

Cumulative e-File History 2013	
Federal	
Locator:	4240CV
Taxpayer Name:	James Lawrence Kernan Hospital, Inc.
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	05/12/2015 09:16:58
Acknowledgement Date:	05/12/2015 09:33:28
Status:	Accepted
Submission ID:	23695320151325000010

IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2013, or fiscal year beginning 07/01, 2013, and ending 06/30, 2014

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

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

2013

Department of the Treasury
Internal Revenue Service

Name of exempt organization

JAMES LAWRENCE KERNAN HOSPITAL, INC.

Name and title of officer

W. W. AUGUSTIN, III, CFO

Employer identification number

52-0591639

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

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

1a	Form 990 check here ▶	<input checked="" type="checkbox"/>	b	Total revenue, if any (Form 990, Part VIII, column (A), line 12) . . .	1b	<u>112561892.</u>
2a	Form 990-EZ check here ▶	<input type="checkbox"/>	b	Total revenue, if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here ▶	<input type="checkbox"/>	b	Total tax (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here ▶	<input type="checkbox"/>	b	Tax based on investment income (Form 990-PF, Part VI, line 5),	4b	
5a	Form 8868 check here ▶	<input type="checkbox"/>	b	Balance Due (Form 8868, Part I, line 3c or Part II, line 8c)	5b	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2013 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

I authorize GRANT THORNTON LLP to enter my PIN

1	4	2	1	9
---	---	---	---	---

 as my signature

ERO firm name

Enter five numbers, but do not enter all zeros

on the organization's tax year 2013 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2013 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶

Date ▶

Part III Certification and Authentication

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

2	3	6	9	5	3	3	6	6	0	5
---	---	---	---	---	---	---	---	---	---	---

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2013 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature ▶

Date ▶

05/06/2015

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

For Paperwork Reduction Act Notice, see back of form.

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Form **990**

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

2013

Department of the Treasury
Internal Revenue Service

▶ Do not enter Social Security numbers on this form as it may be made public.
▶ Information about Form 990 and its instructions is at www.irs.gov/form990.

Open to Public
Inspection

A For the **2013** calendar year, or tax year beginning 07/01, 2013, and ending 06/30, 2014

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 JAMES LAWRENCE KERNAN HOSPITAL, INC. Doing Business As	D Employer identification number 52-0591639
	Number and street (or P.O. box if mail is not delivered to street address) Room/suite 2200 KERNAN DRIVE	E Telephone number (410) 448-2500
	City or town, state or province, country, and ZIP or foreign postal code BALTIMORE, MD 21207	G Gross receipts \$ <u>120,819,482.</u>
	F Name and address of principal officer: MICHAEL JABLONOVER 2200 KERNAN DRIVE BALTIMORE, MD 21207	H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		H(c) Group exemption number ▶
J Website: ▶ N/A		
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: 1895 M State of legal domicile: MD

Part I Summary

Activities & Governance	1	Briefly describe the organization's mission or most significant activities: <u>JAMES L KERNAN HOSPITAL DELIVERS INNOVATIVE, HIGH-QUALITY, AND COST EFFECTIVE REHABILITATION AND SURGICAL SERVICES TO THE COMMUNITY AND REGION.</u>		
	2	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3	Number of voting members of the governing body (Part VI, line 1a)	3	11.
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	8.
	5	Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5	773.
	6	Total number of volunteers (estimate if necessary)	6	109.
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
	b Net unrelated business taxable income from Form 990-T, line 34	7b	0	
Revenue	8	Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9	Program service revenue (Part VIII, line 2g)	4,513,000.	1,800,644.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	102,473,566.	108,350,196.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,022,379.	373,292.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,871,380.	2,037,760.
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	109,880,325.	112,561,892.
	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)	0	0
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	51,763,733.	49,302,278.
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶	0	0
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	54,469,316.	62,311,795.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	106,233,049.	111,614,073.
Net Assets or Fund Balances	19	Revenue less expenses. Subtract line 18 from line 12	3,647,276.	947,819.
	20	Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21	Total liabilities (Part X, line 26)	136,743,723.	150,398,467.
	22	Net assets or fund balances. Subtract line 21 from line 20	41,481,656.	49,366,007.
			95,262,067.	101,032,460.

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		
	W. W. AUGUSTIN, III Type or print name and title CFO			
Paid Preparer Use Only	Print/Type preparer's name FRANK GIARDINI	Preparer's signature 	Date 05/06/2015	Check <input type="checkbox"/> if self-employed PTIN P00532355
	Firm's name ▶ GRANT THORNTON LLP	Firm's EIN ▶ 36-6055558		
	Firm's address ▶ 2001 MARKET STREET, SUITE 700 PHILADELPHIA, PA 19103	Phone no. 215-561-4200		

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2013)

Application for Extension of Time To File an Exempt Organization Return

Department of the Treasury
Internal Revenue Service

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

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

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

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

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

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

All other corporations (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns. Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions. JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number (EIN) or 52-0591639
	Number, street, and room or suite no. If a P.O. box, see instructions. 2200 KERNAN DRIVE	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. BALTIMORE, MD 21207	

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

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

- The books are in the care of ▶ S. MICHELLE LEE, 250 W. PRATT STREET, 14TH FLOOR BALTIMORE, MD 21201

Telephone No. ▶ 410 328-1376 FAX No. ▶ _____

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

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 02/15, 2015, to file the exempt organization return for the organization named above. The extension is for the organization's return for:
 ▶ calendar year 20____ or
 ▶ tax year beginning 07/01, 2013, and ending 06/30, 2014.

