALS

PART VI, LINE 4

DURING THE FISCAL YEAR ENDING JUNE 30, 2012, MEDSTAR HEALTH, INC., A MARYLAND NON-STOCK CORPORATION ("MEDSTAR") REVIEWED ITS BYLAWS AND THE BYLAWS OF NINE MEDSTAR-AFFILIATED HOSPITALS, INCLUDING FRANKLIN SQUARE HOSPITAL CENTER, INC., HARBOR HOSPITAL, INC., MEDSTAR-GEORGETOWN MEDICAL CENTER, INC., MONTGOMERY GENERAL HOSPITAL, INC., NATIONAL REHABILITATION HOSPITAL, INC., ST. MARY'S HOSPITAL OF ST. MARY'S COUNTY, INC., THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC., THE UNION MEMORIAL HOSPITAL AND WASHINGTON HOSPITAL CENTER CORPORATION (COLLECTIVELY THE "HOSPITALS").

Name of the organization	Employer identification number
FRANKLIN SQUARE HOSPITAL CENTER INC.	52-0608007

THE REVISED BYLAWS OF MEDSTAR AND THE HOSPITALS WERE DEVELOPED USING A COMMON TEMPLATE BASED ON THE EXISTING MEDSTAR BYLAWS.

THE BOARD OF DIRECTORS OF MEDSTAR AND THE BOARD OF DIRECTORS OF EACH HOSPITAL VOTED AND APPROVED THE CHANGES TO THEIR BYLAWS.

A SUMMARY OF THE CHANGES TO THE BYLAWS OF MEDSTAR AND THE HOSPITALS IS SET FORTH BELOW. THE BYLAWS CHANGES:

(A) CONFORM PROVISIONS TO MARYLAND, DELAWARE AND DISTRICT OF COLUMBIA LAW, AS APPLICABLE, IN MANY CASES TO GIVE GREATER FLEXIBILITY TO MEDSTAR AND THE BOARD OF DIRECTORS OF EACH HOSPITAL);

(B) CONFORM PROVISIONS TO MAXIMIZE UNIFORMITY AMONG THE HOSPITAL BYLAWS (TO THE EXTENT POSSIBLE);

(C) REFLECT RECENT DEVELOPMENTS IN CORPORATE/HOSPITAL GOVERNANCE;

(D) CLARIFY CERTAIN CORPORATE PROCEDURES; AND

(E) CONFORM LANGUAGE AND STYLE.

ORGANIZATION MEMBERS

PART VI, LINE 6

Name of the organization	Employer identification number
FRANKLIN SQUARE HOSPITAL CENTER INC.	52-0608007

THE ORGANIZATION IS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT MARYLAND NON-STOCK CORPORATION. MEDSTAR HEALTH, INC., OR ONE OF ITS AFFILIATES AND SUBSIDIARIES, IS THE SOLE MEMBER OF THE ORGANIZATION.

DESCRIPTION OF MEMBERS

PART VI, LINE 7A

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT MARYLAND NON-STOCK CORPORATION, THE ORGANIZATION MAY RECOMMEND PERSON(S) FOR MEMBERSHIP ON THE ORGANIZATION'S GOVERNING BODY. ANY SUCH RECOMMENDATION BY THE ORGANIZATION IS SUBJECT TO APPROVAL BY THE GOVERNANCE COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR HEALTH, INC. THE BOARD OF MEDSTAR HEALTH, INC. HAS DELEGATED CERTAIN APPROVAL AUTHORITY TO THE GOVERNANCE COMMITTEE AND THE PRESIDENT & CEO OF MEDSTAR HEALTH, INC.

DECISIONS OF GOVERNING BODY

PART VI, LINE 7B

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT MARYLAND NON-STOCK CORPORATION, THE BYLAWS OF THE ORGANIZATION ARE SUBJECT TO CERTAIN RESERVED POWERS, WHICH PROVIDE THAT THE SOLE MEMBER OF THE ORGANIZATION MUST APPROVE CERTAIN DECISIONS, INCLUDING BUT NOT LIMITED TO MATTERS CONCERNING THE SALE OR PURCHASE OF REAL OR PERSONAL PROPERTY, CAPITAL BUDGETS, STRATEGIC PLANNING, INVESTMENTS, AND CORPORATE GOVERNANCE.

