

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

Department of the Treasury
Internal Revenue Service

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

A For the 2012 calendar year, or tax year beginning 07/01, 2012, and ending 06/30, 2013

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization DIMENSIONS HEALTH CORPORATION Doing Business As			D Employer identification number 52-1289729	
	Number and street (or P.O. box if mail is not delivered to street address)		Room/suite	E Telephone number (240) 456-2245	
	City, town or post office, state, and ZIP code LAUREL, MD 20707			G Gross receipts \$ 359,246,986.	
	F Name and address of principal officer: NEIL MOORE 7300 VAN DUSEN RD LAUREL, MD 20707			H(a) Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		J Website: ▶ WWW.DIMENSIONSHALTH.COM			H(c) Group exemption number ▶
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶				L Year of formation: 1982 M State of legal domicile: MD	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: OUR STATED MISSION IS TO PROVIDE HIGH QUALITY, EFFICIENT HEALTHCARE SERVICES TO PRESERVE, RESTORE AND IMPROVE THE HEALTH STATUS OF OUR COMMUNITY.			
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.			
	3	Number of voting members of the governing body (Part VI, line 1a)	11.	
	4	Number of independent voting members of the governing body (Part VI, line 1b)	11.	
	5	Total number of individuals employed in calendar year 2012 (Part V, line 2a)	2,860.	
	6	Total number of volunteers (estimate if necessary)	111.	
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	0	
	7b	Net unrelated business taxable income from Form 990-T, line 34	0	
Revenue	8	Contributions and grants (Part VIII, line 1h)	33,854,560.	32,307,979.
	9	Program service revenue (Part VIII, line 2g)	341,183,614.	320,893,908.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	-419.	505,411.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,448,002.	5,449,732.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	376,485,757.	359,157,030.
	Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	41,045.
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)	197,705,801.	206,765,320.
16a		Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b		Total fundraising expenses (Part IX, column (D), line 25) ▶	0	
17		Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	155,804,846.	135,340,130.
18		Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	353,551,692.	342,123,464.
Net Assets or Fund Balances	19	Revenue less expenses. Subtract line 18 from line 12	22,934,065.	17,033,566.
	20	Total assets (Part X, line 16)	211,487,005.	232,163,417.
	21	Total liabilities (Part X, line 26)	249,513,475.	239,808,547.
	22	Net assets or fund balances. Subtract line 21 from line 20	-38,026,470.	-7,645,130.

Part II Signature Block

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

Sign Here	Signature of officer _____ Date _____	
	Type or print name and title _____	

Paid Preparer Use Only	Print/Type preparer's name TINA C ECKLOFF	Preparer's signature _____	Date 05/09/2014	Check <input type="checkbox"/> if self-employed	PTIN P01074058
	Firm's name ▶ COHEN, RUTHERFORD + KNIGHT, PC			Firm's EIN ▶ 52-1202280	
	Firm's address ▶ 6903 ROCKLEDGE DRIVE, SUITE 500 BETHESDA, MD 20817-1800			Phone no. 301-828-1008	

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

For Paperwork Reduction Act Notice, see the separate instructions.

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

ATTACHMENT 1

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

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

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

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

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

4a (Code:) (Expenses \$ 307,877,706. including grants of \$ 18,014.) (Revenue \$ 320,893,908.)

ATTACHMENT 2

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

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

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

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

4e Total program service expenses **▶** 307,877,706.

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)? <i>If "Yes," complete Schedule A</i>	X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (see instructions)?	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>		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? <i>If "Yes," complete Schedule C, Part III</i>		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? <i>If "Yes," complete Schedule D, Part I</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		X
9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>		X
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>		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? <i>If "Yes," complete Schedule D, Part VI</i>	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? <i>If "Yes," complete Schedule D, Part VII</i>		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? <i>If "Yes," complete Schedule D, Part VIII</i>		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? <i>If "Yes," complete Schedule D, Part IX</i>	X	
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	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)? <i>If "Yes," complete Schedule D, Part X</i>	X	
12 a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14 a Did the organization maintain an office, employees, or agents outside of the United States?		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>	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? <i>If "Yes," complete Schedule F, Parts II and IV</i>		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? <i>If "Yes," complete Schedule F, Parts III and IV</i>		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? <i>If "Yes," complete Schedule G, Part I (see instructions)</i>		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? <i>If "Yes," complete Schedule G, Part II</i>	X	
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X
20 a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	

Part IV Checklist of Required Schedules *(continued)*

		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? <i>If "Yes," complete Schedule I, Parts I and II.</i>		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? <i>If "Yes," complete Schedule I, Parts I and III.</i>	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? <i>If "Yes," complete Schedule J.</i>	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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25.</i>		X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
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?		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
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? <i>If "Yes," complete Schedule L, Part I.</i>		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? <i>If "Yes," complete Schedule L, Part I.</i>		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? <i>If "Yes," complete Schedule L, Part II.</i>		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? <i>If "Yes," complete Schedule L, Part III.</i>		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? <i>If "Yes," complete Schedule L, Part IV.</i>		X
b	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV.</i>		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? <i>If "Yes," complete Schedule L, Part IV.</i>		X
29	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M.</i>		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M.</i>		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I.</i>		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II.</i>		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? <i>If "Yes," complete Schedule R, Part I.</i>		X
34	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1.</i>	X	
35 a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2.</i>	X	
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2.</i>		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? <i>If "Yes," complete Schedule R, Part VI.</i>		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O	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.

Table with columns for question number, description, and Yes/No response. Includes questions 1a through 14b regarding Form 1096, Form W-2G, Form W-3, and various tax compliance issues.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include questions 1a, 1b, 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

Table with 3 columns: Question, Yes, No. Rows include questions 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD,
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: LISA GOODLETT 7300 VAN DUSEN ROAD LAUREL, MD 20707 301-618-2109

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) THOMAS HENDERSHOTT ----- DIRECTOR	1.00 ----- 1.00	X					0	0	0	
(2) FRANCIS R COSTA, JR. ----- DIRECTOR	1.00 ----- 0	X					0	0	0	
(3) BARBARA FRUSH ----- SECRETARY	1.00 ----- 0	X					0	0	0	
(4) SAID DAAE ----- DIRECTOR	1.00 ----- 0	X					0	0	0	
(5) C PHILIPS NICHOLS JR ----- CHAIRMAN OF THE BOARD	1.00 ----- 0	X					0	0	0	
(6) ELIZABETH HEWLETT ----- DIRECTOR	1.00 ----- 0	X					0	0	0	
(7) BENJAMIN STALLINGS MD ----- TREASURER	1.00 ----- 0	X					0	0	0	
(8) SYED SADIQ ----- DIRECTOR	1.00 ----- 0	X					0	0	0	
(9) TAWANA GAINES ----- VICE CHAIR	1.00 ----- 0	X					0	0	0	
(10) ANDREA HARRISON ----- DIRECTOR	1.00 ----- 0	X					0	0	0	
(11) BRADFORD SEAMON ----- DIRECTOR	1.00 ----- 0	X					0	0	0	
(12) FREDERICK SMALLS ----- DIRECTOR	1.00 ----- 0	X					0	0	0	
(13) NEIL MOORE ----- CEO/CFO	38.00 ----- 2.00			X			576,920.	0	46,922.	
(14) JOHN O'BRIEN III ----- COO	40.00 ----- 0			X			313,462.	0	38,165.	

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) KANWALJIT SINGH TANEJA COO - PGHC	20.00 20.00				X			279,559.	0	39,680.
(16) GITA K SHAH VP MEDICAL AFFAIRS	39.00 0				X			296,037.	0	49,967.
(17) TRUDY HALL VP, MEDICAL AFFAIRS	39.00 1.00				X			0	0	0
(18) JOHN SPEARMAN COO-LRH	39.00 1.00				X			152,986.	0	16,652.
(19) CARNELL COOPER CMO	39.00 1.00				X			365,190.	0	4,456.
(20) DAVID GOLDMAN VICE PRESIDENT QUALITY	39.00 1.00					X		266,604.	0	29,193.
(21) JYOTI DHAROD PERFUSIONIST	40.00 0					X		198,313.	0	21,343.
(22) SHEILA JARRETT RN	40.00 0					X		199,685.	0	39,122.
(23) MICHAEL JACOBS PRESIDENT DHA	20.00 20.00					X		193,195.	0	31,371.
(24) DANIEL J O'BRIEN JR GENERAL COUNSEL	40.00 0					X		217,652.	0	4,386.
(25) KENNETH GLOVER CEO	0 0						X	117,475.	0	25,894.
1b Sub-total								890,382.	0	85,087.
c Total from continuation sheets to Part VII, Section A								2,286,696.	0	262,064.
d Total (add lines 1b and 1c)								3,177,078.	0	347,151.

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 ▶ 223

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

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. 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 ▶ 5

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514		
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a						
	b Membership dues	1b						
	c Fundraising events	1c						
	d Related organizations	1d						
	e Government grants (contributions)	1e	30,487,742.					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	1,820,237.					
	g Noncash contributions included in lines 1a-1f: \$							
	h Total. Add lines 1a-1f		32,307,979.					
Program Service Revenue			Business Code					
	2a NET PATIENT REVENUE		319,104,205.	319,104,205.				
	b CAFETERIA/MEAL SERVICE/ VENDING		934,249.	934,249.				
	c PARKING		327,921.	327,921.				
	d TRAUMA FEES		527,488.	527,488.				
	e SMOKING CESSATION PROGRAM		45.	45.				
	f All other program service revenue							
	g Total. Add lines 2a-2f		320,893,908.					
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)	ATTACHMENT 4		17,411.		17,411.		
	4 Income from investment of tax-exempt bond proceeds			0				
	5 Royalties			0				
	6a Gross rents	(i) Real	(ii) Personal					
		719,898.						
	b Less: rental expenses							
	c Rental income or (loss)	719,898.						
	d Net rental income or (loss)			719,898.		719,898.		
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other					
				488,000.				
	b Less: cost or other basis and sales expenses							
	c Gain or (loss)	488,000.						
	d Net gain or (loss)			488,000.		488,000.		
8a Gross income from fundraising events (not including \$ 72,750. of contributions reported on line 1c). See Part IV, line 18	ATCH 5							
a	56,525.							
b Less: direct expenses	89,956.							
c Net income or (loss) from fundraising events	ATCH 6		-33,431.		-33,431.			
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 OTHER			4,763,265.	4,763,265.				
b								
c								
d All other revenue								
e Total. Add lines 11a-11d			4,763,265.					
12 Total revenue. See instructions			359,157,030.	325,657,173.		1,191,878.		

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21	0			
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	18,014.	18,014.		
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	1,457,199.		1,457,199.	
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	162,020,196.	150,030,701.	11,989,495.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	16,043,007.	14,855,824.	1,187,183.	
9 Other employee benefits	17,312,786.	16,031,640.	1,281,146.	
10 Payroll taxes	9,932,132.	9,197,154.	734,978.	
11 Fees for services (non-employees):				
a Management	724,326.		724,326.	
b Legal	65,670.		65,670.	
c Accounting	796,343.		796,343.	
d Lobbying	0			
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	0			
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	29,340,665.	20,245,059.	9,095,606.	
12 Advertising and promotion	330,542.	204,936.	125,606.	
13 Office expenses	429,345.	309,128.	120,217.	
14 Information technology	167,402.	16,740.	150,662.	
15 Royalties	0			
16 Occupancy	3,911,806.	3,794,452.	117,354.	
17 Travel	203,788.	116,159.	87,629.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	5,489.	4,446.	1,043.	
20 Interest	3,171,068.	2,885,672.	285,396.	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	11,038,842.	8,941,462.	2,097,380.	
23 Insurance	6,424,917.	5,755,948.	668,969.	
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 PROFESSIONAL FEES	2,436,955.	1,681,499.	755,456.	
b PHYSICIAN FEES	17,414,795.	17,414,795.		
c REPAIRS AND MAINT	4,580,115.	3,160,279.	1,419,836.	
d DUES AND MEMBERSHIPS	219,265.	210,494.	8,771.	
e All other expenses <u> ATCH 7 </u>	54,078,797.	53,003,304.	1,075,493.	
25 Total functional expenses. Add lines 1 through 24e	342,123,464.	307,877,706.	34,245,758.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	12,567,991.	1	41,375,362.
	2 Savings and temporary cash investments	28,788,393.	2	4,091,285.
	3 Pledges and grants receivable, net	0	3	0
	4 Accounts receivable, net	45,817,346.	4	37,918,534.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0	6	0
	7 Notes and loans receivable, net	0	7	0
	8 Inventories for sale or use	5,062,611.	8	5,444,819.
	9 Prepaid expenses and deferred charges ATCH 8	3,396,118.	9	4,378,409.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 264,952,798.		
	b Less: accumulated depreciation	10b 198,471,460.	10c	66,481,338.
	11 Investments - publicly traded securities	0	11	0
	12 Investments - other securities. See Part IV, line 11	11,235,823.	12	11,315,233.
	13 Investments - program-related. See Part IV, line 11	0	13	0
	14 Intangible assets	56,199.	14	0
	15 Other assets. See Part IV, line 11	53,176,188.	15	61,158,437.
16 Total assets. Add lines 1 through 15 (must equal line 34)	211,487,005.	16	232,163,417.	
Liabilities	17 Accounts payable and accrued expenses	45,636,289.	17	63,664,074.
	18 Grants payable	0	18	0
	19 Deferred revenue ATCH 9	4,360,856.	19	600,000.
	20 Tax-exempt bond liabilities	55,685,683.	20	52,635,912.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23 Secured mortgages and notes payable to unrelated third parties	0	23	0
	24 Unsecured notes and loans payable to unrelated third parties	0	24	0
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	143,830,647.	25	122,908,561.
	26 Total liabilities. Add lines 17 through 25	249,513,475.	26	239,808,547.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	-40,769,571.	27	-11,334,237.
	28 Temporarily restricted net assets	2,743,101.	28	3,689,107.
	29 Permanently restricted net assets	0	29	0
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 Total net assets or fund balances	-38,026,470.	33	-7,645,130.
34 Total liabilities and net assets/fund balances	211,487,005.	34	232,163,417.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	359,157,030.
2	Total expenses (must equal Part IX, column (A), line 25)	2	342,123,464.
3	Revenue less expenses. Subtract line 2 from line 1	3	17,033,566.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	-38,026,470.
5	Net unrealized gains (losses) on investments	5	3,300.
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	13,344,474.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	-7,645,130.

Part XII Financial Statements and Reporting

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

		Yes	No
1	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		X
b	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	X	
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.	X	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	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	X	

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047

2012

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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.

Name of the organization DIMENSIONS HEALTH CORPORATION	Employer identification number 52-1289729
------------------------------------------------------------------	-----------------------------------------------------

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

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

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

	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)	

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

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

Schedule A (Form 990 or 990-EZ) 2012

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

Section A. Public Support

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

Table with 7 columns: (a) 2008, (b) 2009, (c) 2010, (d) 2011, (e) 2012, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities, 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); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2012 (line 6, column (f) divided by line 11, column (f)); 15 Public support percentage from 2011 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2012; b 33 1/3% support test - 2011; 17a 10%-facts-and-circumstances test - 2012; b 10%-facts-and-circumstances test - 2011; 18 Private foundation.

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

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b.						
8 Public support (Subtract line 7c from line 6.)						