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

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

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

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

Cumulative e-File History 2013

Federal Extension3

Locator:	4240CV
Taxpayer Name:	James Lawrence Kernan Hospital, Inc.
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	11/05/2014 08:33:41
Acknowledgement Date:	11/05/2014 08:57:42
Status:	Accepted
Submission ID:	23695320143095000033

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

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

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

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

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions. JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number (EIN) or 52-0591639
	Number, street, and room or suite no. If a P.O. box, see instructions. 2200 KERNAN DRIVE	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. BALTIMORE, MD 21207	

Enter the Return code for the return that this application is for (file a separate application for each return) **01**

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

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

• The books are in the care of S. MICHELLE LEE, 250 W. PRATT STREET, 14TH FLOOR BALTIMORE, MD 21201
Telephone No. 410 328-1376 Fax No.

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

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

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

5 For calendar year _____, or other tax year beginning 07/01, 20 13, and ending 06/30, 20 14 .

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

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

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

Signature and Verification must be completed for Part II only.

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

Signature  Title EA Date 2/6/2015

Cumulative e-File History 2013	
FED	
Locator:	4240CV
Taxpayer Name:	James Lawrence Kernan Hospital, Inc.
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	02/06/2015 16:28:50
Acknowledgement Date:	02/06/2015 16:56:54
Status:	Rejected
Submission ID:	23695320150375000004
Submitted Date:	02/10/2015 16:24:40
Acknowledgement Date:	02/10/2015 16:57:38
Status:	Accepted
Submission ID:	23695320150415000023

IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2013, or fiscal year beginning 07/01, 2013, and ending 06/30, 2014

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

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

2013

Department of the Treasury
Internal Revenue Service

Name of exempt organization

JAMES LAWRENCE KERNAN HOSPITAL, INC.

Name and title of officer

W. W. AUGUSTIN, III, CFO

Employer identification number

52-0591639

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

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

1a	Form 990 check here ▶	<input checked="" type="checkbox"/>	b	Total revenue, if any (Form 990, Part VIII, column (A), line 12) . . .	1b	<u>112561892.</u>
2a	Form 990-EZ check here ▶	<input type="checkbox"/>	b	Total revenue, if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here ▶	<input type="checkbox"/>	b	Total tax (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here ▶	<input type="checkbox"/>	b	Tax based on investment income (Form 990-PF, Part VI, line 5),	4b	
5a	Form 8868 check here ▶	<input type="checkbox"/>	b	Balance Due (Form 8868, Part I, line 3c or Part II, line 8c)	5b	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2013 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

I authorize GRANT THORNTON LLP to enter my PIN

1	4	2	1	9
---	---	---	---	---

 as my signature

ERO firm name

Enter five numbers, but do not enter all zeros

on the organization's tax year 2013 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2013 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶

Date ▶

Part III Certification and Authentication

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

2	3	6	9	5	3	3	6	6	0	5
---	---	---	---	---	---	---	---	---	---	---

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2013 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature ▶

Date ▶

05/06/2015

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

For Paperwork Reduction Act Notice, see back of form.

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

JAMES L KERNAN HOSPITAL DELIVERS INNOVATIVE, HIGH-QUALITY, AND COST EFFECTIVE REHABILITATION AND SURGICAL SERVICES TO THE COMMUNITY AND REGION.

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 \$ 96,793,982. including grants of \$) (Revenue \$ 110,387,956.)

THE ORGANIZATION OWNS AND OPERATES A MEDICAL SURGICAL AND REHABILITATION HOSPITAL WITH 132 LICENSED BEDS. THE HOSPITAL PROVIDES CHARITY CARE TO PATIENTS WHO ARE UNABLE TO PAY. SUCH PATIENTS ARE IDENTIFIED BASED ON INFORMATION OBTAINED FROM THE PATIENTS AND SUBSEQUENT ANALYSIS. BECAUSE THE HOSPITAL DOES NOT EXPECT COLLECTION OF AMOUNTS DETERMINED AS CHARITY CARE, THEY ARE NOT REPORTED AS REVENUE BASED ON ESTABLISHED RATES. THE HOSPITAL ESTIMATES THAT \$2,626,776 OF CHARITY CARE AT COST WAS PROVIDED IN 2014. OVERALL, THE HOSPITAL DELIVERS INNOVATIVE HIGH QUALITY, COST EFFECTIVE SURGICAL AND REHABILITATION SERVICES TO ITS COMMUNITY.

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 ▶ 96,793,982.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

		Yes	No
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or government 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 or 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 25a.</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	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payable to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If so, complete Schedule L, Part II.		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 or note to any line in this Part V

Table with columns for line numbers (1a-14b), descriptions, and Yes/No checkboxes. Includes entries for Form 1096, Form W-2G, Form W-3, Form 990-T, Form 8886-T, Form 8282, Form 8899, Form 1098-C, Form 4966, Form 720, and Form 700.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (11), 1b (8), 2 (X), 3 (X), 4 (X), 5 (X), 6 (X), 7a (X), 7b (X), 8a (X), 8b (X), 9 (X).