Name of the organization	Employer identification number
FRANKLIN SQUARE HOSPITAL CENTER INC.	52-0608007

PROCESS FOR REVIEWING FORM 990

PART VI, LINE 11A

THE PROCESS FOR REVIEWING THE FORM 990 INCLUDED EDUCATION AND TRANSPARENCY. SENIOR FINANCIAL EXECUTIVES, WORKING WITH INDEPENDENT OUTSIDE EXPERTS, THOROUGHLY REVIEWED FORM 990 AND ACCOMPANYING INSTRUCTIONS. IN ADDITION, SENIOR EXECUTIVES REVIEWED THE RELEVANT SECTIONS OF THE FORM 990 WITH THE FOLLOWING COMMITTEES OF THE ORGANIZATION'S GOVERNING BODY: FINANCE, AUDIT, GOVERNANCE, STRATEGIC PLANNING, AND EXECUTIVE COMPENSATION. FOLLOWING THESE MEETINGS, THE GOVERNING BODY WAS PROVIDED A COPY OF THE FORM 990 IN ITS FINAL FORM AND GIVEN AN OPPORTUNITY TO PROVIDE ANY INPUT OR COMMENTS RELATING TO THE FORM 990 PRIOR TO ITS FILING.

CONFLICT OF INTEREST POLICY

PART VI, LINE 12C

APPOINTMENT OF BOARDS OF DIRECTORS MEDSTAR HEALTH (AND ITS SUBSIDIARIES) REQUIRE ALL NOMINATED DIRECTORS, PRIOR TO THEIR APPOINTMENT OR ELECTION, TO DISCLOSE THE EXISTENCE OF (OR POTENTIAL EXISTENCE OF) ANY TRANSACTION WITH MEDSTAR THAT WOULD RESULT IN A CONFLICT OF INTEREST. SUCH DISCLOSURES (IF ANY) ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE RESOLVED.

ANNUAL DISCLOSURES - ALL OFFICERS, DIRECTORS, AND SENIOR MANAGERS

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

Name of the organization: FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number: 52-0608007

ANNUALLY, TO COMPLETE A SURVEY OF QUESTIONS CONCERNING ANY TRANSACTIONS OR RELATIONSHIPS WHICH WOULD OR COULD REPRESENT A CONFLICT OF INTEREST. SUCH DISCLOSURES (IF ANY) RELATED TO DIRECTORS ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE RESOLVED. SUCH DISCLOSURES (IF ANY) RELATED TO OFFICERS AND SENIOR MANAGERS ARE REVIEWED BY AN APPROPRIATE EXECUTIVE WHO DETERMINES HOW THE MATTER SHOULD BE RESOLVED. IN ADDITION, OFFICERS AND DIRECTORS OF MARYLAND HOSPITALS AND NURSING CENTERS ARE REQUIRED TO ANNUALLY DISCLOSE ADDITIONAL INFORMATION RELATING TO POTENTIAL CONFLICTS OF INTEREST AND SUCH DISCLOSURES ARE REPORTED TO THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION (HSCRC).

DESCRIPTION OF EXECUTIVE COMPENSATION

PART VI, LINE 15

THE EXECUTIVE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR HEALTH, INC. (THE "COMMITTEE") HAS OVERSIGHT OVER THE EXECUTIVE COMPENSATION PROGRAM (THE "PROGRAM") OF MEDSTAR HEALTH, INC. AND ITS AFFILIATES. TOTAL COMPENSATION FOR THE TOP MANAGEMENT OFFICIALS, OFFICERS AND KEY EMPLOYEES OF MEDSTAR HEALTH, INC. AND ITS AFFILIATES ARE REVIEWED AND APPROVED BY THE COMMITTEE WITH ASSISTANCE AND GUIDANCE FROM AN INDEPENDENT THIRD PARTY ADVISOR. THE MEMBERS OF THE COMMITTEE ARE INDEPENDENT FROM ALL OF THE PARTICIPANTS IN THE PROGRAM.