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

19a **33 1/3% support tests - 2012.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

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

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

Schedule of Contributors

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

2012

Name of the organization DIMENSIONS HEALTH CORPORATION	Employer identification number 52-1289729
------------------------------------------------------------------	-----------------------------------------------------

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

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

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

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

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

Name of organization DIMENSIONS HEALTH CORPORATION

Employer identification number
52-1289729**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	STATE OF MD DEPT HUMAN SERVICES ----- 311 W SARATOGA ST ----- BALTIMORE, MD 21201 -----	\$ 15,297,317.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
2	PRINCE GEORGES COUNTY GOVT ----- 14741 GOVERNOR ODEN BOWIE DR ----- UPPER MARLBORO, MD 20772 -----	\$ 15,110,425.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
3	MAGRUDER MEMEORIAL HOSPITAL TRUST ----- PO BOX 658 ----- UPPER MARLBORO, MD 20772 -----	\$ 1,042,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
4	MD DEPT OF HEALTH AND MENTAL HYGINE ----- 201 W PRESTON ST ----- BALTIMORE, MD 21201 -----	\$ 80,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
5	ROSS HEALTH SCIENCES INC ----- 630 ROUTE 1 STE 300 ----- NORTH BRUNSWICK, NJ 08902 -----	\$ 717,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
6	RESTRICTED CONTRIBUTIONS UNDER \$5000 ----- 3001 HOSPITAL DR ----- CHEVERLY, MD 20785 -----	\$ 19,599.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization **DIMENSIONS HEALTH CORPORATION**

Employer identification number
52-1289729

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	PRINCE GEORGES HOSPITAL GUILD ----- 3001 HOSPITAL DR ----- CHEVERLY, MD 20785 -----	\$ ----- 41,388.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
-----	-----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
-----	-----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
-----	-----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
-----	-----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
-----	-----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization **DIMENSIONS HEALTH CORPORATION**

Employer identification number

52-1289729

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

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

Name of organization DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

Part III Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than \$1,000 for the year. Complete columns (a) through (e) and the following line entry.

For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this information once. See instructions.) ▶ \$ _____

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

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

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2012

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990. See separate instructions.

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

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

Table with 3 columns: Line number, Description, (a) Donor advised funds, (b) Funds and other accounts. Rows 1-4 for totals, 5-6 for questions about donor advisement.

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

Table with 3 columns: Line number, Description, Held at the End of the Tax Year. Rows 1-9 for various conservation easement questions and reporting requirements.

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

Table with 3 columns: Line number, Description, Amount. Rows 1a-1b for reporting on collections, 2 for reporting on assets held for financial gain.

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

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

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

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

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

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

Table with 2 columns: Description, Amount. Rows: 1c Beginning balance, 1d Additions during the year, 1e Distributions during the year, 1f Ending balance.

2a Did the organization include an amount on Form 990, Part X, line 21?

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

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

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

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

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

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

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

- (i) unrelated organizations
(ii) related organizations

Table with 2 columns: Yes, No. Rows: 3a(i), 3a(ii), 3b

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

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

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

Table with 5 columns: (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows: 1a Land, b Buildings, c Leasehold improvements, d Equipment, e Other.

Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c)).

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

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

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

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

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

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	45,587,184.
(2) NON-CURRENT ACCOUNTS RECEIVABL	3,636,200.
(3) INVESTMENT AEI	4,834,485.
(4) INVESTMENT DAL	1,000,000.
(5) DEFERRED FINANCING COSTS	210,784.
(6) OTHER ACCOUNTS RECEIVABLE	3,665,989.
(7) DEPOSITS	1,443,129.
(8) INVEST PG FOUNDATION	425,297.
(9) INVEST LRH FOUNDATOIN	355,369.
(10)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.)	61,158,437.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ADVANCES FROM THIRD PARTIES	12,385,945.
(3) CAPITAL LEASE OBLIGATIONS	4,269,774.
(4) DUE TO AFFILIATES	30,246,814.
(5) ACCRUED EMPLOYEE BENEFIT LIAB	76,006,028.
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	122,908,561.

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

Part XIII Supplemental Information (continued)

FIN 48 DISCLOSURE

SCHEDULE D, PART X, LINE 2

THE CORPORATION IS EXEMPT FROM FEDERAL INCOME TAX UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AS A PUBLIC CHARITY. FEDERAL TAX LAW REQUIRES THAT THE CORPORATION BE OPERATED IN A MANNER CONSISTENT WITH ITS INITIAL EXEMPTION APPLICATION IN ORDER TO MAINTAIN ITS EXEMPT STATUS. MANAGEMENT HAS ANALYZED THE OPERATIONS OF THE CORPORATION AND CONCLUDED THAT IT REMAINS IN COMPLIANCE WITH THE REQUIREMENTS FOR EXEMPTION. THE STATE IN WHICH THE CORPORATION OPERATES ALSO RECOGNIZES THIS EXEMPTION FOR STATE INCOME TAX PURPOSES.

ORGANIZATIONS OTHERWISE EXEMPT FROM FEDERAL AND STATE INCOME TAXATION ARE NONETHELESS SUBJECT TO TAXATION AT CORPORATE TAX RATES AT BOTH THE FEDERAL AND STATE LEVELS ON THEIR UNRELATED BUSINESS INCOME. EXEMPTION FROM OTHER STATE TAXES, SUCH AS REAL AND PERSONAL PROPERTY TAX, IS SEPARATELY DETERMINED. FOR 2013 AND 2012, MANAGEMENT HAS DETERMINED THAT IT DID NOT HAVE ANY INCOME TAX LIABILITY.

ALTHOUGH EXEMPT FROM FEDERAL AND STATE INCOME TAXES, THE CORPORATION IS REQUIRED TO FILE AN ANNUAL FEDERAL INFORMATION RETURN ON FORM 990. IN ADDITION, TO THE EXTENT THAT THE CORPORATION HAS GROSS INCOME FROM BUSINESS ACTIVITIES UNRELATED TO ITS EXEMPT PURPOSE IN EXCESS OF \$1,000 FOR ANY TAX YEAR, IT MUST ALSO FILE A FORM 990-T TAX RETURN. GENERALLY, FEDERAL AND STATE TAXING AUTHORITIES MUST PROPOSE ANY TAXABLE ADJUSTMENTS WITHIN THREE YEARS FROM THE DUE DATE OF THE 990-T OR THE ACTUAL FILING DATE, WHICHEVER IS LATER, UNLESS UNRELATED BUSINESS GROSS INCOME IS UNDER

Part XIII Supplemental Information (continued)

REPORTED BY 25% OR MORE, IN WHICH CASE THE RELEVANT TIME PERIOD IS SIX YEARS. NO STATUTE OF LIMITATIONS APPLIES FOR YEARS FOR WHICH NO 990-T HAS BEEN FILED. THE CORPORATION IS NOT CURRENTLY UNDER AUDIT BY ANY TAXING AUTHORITY AND HAS NOT BEEN NOTIFIED OF ANY IMPENDING AUDIT.

CURRENT ACCOUNTING STANDARDS DEFINE THE THRESHOLD FOR RECOGNIZING UNCERTAIN INCOME TAX RETURN POSITIONS IN THE FINANCIAL STATEMENTS AS "MORE LIKELY THAN NOT" THAT THE POSITION IS SUSTAINABLE, BASED ON ITS TECHNICAL MERITS, AND ALSO PROVIDE GUIDANCE ON THE MEASUREMENT, CLASSIFICATION AND DISCLOSURE OF TAX RETURN POSITIONS IN THE FINANCIAL STATEMENTS. MANAGEMENT BELIEVES THERE IS NO IMPACT ON THE CORPORATION'S ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS RELATED TO UNCERTAIN INCOME TAX POSITIONS.

**SCHEDULE F
(Form 990)**

Statement of Activities Outside the United States

OMB No. 1545-0047

2012

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ Complete if the organization answered "Yes" to Form 990,
Part IV, line 14b, 15, or 16.
▶ Attach to Form 990. ▶ See separate instructions.

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

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

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

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

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

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e.g., fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
(1) CENTRAL AMERICA/CARIBBEAN			INVESTMENTS		18,071,000.
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Sub-total					18,071,000.
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)					18,071,000.

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

Schedule F (Form 990) 2012

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

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

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

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

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

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

Part IV Foreign Forms

- 1 Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926).* Yes No

- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A).* Yes No

- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations. (see Instructions for Form 5471).* Yes No

- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund. (see Instructions for Form 8621).* Yes No

- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons With Respect To Certain Foreign Partnerships. (see Instructions for Form 8865).* Yes No

- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to file Form 5713, International Boycott Report (see Instructions for Form 5713).* Yes No

Part V Supplemental Information

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

PART I, LINE 3

THE AMOUNT INDICATED AS FOREIGN INVESTMENTS IN PART I WAS DIMENSIONS HEALTH CORPORATION'S EQUITY OWNERSHIP INTEREST IN DIMENSIONS ASSURANCE COMPANY, LTD ("DAL"), A CAYMAN ISLAND CORPORATION. DAL IS A WHOLLY-OWNED SUBSIDIARY OF DIMENSIONS HEALTH CORPORATION THAT PROVIDES DIRECT COVERAGE FOR PROFESSIONAL, MALPRACTICE, AND COMPREHENSIVE GENERAL LIABILITY FOR DIMENSIONS HEALTH CORPORATION AND ITS ASSOCIATED HEALTH CARE FACILITIES. AS OF THE END OF THE 2012 TAX YEAR, THE VALUE OF DIMENSIONS HEALTH CORPORATION'S EQUITY OWNERSHIP IN DAL WAS \$18,071,000.

**SCHEDULE G
(Form 990 or 990-EZ)**

Department of the Treasury
Internal Revenue Service

**Supplemental Information Regarding
Fundraising or Gaming Activities**

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

OMB No. 1545-0047

2012

**Open to Public
Inspection**

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

Part I

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

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

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

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

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

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

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

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

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events
		GOLF TOURN (event type)	(event type)	(total number)	(add col. (a) through col. (c))
Revenue	1 Gross receipts	129,275.			129,275.
	2 Less: Contributions	72,750.			72,750.
	3 Gross income (line 1 minus line 2)	56,525.			56,525.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes	5,278.			5,278.
	6 Rent/facility costs	41,339.			41,339.
	7 Food and beverages	24,200.			24,200.
	8 Entertainment				
	9 Other direct expenses	19,139.			19,139.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				(89,956.)
11 Net income summary. Combine line 3, column (d), and line 10 ▶				-33,431.	

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

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

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

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

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

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

Name ▶ _____

Address ▶ _____

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

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ \$ _____

Description of services provided ▶ _____

Director/officer Employee Independent contractor

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

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

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2012

Open to Public Inspection

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

Department of the Treasury
Internal Revenue Service

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	X	
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>500.0000</u> %	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?		X
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a Did the organization prepare a community benefit report during the tax year?	X	
b If "Yes," did the organization make it available to the public?	X	

7 Financial Assistance and Certain Other Community Benefits at Cost

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			21,256,309.		21,256,309.	6.21
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			21,256,309.		21,256,309.	6.21
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		5618	342,496.	12,619.	329,877.	.10
f Health professions education (from Worksheet 5)		504	180,311.		180,311.	.05
g Subsidized health services (from Worksheet 6)			23,649,616.		23,649,616.	6.91
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			43,425.		43,425.	.01
j Total Other Benefits		6122	24,215,848.	12,619.	24,203,229.	7.07
k Total. Add lines 7d and 7j.		6122	45,472,157.	12,619.	45,459,538.	13.28

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

Schedule H (Form 990) 2012

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development			17,419.		17,419.	.01
9 Other						
10 Total			17,419.		17,419.	.01

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?		X
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	102,220,781.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	81,121,337.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	21,099,444.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other		

Section C. Collection Practices

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

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

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

Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, and primary website address

1 PRINCE GEORGES HOSPITAL CENTER
3001 HOSPITAL DR
CHEVERLY MD 20707

2 LAUREL REGIONAL HOSPITAL
7300 VAN DUSEN RD
LAUREL MD 20707

3

4

5

6

7

8

9

10

11

12

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

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group PRINCE GEORGES HOSPITAL CENTER

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

		Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)			
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	X	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j	<input type="checkbox"/> Other (describe in Part VI)		
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>1</u> <u>2</u>		
3	In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? 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.	X	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI		X
5	Did the hospital facility make its CHNA report widely available to the public?	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	<input checked="" type="checkbox"/> Hospital facility's website		
b	<input type="checkbox"/> Available upon request from the hospital facility		
c	<input type="checkbox"/> Other (describe in Part VI)		
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):		
a	<input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA		
b	<input type="checkbox"/> Execution of the implementation strategy		
c	<input checked="" type="checkbox"/> Participation in the development of a community-wide plan		
d	<input checked="" type="checkbox"/> Participation in the execution of a community-wide plan		
e	<input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans		
f	<input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA		
g	<input checked="" type="checkbox"/> Prioritization of health needs in its community		
h	<input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i	<input type="checkbox"/> Other (describe in Part VI)		
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs . . .	X	
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
8b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group LAUREL REGIONAL HOSPITAL

For single facility filers only: line number of hospital facility (from Schedule H, Part V, Section A) 2

		Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)			
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9 If "Yes," indicate what the CHNA report describes (check all that apply):	X	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j	<input type="checkbox"/> Other (describe in Part VI)		
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>1 2</u>		
3	In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? 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.	X	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI		X
5	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	X	
a	<input checked="" type="checkbox"/> Hospital facility's website		
b	<input type="checkbox"/> Available upon request from the hospital facility		
c	<input type="checkbox"/> Other (describe in Part VI)		
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):		
a	<input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA		
b	<input type="checkbox"/> Execution of the implementation strategy		
c	<input checked="" type="checkbox"/> Participation in the development of a community-wide plan		
d	<input checked="" type="checkbox"/> Participation in the execution of a community-wide plan		
e	<input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans		
f	<input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA		
g	<input checked="" type="checkbox"/> Prioritization of health needs in its community		
h	<input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i	<input type="checkbox"/> Other (describe in Part VI)		
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs . . .	X	
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
8b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy PRINCE GEORGES HOSPITAL CENTER		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate the FPG family income limit for eligibility for free care: <u>2</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	X	
11	Used FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>5</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	X	
12	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply):	X	
a	<input checked="" type="checkbox"/> Income level		
b	<input checked="" type="checkbox"/> Asset level		
c	<input checked="" type="checkbox"/> Medical indigency		
d	<input checked="" type="checkbox"/> Insurance status		
e	<input type="checkbox"/> Uninsured discount		
f	<input type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input checked="" type="checkbox"/> Other (describe in Part VI)		
13	Explained the method for applying for financial assistance?	X	
14	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input checked="" type="checkbox"/> The policy was attached to billing invoices		
c	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Part VI)		
Billing and Collections			
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged:		X
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		

Part V Facility Information (continued)		Yes	No
Financial Assistance Policy LAUREL REGIONAL HOSPITAL			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate the FPG family income limit for eligibility for free care: <u>2</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	X	
11	Used FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>5</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	X	
12	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply):	X	
a	<input checked="" type="checkbox"/> Income level		
b	<input checked="" type="checkbox"/> Asset level		
c	<input checked="" type="checkbox"/> Medical indigency		
d	<input checked="" type="checkbox"/> Insurance status		
e	<input type="checkbox"/> Uninsured discount		
f	<input type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input checked="" type="checkbox"/> Other (describe in Part VI)		
13	Explained the method for applying for financial assistance?	X	
14	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input checked="" type="checkbox"/> The policy was attached to billing invoices		
c	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Part VI)		
Billing and Collections			
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged:		X
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		

Part V Facility Information (continued) PRINCE GEORGES HOSPITAL CENTER

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

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

Policy Relating to Emergency Medical Care

19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

	Yes	No
19	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)

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

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

- a The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d Other (describe in Part VI)

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

20		X
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If "Yes," explain in Part VI.

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

21		X
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If "Yes," explain in Part VI.

Part V Facility Information (continued) LAUREL REGIONAL HOSPITAL

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

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

Policy Relating to Emergency Medical Care

19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

	Yes	No
19	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)

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

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

- a The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d Other (describe in Part VI)

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

20		X

If "Yes," explain in Part VI.