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

Table with 3 columns: Question, Yes, No. Rows include: 10a (X), 10b, 11a (X), 11b, 12a (X), 12b (X), 12c (X), 13 (X), 14 (X), 15a (X), 15b (X), 16a (X), 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: S. MICHELLE LEE 250 W. PRATT STREET, 14TH FLOOR BALTIMORE, MD 21201 410-328-1376

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

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

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) DAVIS V.R. SHERMAN CHAIRMAN	1.00	X		X				0	0	0
(2) ANTHONY F. LEHMAN DIRECTOR	1.00	X						0	0	0
(3) LISA A. GLADDEN DIRECTOR	1.00	X						0	0	0
(4) JOHN T. CHAY DIRECTOR	1.00	X						0	0	0
(5) ROBERT A CHRENCIK TREASURER	1.00 49.00	X		X				0	1,735,933.	246,647.
(6) HEMA PATEL, MD HOSPITALIST	40.00	X						226,320.	0	26,239.
(7) ANTHONY T. HAWKINS DIRECTOR	1.00	X						0	0	0
(8) WILLIAM PECK DIRECTOR	1.00	X						0	0	0
(9) ANDREW POLLAK DIRECTOR	1.00	X						0	0	0
(10) KAREN E. DOYLE DIRECTOR	1.00	X						0	277,697.	22,243.
(11) OLIVER S. TRAVERS, JR. DIRECTOR	1.00	X						0	0	0
(12) MICHAEL R. JABLONOVER CEO	40.00			X				406,334.	0	23,876.
(13) W. W. AUGUSTIN, III CFO	40.00			X				259,386.	0	18,834.
(14) JUANITA D. ROBBINS COO	40.00				X			193,779.	0	22,437.

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) JOHN STRAUMANIS SVP-CMO	40.00				X			262,500.	0	44,964.
(16) CHERYL D. LEE VP - CNO	40.00				X			203,095.	0	30,262.
(17) LORI PATRIA MANAGER- AMBULATORY	40.00					X		141,579.	0	20,974.
(18) LOBNA ZADA DENTAL CLINICAL CHIEF	40.00					X		201,055.	0	15,903.
(19) THOMAS MERKLE HOSPITALIST	40.00					X		172,770.	0	19,141.
(20) NORBERT ROBINSON DIR-PHARMACY	40.00					X		163,490.	0	22,039.
(21) MARGARET BEATTY RN - STAFFING & RESOURCE	40.00					X		145,764.	0	10,222.
1b Sub-total								1,085,819.	2,013,630.	360,276.
c Total from continuation sheets to Part VII, Section A								1,290,253.	0	163,505.
d Total (add lines 1b and 1c)								2,376,072.	2,013,630.	523,781.

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 ▶ 63

	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 1		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ▶ 28

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a						
	b Membership dues	1b						
	c Fundraising events	1c						
	d Related organizations	1d	1,345,147.					
	e Government grants (contributions)	1e	443,437.					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	12,060.					
	g Noncash contributions included in lines 1a-1f: \$							
	h Total. Add lines 1a-1f ▶			1,800,644.				
Program Service Revenue	Business Code							
	2a PATIENT SERVICE REVENUE		900099	108,350,196.	108,350,196.			
	b _____							
	c _____							
	d _____							
	e _____							
	f All other program service revenue							
g Total. Add lines 2a-2f ▶			108,350,196.					
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶			147,192.			147,192.	
	4 Income from investment of tax-exempt bond proceeds ▶			0				
	5 Royalties ▶			0				
	6a Gross rents	(i) Real	(ii) Personal					
		b Less: rental expenses						
		c Rental income or (loss)						
		d Net rental income or (loss) ▶			0			
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other					
		8,483,690.						
		b Less: cost or other basis and sales expenses			8,257,590.			
		c Gain or (loss)			226,100.			
	d Net gain or (loss) ▶			226,100.			226,100.	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 a							
	b Less: direct expenses b							
	c Net income or (loss) from fundraising events ▶			0				
	9a Gross income from gaming activities. See Part IV, line 19 a							
	b Less: direct expenses b							
c Net income or (loss) from gaming activities ▶			0					
10a Gross sales of inventory, less returns and allowances a								
b Less: cost of goods sold b								
c Net income or (loss) from sales of inventory ▶			0					
Miscellaneous Revenue			Business Code					
11a CAFÉ/VENDING		722210	411,599.	411,599.				
b OUTPATIENT PHARMACY		446110	1,459,213.	1,459,213.				
c MISC		900099	166,948.	166,948.				
d All other revenue								
e Total. Add lines 11a-11d ▶			2,037,760.					
12 Total revenue. See instructions ▶			112,561,892.	110,387,956.			373,292.	

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21 .	0			
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	0			
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	2,439,039.	2,073,183.	365,856.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	37,716,965.	32,059,420.	5,657,545.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,720,398.	1,462,338.	258,060.	
9 Other employee benefits	4,588,295.	3,900,051.	688,244.	
10 Payroll taxes	2,837,581.	2,411,944.	425,637.	
11 Fees for services (non-employees):				
a Management	0			
b Legal	118,042.		118,042.	
c Accounting	713,558.		713,558.	
d Lobbying	5,378.		5,378.	
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.)	10,661,819.	9,062,546.	1,599,273.	
12 Advertising and promotion	264,511.	224,834.	39,677.	
13 Office expenses	604,516.	513,839.	90,677.	
14 Information technology	2,493,172.	2,119,196.	373,976.	
15 Royalties	0			
16 Occupancy	2,997,360.	2,547,756.	449,604.	
17 Travel	58,502.	49,727.	8,775.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	0			
20 Interest	780,155.	663,132.	117,023.	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	4,617,037.	3,924,481.	692,556.	
23 Insurance	2,108,765.	1,792,450.	316,315.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <u>MEDICAL SUPPLIES</u>	15,780,308.	13,413,262.	2,367,046.	
b <u>BAD DEBT</u>	8,877,661.	8,877,661.		
c <u>PHYSICIAN FEE</u>	8,648,209.	8,648,209.		
d <u>PURCHASED SERVICES</u>	2,452,547.	2,089,236.	363,311.	
e All other expenses	1,130,255.	960,717.	169,538.	
25 Total functional expenses. Add lines 1 through 24e	111,614,073.	96,793,982.	14,820,091.	
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 or note to any line in this Part X