THE MAIN OBJECTIVE OF THE PROGRAM IS TO PROVIDE MARKET COMPETITIVE TOTAL COMPENSATION THAT IS INTERNALLY EQUITABLE AND HAS A STRONG PAY-FOR-PERFORMANCE LINKAGE. PERFORMANCE IS EVALUATED AT THE SYSTEM,

Name of the organization: FRANKLIN SQUARE HOSPITAL CENTER INC.
Employer identification number: 52-0608007

OPERATING UNIT, AND INDIVIDUAL LEVELS. THE OVERALL TOTAL COMPENSATION PHILOSOPHY IS MANAGED AT THE 75TH PERCENTILE OF THE COMPETITIVE MARKET FOR COMPARABLE SIZE (NET REVENUE) AND TYPE (TAX-EXEMPT HEALTHCARE ORGANIZATIONS). WHERE APPROPRIATE, ADDITIONAL INDUSTRY DATA IS CONSIDERED (GENERAL BUSINESS AND/OR TAXABLE HEALTHCARE) FOR SELECTED POSITIONS THAT CAN BE RECRUITED FROM OR POTENTIALLY LOST TO THESE INDUSTRIES (E.G., INFORMATION TECHNOLOGY, FINANCE, ETC.).

THE COMMITTEE HAS ENGAGED ERNST & YOUNG LLP ("E&Y") TO SERVE AS AN ADVISOR ON THE REASONABLENESS AND COMPETITIVENESS OF THE PROGRAM. IN DETERMINING REASONABLENESS AND COMPETITIVENESS, E&Y REVIEWS MARKET PRACTICES AND TRENDS, AND MAKES RECOMMENDATIONS RELATED TO THE PROGRAM. E&Y UTILIZES INFORMATION FROM CUSTOM SURVEYS, NATIONAL COMPENSATION SURVEYS, PROPRIETARY DATABASES, AND CLIENT EXPERIENCES TO DETERMINE ITS FINAL RECOMMENDATIONS. E&Y PRESENTS THEIR FINDINGS AND RECOMMENDATIONS TO THE COMMITTEE. THE COMMITTEE MAKES THE FINAL DECISIONS ON ALL OF THE COMPENSATION DETERMINATIONS OF THE PROGRAM. ALL DECISIONS MADE BY THE COMMITTEE ARE CONTEMPORANEOUSLY DOCUMENTED.

FINANCIAL STATEMENT AVAILABILITY

PART VI, LINE 19

MEDSTAR HEALTH POSTS ITS ANNUAL FINANCIAL AUDIT AND QUARTERLY FINANCIAL REPORTS TO THE ELECTRONIC MUNICIPAL MARKET ACCESS (EMMA) SYSTEM. THE ORGANIZATION ALSO E-MAILS ITS ANNUAL AND QUARTERLY DISCLOSURES TO HOLDERS OF THE COMPANY'S PUBLICLY TRADED DEBT. THE COMPANY'S GOVERNANCE DOCUMENTS

Name of the organization: FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number: 52-0608007

AND CONFLICTS OF INTEREST POLICIES ARE AVAILABLE UPON REQUEST THROUGH ITS CORPORATE (OR AS APPLICABLE ENTITY) PUBLIC INFORMATION OFFICES.

OTHER CHANGES IN NET ASSETS

PART XI, LINE 5

EQUITY TRANSFERS	$(20,651,248)
UNREALIZED LOSS ON INVESTMENTS	(17,933)
TOTAL:	$ (20,669,181)

ATTACHMENT 1

FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR FRANKLIN SQUARE MEDICAL CENTER'S MISSION IS TO PROVIDE SAFE, HIGH QUALITY CARE, EXCELLENT SERVICE, AND EDUCATION TO IMPROVE THE HEALTH OF THE COMMUNITY. MEDSTAR FRANKLIN SQUARE MEDICAL CENTER (MFSMC) IS AN ACUTE-CARE TEACHING HOSPITAL LOCATED IN EASTERN BALTIMORE COUNTY, MARYLAND. THE HOSPITAL'S CANCER INSTITUTE IS A 64,000 SQUARE FOOT FACILITY PROVIDING CANCER PATIENTS AND THEIR FAMILIES WITH A BROAD RANGE OF ONCOLOGY SERVICES, INCLUDING SCREENING, DIAGNOSIS AND TREATMENT. IN FISCAL YEAR 2012, MFSMC HAD 24,490 INPATIENT ADMISSIONS, 285,458 OUTPATIENT VISITS, AND 114,684 EMERGENCY VISITS.