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

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? 6

Name and address	Type of Facility (describe)
1 GLADYS SPELLMAN SPECIALTY CARE UNIT 7300 VAN DUSEN ROAD LAUREL MD 20707	ACUTE CARE
2 DIMENSIONS SURGERY CENTER 14999 HEALTH CENTER DR STE 103 BOWIE MD 20716	AMBULATORY SURGERY CENTER
3 CORA B WOOD SENIOR CENTER 3601 TAYLOR STREET STE 108 BRENTWOOD MD 20722	SENIOR HEALTH CENTER
4 LARKIN CHASE CARE & REHABILITATION 15005 HEALTH CENTER DRIVE BOWIE MD 20716	REHABILITATION CENTER
5 GLENRIDGE MEDICAL CENTER 7582 ANNAPOLIS ROAD LANHAM MD 20784	MEDICAL CENTER
6 BOWIE HEALTH CENTER 15001 HEALTH CENTER DRIVE BOWIE MD 20716	FREESTANDING EMERGENCY MEDICAL FACILITY
7	
8	
9	
10	

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART I, LINE 3

IN THE EVALUATION OF AN APPLICATION FOR FINANCIAL ASSISTANCE, A PATIENT'S TOTAL RESOURCE WILL BE TAKEN INTO ACCOUNT WHICH WILL INCLUDE AN ANALYSIS OF THE ASSETS HELD BY THE PATIENT (NARROWLY DEFINED UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY AS THOSE ASSETS THAT ARE CONVERTIBLE TO CASH AND UNNECESSARY FOR THE PATIENT'S DAILY LIVING EXPENSES) .

IN ADDITION, IF A SELF-PAY PATIENT THAT RECEIVES EMERGENCY OR OTHER MEDICALLY NECESSARY SERVICES DOES NOT PROVIDE THE ORGANIZATION WITH SUFFICIENT INFORMATION FOR THE ORGANIZATION TO DETERMINE WHETHER THE PATIENT MAY QUALIFY FOR FINANCIAL ASSISTANCE PURSUANT TO THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY, AND THE ORGANIZATION DETERMINES THAT THE ACCOUNT IS LIKELY UNCOLLECTIBLE BECAUSE THE PATIENT HAS NOT PAID AT ALL, OR A PORTION, OF THE SUBSEQUENT BILL FOR SERVICES PROVIDED, THE ORGANIZATION WILL RUN THE PATIENT'S ACCOUNT THROUGH A PROGRAM CALLED ISOLUTIONS TO DETERMINE WHETHER THE PATIENT MAY QUALIFY

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

FOR PRESUMPTIVE CHARITY CARE. ISOLUTIONS TAKES THE PATIENT'S FINANCIAL AND DEMOGRAPHIC INFORMATION AND DETERMINES WHETHER THE PATIENT IS LIKELY TO QUALIFY UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY. IF THE ISOLUTIONS PROGRAM INDICATES THAT A PATIENT IS LIKELY TO QUALIFY FOR FREE OR DISCOUNTED CARE, THE ORGANIZATION WILL ACCEPT THAT PATIENT INTO ITS FINANCIAL ASSISTANCE POLICY AND DISCOUNT THE PATIENT'S ACCOUNT FROM 25 TO 100%, DEPENDING UPON THE RESULTS OF THE ISOLUTIONS PROGRAM.

PART I, LINE 5

THE ORGANIZATION DOESN'T BUDGET A PRESET PERCENTAGE FOR CHARITY CARE. IT IS THE ORGANIZATION'S POLICY TO PROVIDE FINANCIAL ASSISTANCE TO ANY INDIVIDUAL THAT QUALIFIES UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY, REGARDLESS OF THE AMOUNT OF CHARITY CARE PROVIDED BY THE ORGANIZATION DURING THE YEAR. IT IS PART OF OUR MISSION TO SERVE AS THE SAFETY NET FOR THE UNINSURED AND UNDERINSURED.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART I, LINE 6A COMMUNITY BENEFIT REPORT

THE ORGANIZATION SUBMITS A COMMUNITY BENEFIT REPORT ANNUALLY TO THE MARYLAND HSCRC.

PART I, LINE 7A COLUMN D CHARITY CARE

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

PART I, LINE 7B COLUMNS C-F UNREIMBURSED MEDICAID

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

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

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 DIRECTED OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. COMMUNITY BENEFIT EXPENSES ARE EQUAL TO MEDICAID REVENUES IN MARYLAND, AS SUCH, THE NET EFFECT IS ZERO. THE EXCEPTION TO THIS IS THE IMPACT ON THE HOSPITAL OF ITS SHARE OF THE MEDICAID ASSESSMENT. IN RECENT YEARS, THE STATE OF MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING HOSPITALS THROUGH THE RATE-SETTING SYSTEM.

PART I, LINE 7F, HEALTH PROFESSIONS EDUCATION COLUMN D
 MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION, (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S
UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED
CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO
BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

PART I, LINE 7 COLUMN F

THE ORGANIZATION'S BAD DEBT EXPENSE THAT WAS REPORTED ON FORM 990, PART
IX \$30,276,887 WAS REDUCED FROM TOTAL EXPENSE TO DETERMINE THE
PERCENTAGES OF TOTAL EXPENSES.

PART I, LINE 7G COLUMN C

ACCESS TO PRIMARY AND SPECIALIST HEALTH CARE SERVICES IS AN IDENTIFIED
AND CONSIDERABLE HEALTH NEED THROUGHOUT THE ORGANIZATION'S COMMUNITY. FOR
EXAMPLE, THE NATIONAL BENCHMARK IS 631 PEOPLE: 1 PRIMARY CARE PHYSICIAN,
WHEREAS, FOR PRINCE GEORGE'S COUNTY, THE NUMBER OF PEOPLE PER PRIMARY
CARE PHYSICIAN IS APPROXIMATELY 1077:1. THIS STEMS IN LARGE PART FROM THE
COUNTY'S VERY HIGH UNINSURED AND UNDERINSURED POPULATION THAT CAN AFFORD

Part VI Supplemental Information

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TO PAY LITTLE TO NO REIMBURSEMENT FOR SERVICES RECEIVED.

IN ORDER TO MEET THIS SUBSTANTIAL COMMUNITY HEALTH NEED, THE ORGANIZATION HAS BROUGHT IN SPECIALISTS AND PRIMARY CARE PHYSICIANS INTO THE ORGANIZATION'S COMMUNITY AND INTO THE ORGANIZATION'S TWO HOSPITAL FACILITIES (PGHC AND LRH). FIRST, THE ORGANIZATION PAYS PHYSICIANS TO COVER THE BAD DEBTS THEY INCUR WHEN PROVIDING SERVICES TO UNINSURED AND UNDERINSURED PATIENTS AT PGHC AND LRH. SUCH PHYSICIAN SUBSIDIES HAVE BEEN REPORTED ON PART I, LINE 7G AS SUBSIDIZED HEALTH SERVICES.

IN ADDITION, THE ORGANIZATION HAS EMPLOYED PRIMARY CARE AND SPECIALIST PHYSICIANS THROUGH ITS DIRECT TAX-EXEMPT SUBSIDIARY PHYSICIAN PRACTICE, DIMENSIONS HEALTHCARE ASSOCIATES, TO PROVIDE PATIENT SERVICES TO THE COMMUNITY, INCLUDING UNINSURED AND UNDERINSURED PATIENTS THAT WOULD NOT OTHERWISE HAVE ACCESS TO PHYSICIAN SERVICES. THE DIRECT SUBSIDIES PAID FROM THE ORGANIZATION TO DHA DURING THE TAX YEAR TO SUPPORT THE CONTINUED EXISTENCE OF THE PHYSICIAN PRACTICE, AND TO HELP REDUCE THE PHYSICIAN

Part VI Supplemental Information

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SHORTFALL IN THE COMMUNITY, HAVE NOT BEEN REPORTED ON PART I, LINE 7G AS
SUBSIDIZED HEALTH SERVICES BECAUSE THE LOSSES WERE INCURRED BY A
SUBSIDIARY ORGANIZATION. HOWEVER, THIS SUBSTANTIAL LOSS IS INCURRED
INDIRECTLY BY THE HOSPITAL ORGANIZATION IN ORDER TO MEET AN IDENTIFIED
COMMUNITY NEED AND HAD A NET COMMUNITY BENEFIT EXPENSE OF \$15,390,302
DURING THE 2012 TAX YEAR.

PART III, LINE 4 BAD DEBT

THE ORGANIZATION'S FOOTNOTE FOR "ACCOUNTS RECEIVABLE AND CONTRACTUAL
ALLOWANCES"

THE CORPORATION'S POLICY IS TO WRITE OFF ALL PATIENT ACCOUNTS THAT HAVE
BEEN IDENTIFIED AS UNCOLLECTIBLE. AN ALLOWANCE FOR DOUBTFUL ACCOUNTS IS
RECORDED FOR ACCOUNTS NOT YET WRITTEN OFF THAT ARE ANTICIPATED TO BECOME
UNCOLLECTIBLE IN FUTURE PERIODS.

IN EVALUATING THE COLLECTIBILITY OF ACCOUNTS RECEIVABLE, THE CORPORATION

Part VI Supplemental Information

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ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYERS OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYERS OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. FOR ACCOUNTS RECEIVABLE ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE CORPORATION ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYER HAS NOT YET PAID, OR FOR PAYERS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR ACCOUNTS RECEIVABLE ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE CORPORATION RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE

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UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

DISCOUNTS RANGING FROM 2 % TO 6% OF HOSPITAL CHARGES ARE GIVEN TO MEDICARE, MEDICAID AND CERTAIN APPROVED COMMERCIAL HEALTH INSURANCE AND HEALTH MAINTENANCE ORGANIZATIONS (HMOS). ALSO, THESE PAYERS ROUTINELY REVIEW PATIENT BILLINGS AND DENY PAYMENT FOR CERTAIN PROCEDURES THAT THEY DEEM MEDICALLY UNNECESSARY OR PERFORMED WITHOUT APPROPRIATE PRE-AUTHORIZATION. DISCOUNTS AND DENIALS ARE RECORDED AS REDUCTIONS OF NET PATIENT REVENUE. ACCOUNTS RECEIVABLE FROM THESE THIRD-PARTY PAYERS HAVE BEEN ADJUSTED TO REFLECT THE DIFFERENCE BETWEEN CHARGES AND THE ESTIMATED REIMBURSABLE AMOUNTS.

THE AMOUNT OF BAD DEBT REPORTED ON LINE 2 WAS THE COST OF THE BAD DEBT

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EXPENSE, AS DETERMINED USING THE RATIO OF PATIENT CARE COST TO CHARGES

DETERMINED IN WORKSHEET 2.

THE ORGANIZATION ESTIMATES THAT ONLY A MINIMAL AMOUNT OF ITS BAD DEBT EXPENSE WAS ATTRIBUTABLE TO PATIENTS THAT WOULD BE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY. AS REFERENCED IN THE DISCLOSURE TO SCHEDULE H, PART I, LINE 3, THE ORGANIZATION USES A COMPUTER PROGRAM TO HELP DETERMINE WHETHER PATIENTS MAY QUALIFY FOR PRESUMPTIVE CHARITY CARE, AND THE ORGANIZATION BELIEVES THIS PROGRAM HELPS CAPTURE THE VAST MAJORITY OF THE PATIENTS THAT ARE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY THAT DID NOT PROVIDE THE ORGANIZATION WITH SUFFICIENT INFORMATION TO QUALIFY THEM FOR FINANCIAL ASSISTANCE.

PART III, LINE 8 MEDICARE

THE COSTING SOURCE IS THE MEDICARE COST REPORT AND THE METHODOLOGY IS MEDICARE ALLOWABLE COST TO MEDICARE REVENUES RECEIVED.

Part VI Supplemental Information

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PART III, LINE 9 DEBT COLLECTION POLICY

ALL SELF-PAY PATIENTS MAY APPLY FOR THE FINANCIAL ASSISTANCE PROGRAM.

PATIENTS MAY APPLY FOR THE PROGRAM IN PATIENT FINANCIAL SERVICES CUSTOMER SERVICE AREA OR PATIENT ACCESS DEPARTMENT. INCOME, ASSETS AND OTHER CRITERIA ARE EVALUATED FOR DETERMINATION OF PATIENT FINANCES TO QUALIFY FOR THE PROGRAM. ONCE THE COLLECTION PROCESS HAS BEGUN, THE ORGANIZATION CONTINUES TO MONITOR WHETHER THE PATIENT QUALIFIES FOR CHARITY CARE UNDER THE FINANCIAL ASSISTANCE POLICY. IF THE ORGANIZATION DETERMINES THAT A PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE, INCLUDING ONCE THE COLLECTION PROCESS HAS BEGUN, THE ORGANIZATION WILL APPROVE THE PATIENT FOR CHARITY CARE. THE WRITE OFF (RANGING FROM 25% TO 100%) TO CHARITY CARE IS ACCORDING TO A SLIDING FEE SCALE FOR INCOME. ONCE CHARITY CARE HAS BEEN APPROVED, THERE IS NO FURTHER ATTEMPT MADE BY THE ORGANIZATION TO COLLECT. FURTHERMORE, THE ORGANIZATION WILL REFUND ANY PATIENT PAYMENTS IN EXCESS OF THE AMOUNTS DUE PURSUANT TO THE FINANCIAL ASSISTANCE POLICY, IF IT IS LATER FOUND OUT (EVEN AFTER COLLECTION EFFORTS HAVE BEGUN) THAT THE PATIENT WAS ELIGIBLE FOR FINANCIAL ASSISTANCE AT THE TIME OF THE

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SERVICE.

PART V, LINE 3

PRINCE GEORGES HOSPITAL CENTER

THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) TOOK INTO ACCOUNT INPUT FROM REPRESENTATIVES OF THE COMMUNITY SERVED BY THE HOSPITAL FACILITY, INCLUDING PERSONS WITH SPECIAL KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH, AS WELL AS LEADERS AND REPRESENTATIVES OF MEDICALLY UNDERSERVED, LOW-INCOME, AND MINORITY POPULATIONS. IN PARTICULAR, TWO COMMUNITY INPUT MEETINGS WERE CONDUCTED, ONE WITH COMMUNITY LEADERS AND ONE WITH HEALTH EXPERTS. AT THE MEETING WITH COMMUNITY LEADERS, PARTICIPANTS INCLUDED REPRESENTATIVES FROM THE PRINCE GEORGES COUNTY HEALTH DEPARTMENT, FEDERALLY QUALIFIED HEALTH CENTERS, FAITH-BASED ORGANIZATIONS, AND BUSINESS LEADERS. AT THE MEETING WITH PUBLIC HEALTH EXPERTS, ATTENDEES INCLUDED HOSPITAL BOARD MEMBERS, ADMINISTRATORS, PHYSICIANS, AND NURSES. FURTHERMORE, THE CHNA TOOK INTO ACCOUNT DATA RECEIVED PURSUANT TO THE UNIVERSITY OF MARYLAND SCHOOL OF PUBLIC HEALTH PUBLIC HEALTH IMPACT STUDY

Part VI Supplemental Information

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(SPHPHIS) RANDOM HOUSEHOLD SURVEY CONDUCTED IN 2012, PURSUANT TO WHICH

PRINCE GEORGES COUNTY RESIDENTS 18 YEARS AND OLDER RESPONDED TO A

TELEPHONE INTERVIEW SURVEY.

PART V, LINE 3

LAUREL REGIONAL HOSPITAL

THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) TOOK INTO ACCOUNT INPUT FROM

REPRESENTATIVES OF THE COMMUNITY SERVED BY THE HOSPITAL FACILITY,

INCLUDING PERSONS WITH SPECIAL KNOWLEDGE OF OR EXPERTISE IN PUBLIC

HEALTH, AS WELL AS LEADERS AND REPRESENTATIVES OF MEDICALLY UNDERSERVED,

LOW-INCOME, AND MINORITY POPULATIONS. IN PARTICULAR, TWO COMMUNITY INPUT

MEETINGS WERE CONDUCTED, ONE WITH COMMUNITY LEADERS AND ONE WITH HEALTH

EXPERTS. AT THE MEETING WITH COMMUNITY LEADERS, PARTICIPANTS INCLUDED

REPRESENTATIVES FROM THE PRINCE GEORGES COUNTY HEALTH DEPARTMENT, PUBLIC

SCHOOLS, SENIOR SERVICE ORGANIZATIONS, LOCAL GOVERNMENT OFFICES,

FAITH-BASED ORGANIZATIONS, AND BUSINESS LEADERS. AT THE MEETING WITH

PUBLIC HEALTH EXPERTS, ATTENDEES INCLUDED HOSPITAL BOARD MEMBERS,

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ADMINISTRATORS, PHYSICIANS, A SENIOR SERVICES REPRESENTATIVE, AND NURSES.