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	6,887,050.	1	25,635,911.
	2 Savings and temporary cash investments	0	2	0
	3 Pledges and grants receivable, net	0	3	0
	4 Accounts receivable, net	14,670,958.	4	16,192,464.
	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	1,054,308.	8	1,188,192.
	9 Prepaid expenses and deferred charges	0	9	10,000.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 99,144,336.		
	b Less: accumulated depreciation	10b 53,710,664.	45,131,779.	10c 45,433,672.
	11 Investments - publicly traded securities	6,740,290.	11	8,482,652.
	12 Investments - other securities. See Part IV, line 11	5,297,710.	12	5,217,140.
	13 Investments - program-related. See Part IV, line 11	0	13	0
	14 Intangible assets	0	14	0
	15 Other assets. See Part IV, line 11	56,961,628.	15	48,238,436.
16 Total assets. Add lines 1 through 15 (must equal line 34)	136,743,723.	16	150,398,467.	
Liabilities	17 Accounts payable and accrued expenses	13,312,096.	17	10,740,403.
	18 Grants payable	0	18	0
	19 Deferred revenue	0	19	0
	20 Tax-exempt bond liabilities	0	20	0
	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	28,169,560.	25	38,625,604.
	26 Total liabilities. Add lines 17 through 25	41,481,656.	26	49,366,007.
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	64,638,067.	27	66,896,460.
	28 Temporarily restricted net assets	30,624,000.	28	34,136,000.
	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	95,262,067.	33	101,032,460.	
34 Total liabilities and net assets/fund balances	136,743,723.	34	150,398,467.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	112,561,892.
2	Total expenses (must equal Part IX, column (A), line 25)	2	111,614,073.
3	Revenue less expenses. Subtract line 2 from line 1	3	947,819.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	95,262,067.
5	Net unrealized gains (losses) on investments	5	0
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	4,822,574.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	101,032,460.

Part XII Financial Statements and Reporting

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

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

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

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

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

OMB No. 1545-0047

2013

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number 52-0591639
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Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

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

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

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

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

	Yes	No
11g(iii)		
- h Provide the following information about the supported organization(s).

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

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) 2009, (b) 2010, (c) 2011, (d) 2012, (e) 2013, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2009, (b) 2010, (c) 2011, (d) 2012, (e) 2013, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2013; 15 Public support percentage from 2012 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2013; b 33 1/3% support test - 2012; 17a 10%-facts-and-circumstances test - 2013; b 10%-facts-and-circumstances test - 2012; 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) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(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) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(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 2013 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2012 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2013 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2012 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2013. 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 - 2012. 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.** 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

2013

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

Name of the organization JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number 52-0591639
---	---

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 its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number 52-0591639
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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 MARYLAND ----- 45 CALVERT STREET ----- ANNAPOLIS, MD 21401 -----	\$ 443,437.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **JAMES LAWRENCE KERNAN HOSPITAL, INC.**

Employer identification number

52-0591639

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

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

Name of organization JAMES LAWRENCE KERNAN HOSPITAL, INC.

Employer identification number
52-0591639

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

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

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

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

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

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

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

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

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

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

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2013

Open to Public Inspection

For Organizations Exempt From Income Tax Under section 501(c) and section 527
 ▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
 ▶ **See separate instructions.** ▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.**

Department of the Treasury
Internal Revenue Service

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

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

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

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

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

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

Name of organization JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number 52-0591639
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
- 2 Political expenditures ▶ \$ _____
- 3 Volunteer hours _____

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

- 1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ \$ _____
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$ _____
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? Yes No
- 4a Was a correction made? Yes No
- b If "Yes," describe in Part IV.

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

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ \$ _____
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ \$ _____
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ \$ _____
- 4 Did the filing organization file **Form 1120-POL** for this year? Yes No
- 5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

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

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

Schedule C (Form 990 or 990-EZ) 2013

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

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

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

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

4-Year Averaging Period Under Section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

Table with 3 main columns: (a) Yes/No, (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation...; 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?

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

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

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

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

Part IV Supplemental Information

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

SEE PAGE 4

Part IV Supplemental Information (continued)

OTHER ACTIVITIES

SCHEDULE C, PART II-B, LINE 11

THE ORGANIZATION DOES NOT ENGAGE IN ANY DIRECT LOBBYING ACTIVITIES. THE ORGANIZATION PAYS MEMBERSHIP DUES TO THE MARYLAND HOSPITAL ASSOCIATION (MHA) AND THE AMERICAN HOSPITAL ASSOCIATION (AHA). MHA AND AHA ENGAGE IN MANY SUPPORT ACTIVITIES INCLUDING LOBBYING AND ADVOCATING FOR THEIR MEMBER HOSPITALS. THE MHA AND AHA REPORTED THAT 6.22% AND 23.65% OF MEMBER DUES WERE USED FOR LOBBYING PURPOSES AND AS SUCH, THE ORGANIZATION HAS REPORTED THIS AMOUNT ON SCHEDULE C PART IV AS LOBBYING ACTIVITIES.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

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.