ATTACHMENT 2

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

NAME AND TITLE	HOURS DEVOTED FOR RELATED ORGANIZATION

Name of the organization: FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number: 52-0608007

ATTACHMENT 2 (CONT'D)

KENNETH A SAMET
DIRECTOR 40.00

ATTACHMENT 3

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
CHESAPEAKE PERIOPERATIVE SERVICES PO BOX 17568 BALTIMORE, MD 21297	MEDICAL SERVICES	9,870,535.
BOVIS LEND LEASE ONE PRESERVE PARKWAY ROCKVILLE, MD 20852	CONSTRUCTION MGMT	4,414,938.
MORRISON MANAGEMENT SPECIALIST 4721 MORRISON DRIVE MOBILE, AL 36609	FOOD SRVC PROVIDER	3,874,905.
PULMONARY & CRITICAL CARE 400 REDLAND COURT OWINGS MILL, MD 21117-3292	MEDICAL SERVICES	1,426,975.
NURSEFINDERS PO BOX 910738 DALLAS, TX 75391-0738	MEDICAL STAFFING	2,447,198.
TOTAL COMPENSATION		22,034,551.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ 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.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number
52-0608007

Part I Identification of Disregarded Entities (Complete if the organization answered "Yes" to 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) MEDSTAR HEALTH ANESTHESIA SERVICES B LLC 20-5909703 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237	HEALTH SVCS	MD	8,795,282.	1,012,968.	N/A
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) CHURCH HOME CORPORATION 23-7374724 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL FUND	MD	501(C)(3)	PF	N/A	X	
(2) HARBOR HOSPITAL, INC. 52-0491660 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225	HOSPITAL	MD	501(C)(3)	3	N/A	X	
(3) MEDSTAR HEALTH, INC. 52-2087445 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SVCS	MD	501(C)(3)	11B II	N/A		X
(4) MONTGOMERY GENERAL HOSPITAL 52-0646893 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	HOSPITAL	MD	501(C)(3)	3	N/A	X	
(5) THE GOOD SAMARITAN HOSPITAL OF MARYLAND, 52-0591607 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	HOSPITAL	MD	501(C)(3)	3	N/A	X	
(6) THE UNION MEMORIAL HOSPITAL 52-0591685 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218	HOSPITAL	MD	501(C)(3)	3	N/A	X	
(7) MEDSTAR RESEARCH INSTITUTE 52-6056274 108 IRVING STREET NW WASHINGTON, DC 20010	HOSPITAL	DC	501(C)(3)	3	N/A	X	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ 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.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number
52-0608007

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
(1) THE MEDSTAR-GEORGETOWN MEDICAL CENTER, I 52-2218584 HOPSITAL ADMIN, 1 MAIN BLDG WASHINGTON, DC 20007	HOSPITAL	DC	501(C)(3)	3	N/A	X	
(2) WASHINGTON HOSPITAL CENTER CORPORATION 52-1272129 110 IRVING STREET NW WASHINGTON, DC 20010	HOSPITAL	DC	501(C)(3)	3	N/A	X	
(3) HH MEDSTAR HEALTH, INC. 52-1542230 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SVCS	MD	501(C)(3)	11B II	N/A	X	
(4) BAY DEVELOPMENT CORP 52-1132992 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	FOUNDATION	MD	501(C)(3)	11A I	N/A	X	
(5) BAY LIFE SERVICES, INC. 52-1496539 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MENTAL HEALTH	MD	501(C)(3)	9	N/A	X	
(6) MEDSTAR SURGERY CENTER, INC. 52-1061679 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705	MEDICAL SVCS	MD	501(C)(3)	9	N/A	X	
(7) CHURCH HOME AND HOSPITAL OF THE CITY OF 52-0591600 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	HOSPITAL	MD	501(C)(3)	3	N/A	X	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ 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.