FURTHERMORE, THE CHNA TOOK INTO ACCOUNT DATA RECEIVED PURSUANT TO THE UNIVERSITY OF MARYLAND SCHOOL OF PUBLIC HEALTH PUBLIC HEALTH IMPACT STUDY (SPHPHIS) RANDOM HOUSEHOLD SURVEY CONDUCTED IN 2012, PURSUANT TO WHICH PRINCE GEORGES COUNTY RESIDENTS 18 YEARS AND OLDER RESPONDED TO A TELEPHONE INTERVIEW SURVEY.

PART V, LINE 6

PRINCE GEORGES HOSPITAL CENTER

PRINCE GEORGE'S HOSPITAL CENTER (PGHC) FINISHED CONDUCTING ITS FIRST CHNA IN JUNE 2013. AS A RESULT, PGHC DID NOT BEGIN EXECUTING THE IMPLEMENTATION STRATEGY PRIOR TO THE END OF ITS 2012 TAX YEAR (JUNE 30, 2013). PGHC HAS PUT PROCESSES IN PLACE TO BEGIN ADDRESSING THE COMMUNITY HEALTH NEEDS IDENTIFIED IN THE CHNA DURING ITS 2013 TAX YEAR. IT IS THE INTENTION OF DIMENSIONS HEALTH CORPORATION TO DESCRIBE ACTIONS TAKEN BY PGHC TO ADDRESS COMMUNITY HEALTH NEEDS IDENTIFIED IN THE CHNA ON ITS 2013 FORM 990.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART V, LINE 6

LAUREL REGIONAL HOSPITAL

LAUREL REGIONAL HOSPITAL (LRH) FINISHED CONDUCTING ITS FIRST CHNA IN JUNE 2013. AS A RESULT, LRH DID NOT BEGIN EXECUTING THE IMPLEMENTATION STRATEGY PRIOR TO THE END OF ITS 2012 TAX YEAR (JUNE 30, 2013). LRH HAS PUT PROCESSES IN PLACE TO BEGIN ADDRESSING THE COMMUNITY HEALTH NEEDS IDENTIFIED IN THE CHNA DURING ITS 2013 TAX YEAR. IT IS THE INTENTION OF DIMENSIONS HEALTH CORPORATION TO DESCRIBE ACTIONS TAKEN BY LRH TO ADDRESS COMMUNITY HEALTH NEEDS IDENTIFIED IN THE CHNA ON ITS 2013 FORM 990.

PART V, LINE 7

PRINCE GEORGES HOSPITAL CENTER

PURSUANT TO THE CHNA AND CHNA IMPLEMENTATION STRATEGY, THE HOSPITAL FACILITY UNDERTOOK A PRIORITIZATION PROCESS FOR DETERMINING THOSE IDENTIFIED COMMUNITY HEALTH NEEDS THAT THE HOSPITAL FACILITY WOULD ATTEMPT TO ADDRESS. AS A RESULT OF THIS PRIORITIZATION PROCESS, THE HOSPITAL FACILITY DETERMINED THAT IT WAS NOT CURRENTLY POSITIONED 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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

FOCUS ON CERTAIN HEALTH CONCERNS IDENTIFIED BY THE CHNA. FOR EXAMPLE, THE HOSPITAL FACILITY WILL NOT FOCUS UPON ADDRESSING RESPIRATORY HEALTH AND SEPTICEMIA HEALTH CONCERNS DUE TO THE LACK OF AVAILABLE RESOURCES TO MAKE THE MOST IMPACTFUL CHANGE IN THESE AREAS. ALTHOUGH THESE NEEDS WILL NOT BE FOCUS AREAS UNDER THE CHNA IMPLEMENTATION STRATEGY, THEY WILL BE TAKEN INTO ACCOUNT AND INCORPORATED INTO THE STRATEGIC PLAN WHERE APPROPRIATE.

IN ADDITION, SINCE THE HOSPITAL FACILITY CURRENTLY PROVIDES EMERGENCY PSYCHIATRIC, INPATIENT BEHAVIORAL HEALTH AND OUTPATIENT PARTIAL HOSPITALIZATION SERVICES TO ASSIST WITH THE MENTAL HEALTH NEEDS IN THE COMMUNITY, BEHAVIORAL HEALTH WAS NOT SELECTED AS ONE OF THE COMMUNITY HEALTH NEEDS FOCUS AREAS. THOUGH THESE NEEDS ARE NOT PRESENTLY BEING ADDRESSED BY PGHC AS AN AREA OF FOCUS, THE HOSPITAL FACILITY WILL EXPLORE OPPORTUNITIES TO COLLABORATE WITH OTHER COMMUNITY AND PUBLIC HEALTH ORGANIZATIONS SUCH AS THE HEALTH DEPARTMENT AND FEDERALLY QUALIFIED HEALTH CENTERS TO ADDRESS THESE NEEDS.

Part VI Supplemental Information

Complete this part to provide the following information.

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

LAUREL REGIONAL HOSPITAL

PURSUANT TO THE CHNA AND CHNA IMPLEMENTATION STRATEGY, THE HOSPITAL FACILITY UNDERTOOK A PRIORITIZATION PROCESS FOR DETERMINING THOSE IDENTIFIED COMMUNITY HEALTH NEEDS THAT THE HOSPITAL FACILITY WOULD ATTEMPT TO ADDRESS. AS A RESULT OF THIS PRIORITIZATION PROCESS, THE HOSPITAL FACILITY DETERMINED THAT IT WAS NOT CURRENTLY POSITIONED TO FOCUS ON CERTAIN HEALTH CONCERNS IDENTIFIED BY THE CHNA. FOR EXAMPLE, THE HOSPITAL FACILITY WILL NOT FOCUS UPON ADDRESSING HEART AND KIDNEY FAILURE HEALTH CONCERNS DUE TO THE LACK OF AVAILABLE RESOURCES TO MAKE THE MOST IMPACTFUL CHANGE IN THESE AREAS. THOUGH THESE NEEDS ARE NOT PRESENTLY BEING ADDRESSED BY LRH AS AN AREA OF FOCUS, THE HOSPITAL FACILITY WILL EXPLORE OPPORTUNITIES TO COLLABORATE WITH OTHER COMMUNITY AND PUBLIC HEALTH ORGANIZATIONS SUCH AS THE HEALTH DEPARTMENT AND FEDERALLY QUALIFIED HEALTH CENTERS TO ADDRESS THESE NEEDS.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART V, LINE 18

PRINCE GEORGES HOSPITAL CENTER

THE HOSPITAL FACILITY OR AN AUTHORIZED THIRD PARTY DID NOT UNDERTAKE ANY OF THE COLLECTION ACTIONS NOTED IN PART V, SECTION B, LINE 16 BEFORE MAKING REASONABLE EFFORTS TO DETERMINE ANY PATIENT'S ELIGIBILITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY. IN ORDER TO HELP DETERMINE PATIENTS' ELIGIBILITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL UNDERTAKES A NUMBER OF ACTIONS, INCLUDING NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY ON ADMISSION, NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY PRIOR TO DISCHARGE, NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY IN COMMUNICATIONS WITH THE PATIENTS' BILLS, AND DOCUMENTING ITS DETERMINATION OF WHETHER PATIENTS WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE 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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
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- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART V, LINE 18

LAUREL REGIONAL HOSPITAL

THE HOSPITAL FACILITY OR AN AUTHORIZED THIRD PARTY DID NOT UNDERTAKE ANY OF THE COLLECTION ACTIONS NOTED IN PART V, SECTION B, LINE 17 BEFORE MAKING REASONABLE EFFORTS TO DETERMINE ANY PATIENT'S ELIGIBILITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY. IN ORDER TO HELP DETERMINE PATIENTS' ELIGIBILITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL UNDERTAKES A NUMBER OF ACTIONS, INCLUDING NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY ON ADMISSION, NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY PRIOR TO DISCHARGE, NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY IN COMMUNICATIONS WITH THE PATIENTS' BILLS, AND DOCUMENTING ITS DETERMINATION OF WHETHER PATIENTS WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE 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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
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- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART V, LINE 20

PRINCE GEORGES HOSPITAL CENTER

THE HOSPITAL FACILITY PROVIDES A DISCOUNT OF AT LEAST 25% OFF OF GROSS CHARGES FOR THE PROVISION OF EMERGENCY AND OTHER MEDICALLY NECESSARY CARE TO ANY INDIVIDUAL THAT IS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY. PURSUANT TO THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) ALL-PAYOR SYSTEM FOR HOSPITALS IN THE STATE OF MARYLAND, THE GREATEST DISCOUNT OFF OF GROSS CHARGES FOR THE PROVISION OF EMERGENCY AND OTHER MEDICALLY NECESSARY CARE PERMITTED TO ANY COMMERCIAL INSURER OR MEDICARE IS ONLY 6%. AS A RESULT, THE HOSPITAL FACILITY WAS ABLE TO DETERMINE THAT THE MAXIMUM AMOUNT CHARGED TO INDIVIDUALS THAT WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY WAS NOT GREATER THAN THE AMOUNT GENERALLY BILLED TO INDIVIDUALS WHO HAVE INSURANCE COVERING SUCH 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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART V, LINE 20

LAUREL REGIONAL HOSPITAL

THE HOSPITAL FACILITY PROVIDES A DISCOUNT OF AT LEAST 25% OFF OF GROSS CHARGES FOR THE PROVISION OF EMERGENCY AND OTHER MEDICALLY NECESSARY CARE TO ANY INDIVIDUAL THAT IS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY. PURSUANT TO THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) ALL-PAYOR SYSTEM FOR HOSPITALS IN THE STATE OF MARYLAND, THE GREATEST DISCOUNT OFF OF GROSS CHARGES FOR THE PROVISION OF EMERGENCY AND OTHER MEDICALLY NECESSARY CARE PERMITTED TO ANY COMMERCIAL INSURER OR MEDICARE IS ONLY 6%. AS A RESULT, THE HOSPITAL FACILITY WAS ABLE TO DETERMINE THAT THE MAXIMUM AMOUNT CHARGED TO INDIVIDUALS THAT WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY WAS NOT GREATER THAN THE AMOUNT GENERALLY BILLED TO INDIVIDUALS WHO HAVE INSURANCE COVERING SUCH CARE.

Part VI Supplemental Information

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

PART V, LINE 22

PRINCE GEORGES HOSPITAL CENTER

THE HOSPITAL FACILITY DOES NOT CHARGE ANY INDIVIDUALS THAT IT KNOWS ARE ELIGIBLE FOR FINANCIAL ASSISTANCE AN AMOUNT EQUAL TO THE GROSS CHARGE FOR ANY SERVICE. THE HOSPITAL USES THE CHARGE MASTER RATES FOR A SERVICE AS A STARTING POINT AGAINST WHICH THE DISCOUNTS MANDATED IN THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY ARE APPLIED TO DETERMINE THE AMOUNT ACTUALLY BILLED TO PATIENTS ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY. THE HOSPITAL FACILITY WILL NOT COLLECT PAYMENT FROM ANY PATIENT ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY IN EXCESS OF THE REDUCED AMOUNT THAT IS ACTUALLY BILLED TO SUCH FINANCIAL ASSISTANCE PATIENT.

PART V, LINE 22

LAUREL REGIONAL HOSPITAL

THE HOSPITAL FACILITY DOES NOT CHARGE ANY INDIVIDUALS THAT IT KNOWS ARE ELIGIBLE FOR FINANCIAL ASSISTANCE AN AMOUNT EQUAL TO THE GROSS CHARGE FOR

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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ANY SERVICE. THE HOSPITAL USES THE CHARGE MASTER RATES FOR A SERVICE AS A STARTING POINT AGAINST WHICH THE DISCOUNTS MANDATED IN THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY ARE APPLIED TO DETERMINE THE AMOUNT ACTUALLY BILLED TO PATIENTS ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY. THE HOSPITAL FACILITY WILL NOT COLLECT PAYMENT FROM ANY PATIENT ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY IN EXCESS OF THE REDUCED AMOUNT THAT IS ACTUALLY BILLED TO SUCH FINANCIAL ASSISTANCE PATIENT.

PART VI, LINE 2, NEEDS ASSESSMENT

IN ADDITION TO CONDUCTING A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FOR PGHC AND LRH, THE ORGANIZATION HAS UNDERTAKEN CERTAIN ACTIVITIES TO HELP DETERMINE THE NEEDS OF ITS COMMUNITY.

A PRINCE GEORGE'S COUNTY HEALTH PROFILE SNAPSHOT REPORT WAS COMPLETED BY PGHC IN JUNE 2006. THE REPORT WAS GENERATED AS A RESULT OF A COLLABORATIVE EFFORT BETWEEN PGHC AND THE PRINCE GEORGES' COUNTY HEALTH DEPARTMENT. THE DATA REFERENCED IN THE REPORT WAS ACQUIRED FROM US CENSUS

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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DATA AND FROM THE PUBLIC HEALTH QUICK STATS FOR PRINCE GEORGES' COUNTY,

MARYLAND AND THE MOST RECENT MARYLAND VITAL STATISTICS REPORT.

ADDITIONALLY, THERE HAVE BEEN HEALTHCARE ASSESSMENT REPORTS/STUDIES

PREPARED BY RAND CORPORATION IN FEBRUARY 2009, PRINCE GEORGE'S COUNTY

GOVERNMENT IMPROVEMENT PLAN IN 2011, AND A PUBLIC IMPACT HEALTH STUDY BY

THE UNIVERSITY OF MARYLAND SCHOOL OF PUBLIC HEALTH IN 2012. THE MAIN

FINDINGS OF BOTH THE 2006 PG COUNTY HEALTH PROFILE SNAPSHOT REPORT, THE

2009 RAND REPORT, THE PRINCE GEORGE'S COUNTY REPORT AND THE 2012 UM SPH

PUBLIC HEALTH IMPACT STUDY IS THAT THERE ARE SIGNIFICANT HEALTH

DISPARITIES IN PRINCE GEORGES' COUNTY AND THAT THE COUNTY LACKS A ROBUST

HEALTH SAFETY NET. A COMMON THEME IS THAT THERE ARE HEALTHCARE

DISPARITIES WHICH INCLUDE (1) RATES OF UNINSURANCE THAT ARE RELATIVELY

HIGH WHEN COMPARED WITH SURROUNDING JURISDICTIONS AND (2) A SHORTAGE OF

PRIMARY CARE PHYSICIANS IN THE COMMUNITY.

IN MARCH 2008, THE PGCH BOARD OF DIRECTORS ESTABLISHED A COMMUNITY HEALTH

TASK FORCE (CHTF) COMMITTEE. THE CHTF INCLUDES COLLABORATIONS WITH SUCH

Part VI Supplemental Information

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ORGANIZATIONS AS THE PRINCE GEORGE'S COUNTY HEALTH ACTION FORUM AND THE PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT. THE PURPOSE OF THE CHTF IS TO ASSIST MANAGEMENT IN THE DEVELOPMENT OF RELATIONSHIPS AND A PLAN TO WORK WITH IDENTIFIED COMMUNITY-BASED HEALTH SERVICES AND TO MAKE AN OPTIMAL RANGE OF SERVICES MORE WIDELY AVAILABLE TO IMPROVE COMMUNITY HEALTH STATUS. TO DATE, THE CHTF HAS FOCUSED ATTENTION ON COMMUNITY HEALTH NEEDS, PROVIDING IMPROVED HEALTH INFORMATION, AND IS CURRENTLY WORKING WITH THE NATIONAL INSTITUTE OF HEALTH - NATIONAL LIBRARY OF MEDICINE (NIH-NLM) TO IDENTIFY SUSTAINABLE COMMUNITY HEALTH DELIVERY INITIATIVES.