2013

Department of the Treasury Internal Revenue Service

Attach to Form 990.

Open to Public Inspection

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

Name of the organization

Employer identification number

JAMES LAWRENCE KERNAN HOSPITAL, INC.

52-0591639

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

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

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate contributions to (during year), 3 Aggregate grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?, 6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

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

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year., 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year, 4 Number of states where property subject to conservation easement is located, 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?, 6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year, 7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year, 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B) (i) and section 170(h)(4)(B)(ii)?, 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

Table with 2 columns: Amounts. Rows include: 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items., 1b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenues included in Form 990, Part VIII, line 1, (ii) Assets included in Form 990, Part X, 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items: a Revenues included in Form 990, Part VIII, line 1, b Assets included in Form 990, Part X

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

Schedule D (Form 990) 2013

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

- 3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):
- a Public exhibition
 - b Scholarly research
 - c Preservation for future generations
 - d Loan or exchange programs
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

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

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b If "Yes," explain the arrangement in Part XIII and complete the following table:
- | | Amount |
|---|--------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a Did the organization include an amount on Form 990, Part X, line 21? Yes No
- b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII.

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

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

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment ▶ _____ %
 - b Permanent endowment ▶ _____ %
 - c Temporarily restricted endowment ▶ _____ %
- The percentages in lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|--------|----|
| (i) unrelated organizations | 3a(i) | |
| (ii) related organizations | 3a(ii) | |
| b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R? | 3b | |
- 4 Describe in Part XIII the intended uses of the organization's endowment funds.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		697,964.		697,964.
b Buildings		58,509,630.	26,631,914.	31,877,716.
c Leasehold improvements				
d Equipment		35,465,835.	26,580,248.	8,885,587.
e Other		4,470,907.	498,502.	3,972,405.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				45,433,672.

Part VII Investments - Other Securities.

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

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

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	
(2) KERNAN ENDOWMENT	31,808,657.
(3) ECONOMIC INT IN UMMS FND	2,194,160.
(4) OTHER A/R	1,681,365.
(5) ASSETS WHOSE USE IS LIMITED	12,554,254.
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	48,238,436.

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO THIRD PARTY	3,880,283.
(3) PATIENT A/R CREDIT BALANCES	981,614.
(4) FIN 47 ACCRUAL	415,068.
(5) DUE TO AFFILIATES	22,466,688.
(6) OTHER LIABILITIES	10,881,951.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	38,625,604.

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

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include descriptions, sub-headers (2a-2d, 4a-4b), and totals (1, 2e, 3, 4c, 5).

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

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include descriptions, sub-headers (2a-2d, 4a-4b), and totals (1, 2e, 3, 4c, 5).

Part XIII Supplemental Information.

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

SEE PAGE 5

Series of horizontal dashed lines for providing supplemental information.

Part XIII Supplemental Information *(continued)*

SCHEDULE D, PART X, LINE 2

FIN 48 FOOTNOTE PER AUDIT REPORT

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

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2013

Open to Public Inspection

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

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

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

Department of the Treasury
Internal Revenue Service

Name of the organization

JAMES LAWRENCE KERNAN HOSPITAL, INC.

Employer identification number

52-0591639

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			626,776.		626,776.	.56
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			626,776.		626,776.	.56
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			162,825.		162,825.	.15
f Health professions education (from Worksheet 5)			9,183,777.		9,183,777.	8.23
g Subsidized health services (from Worksheet 6)			381,649.	116,468.	265,181.	.24
h Research (from Worksheet 7)			367,970.		367,970.	.33
i Cash and in-kind contributions for community benefit (from Worksheet 8)			114,787.		114,787.	.10
j Total. Other Benefits			10,211,008.	116,468.	10,094,540.	9.05
k Total. Add lines 7d and 7j.			10,837,784.	116,468.	10,721,316.	9.61

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						
9 Other						
10 Total						

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	32,363,285.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	31,185,638.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	1,177,647.
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 checked="" type="checkbox"/> Cost to charge ratio <input 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? 1

Name, address, primary website address, and state license number

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 JAMES LAWRENCE KERNAN HOSPITAL 2200 KERNAN DRIVE BALTIMORE MD 21207	X	X							REHABILITATION	A
2										
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group JAMES LAWRENCE KERNAN HOSPITAL

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)

	Yes	No
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 Section C)		
2 Indicate the tax year the hospital facility last conducted a CHNA: <u>20 1 2</u>		
3 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
4 Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	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 (list url): <u>HTTP://WWW.UMREHABORTHO.ORG/</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input type="checkbox"/> Available upon request from the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
6 If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year):		
a <input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA		
b <input checked="" 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 checked="" 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 Section C)		
7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C 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 JAMES LAWRENCE KERNAN HOSPITAL

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate the FPG family income limit for eligibility for free care: <u>2</u> <u>0</u> <u>0</u> % If "No," explain in Section C 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 Section C 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 checked="" type="checkbox"/> Uninsured discount		
f	<input checked="" type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input type="checkbox"/> Residency		
i	<input type="checkbox"/> Other (describe in Section C)		
13	Explained the method for applying for financial assistance?	X	
14	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input checked="" type="checkbox"/> The policy was attached to billing invoices		
c	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Section C)		