OMB No. 1545-0047
2011
Open to Public Inspection

Name of the organization
FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number
52-0608007

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	No
(1) GOOD SAMARITAN HOSPITAL FOUNDATION, INC. 52-2307122 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	FOUNDATION	MD	501(C)(3)	3	N/A	X	
(2) GOOD SAMARITAN NURSING CENTER, INC. 52-1672866 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	MEDICAL SVCS	MD	501(C)(3)	11B II	N/A	X	
(3) GS HOUSING, INC. 52-1481656 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ELDER HOUSING	MD	501(C)(3)	3	N/A	X	
(4) GS PROPERTIES, INC. 52-1429853 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ADMIN SVCS	MD	501(C)(3)	3	N/A	X	
(5) HARBOR HOSPITAL FOUNDATION, INC. 52-1284532 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225	FOUNDATION	MD	501(C)(3)	3	N/A	X	
(6) MEDSTAR HEALTH INFUSION, INC. 52-1980510 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705	MEDICAL SVCS	MD	501(C)(3)	3	N/A	X	
(7) MEDSTAR HEALTH VISITING NURSES ASSOCIATI 53-0196597 4061 POWDERMILL ROAD CALVERTON, MD 20705	MEDICAL SVCS	MD	501(C)(3)	3	N/A	X	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ 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.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number
52-0608007

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
(1) MEDSTAR VNA HEALTHCARE 52-1458516 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705	MEDICAL SVCS	MD	501(C)(3)	11B II	N/A	X	
(2) MGH COMMUNITY HEALTH, INC. 52-1372467 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SVCS	MD	501(C)(3)	11A I	N/A	X	
(3) MGH HEALTH FOUNDATION, INC. 52-1129959 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	FOUNDATION	MD	501(C)(3)	9	N/A	X	
(4) MGH HEALTH SERVICES, INC. 52-1366812 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	FOUNDATION	MD	501(C)(3)	9	N/A	X	
(5) MGH WOMEN'S BOARD 52-6039600 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	FOUNDATION	MD	501(C)(3)	3	N/A	X	
(6) NATIONAL REHABILITATION HOSPITAL 52-1369749 102 IRVING STREET NW WASHINGTON, DC 20010	HOSPITAL	DC	501(C)(3)	11A I	N/A	X	
(7) REGIONAL REHAB AT OLNEY, INC. 52-2310902 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SVCS	MD	501(C)(3)	11A I	N/A	X	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ 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.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number
52-0608007

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	No
(1) SUBURBAN / NRH MEDICAL REHABILITATION, I 52-1931151 102 IRVING STREET NW WASHINGTON, DC 20010	MEDICAL SVCS	DC	501(C)(3)	9	N/A	X	
(2) THE THOMAS O'NEIL CATHOLIC HEALTH CARE F 52-1104382 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	FOUNDATION	MD	501(C)(3)	9	N/A	X	
(3) UNION MEMORIAL HOSPITAL FOUNDATION, INC. 52-1446828 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218	FOUNDATION	MD	501(C)(3)	11A I	N/A	X	
(4) VNA, INC. 52-1332411 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705	ADMIN SVCS	MD	501(C)(3)	11A I	N/A	X	
(5) WHC FOUNDATION, INC. 52-1791670 110 IRVING STREET NW WASHINGTON, DC 20010	FOUNDATION	DC	501(C)(3)	9	N/A	X	
(6) WOODBOURNE WOODS, INC. 52-2299070 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ELDER HOUSING	MD	501(C)(3)	9	N/A	X	
(7) HOSPICE OF ST. MARY'S, INC. 52-2153926 PO BOX 527 LEONARDTOWN, MD 20650	SUPPORT ORG	MD	501(C)(3)	3	N/A	X	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ 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.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number
52-0608007

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	No
(1) ST. MARY'S HOSPITAL OF ST. MARY'S COUNTY 52-0619006 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650	HOSPITAL	MD	501(C)(3)	9	N/A	X	
(2) ST. MARY'S HOSPITAL FOUNDATION, INC. 52-1051368 PO BOX 527 LEONARDTOWN, MD 20650	SUPPORT ORG	MD	501(C)(3)	9	N/A	X	
(3) FRANKLIN SQUARE HOSPITAL CENTER FDN 52-2329546 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237	FOUNDATION	MD	501(C)(3)	7	N/A	X	
(4)							
(5)							
(6)							
(7)							