LRH MANAGEMENT ACTIVELY SOLICITS INFORMATION FROM COMMUNITY STAKEHOLDERS AND OTHER COMMUNITY-BASED ORGANIZATIONS TO ASSESS THE HEALTH NEEDS IN OUR COMMUNITY. LRH REPRESENTATIVES SERVE AS MEMBERS OF A VARIETY OF HEALTHCARE FOCUSED COMMUNITY ORGANIZATIONS AND PROVIDE STAFF EXPERTISE AND OTHER RESOURCES, INCLUDING HOSTING MEETINGS AT OUR FACILITY, AND PARTICIPATING IN EVENTS, BY PROVIDING HEALTH SCREENING SERVICES. SOME OF

Part VI Supplemental Information

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THESE ORGANIZATIONS INCLUDE:

*PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT

*PRINCE GEORGE'S CARE ACCESS NETWORK HEALTH INFORMATION AND RESOURCE
INITIATIVE (PG CAN)

*HEALTH ACTION FORUM OF PRINCE GEORGE'S COUNTY

*PRINCE GEORGE'S HEALTHCARE ACTION COALITION

*NATIONAL CAPITAL AREA BREAST HEALTH QUALITY CONSORTIUM

*THE PRINCE GEORGE'S COUNTY LOCAL HEALTH DISPARITIES COMMITTEE

*THE HEALTH EMPOWERMENT NETWORK OF MARYLAND, INC. (HENM) - A COMMUNITY
BASED ORGANIZATION MADE UP OF PARTNERS SUCH AS THE PRINCE GEORGE'S COUNTY
HEALTH DEPARTMENT, UNIVERSITY OF MARYLAND PREVENTION RESOURCE CENTER,
PRINCE GEORGE'S COUNTY AREA AGENCY ON AGING, DEPARTMENT OF MENTAL HEALTH
AND HYGIENE, INTEGRITY HEALTH PARTNERS AND THE CITY OF SEAT PLEASANT
AMONG OTHERS.

Part VI Supplemental Information

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PART VI, LINE 3, PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

DIMENSIONS HEALTHCARE SYSTEM PROVIDES COMPASSIONATE CARE FOR ALL,
REGARDLESS OF AN INDIVIDUAL'S ABILITY TO PAY. IT IS OUR MISSION TO SERVE
AS THE SAFETY NET FOR THE UNINSURED AND UNDERINSURED AND TO HELP SAVE
LIVES AND IMPROVE OUR PATIENTS' QUALITY OF LIVING.

DIMENSIONS HEALTHCARE SYSTEM, THROUGH THE PROVISION OF DISCOUNTED OR FREE
HEALTH CARE SERVICES, (DEPENDING UPON THE ESTABLISHED CRITERIA SET OUT
BELOW), PROVIDES FINANCIAL ASSISTANCE TO THOSE WHO NEED EMERGENCY AND
OTHER MEDICALLY NECESSARY SERVICES BUT DO NOT HAVE THE RESOURCES TO PAY
FOR THAT CARE. IT DOES SO BY PRESERVING THE DIGNITY OF THE INDIVIDUAL WHO
NEEDS ASSISTANCE.

THE PROVISION OF FREE AND DISCOUNTED CARE THROUGH OUR FINANCIAL
ASSISTANCE PROGRAM IS CONSISTENT, APPROPRIATE AND ESSENTIAL TO THE
EXECUTION OF OUR MISSION, VISION AND VALUES, AND IS CONSISTENT WITH OUR
TAX-EXEMPT, CHARITABLE STATUS.

Part VI Supplemental Information

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DIMENSIONS HEALTHCARE SYSTEM IS COMMITTED TO: COMMUNICATING THE ORGANIZATION'S MISSION TO THE PATIENT SO THEY CAN MORE FULLY AND FREELY PARTICIPATE IN PROVIDING THE NEEDED FINANCIAL INFORMATION WITHOUT FEAR OF LOSING BASIC ASSETS AND INCOME; ASSESSING THE PATIENTS' CAPACITY TO PAY AND REACH PAYMENT ARRANGEMENTS THAT DO NOT JEOPARDIZE THE PATIENTS' HEALTH AND BASIC LIVING ARRANGEMENTS OR UNDERMINE THEIR CAPACITY FOR SELF-SUFFICIENCY; UPHOLDING AND HONORING PATIENTS' RIGHTS TO APPEAL DECISIONS AND SEEK RECONSIDERATION FOR FINANCIAL ASSISTANCE AND TO HAVE A SELF-SELECTED ADVOCATE TO ASSIST THE PATIENT THROUGHOUT THE PROCESS; AVOIDING SEEKING OR DEMANDING PAYMENT FROM OR SEIZING INCOME OR ASSETS FROM PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE; AND PROVIDING OPTIONS FOR PAYMENT ARRANGEMENTS, WITHOUT REQUIRING THAT THE PATIENT SELECT HIGHER COST OPTIONS FOR REPAYMENT.

IN ORDER TO PROMOTE THE HEALTH AND WELL-BEING OF THE COMMUNITY SERVED, INDIVIDUALS WITH LIMITED FINANCIAL RESOURCES WHO ARE UNABLE TO ACCESS

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ENTITLEMENT PROGRAMS SHALL BE ELIGIBLE FOR FREE OR DISCOUNTED HEALTH CARE SERVICES BASED ON ESTABLISHED CRITERIA. ELIGIBILITY CRITERIA WILL BE BASED, IN LARGE PART, UPON THE FEDERAL POVERTY GUIDELINES AND WILL BE UPDATED ANNUALLY IN CONJUNCTION WITH THE PUBLISHED UPDATES BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES. ALL OPEN SELF-PAY BALANCES MAY BE CONSIDERED FOR FINANCIAL ASSISTANCE. IF A DETERMINATION IS MADE THAT THE PATIENT HAS THE ABILITY TO PAY ALL OR A PORTION OF THE BILL, SUCH A DETERMINATION DOES NOT PREVENT A REASSESSMENT OF THE PERSON'S ABILITY TO PAY AT A LATER DATE. THE NEED FOR FINANCIAL ASSISTANCE IS TO BE RE-EVALUATED AT THE FOLLOWING TIMES:

*SUBSEQUENT RENDERING OF SERVICES,

*INCOME CHANGE,

*FAMILY SIZE CHANGE,

*WHEN AN ACCOUNT THAT IS CLOSED IS TO BE REOPENED, OR

*WHEN THE LAST FINANCIAL EVALUATION WAS COMPLETED MORE THAN SIX MONTHS BEFORE.

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APPROPRIATE SIGNAGE WILL BE VISIBLE IN THE FACILITY IN ORDER TO CREATE AWARENESS OF THE FINANCIAL ASSISTANCE PROGRAM AND THE ASSISTANCE AVAILABLE. AT A MINIMUM, SIGNAGE WILL BE POSTED IN ALL PATIENT INTAKE AREAS, INCLUDING, BUT NOT LIMITED TO, THE EMERGENCY DEPARTMENT, THE BILLING OFFICE, AND THE ADMISSION/PATIENT REGISTRATION AREAS. INFORMATION SUCH AS BROCHURES WILL BE INCLUDED IN PATIENT SERVICES/INFORMATION FOLDERS AND/OR AT PATIENT INTAKE AREAS. ALL PUBLIC INFORMATION AND/OR FORMS REGARDING THE PROVISION OF FINANCIAL ASSISTANCE WILL USE LANGUAGES THAT ARE APPROPRIATE FOR THE FACILITY'S SERVICE AREA IN ACCORDANCE WITH THE STATE'S LANGUAGE ASSISTANCE SERVICES ACT.

THE NECESSITY FOR MEDICAL TREATMENT OF ANY PATIENT WILL BE BASED ON THE CLINICAL JUDGMENT OF THE PROVIDER WITHOUT REGARD TO THE FINANCIAL STATUS OF THE PATIENT. ALL PATIENTS WILL BE TREATED WITH RESPECT AND FAIRNESS REGARDLESS OF THEIR ABILITY TO PAY.

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WHERE POSSIBLE, PRIOR TO THE ADMISSION OF THE PATIENT, THE HOSPITAL WILL CONDUCT A PRE-ADMISSION INTERVIEW WITH THE PATIENT, THE GUARANTOR, AND/OR HIS/HER LEGAL REPRESENTATIVE TO DETERMINE POTENTIAL ELIGIBILITY UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY. IF A PRE-ADMISSION INTERVIEW IS NOT POSSIBLE, THIS INTERVIEW SHOULD BE CONDUCTED UPON ADMISSION OR AS SOON AS POSSIBLE THEREAFTER. IN THE CASE OF AN EMERGENCY ADMISSION, THE HOSPITAL'S EVALUATION OF PAYMENT ALTERNATIVES SHOULD NOT TAKE PLACE UNTIL THE REQUIRED MEDICAL CARE HAS BEEN PROVIDED. AT THE TIME OF THE INITIAL INTERVIEW, THE FOLLOWING INFORMATION SHOULD BE GATHERED:

- A) ROUTINE AND COMPREHENSIVE DEMOGRAPHIC AND FINANCIAL DATA.
- B) COMPLETE INFORMATION REGARDING ALL EXISTING THIRD PARTY COVERAGE.

IDENTIFICATION OF POTENTIALLY ELIGIBLE PATIENTS CAN TAKE PLACE AT ANY TIME DURING THE RENDERING OF SERVICES OR DURING THE COLLECTION PROCESS. ALSO, THOSE PATIENTS WHO MAY QUALIFY FOR MEDICAL ASSISTANCE FROM A

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GOVERNMENTAL PROGRAM SHOULD BE REFERRED TO THE APPROPRIATE PROGRAM, SUCH AS MEDICAID, PRIOR TO CONSIDERATION FOR FINANCIAL ASSISTANCE.

MEDICAID ELIGIBILITY

ALL UNINSURED INPATIENTS AT DIMENSIONS ARE ASSISTED BY DHS MEDICAID ELIGIBILITY STAFF TO EVALUATE THE PATIENTS FOR MARYLAND MEDICAID ELIGIBILITY. ONCE THEY ARE EVALUATED, THE STAFF WILL ASSIST THE PATIENTS WITH THE COMPLETION OF THE MEDICAID APPLICATION. THE APPLICATION IS PRESENTED TO DSS FOR REVIEW AND CERTIFICATION. THE STAFF MONITORS THE APPLICATION PROCESS TO ENSURE THAT A DETERMINATION IS MADE ON THE APPLICATION. DHS PATIENTS DO NOT RECEIVE A BILL DURING THIS PROCESS. ONCE THE MEDICAID APPLICATION DETERMINATION HAS BEEN MADE, PATIENTS WHO QUALIFY WILL RECEIVE A BILL. IF A PATIENT IS DEEMED INELIGIBLE FOR MEDICAID, THE PATIENT WILL BE CATEGORIZED AS SELF PAY AND ASSESSED FOR POSSIBLE ELIGIBILITY UNDER THE FINANCIAL ASSISTANCE PROGRAM. ASSESSED FOR POSSIBLE ELIGIBILITY UNDER THE FINANCIAL ASSISTANCE PROGRAM.

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PART VI, LINE 4, COMMUNITY INFORMATION

DIMENSIONS HEALTHCARE SYSTEM (DHS) IS THE LARGEST NOT-FOR-PROFIT PROVIDER OF HEALTH CARE SERVICES IN PRINCE GEORGE'S COUNTY. ADDITIONAL COUNTIES AND AREAS SERVED INCLUDE ANNE ARUNDEL, HOWARD, AND MONTGOMERY COUNTIES AND THE DISTRICT OF COLUMBIA.

DHS HOSPITALS' PRIMARY COVERAGE AREA IS PRINCE GEORGE'S COUNTY. THE POPULATION ESTIMATE FOR PRINCE GEORGE'S COUNTY IN 2010 WAS 863,420. IN PRINCE GEORGE'S COUNTY, THE MEDIAN HOUSEHOLD INCOME WAS \$73,447 AND THE PERCENTAGE OF PERSONS BELOW POVERTY LEVEL WAS 8.2%. OF THE COUNTIES AND AREAS SERVED, PRINCE GEORGE'S COUNTY HAS THE HIGHEST PERCENTAGE OF HOUSEHOLDS WITH INCOME BELOW THE FEDERAL POVERTY LINE AS WELL AS HIGHER PERCENTAGE OF UNINSURED (15.6%), MEDICAID RECIPIENTS (15.7%) AND THE HIGHEST MORTALITY RATE (747.8%/100,000). IN THE OTHER SERVICE AREAS, ANNE ARUNDEL COUNTY, THE DISTRICT OF COLUMBIA, HOWARD AND MONTGOMERY COUNTIES, MEDIAN HOUSEHOLD INCOME WAS \$85,690, \$61,835 \$105,692 AND \$95,660, THE PERCENTAGE OF PERSONS BELOW POVERTY LEVEL BEING 5.5%, 18.2%,

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4.5% AND 6.3% RESPECTIVELY (US CENSUS BUREAU STAT AND COUNTY QUICK FACTS) .

FOR EACH OF THE COUNTIES AND AREAS COMPRISING THE SERVICE AREA,
9.9%–10.2% OF THE POPULATION IS 65 YEARS OF AGE OF OLDER AND
APPROXIMATELY 7%–27.4% REPRESENT MEDICAID PATIENTS.

IN PRINCE GEORGE'S AND OTHER SERVICE AREAS, SMOKING, OBESITY AND
EXCESSIVE ALCOHOL CONSUMPTION ARE HEALTH RISK FACTORS. THERE ARE RISK
FACTORS FOR PREMATURE DEATH; SUCH AS HIGH BLOOD PRESSURE RANGING BETWEEN
19.8% –28.2%; OBESITY 16.4% – 34%; SMOKER 11.9% – 22.4%.

ACCESS TO PRIMARY HEALTH CARE SERVICES REMAINS AN ISSUE OF CONCERN IN
PRINCE GEORGE'S COUNTY. PRINCE GEORGE'S COUNTY HAS SUBSTANTIALLY LOWER
PER CAPITA NUMBERS OF PRIMARY CARE PHYSICIANS WHEN COMPARED TO
NEIGHBORING JURISDICTIONS. THE NATIONAL BENCHMARK IS 631:1 FOR ACCESS TO
PRIMARY CARE PHYSICIAN, COMPARED TO 1077:1 FOR PRINCE GEORGE'S COUNTY.

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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

THE NUMBER OF SAFETY NET CLINICS IN PRINCE GEORGE'S HOSPITAL IS 5, WHICH COMPARES TO 38-40 IN THE DISTRICT OF COLUMBIA AND 11 IN MONTGOMERY COUNTY.

IN LIGHT OF THE COUNTY'S HIGH UNINSURED OR UNDERINSURED POPULATION THAT PAYS LITTLE TO NO REIMBURSEMENT FOR SERVICES RECEIVED, THE COUNTY'S LEVEL OF PRIVATE-PRACTICE PRIMARY CARE DOCTORS AND PRIMARY CARE CLINICS HAS NOT KEPT PACE WITH THE HEALTH CARE NEEDS OF COUNTY RESIDENTS. THE CAPACITY OF COMMUNITY-BASED CARE, INCLUDING SAFETY-NET CLINICS, REMAINS SEVERELY LIMITED. THIS LACK OF PRIMARY CARE SERVICES AND PATIENT "MEDICAL HOMES" HAS RESULTED IN AN INCREASE USE OF THE HOSPITAL'S EMERGENCY DEPARTMENTS AND OTHER SPECIALTY HEALTH CARE SERVICES. FOR THE FISCAL YEAR ENDING JUNE 30, 2013, PGHC AND LRH, HAD A PATIENT AND THIRD PARTY PAYER MIX THAT INCLUDED 57.9% AND 38.7%, RESPECTIVELY, FOR MEDICAID AND UNINSURED SELF-PAY PATIENTS.