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 individual'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 Section C)		
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 individual'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 Section C)		

Part V Facility Information (continued) JAMES LAWRENCE KERNAN 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 individuals regarding the individuals' bills
 - d** Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
 - e** Other (describe in Section C)

Policy Relating to Emergency Medical Care

- | | | Yes | No |
|---|-----------|-----|----|
| 19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?
If "No," indicate why: | 19 | | X |
| a <input checked="" type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions | | | |
| b <input type="checkbox"/> The hospital facility's policy was not in writing | | | |
| c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | | |
| d <input type="checkbox"/> Other (describe in Section C) | | | |

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 <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | | |
| b <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | | |
| c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | | |
| d <input checked="" type="checkbox"/> Other (describe in Section C) | | | |
| 21 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?
If "Yes," explain in Section C. | 21 | | X |
| 22 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?
If "Yes," explain in Section C. | 22 | | X |

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

JAMES LAWRENCE KERNAN HOSPITAL

SCHEDULE H, PART V, SECTION B

LINE 20D - ALL PATIENTS ARE CHARGE STATE REGULATED RATES REGARDLESS OF
THEIR ABILITY TO PAY.

LINE 22 - THE STATE OF MARYLAND IS A UNIQUE STATE IN REGARD TO THE
PROVISION OF HEALTH CARE SERVICES AND THEIR RELATED CHARGES BY HOSPITALS.
ALL HOSPITAL CHARGES PROCESSED TO ALL PAYORS, INCLUDING GOVERNMENTAL
PAYORS, ARE SET THROUGH MARYLAND'S HEALTH SERVICES COST COMMISSION.
ACCORDINGLY, ALL HOSPITAL CHARGES ARE NOT GROSS CHARGES AS DEFINED BY THE
IRS UNDER INTERNAL REVENUE CODE SECTION 501(R)(5)(B).

Part V Facility Information (continued)

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

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

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

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

Part VI Supplemental Information

Provide the following information.

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

RELATED ORGANIZATION REPORT

SCHEDULE H, PART I, LINE 6A

AN ANNUAL COMMUNITY BENEFIT REPORT IS PREPARED FOR EACH FISCAL YEAR ENDING JUNE 30. THIS REPORT IS SUBMITTED TO THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC), A STATE REGULATORY AGENCY, BY DECEMBER 15 OF EACH YEAR. IN ADDITION, THE ANNUAL COMMUNITY BENEFIT REPORT IS AVAILABLE UPON REQUEST AT THE ENTITY'S CORPORATE OFFICES.

COSTING METHODOLOGY

SCHEDULE H, PART I, LINE 7A, COLUMN (D)

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

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, LINE 7B, COLUMNS (C) THROUGH (F)

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

SCHEDULE H, LINE 7F COLUMN (C)

Part VI Supplemental Information

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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.

SCHEDULE H, LINE 7F COLUMN (D)

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

Part VI Supplemental Information

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BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

COMMUNITY BUILDING ACTIVITIES

SCHEDULE H, PART II

THE JAMES LAWRENCE KERNAN HOSPITAL PROVIDES HEALTH INFORMATION AND SCREENINGS/EVENTS AS PART OF ITS COMMUNITY HEALTH OUTREACH AND ADVOCACY WORK. THE HOSPITAL HAS A STAFF PERSON WHO IS RESPONSIBLE FOR COORDINATING AND IMPLEMENTING EVENTS AND PARTICIPATION WITH THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM TEAM EVENTS.

THE FOLLOWING ARE THE INITIATIVES KERNAN HAS UNDERTAKEN TO MEET THE MAJOR HEALTH NEEDS PERTINENT TO KERNAN'S SPECIALTY PATIENT POPULATION AND IDENTIFIED IN HEALTHY BALTIMORE 2015, MARYLAND'S STATE HEALTH IMPROVEMENT PLAN (SHIP) AND IN THE UMMS MARKET RESEARCH SURVEY. THESE INITIATIVES HAVE ALSO BEEN IDENTIFIED IN KERNAN'S 2012 COMMUNITY HEALTH NEEDS ASSESSMENT AND HELP TO PROMOTE THE HEALTH OF THE COMMUNITY THAT IT SERVES. KERNAN STAFF COORDINATED AND PARTICIPATED IN THE FOLLOWING INITIATIVES THAT HELP PROMOTE THE HEALTH OF ITS COMMUNITY:

Part VI Supplemental Information

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- CHRONIC DISEASE: HEART DISEASE- REDUCE DEATHS FROM HEART DISEASE.

INITIATIVE 1

- ADAPTED SPORTS FESTIVAL WAS CREATED TO HELP DISABLED ADULTS FIGHT OBESITY AND HEART DISEASE, DIABETES
- CHRONIC DISEASE: OBESITY - REDUCE THE PROPORTION OF CHILDREN AND ADOLESCENTS WHO ARE CONSIDERED OBESE

INITIATIVE 2

- PROMOTING PHYSICAL ACTIVITY IN HIGH SCHOOLS THROUGH SPORTS
- HEALTHCARE ACCESS
- REDUCE THE PROPORTION OF INDIVIDUALS WHO ARE UNABLE TO AFFORD TO SEE A DOCTOR

INITIATIVE 3

- SUPPORT GROUPS/PATIENT EDUCATION
- CHRONIC DISEASE

Part VI Supplemental Information

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- REDUCE DEATHS FROM HEART DISEASE.