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) SURGICENTER AT PASADENA, LLC 5 5565 STERRETT PLACE, 5TH FLOOR	MEDICAL SERVICES	MD	N/A					X			X	
(2) SJMC-RA, LLC 75-3160895 5565 STERRETT PLACE, 5TH FLOOR	RADIATION THERAPY	MD	N/A					X			X	
(3) PHYSICIAN IMAGING OF WASHINGTO 6525 BELCREST ROAD, SUITE G 50	LAB SERVICES	MD	N/A					X			X	
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) MEDSTAR PHARMACIES, INC. 52-1513056 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	DRUG SALES	MD	N/A	C CORP			
(2) EXTENCARE, INC. 52-1556228 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SERVI	MD	N/A	C CORP			
(3) HELIX RESOURCES MANAGEMENT, INC. 52-1913070 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	ADMIN SERVICE	MD	N/A	C CORP			
(4) HELIXCARE MEDICAL GROUP, LLC 52-1955580 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SERVICES	MD	N/A	C CORP			
(5) HELIXCARE PROPERTIES, LLC 52-1966695 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MEDICAL SERVICES	MD	N/A	C CORP			
(6) PARKWAY VENTURES, INC. 52-1893569 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	HOLDING COMPANY	MD	N/A	C CORP			
(7) PHYSICIANS ADMINISTRATIVE SERVICES, INC. 23-7042074 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	BILLING SERVICES	MD	N/A	C CORP			

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) MEDSTAR FAMILY CHOICE, INC. 52-1995521 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	MANAGED CARE	MD	N/A	C CORP			
(2) MEDSTAR ENTERPRISES, INC. 52-2139841 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	ADMIN SERVICE	MD	N/A	C CORP			
(3) NASCOTT, INC. 52-1693808 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SERVICES	MD	N/A	C CORP			
(4) STAR BILLING, INC. 52-1850113 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	BILLING SERVICES	MD	N/A	C CORP			
(5) WASHINGTON RISK NETWORK MANAGEMENT, INC. 52-2132677 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SERVICES	MD	N/A	C CORP			
(6) WASHINGTON HOSPITAL CENTER PHYSICIAN HOS 52-1931000 100 IRVING STREET NW WASHINGTON, DC 20010	MEDICAL SERVICES	MD	N/A	C CORP			
(7) MEDSTAR PHYSICIAN PARTNERS, INC. 52-2030809 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SERVICES	MD	N/A	C CORP			

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) NRH AMBULATORY SERVICES, INC. 52-1930165 102 IRVING STREET NW WASHINGTON, DC 20010	REHAB SERVICES	MD	N/A	C CORP			
(2) FRANKLIN SQUARE DRIVE LAND CONDO ASSOCIA 76-0756352 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044	CONDO OWNER ASSOC	MD	N/A	C CORP			
(3) MGH DIVERSIFIED SERVICES, INC. 52-1943602 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SERVICES	MD	N/A	C CORP			
(4) ST. MARY'S HEALTH ALLIANCE, INC. 52-1930331 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650	MEDICAL SERVICES	MD	N/A	C CORP			
(5) GREENSPRING FINANCIAL INSURANCE LIMITED 98-0188617 23 LIME TREE BAY AVENUE PO BOX 1051 KY1-1102 GRAND CAYMAN	INSURANCE	CJ	N/A	C CORP			
(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	1a		X
b	Gift, grant, or capital contribution to related organization(s)	1b		X
c	Gift, grant, or capital contribution from related organization(s)	1c		X
d	Loans or loan guarantees to or for related organization(s)	1d		X
e	Loans or loan guarantees by related organization(s)	1e		X
f	Sale of assets to related organization(s)	1f		X
g	Purchase of assets from related organization(s)	1g		X
h	Exchange of assets with related organization(s)	1h		X
i	Lease of facilities, equipment, or other assets to related organization(s)	1i		X
j	Lease of facilities, equipment, or other assets from related organization(s)	1j		X
k	Performance of services or membership or fundraising solicitations for related organization(s)	1k		X
l	Performance of services or membership or fundraising solicitations by related organization(s)	1l		X
m	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1m		X
n	Sharing of paid employees with related organization(s)	1n		X
o	Reimbursement paid to related organization(s) for expenses	1o	X	
p	Reimbursement paid by related organization(s) for expenses	1p	X	
q	Other transfer of cash or property to related organization(s)	1q		X
r	Other transfer of cash or property from related organization(s)	1r		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)	CHURCH HOME AND HOSPITAL OF THE CITY OF BALTI	O	500,000.	FMV
(2)	HH MEDSTAR HEALTH INC	P	285,309.	FMV
(3)	THE GOOD SAMARITAN HOSPITAL OF MARYLAND	P	202,719.	FMV
(4)	HARBOR HOSPITAL INC	P	65,419.	FMV
(5)				
(6)				

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

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

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