COMMUNITY CHALLENGES & HEALTH STATISTICS:

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

DESPITE THE HIGHER THAN AVERAGE MEDIAN HOUSEHOLD INCOME, EDUCATIONAL ATTAINMENT, AND PERCENTAGE OF INDIVIDUALS IN THE WORK FORCE REPRESENTED BY PRINCE GEORGIANS IN COMPARISON WITH NATIONAL FIGURES, THE COUNTY DOES CONTAIN SEVERAL POCKETS OF LOW SOCIOECONOMIC STATUS. THE 2009 COMMUNITY HEALTH STATUS REPORT DATA REVEALS THAT MEDICALLY VULNERABLE PRINCE GEORGIAN'S (UNINSURED AND MEDICAID ENROLLED INDIVIDUALS) NUMBER APPROXIMATELY 297,784 OR 35.7% OF THE POPULATION. AS A RESULT, ISSUES SUCH AS DIABETES MORTALITY, HEART DISEASE, HYPERTENSION, STROKE, AND DEATHS FROM BREAST, COLORECTAL AND PROSTATE CANCERS, HIV AND INFANT MORTALITY ALL REPRESENT SIGNIFICANT HEALTH CHALLENGES FOR COMMUNITY MEMBERS. FURTHERMORE, PERSISTENT DISPARITIES IN MORTALITY AND HEALTH STATUS FOR SEVERAL HEALTH INDICES ARE SEEN IN VARIOUS RACIAL AND ETHNIC POPULATIONS. THE RACIAL AND ETHNIC MINORITIES ARE APPROXIMATELY 2/3 OF PRINCE GEORGE'S COUNTY MEDICAID BENEFICIARIES. COUNTY AND MARYLAND STATE HEALTH STATISTICS ARE SIMILAR TO NATIONAL TRENDS REGARDING THE STATUS OF MINORITY 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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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- 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.).
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- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART VI, LINE 5, PROMOTION OF COMMUNITY HEALTH

DIMENSIONS HEALTH CORPORATION (DHC) MAINTAINS CLINICAL AFFILIATION

AGREEMENTS WITH AND SUPPORTS CLINICAL PLACEMENTS FOR BOTH NURSING AND

ANCILLARY PROGRAMS IN AND OUT OF STATE. IN ADDITION, WITH STATE SUPPORT,

DHC PARTICIPATES IN THE NSP II GRANT WHICH IS A PARTNERSHIP DESIGNED TO

PROMOTE BSN AND MSN COMPLETION FOR RNS. DHC ALSO PARTICIPATED IN THE NSP

I GRANT. ONE OF THE PROVISIONS IN THIS GRANT IS THE AVAILABILITY OF

\$4,000 PER YEAR FOR UP TO 15 PRINCE GEORGE'S COUNTY RESIDENTS WHO ARE

ENROLLED IN AN ENTRY LEVEL NURSING PROGRAM. IN TERMS OF COMMUNITY-BASED

MENTORING DHC STAFF MEMBERS PARTICIPATE ON A SMALL SCALE IN CAREER DAYS

AT LOCAL COUNTY SCHOOLS. ADDITIONALLY, DHC HAS ESTABLISHED COLLABORATIONS

WITH SUCH ORGANIZATIONS AS THE PRINCE GEORGE'S COUNTY (MARYLAND) HEALTH

ACTION FORUM AND THE PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT. THE

PURPOSE OF THE COLLABORATIONS IS TO ASSIST MANAGEMENT IN THE DEVELOPMENT

OF RELATIONSHIPS AND A PLAN TO WORK WITH IDENTIFIED COMMUNITY-BASED

HEALTH SERVICES AND TO MAKE AN OPTIMAL RANGE OF SERVICES MORE WIDELY

AVAILABLE TO IMPROVE COMMUNITY HEALTH STATUS. TO DATE, THIS EFFORT HAS

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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FOCUSED ATTENTION ON COMMUNITY HEALTH NEEDS, PROVIDED IMPROVED HEALTH INFORMATION, AND DHC IS CURRENTLY WORKING WITH THE NATIONAL INSTITUTE OF HEALTH - NATIONAL LIBRARY OF MEDICINE TO IDENTIFY SUSTAINABLE COMMUNITY HEALTH INFORMATION DELIVERY INITIATIVES. DHC ALSO PROVIDED A NUMBER OF HEALTH FAIRS, HEALTH EMPLOYEE INTERNSHIPS, AND OTHER PROGRAMS TO PROMOTE HEALTH IN THE SURROUNDING COMMUNITIES.

DHC IS COMPRISED OF AN 11 MEMBER BOARD OF DIRECTORS. THE BOARD IS ENTIRELY COMPOSED OF INDEPENDENT INDIVIDUALS WHO LIVE IN THE COMMUNITY.

THE DIMENSIONS HEALTH SYSTEM PROVIDES A BROAD ARRAY OF INPATIENT AND COMMUNITY BASED SERVICES TO RESIDENTS IN THE METROPOLITAN REGION. THE SYSTEM OPERATES SEVERAL FACILITIES, INCLUDING TWO ACUTE CARE HOSPITALS. ALL PHYSICIANS LICENSED IN THE STATE OF MARYLAND WHO MEET THE FACILITY BYLAW REQUIREMENTS ARE ELIGIBLE TO APPLY FOR PRIVILEGES AT THE TWO ACUTE CARE HOSPITALS, PGHC AND LRH. ALTHOUGH PGHC HAS ONE OF THE LARGEST

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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POPULATIONS OF UNINSURED PATIENTS IN THE STATE, WE BELIEVE THAT ALL PATIENTS SHOULD RECEIVE THE HIGHEST LEVEL OF CARE REGARDLESS OF ECONOMIC STANDING. THIS GOAL CAN ONLY BE ACHIEVED WITH EXPERIENCED SPECIALIST PHYSICIANS CARING FOR ALL OF OUR PATIENTS, EVEN WHEN SO MANY OF OUR PATIENTS CANNOT AFFORD TO PAY. TO OVERCOME THIS FORMIDABLE DILEMMA, WE REIMBURSE PHYSICIANS FOR BAD DEBTS INCURRED BY THE PHYSICIANS CARING FOR HOSPITAL PATIENTS, SO THE "GAP" EXISTS IN THE HOSPITAL'S PROFITS BUT NOT IN PATIENT CARE. IN PARTICULAR, WE ARE NOT REIMBURSED FROM THE HSCRC ALL-PAYOR SYSTEM FOR THESE PHYSICIAN SUBSIDY PAYMENTS.

WE HAVE ALSO IDENTIFIED SEVERAL HEALTH-RELATED TRENDS, NEEDS, AND PROBLEMS FACING OUR POPULATION, INCLUDING ACCESS TO SPECIALTY CARE, MATERNAL AND CHILD HEALTH, ETC. THE ORGANIZATION'S STRATEGIES FOR ADDRESSING THESE ISSUES INCLUDE PROVIDING CLASSES, SEMINARS, SCREENING AND HEALTH SERVICES, DIABETES EDUCATION, CPR, ACLS, PREEMIE SUPPORT GROUP, SMOKING CESSATION PRESENTATIONS, PROVIDE FLU SHOTS TO THE PUBLIC, PROVIDE BLOOD PRESSURE SCREENINGS TO LOCAL CHURCHES.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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PRINCE GEORGE'S HOSPITAL CENTER (PGHC) AND LAUREL REGIONAL HOSPITAL (LRH) HAVE PARTNERED WITH COMMUNITY-BASED ORGANIZATIONS TO INCREASE THEIR CAPACITY TO PROVIDE SERVICES TO THE COMMUNITY. THIS INCLUDES PROVIDING VARIOUS FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) SITES IN PRINCE GEORGE'S COUNTY WITH ADDITIONAL HEALTHCARE PROVIDERS TO FACILITATE ACCESS TO SUB-SPECIALTY SERVICES FOR UNINSURED AND UNDERINSURED RESIDENTS. WE ARE ALSO PROUD TO PARTNER WITH OUTREACH GROUPS SUCH AS ALCOHOLICS ANONYMOUS, NARCOTICS ANONYMOUS, AND PARKINSON'S SUPPORT GROUP. THE HOSPITALS HAVE ALSO WORKED WITH LOCAL AND STATE HEALTH OFFICIALS TO DEVELOP THE PRINCE GEORGE'S COUNTY AND THE STATE HEALTH IMPROVEMENT PLANS AND CONTINUES TO WORK CLOSELY WITH THE HEALTH DEPARTMENT TO IMPLEMENT PROGRAMS THAT ADDRESS THE HEALTH PLAN GOALS.

PGHC AND LRH ARE IMPROVING AND ADAPTING CURRENT HEALTH PROGRAMS INTO SUSTAINABLE COMMUNITY-BASED PROGRAMS TO IMPACT THE OVERALL HEALTH AND WELLNESS OF THE COMMUNITY IN A POSITIVE WAY. THIS SERVICE EXPANSION 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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

ADAPTATION IS BEING ACHIEVED THROUGH COLLABORATIVE PARTNERSHIPS WITH
COMMUNITY ORGANIZATIONS AS WELL AS STATE AND LOCAL HEALTH AGENCIES

PART VI, LINE 6, AFFILIATED HEALTHCARE SYSTEM

DIMENSIONS HEALTHCARE SYSTEM IS THE LARGEST NOT-FOR-PROFIT PROVIDER OF
HEALTH CARE SERVICES IN PRINCE GEORGE'S COUNTY. DIMENSION HEALTH
CORPORATION PROVIDES MANY DIFFERENT SERVICES TO THE COMMUNITY IT SERVES,
INCLUDING OPERATING PRINCE GEORGE'S HOSPITAL CENTER (PGHC), LAUREL
REGIONAL HOSPITAL, GLADYS SPELLMAN CARE UNITY AND BOWIE HEALTH CENTER.
PGHC OFFERS A COMPREHENSIVE RANGE OF INPATIENT AND OUTPATIENT MEDICAL AND
SURGICAL SERVICES INCLUDING: EMERGENCY AND TRAUMA SERVICES (DESIGNATED
LEVEL II REGIONAL TRAUMA CENTER FOR SOUTHERN MARYLAND), CRITICAL CARE
SERVICES, CARDIAC CARE SERVICES (COMPREHENSIVE CARDIAC CARE - ONLY
PROGRAM OF ITS KIND IN THE COUNTY). LAUREL REGIONAL HOSPITAL OFFERS A
COMPREHENSIVE RANGE OF INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL
SERVICES INCLUDING EMERGENCY SERVICES, CRITICAL CARE SERVICES, CARDIAC
CARE SERVICES, LABORATORY AND PATHOLOGY TESTING, MEDICAL AND SURGICAL

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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SERVICES, MATERNAL AND CHILD HEALTH, PHYSICAL REHABILITATION (ONLY HOSPITAL-BASED CARF ACCREDITED REHAB UNIT IN THE COUNTY), PULMONARY REHABILITATION PROGRAM, WOUND CARE CENTER (94 PERCENT HEALING RATE). GLADYS SPELLMAN, WHICH IS NOW LOCATED WITHIN LRH'S FACILITY, PROVIDES NURSING HOME CARE. BOWIE HEALTH CENTER IS A HOSPITAL-BASED EMERGENCY SERVICE CENTER.

IN ADDITION, DIMENSIONS HEALTHCARE ASSOCIATES, INC. (DHA), A SUBSIDIARY OF DIMENSIONS HEALTH CORPORATION, EMPLOYS MULTI-SPECIALTY PHYSICIANS, INCLUDING PRIMARY CARE PHYSICIANS, TO PROVIDE PATIENT SERVICES TO THE COMMUNITY, INCLUDING UNINSURED AND UNDERINSURED PATIENTS THAT WOULD NOT OTHERWISE HAVE ACCESS TO PHYSICIAN SERVICES. THE COST TO DHC OF FUNDING THE SHORTFALL OF THIS TAX-EXEMPT PHYSICIAN PRACTICE WAS \$15,390,302 DURING THE 2012 TAX YEAR. IT HAS BEEN DETERMINED THAT SUBSIDIZING THE OPERATING LOSSES OF DHA MEETS AN IDENTIFIED COMMUNITY NEED FOR PROVIDING ADDITIONAL PRIMARY CARE AND SPECIALIST PHYSICIANS IN THE COMMUNITY.

**SCHEDULE I
(Form 990)**

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

OMB No. 1545-0047

2012

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

Part I General Information on Grants and Assistance

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

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

1	(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								

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

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

Schedule I (Form 990) (2012)

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1 SCHOLARSHIPS	4.	18,014.			
2					
3					
4					
5					
6					
7					

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

PROCEDURES FOR MONITORING GRANT USE

SCHEDULE I, PART I, LINE 2

PURSUANT TO THE NSP I GRANT PARTICIPATED IN BY DHC, DHC PAYS ON A CONTINUING BASIS FOR THE COST OF TUITION AND RELATED EXPENSES SUCH AS BOOKS, LICENSING FEES, AND EXAMINATIONS, UP TO \$4,000.00 PER FISCAL YEAR. STUDENTS MUST BE ENROLLED IN THE ASSOCIATE/BACHELORS DEGREE NURSING PROGRAM OR COMPLETE PRE-REQUISITES WITH NURSING AS THEIR STATED FIELD OF STUDY. AS A CONDITION OF DIMENSIONS HEALTHCARE SYSTEM'S OBLIGATIONS DESCRIBED ABOVE, EACH SCHOLARSHIP RECIPIENT AGREES TO THE FOLLOWING:

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1					
2					
3					
4					
5					
6					
7					

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

1. TO SUPPLY EVIDENCE OF CURRENT ENROLLMENT IN A NURSING PROGRAM OF STUDY

AND/OR PRE-REQUISITE STUDY FOR ACCEPTANCE INTO THE SCHOOL OF NURSING PROGRAM. A COPY OF YOUR COURSE REGISTRATION MEETS THIS REQUIREMENT.

2. TO WRITE A 200 WORD ESSAY ON HOW THIS SCHOLARSHIP IS ENABLING YOU TO PURSUE YOUR NURSING EDUCATION AND AN UPDATE ON YOUR PROGRESS THROUGH YOUR NURSING PROGRAM.

3. TO MAINTAIN A FULL-TIME COURSE OF STUDY FOR THE PERIOD OF TIME COVERED BY THIS AGREEMENT.

4. TO MAINTAIN A CUMULATIVE GPA OF AT LEAST 2.5 ON A SCALE OF 4.0 THROUGHOUT THE DURATION OF THIS AGREEMENT. SUCH EVIDENCE WILL REQUIRE

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1					
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Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

SUBMISSION OF A COPY OF THE TRANSCRIPT FOR EACH QUARTER OR SEMESTER.

5. TO INTERVIEW, IF REQUESTED, WITH NURSING AND HUMAN RESOURCES REPRESENTATIVES AS APPOINTED BY THE CORPORATION.

6. TO SUCCESSFULLY GRADUATE WITH AN ASSOCIATE DEGREE (OR HIGHER) IN NURSING. SUCH EVIDENCE WILL REQUIRE SUBMISSION OF AN ORIGINAL DIPLOMA, WHICH WILL BE COPIED BY THE CORPORATION.

7. TO TAKE THE NCLEX-RN EXAMINATION AT THE FIRST AVAILABLE TESTING DATE AFTER GRADUATION. IF THE SCHOLARSHIP RECIPIENT IS UNSUCCESSFUL IN PASSING THE NCLEX-RN EXAMINATION ON THE FIRST ATTEMPT, HE/SHE MUST SCHEDULE RETESTING AT THE FIRST AVAILABLE DATE.

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1					
2					
3					
4					
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7					

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

8. THAT SHE/HE WILL MEET ALL CONDITIONS OF EMPLOYMENT AS A REGISTERED

NURSE AS REQUIRED BY DIMENSIONS HEALTHCARE SYSTEM. AS PART OF THE APPLICATION PROCESS FOR EMPLOYMENT, SHE/HE WILL BE REQUIRED TO COMPLETE PRE-EMPLOYMENT DRUG TESTING AND UNDERGO A CRIMINAL BACKGROUND CHECK.