INITIATIVE 4

- TAKE A LOVED ONE TO THE DOCTOR DAY
- TARGETS OBESITY, DIABETES, HIGH BLOOD PRESSURE AND CARDIAC ISSUES.
- HEALTHCARE ACCESS
- INCREASE THE PROPORTION OF CHILDREN AND ADOLESCENTS WHO RECEIVE DENTAL CARE

INITIATIVE 5

- DENTAL CARE FOR THOSE IN NEED

BAD DEBT EXPENSE

SCHEDULE H, PART III, LINES 2, 3, AND 4

PART III, LINES 2 AND 3:

THE ORGANIZATION DOES NOT CODE CHARITY CARE AND BAD DEBT EXPENSE INTO THE SAME GENERAL LEDGER ACCOUNT. CHARITY CARE IS BOOKED TO A SEPARATE ACCOUNT AND IS CLASSIFIED AS A "DEDUCTION FROM REVENUE." AS SUCH IT IS NETTED

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AGAINST TOTAL PATIENT REVENUE IN ARRIVING AT NET PATIENT REVENUE ON THE ENTITY'S INCOME STATEMENTS.

BAD DEBT EXPENSE IS BOOKED TO A SEPARATE ACCOUNT ON THE GENERAL LEDGER AND DOES NOT INCLUDE ANY OTHER UNCOMPENSATED CARE AMOUNTS.

PART III, LINE 4:

THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING HISTORICAL BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS. PERIODICALLY THROUGHOUT THE YEAR, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED UPON HISTORICAL WRITE OFF EXPERIENCE BY PAYOR CATEGORY. THE RESULTS OF THIS REVIEW ARE THEN USED TO MAKE MODIFICATIONS TO THE PROVISION FOR BAD DEBTS AND TO ESTABLISH AN ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES. AFTER COLLECTION OF AMOUNTS DUE FROM INSURERS, THE CORPORATION FOLLOWS INTERNAL GUIDELINES FOR PLACING CERTAIN PAST DUE BALANCES WITH COLLECTION AGENCIES.

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MEDICARE COST REPORT

SCHEDULE H, PART III, LINE 8

IN MARYLAND, THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) STARTED SETTING HOSPITAL RATES IN 1974. AT THAT TIME, THE HSCRC APPROVED RATES APPLIED ONLY TO COMMERCIAL INSURERS. IN 1977, THE HSCRC NEGOTIATED A WAIVER FROM MEDICARE HOSPITAL PAYMENT RULES FOR MARYLAND HOSPITALS TO BRING THE FEDERAL MEDICARE PAYMENTS UNDER HSCRC CONTROL.

MEDICARE REIMBURSES MARYLAND HOSPITALS ACCORDING TO RATES ESTABLISHED BY THE HSCRC AS LONG AS THE STATE CONTINUES TO MEET A TWO-PART TEST. THIS TWO-PART WAIVER TEST ALLOWS MEDICARE TO PARTICIPATE IN THE MARYLAND SYSTEM AS LONG AS TWO CONDITIONS ARE MET.

- ALL OTHER PAYERS PARTICIPATING IN THE SYSTEM PAY HSCRC SET RATES AND
- THE RATE OF GROWTH IN MEDICARE PAYMENTS TO MARYLAND HOSPITALS FROM 1981 TO THE PRESENT IS NOT GREATER THAN THE RATE OF GROWTH IN MEDICARE PAYMENTS TO HOSPITALS NATIONALLY OVER THE SAME TIME FRAME.

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COLLECTION PRACTICES

SCHEDULE H, PART III, LINE 9B

THE ORGANIZATION EXPECTS PAYMENT AT THE TIME THE SERVICE IS PROVIDED. OUR POLICY IS TO COMPLY WITH ALL STATE AND FEDERAL LAW AND THIRD PARTY REGULATIONS AND TO PERFORM ALL CREDIT AND COLLECTION FUNCTIONS IN A DIGNIFIED AND RESPECTFUL MANNER. FINANCIAL ASSISTANCE IS AVAILABLE FOR PATIENTS BASED ON FINANCIAL NEED AS DEFINED IN THE FINANCIAL ASSISTANCE POLICY. THE ORGANIZATION DOES NOT DISCRIMINATE ON THE BASIS OF AGE, RACE, CREED, SEX OR ABILITY TO PAY.

PATIENTS WHO ARE UNABLE TO PAY MAY REQUEST A FINANCIAL ASSISTANCE APPLICATION AT ANY TIME PRIOR TO SERVICE OR DURING THE BILLING AND COLLECTION PROCESS. THE ORGANIZATION MAY REQUEST THE PATIENT TO APPLY FOR MEDICAL ASSISTANCE PRIOR TO APPLYING FOR FINANCIAL ASSISTANCE. THE ACCOUNT WILL NOT BE FORWARDED FOR COLLECTION DURING THE MEDICAL ASSISTANCE APPLICATION PROCESS OR THE FINANCIAL ASSISTANCE APPLICATION PROCESS.

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COMMUNITY HEALTH CARE NEEDS ASSESSMENT

SCHEDULE H, PART VI, LINE 2

HOSPITALS MUST PERFORM A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) EITHER FISCAL YEAR 2011, 2012, OR 2013, ADOPT AN IMPLEMENTATION STRATEGY TO MEET THE COMMUNITY HEALTH NEEDS IDENTIFIED, AND PERFORM AN ASSESSMENT AT LEAST EVERY THREE YEARS. THE NEEDS ASSESSMENT MUST TAKE INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE HOSPITAL FACILITY, INCLUDING THOSE WITH SPECIAL KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH, AND MUST BE MADE WIDELY AVAILABLE TO THE PUBLIC.