9. THAT SHE/HE WILL BE SUBJECT TO AND COMPLY WITH ALL POLICIES, RULES, AND REGULATIONS OF DIMENSIONS HEALTHCARE SYSTEM.

10. IF SHE/HE DOES NOT COMPLY WITH THE CONDITIONS AS DESCRIBED IN PARAGRAPHS 1 THROUGH 10 OF SECTION B, WITHDRAWS FROM THE PROGRAM, DOES NOT GRADUATE FROM THE PROGRAM OR DOES NOT BEGIN EMPLOYMENT WITH DIMENSIONS HEALTHCARE SYSTEM WITHIN THREE (3) MONTHS OF GRADUATION, THIS

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1					
2					
3					
4					
5					
6					
7					

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

AGREEMENT BECOMES NULL AND VOID AND SCHOLARSHIP RECIPIENT AGREES TO REPAY

ANY AND ALL FUNDS REMITTED BY DIMENSIONS HEALTHCARE SYSTEM THROUGH THIS

SCHOLARSHIP PROGRAM TO DIMENSIONS HEALTHCARE SYSTEM WITHIN THREE (3)

MONTHS OF GRADUATION OR WITHDRAWAL FROM THE PROGRAM.

11. IF SHE/HE BEGINS EMPLOYMENT WITH DIMENSIONS HEALTHCARE SYSTEM, BUT

DOES NOT REMAIN AN EMPLOYEE FOR ONE (1) YEAR, SHE/HE AGREES TO REPAY ANY

AND ALL FUNDS REMITTED BY DIMENSIONS HEALTHCARE SYSTEM THROUGH THIS

SCHOLARSHIP PROGRAM TO DIMENSIONS HEALTHCARE SYSTEM ON A PRORATED BASIS,

BASED ON THE AMOUNT OF TIME WORKED AT TIME OF SEPARATION. THIS PAYMENT

WILL BE REMITTED TO DIMENSIONS HEALTHCARE SYSTEM WITHIN THREE (3) MONTHS

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1					
2					
3					
4					
5					
6					
7					

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

OF SEPARATION.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

Part I Questions Regarding Compensation

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

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

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

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

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

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

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

- a** Receive a severance payment or change-of-control payment?
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
- c** Participate in, or receive payment from, an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3) 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?
- b** Any related organization?
- 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?
- b** Any related organization?
- If "Yes" to line 6a or 6b, describe in Part III.

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

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

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

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

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

Schedule J (Form 990) 2012

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 NEIL MOORE CEO/CFO	(i)	576,920.	0	0	22,500.	24,422.	623,842.	0
	(ii)	0	0	0	0	0	0	0
2 JOHN O'BRIEN III COO	(i)	313,462.	0	0	22,236.	15,929.	351,627.	0
	(ii)	0	0	0	0	0	0	0
3 KANWALJIT SINGH TANEJA COO - PGHC	(i)	279,559.	0	0	22,500.	17,180.	319,239.	0
	(ii)	0	0	0	0	0	0	0
4 GITA K SHAH VP MEDICAL AFFAIRS	(i)	296,037.	0	0	22,500.	27,467.	346,004.	0
	(ii)	0	0	0	0	0	0	0
5 DAVID GOLDMAN VICE PRESIDENT QUALITY	(i)	266,604.	0	0	10,610.	18,583.	295,797.	0
	(ii)	0	0	0	0	0	0	0
6 KENNETH GLOVER CEO	(i)	81,475.	0	36,000.	0	25,894.	143,369.	0
	(ii)	0	0	0	0	0	0	0
7 JYOTI DHAROD PERFUSIONIST	(i)	198,313.	0	0	15,917.	5,426.	219,656.	0
	(ii)	0	0	0	0	0	0	0
8 SHEILA JARRETT RN	(i)	199,685.	0	0	22,500.	16,622.	238,807.	0
	(ii)	0	0	0	0	0	0	0
9 MICHAEL JACOBS PRESIDENT DHA	(i)	193,195.	0	0	11,965.	19,406.	224,566.	0
	(ii)	0	0	0	0	0	0	0
10 DANIEL J O'BRIEN JR GENERAL COUNSEL	(i)	217,652.	0	0	0	4,386.	222,038.	0
	(ii)	0	0	0	0	0	0	0
11 JOHN SPEARMAN COO-LRH	(i)	152,986.	0	0	0	16,652.	169,638.	0
	(ii)	0	0	0	0	0	0	0
12 CARNELL COOPER CMO	(i)	365,190.	0	0	0	4,456.	369,646.	0
	(ii)	0	0	0	0	0	0	0
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

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

SEVERANCE PAYMENT

SCHEDULE J, PART I, LINE 4A

A SEVERANCE PAYMENT WAS MADE TO THE FOLLOWING INDIVIDUAL:

KENNETH E. GLOVER \$36,000

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

**Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.**

OMB No. 1545-0047

2012

**Open to Public
Inspection**

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

DESCRIPTION OF 990 REVIEW PROCESS

PART VI, LINE 11

A DRAFT OF THE 990 IS PREPARED IN COORDINATION BETWEEN THE ORGANIZATION'S FINANCE DEPARTMENT, THE ORGANIZATION'S OPERATIONS DEPARTMENT, AND THE ORGANIZATION'S OUTSIDE ACCOUNTANTS. THE EXECUTIVE VICE PRESIDENT AND CHIEF FINANCIAL OFFICER REVIEWS THE DRAFT 990 THAT IS PREPARED AND ANY COMMENTS OR QUESTIONS ARE REFLECTED IN A FURTHER REVISED 990. THE LATEST VERSION OF THE 990 IS MADE AVAILABLE TO ALL MEMBERS OF THE BOARD OF DIRECTORS FOR THEIR REVIEW AND COMMENTS PRIOR TO FILING. ANY ADDITIONAL COMMENTS FROM BOARD MEMBERS ARE RESPONDED TO PRIOR TO FILING THE FORM 990.

CONFLICTS MONITORING AND ENFORCEMENT

PART VI, LINE 12

THE ORGANIZATION HAS ADOPTED A CONFLICT OF INTEREST POLICY THAT COVERS THE ORGANIZATION AND ITS SUBSIDIARIES. ANY POSSIBLE CONFLICT OF INTEREST ON THE PART OF ANY DIRECTOR SHOULD BE DISCLOSED IN WRITING TO THE MEMBERS OF THE BOARD OF DIRECTORS AND MADE A MATTER OF RECORD. ANY MEMBER OF THE BOARD OF DIRECTORS HAVING A POTENTIAL CONFLICT OF INTEREST ON ANY MATTER UNDER CONSIDERATION WILL NOT VOTE OR USE HIS OR HER PERSONAL INFLUENCE ON THE MATTER, AND HE OR SHE SHOULD NOT BE COUNTED IN DETERMINING THE QUORUM FOR THE MEETING.

DETERMINATION OF COMPENSATION

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

PART VI, LINE 15

THE ORGANIZATION HAS ADOPTED A PROCESS FOR DETERMINING EXECUTIVE COMPENSATION THAT COVERS THE ORGANIZATION AND ITS SUBSIDIARIES. THE ORGANIZATION UTILIZES A WRITTEN EMPLOYMENT CONTRACT, A COMPENSATION SURVEY OR STUDY, AN APPROVAL BY BOARD/COMPENSATION COMMITTEE AND CONTEMPORANEOUS WRITTEN SUBSTANTIATION OF THE DECISION-MAKING PROCESS.

IN ADDITION, DHC HAS A PROCESS IN PLACE TO ENSURE THE COMPENSATION PAID TO EMPLOYED PHYSICIANS IS NOT GREATER THAN FAIR MARKET VALUE, WHICH COVERS DHC AND ITS AFFILIATES. IN PARTICULAR, COMPENSATION SURVEYS ARE REGULARLY CONSULTED AND EACH PHYSICIAN CONTRACT IS APPROVED BY DHC COUNSEL, DHC CEO, AND DHC CFO.

DOCUMENT AVAILABILITY

PART VI, LINE 19

THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.

NET ASSET RECONCILIATION

PART XI, LINE 5

CHANGE IN MINIMUM PENSION LIABILITY	\$ 28,348,881
NET ASSETS TRANSFER TO DHA	(15,390,303)
CHANGE IN BENEFICIAL INT IN FOUNDATIONS	385,896

TOTAL	\$ 13,344,474

Name of the organization DIMENSIONS HEALTH CORPORATION	Employer identification number 52-1289729
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AUDITS

PART XII, QUESTIONS 2 AND 3

DIMENSIONS HEALTH CORPORATION AND ITS SUBSIDIARIES UNDERWENT A CONSOLIDATED AUDIT OF THEIR FINANCIAL STATEMENT THAT COMPLIED WITH SINGLE AUDIT ACT/OMB CIRCULAR A-133 REQUIREMENTS DUE TO THE EXPENDITURE OF FEDERAL AWARDS. THE ACCOUNTING FIRM OF COHEN, RUTHERFORD + KNIGHT P.C. HAS ISSUED AN UNMODIFIED OPINION REGARDING THE CONSOLIDATED FINANCIAL STATEMENTS IN CONFORMANCE WITH GENERALLY ACCEPTED AUDIT STANDARDS AND GOVERNMENT AUDITING STANDARDS AND UNMODIFIED REPORT RELATED TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS IN ACCORDANCE WITH THE SINGLE AUDIT ACT/OMB CIRCULAR A-133 REQUIREMENTS FOR THE FISCAL YEAR THAT CORRESPONDS TO THE TAX REPORTING YEAR GOVERNED BY THIS FORM 990.

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

OUR STATED MISSION IS TO PROVIDE HIGH QUALITY, EFFICIENT HEALTHCARE SERVICES TO PRESERVE, RESTORE AND IMPROVE THE HEALTH STATUS OF OUR COMMUNITY. THIS MISSION IS PURSUED IN COLLABORATION WITH OUR RELATED ORGANIZATIONS. WE URGE THOSE INTERESTED TO ACCESS MORE DETAILED AND COMPLETE INFORMATION AT WWW.DIMENSIONSHALTH.ORG

ATTACHMENT 2FORM 990, PART III - PROGRAM SERVICE, LINE 4A

THE MAIN FUNCTION OF THE ORGANIZATION IS TO PROVIDE COMMUNITY BENEFITS THROUGH PROGRAMS AND ACTIVITIES THAT IMPROVE ACCESS TO HEALTH CARE AND IMPROVE THE OVERALL HEALTH OF THE COMMUNITIES WE

Name of the organization DIMENSIONS HEALTH CORPORATION	Employer identification number 52-1289729
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ATTACHMENT 2 (CONT'D)

SERVE. OUR STATED MISSION IS TO PROVIDE HIGH QUALITY, EFFICIENT HEALTHCARE SERVICES TO PRESERVE, RESTORE AND IMPROVE THE HEALTH STATUS OF OUR COMMUNITY. THIS MISSION IS PURSUED IN COLLABORATION WITH OUR RELATED ORGANIZATIONS, WHICH ARE LISTED IN PART VI. WHILE WE HAVE ATTEMPTED TO SUMMARIZE OUR PROGRAM SERVICE ACCOMPLISHMENTS BELOW, WE URGE THOSE INTERESTED TO ACCESS MORE DETAILED AND COMPLETE INFORMATION AT WWW.DIMENSIONSHALTH.ORG.

THE ORGANIZATION OPERATES LAUREL REGIONAL HOSPITAL (LRH), WHICH SERVES THE COMMUNITIES LOCATED IN PRINCE GEORGE'S, ANNE ARUNDEL, HOWARD, AND MONTGOMERY COUNTIES WITH A POPULATION OF APPROXIMATELY 2,400,000. IN ACCORDANCE WITH OUR TAX-EXEMPT PURPOSE, THE ORGANIZATION OPERATES AN EMERGENCY ROOM OPEN TO ALL PERSONS REGARDLESS OF THE ABILITY TO PAY THAT SERVED APPROXIMATELY 36,402 PATIENTS DURING THE 2012 TAX YEAR. ALL PHYSICIANS LICENSED IN THE STATE OF MARYLAND WHO MEET THE FACILITY BYLAW REQUIREMENTS ARE ELIGIBLE TO APPLY FOR MEDICAL STAFF PRIVILEGES. APPROXIMATELY, 410 HAVE PRIVILEGES AT LRH. THE ORGANIZATION HAS A GOVERNING BODY PRIMARILY COMPRISED OF INDEPENDENT PERSONS REPRESENTATIVE OF THE COMMUNITY, AND PARTICIPATES IN THE MEDICARE AND MEDICAID PROGRAMS.

WE HAVE IDENTIFIED SEVERAL HEALTH-RELATED TRENDS, NEEDS, AND PROBLEMS FACING OUR POPULATION, INCLUDING ACCESS TO PRENATAL CARE, ISSUES RELATED TO AGING, SUBSTANCE ABUSE, ACCESS TO SPECIALTY

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

ATTACHMENT 2 (CONT'D)

CARE, MATERNAL AND CHILD HEALTH ETC. THE ORGANIZATION'S STRATEGIES FOR ADDRESSING THESE ISSUES INCLUDES PROVIDING CLASSES, SEMINARS, SCREENING AND HEALTH SERVICES, DIABETES EDUCATION. MORE INFORMATION ABOUT THESE STRATEGIES IS AVAILABLE ON THE WEB SITE IDENTIFIED ABOVE.

DURING THE MOST RECENT REPORTING PERIOD LRH PROVIDED OVER \$4,309,302.40 IN CHARITY CARE, AT COST, TO THE COMMUNITY. ADDITIONALLY, LRH EXPENDED APPROXIMATELY \$9,161,902 ON COMMUNITY BENEFIT PROGRAMS SUCH AS MISSION-DRIVEN HEALTH SERVICES, EDUCATION AND OUTREACH, GRANTS AND SCHOLARSHIPS. THESE ARE PROGRAMS AND ACTIVITIES BENEFITING THE COMMUNITIES WE SERVE, INCLUDING SCREENINGS AND SPEAKERS WHO ARE EDUCATED ON A WIDE RANGE OF TOPICS. LRH ALSO OFFERS CPR, ACLS, AND SMOKING CESSATION CLASSES. LRH IS PROUD TO PARTNER WITH OUTREACH GROUPS SUCH AS ALCOHOLICS ANONYMOUS, NARCOTICS ANONYMOUS, AND A PARKINSON'S SUPPORT GROUP. FOR MORE DETAILED INFORMATION, PLEASE VISIT THE WEB SITE IDENTIFIED ABOVE.

IN ADDITION, THE ORGANIZATION OPERATES PRINCE GEORGE'S HOSPITAL CENTER (PGHC), AN ACUTE CARE HOSPITAL IN PRINCE GEORGE'S COUNTY, WHICH PROVIDES QUALITY CARE TO A POPULATION OF APPROXIMATELY 1,500,000. IN ACCORDANCE WITH OUR TAX-EXEMPT PURPOSE PGHC OPERATES AN EMERGENCY ROOM OPEN TO ALL PERSONS REGARDLESS OF ABILITY TO PAY THAT SERVED APPROXIMATELY 51,881 PATIENTS DURING THE 2012 TAX

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

ATTACHMENT 2 (CONT'D)

YEAR. ALL PHYSICIANS LICENSED IN THE STATE OF MARYLAND WHO MEET THE FACILITY BYLAW REQUIREMENTS ARE ELIGIBLE TO APPLY FOR MEDICAL STAFF PRIVILEGES. APPROXIMATELY, 563 HAVE PRIVILEGES AT PGHC. THE ORGANIZATION THAT OPERATES PRINCE GEORGES HOSPITAL CENTER HAS A GOVERNING BODY PRIMARILY COMPRISED OF INDEPENDENT PERSONS REPRESENTATIVE OF THE COMMUNITY, AND PGHC PARTICIPATES IN THE MEDICARE AND MEDICAID PROGRAMS.

WE HAVE IDENTIFIED SEVERAL HEALTH-RELATED TRENDS, NEEDS, AND PROBLEMS FACING THE PGHC COMMUNITY POPULATION, INCLUDING ACCESS TO PRENATAL CARE, ISSUES RELATED TO AGING, SUBSTANCE ABUSE AND ACCESS TO SPECIALTY CARE, E.G. EMERGENCY AND TRAUMA SERVICES, MATERNAL AND CHILD HEALTH. THE ORGANIZATION'S STRATEGIES FOR ADDRESSING THESE ISSUES INCLUDES PROVIDING CLASSES, SEMINARS, SCREENING AND HEALTH SERVICES, DIABETES EDUCATION. MORE INFORMATION ABOUT THESE STRATEGIES IS AVAILABLE ON THE WEB SITE IDENTIFIED ABOVE.

DURING THE MOST RECENT REPORTING PERIOD PGHC PROVIDED OVER \$16,193,038.16 IN CHARITY CARE, AT COST, TO THE COMMUNITY. ADDITIONALLY, PGHC EXPENDED APPROXIMATELY \$14,410,962 TO COMMUNITY BENEFIT PROGRAMS SUCH AS EDUCATION AND OUTREACH, GRANTS AND SCHOLARSHIPS, AND MISSION DRIVEN HEALTH CARE SERVICES ON PROGRAMS AND ACTIVITIES BENEFITING THE COMMUNITIES PGHC SERVES. THESE PROGRAMS AND ACTIVITIES INCLUDED TRAUMA SERVICES, PREEMIE SUPPORT GROUP, SMOKING CESSATION PRESENTATIONS, PROVIDED FLU SHOTS TO THE

Name of the organization DIMENSIONS HEALTH CORPORATION	Employer identification number 52-1289729
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ATTACHMENT 2 (CONT'D)

PUBLIC, PROVIDE BLOOD PRESSURE SCREENINGS TO LOCAL CHURCHES, ETC.

FOR MORE DETAILED INFORMATION, PLEASE VISIT THE WEB SITE

IDENTIFIED ABOVE.

ATTACHMENT 3990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
PHOENIX 1130 EAST ARAPHAO ROAD STE 500 RICHARDSON, TX 75081	INFORMATION SYSTEM	4,557,444.
SODEXHO PO BOX 536922 ATLANTA, GA 30353-6922	FOOD SERVICE	4,373,819.
ALLIANT/ADVANTAGE 7201 WISCONSIN AVENUE, SUITE 705 BETHESDA, MD 20814	STAFFING	1,638,251.
EMCARE OF MARYLAND LLC 7032 COLLECTION CTR DR CHICAGO, IL 60693	STAFFING	2,662,455.
BROADWAY SERVICES INC 3709 EAST MONUMENT STREET BALTIMORE, MD 21205	SECURITY	2,089,525.

ATTACHMENT 4FORM 990, PART VIII - INVESTMENT INCOME

<u>DESCRIPTION</u>	(A) <u>TOTAL REVENUE</u>	(B) <u>RELATED OR EXEMPT REVENUE</u>	(C) <u>UNRELATED BUSINESS REV.</u>	(D) <u>EXCLUDED REVENUE</u>
INVESTMENT INCOME	17,411.			17,411.
TOTALS	<u>17,411.</u>			<u>17,411.</u>

Name of the organization DIMENSIONS HEALTH CORPORATION	Employer identification number 52-1289729
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ATTACHMENT 5

FORM 990, PART VIII - EXCLUDED CONTRIBUTIONS

<u>DESCRIPTION</u>	<u>AMOUNT</u>
GOLF TOURNAMENT	72,750.
TOTAL	<u>72,750.</u>

ATTACHMENT 6

FORM 990, PART VIII - FUNDRAISING EVENTS

<u>DESCRIPTION</u>	<u>GROSS INCOME</u>	<u>DIRECT EXPENSES</u>	<u>NET INCOME</u>
GOLF TOURNAMENT	56,525.	89,956.	-33,431.
TOTALS	<u>56,525.</u>	<u>89,956.</u>	<u>-33,431.</u>

ATTACHMENT 7

FORM 990, PART IX - OTHER EXPENSES

<u>DESCRIPTION</u>	<u>(A) TOTAL EXPENSES</u>	<u>(B) PROGRAM SERVICE EXP.</u>	<u>(C) MANAGEMENT AND GENERAL EXPENSES</u>	<u>(D) FUNDRAISING EXPENSES</u>
SUPPLIES	51,657,200.	51,140,628.	516,572.	
EQUIP RENT AND MAINT	1,944,119.	1,730,266.	213,853.	
EDUCATION HONORARIUM	72,690.		72,690.	
PERMITS AND LIC	76,290.		76,290.	
TAXES	136,600.		136,600.	
OTHER	191,898.	132,410.	59,488.	
TOTALS	<u>54,078,797.</u>	<u>53,003,304.</u>	<u>1,075,493.</u>	

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

ATTACHMENT 8FORM 990, PART X - PREPAID EXPENSES AND DEFERRED CHARGES

<u>DESCRIPTION</u>	<u>ENDING BOOK VALUE</u>
PREPAID EXPENSES	4,378,409.
TOTALS	<u>4,378,409.</u>

ATTACHMENT 9FORM 990, PART X - DEFERRED REVENUE

<u>DESCRIPTION</u>	<u>ENDING BOOK VALUE</u>
DEFERRED REVENUE	600,000.
TOTALS	<u>600,000.</u>

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2012

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

▶ **Attach to Form 990.**

▶ **See separate instructions.**

Name of the organization

DIMENSIONS HEALTH CORPORATION

Employer identification number

52-1289729

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) DIMENSIONS HEALTHCARE ASSOCIATES 52-1902711 7300 VAN DUSEN RD LAUREL, MD 20707	HEALTHCARE	MD	501 (C) (3)	509 (A) (3)	DHC	X	
(2) -----							
(3) -----							
(4) -----							
(5) -----							
(6) -----							
(7) -----							

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

Schedule R (Form 990) 2012

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) -----												
(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	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) AFFILIATED ENTERPRISES 52-1542144 7300 DUSEN RD LAUREL, MD 20707	HEALTHCARE	MD	DHC	C CORP	951,689.	3,852,381.	100.0000	X	
(2) DIMENSIONS ASSURANCE 98-0348082 PO BOX 1363 GENESIS BUILDING GEORGE TOWN, GRAND CAYMAN CJ	INSURANCE	CJ	DHC	C CORP	10,910,670.	44,493,995.	100.0000	X	
(3) MADISON MANOR 52-1269059 7300 VAN DUSEN RD LAUREL, MD 20707	HEALTHCARE	MD	DHC	C CORP	267,372.	3,748,645.	100.0000	X	
(4) -----									
(5) -----									
(6) -----									
(7) -----									

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

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

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
- b** Gift, grant, or capital contribution to related organization(s)
- c** Gift, grant, or capital contribution from related organization(s)
- d** Loans or loan guarantees to or for related organization(s)
- e** Loans or loan guarantees by related organization(s)
- f** Dividends from related organization(s)
- g** Sale of assets to related organization(s)
- h** Purchase of assets from related organization(s)
- i** Exchange of assets with related organization(s)
- j** Lease of facilities, equipment, or other assets to related organization(s)
- k** Lease of facilities, equipment, or other assets from related organization(s)
- l** Performance of services or membership or fundraising solicitations for related organization(s)
- m** Performance of services or membership or fundraising solicitations by related organization(s)
- n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)
- o** Sharing of paid employees with related organization(s)
- p** Reimbursement paid to related organization(s) for expenses
- q** Reimbursement paid by related organization(s) for expenses
- r** Other transfer of cash or property to related organization(s)
- s** Other transfer of cash or property from related organization(s)

	Yes	No
1a		X
1b		X
1c		X
1d		X
1e		X
1f		X
1g		X
1h		X
1i		X
1j	X	
1k		X
1l	X	
1m		X
1n	X	
1o	X	
1p	X	
1q	X	
1r		X
1s		X

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

(a) Name of other organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) DIMENSIONS HEALTHCARE ASSOCIATES	L, O, Q	15,390,303.	FMV
(2) AFFILIATED ENTERPRISES	J	122,246.	FMV
(3)			
(4)			
(5)			
(6)			

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

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

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

Part VII **Supplemental Information**

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

RENT AND ROYALTY INCOME

Taxpayer's Name DIMENSIONS HEALTH CORPORATION	Identifying Number 52-1289729
---------------------------------------------------------	-----------------------------------------

DESCRIPTION OF PROPERTY
RENTAL PROPERTY

Yes	No	Did you actively participate in the operation of the activity during the tax year?
-----	----	------------------------------------------------------------------------------------

TYPE OF PROPERTY:		
REAL RENTAL INCOME	719,898.	
OTHER INCOME:		
TOTAL GROSS INCOME		719,898.
OTHER EXPENSES:		
DEPRECIATION (SHOWN BELOW)		
LESS: Beneficiary's Portion		
AMORTIZATION		
LESS: Beneficiary's Portion		
DEPLETION		
LESS: Beneficiary's Portion		
TOTAL EXPENSES		
TOTAL RENT OR ROYALTY INCOME (LOSS)		719,898.

Less Amount to		
Rent or Royalty		
Depreciation		
Depletion		
Investment Interest Expense		
Other Expenses		
Net Income (Loss) to Others		
Net Rent or Royalty Income (Loss)		719,898.
Deductible Rental Loss (if Applicable)		

SCHEDULE FOR DEPRECIATION CLAIMED

(a) Description of property	(b) Cost or unadjusted basis	(c) Date acquired	(d) ACRS des.	(e) Bus. %	(f) Basis for depreciation	(g) Depreciation in prior years	(h) Method	(i) Life or rate	(j) Depreciation for this year
Totals									

RENT AND ROYALTY SUMMARY

<u>PROPERTY</u>	<u>TOTAL INCOME</u>	<u>DEPLETION/ DEPRECIATION</u>	<u>OTHER EXPENSES</u>	<u>ALLOWABLE NET INCOME</u>
RENTAL PROPERTY	719,898.			719,898.
TOTALS	<u>719,898.</u>			<u>719,898.</u>

Sales of Business Property
(Also Involuntary Conversions and Recapture Amounts Under Sections 179 and 280F(b)(2))

Department of the Treasury
Internal Revenue Service

▶ **Attach to your tax return.**
▶ **Information about Form 4797 and its separate instructions is at www.irs.gov/form4797.**

Attachment Sequence No. **27**

Name(s) shown on return
DIMENSIONS HEALTH CORPORATION

Identifying number
52-1289729

1 Enter the gross proceeds from sales or exchanges reported to you for 2012 on Form(s) 1099-B or 1099-S (or substitute statement) that you are including on line 2, 10, or 20 (see instructions) **1**

Part I Sales or Exchanges of Property Used in a Trade or Business and Involuntary Conversions From Other Than Casualty or Theft - Most Property Held More Than 1 Year (see instructions)

2	(a) Description of property	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Gross sales price	(e) Depreciation allowed or allowable since acquisition	(f) Cost or other basis, plus improvements and expense of sale	(g) Gain or (loss) Subtract (f) from the sum of (d) and (e)
	ATTACHMENT 1						488,000.

3 Gain, if any, from Form 4684, line 39 **3**

4 Section 1231 gain from installment sales from Form 6252, line 26 or 37 **4**

5 Section 1231 gain or (loss) from like-kind exchanges from Form 8824 **5**

6 Gain, if any, from line 32, from other than casualty or theft **6**

7 Combine lines 2 through 6. Enter the gain or (loss) here and on the appropriate line as follows: **7** **488,000.**

Partnerships (except electing large partnerships) and S corporations. Report the gain or (loss) following the instructions for Form 1065, Schedule K, line 10, or Form 1120S, Schedule K, line 9. Skip lines 8, 9, 11, and 12 below.

Individuals, partners, S corporation shareholders, and all others. If line 7 is zero or a loss, enter the amount from line 7 on line 11 below and skip lines 8 and 9. If line 7 is a gain and you did not have any prior year section 1231 losses, or they were recaptured in an earlier year, enter the gain from line 7 as a long-term capital gain on the Schedule D filed with your return and skip lines 8, 9, 11, and 12 below.

8 Nonrecaptured net section 1231 losses from prior years (see instructions) **8** **23,379.**

9 Subtract line 8 from line 7. If zero or less, enter -0-. If line 9 is zero, enter the gain from line 7 on line 12 below. If line 9 is more than zero, enter the amount from line 8 on line 12 below and enter the gain from line 9 as a long-term capital gain on the Schedule D filed with your return (see instructions) **9** **464,621.**

Part II Ordinary Gains and Losses (see instructions)

10 Ordinary gains and losses not included on lines 11 through 16 (include property held 1 year or less):

11 Loss, if any, from line 7 **11** ()

12 Gain, if any, from line 7 or amount from line 8, if applicable **12** **23,379.**

13 Gain, if any, from line 31 **13**

14 Net gain or (loss) from Form 4684, lines 31 and 38a **14**

15 Ordinary gain from installment sales from Form 6252, line 25 or 36 **15**

16 Ordinary gain or (loss) from like-kind exchanges from Form 8824 **16**

17 Combine lines 10 through 16 **17** **23,379.**

18 For all except individual returns, enter the amount from line 17 on the appropriate line of your return and skip lines a and b below. For individual returns, complete lines a and b below:

a If the loss on line 11 includes a loss from Form 4684, line 35, column (b)(ii), enter that part of the loss here. Enter the part of the loss from income-producing property on Schedule A (Form 1040), line 28, and the part of the loss from property used as an employee on Schedule A (Form 1040), line 23. Identify as from "Form 4797, line 18a." See instructions **18a**

b Redetermine the gain or (loss) on line 17 excluding the loss, if any, on line 18a. Enter here and on Form 1040, line 14 **18b**

For Paperwork Reduction Act Notice, see separate instructions. Form **4797** (2012)

Part III Gain From Disposition of Property Under Sections 1245, 1250, 1252, 1254, and 1255
(see instructions)

19 (a) Description of section 1245, 1250, 1252, 1254, or 1255 property:		(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)
A			
B			
C			
D			
These columns relate to the properties on lines 19A through 19D. ▶		Property A	Property B
Property C		Property D	
20	Gross sales price (Note: See line 1 before completing.)	20	
21	Cost or other basis plus expense of sale	21	
22	Depreciation (or depletion) allowed or allowable	22	
23	Adjusted basis. Subtract line 22 from line 21	23	
24	Total gain. Subtract line 23 from line 20	24	
25 If section 1245 property:			
a	Depreciation allowed or allowable from line 22	25a	
b	Enter the smaller of line 24 or 25a	25b	
26 If section 1250 property: If straight line depreciation was used, enter -0- on line 26g, except for a corporation subject to section 291.			
a	Additional depreciation after 1975 (see instructions)	26a	
b	Applicable percentage multiplied by the smaller of line 24 or line 26a (see instructions)	26b	
c	Subtract line 26a from line 24. If residential rental property or line 24 is not more than line 26a, skip lines 26d and 26e	26c	
d	Additional depreciation after 1969 and before 1976	26d	
e	Enter the smaller of line 26c or 26d	26e	
f	Section 291 amount (corporations only)	26f	
g	Add lines 26b, 26e, and 26f	26g	
27 If section 1252 property: Skip this section if you did not dispose of farmland or if this form is being completed for a partnership (other than an electing large partnership).			
a	Soil, water, and land clearing expenses	27a	
b	Line 27a multiplied by applicable percentage (see instructions)	27b	
c	Enter the smaller of line 24 or 27b	27c	
28 If section 1254 property:			
a	Intangible drilling and development costs, expenditures for development of mines and other natural deposits, mining exploration costs, and depletion (see instructions)	28a	
b	Enter the smaller of line 24 or 28a	28b	
29 If section 1255 property:			
a	Applicable percentage of payments excluded from income under section 126 (see instructions)	29a	
b	Enter the smaller of line 24 or 29a (see instructions)	29b	

Summary of Part III Gains. Complete property columns A through D through line 29b before going to line 30.

30	Total gains for all properties. Add property columns A through D, line 24	30	
31	Add property columns A through D, lines 25b, 26g, 27c, 28b, and 29b. Enter here and on line 13	31	
32	Subtract line 31 from line 30. Enter the portion from casualty or theft on Form 4684, line 33. Enter the portion from other than casualty or theft on Form 4797, line 6	32	

Part IV Recapture Amounts Under Sections 179 and 280F(b)(2) When Business Use Drops to 50% or Less
(see instructions)

		(a) Section 179	(b) Section 280F(b)(2)
33	Section 179 expense deduction or depreciation allowable in prior years	33	
34	Recomputed depreciation (see instructions)	34	
35	Recapture amount. Subtract line 34 from line 33. See the instructions for where to report	35	