COMMUNITY BENEFITS IS A PART OF OUR HOSPITAL'S STRATEGIC PLAN. IN ADDITION, STAKEHOLDERS IN THE HOSPITAL ARE INVOLVED IN YOUR HOSPITAL COMMUNITY BENEFIT PROCESS/STRUCTURE TO IMPLEMENT AND DELIVER COMMUNITY BENEFIT ACTIVITIES WHICH INCLUDES THE CEO, CFO AND CLINICAL LEADERS IN THERAPY.

THE COMMUNITY BENEFIT DEPARTMENT COMMITTEE IS COMPRISED OF THE SR. DIRECTOR OF DEVELOPMENT AND MARKETING, DIRECTOR OF SERVICE EXCELLENCE AND

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VOLUNTEER SERVICES AND DIRECTOR OF OUTREACH. AN INTERNAL AUDIT (I.E., AN INTERNAL REVIEW) OF THE COMMUNITY BENEFIT REPORT IS CONDUCTED AT THE HOSPITAL AND THEN BY THE APPROVED BY HOSPITAL'S BOARD. THE COMPLETED COMMUNITY BENEFIT REPORT IS SUBMITTED TO THE HSCRC

THE COMMUNITY HEALTH NEEDS ASSESSMENT FOR THE UM REHAB & ORTHO WAS CONDUCTED THROUGH MEETINGS WITH HEALTH CARE LEADERS, FAITH-BASED LEADERS, DISCUSSIONS WITH AREA HEALTH CARE STAKEHOLDERS, AND SURVEYS WITH COMMUNITY RESIDENTS, HOSPITAL VISITORS AND COMMUNITY HEALTH FAIR ATTENDEES. SECONDARY DATA WAS USED IN CONJUNCTION WITH OTHER UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) BALTIMORE CITY HOSPITALS INCLUDING UMMC, UM MIDTOWN CAMPUS AND MT. WASHINGTON PEDIATRIC HOSPITALS. THIS INFORMATION WAS REVIEWED AND COMPARED WITH STATISTICS AVAILABLE THROUGH THE STATE OF MARYLAND'S HEALTH IMPROVEMENT PLAN, STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE DATA, BALTIMORE CITY HEALTH DEPARTMENT HEALTHY BALTIMORE 2015, HEALTHY PEOPLE 2020 AND AMERICAN COMMUNITY SURVEY DATA.

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UM REHAB & ORTHO HAS WORKED WITH A VARIETY OF GROUPS TO GATHER INFORMATION IN ORDER TO COMPILE THE HOSPITAL'S COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). INFORMATION ON AREA HEALTH NEEDS WAS OBTAINED THROUGH COMMUNITY MEETINGS WITH THE BALTIMORE CITY HEALTH DEPARTMENT NEIGHBORHOOD HEALTH INITIATIVE, THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM COMMUNITY HEALTH OUTREACH AND ADVOCACY, UMMS COMMUNITY NEEDS SURVEY, AND A MEETING WITH BALTIMORE CITY COMMUNITY GROUP STAKEHOLDERS. UMMS CREATED THE UNIVERSITY OF MARYLAND COMMUNITY HEALTH OUTREACH AND ADVOCACY TEAM THAT MEETS BI-MONTHLY TO ADDRESS THE HEALTH CARE NEEDS OF THE WEST BALTIMORE COMMUNITY. THE GROUP IS COMPRISED OF COMMUNITY OUTREACH MANAGEMENT AND STAFF, SOCIAL WORKERS, DIRECTORS, VICE PRESIDENTS, AND PHYSICIANS FROM UMMS SYSTEM HOSPITALS. UM REHAB & ORTHO, IN PARTNERSHIP WITH UMMS, IS A MAJOR PARTICIPANT AND SPONSOR IN MAJOR ANNUAL OUTREACH EFFORTS, AND SEES FIRSTHAND THE NEEDS OF ITS PATIENT COMMUNITY. IN ADDITION TO UM REHAB & ORTHO'S PARTICIPATION IN UMMS EVENTS, ADDITIONAL COMMUNITY OUTREACH INITIATIVES, INVOLVING PARTNERSHIPS WITH BOTH LOCAL EDUCATION AND COMMUNITY GROUPS, AS WELL AS ORGANIZATIONS WITH SPECIFIC TIES TO THE

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DISABLED COMMUNITY, AND THE DISABILITIES TREATED AT UM REHAB & ORTHO.

STAKEHOLDERS EXPRESSED THROUGH ROUNDTABLE DISCUSSION, AREAS THAT THEY FELT ARE IMPORTANT TO THE COMMUNITY, AND NEEDED TO BE ADDRESSED. UMMS OUTREACH TEAM MEMBERS TOOK NOTE OF THOSE ITEMS AND A DISCUSSION FOLLOWED TO ADDRESS WHAT COULD OCCUR WITHIN THE SCOPE OF HEALTHCARE. ADDITIONALLY COMMUNITY LEADERS FROM THE SURROUNDING BALTIMORE CITY NEIGHBORHOODS TO UM REHAB & ORTHO HOSPITAL ATTENDED MEETINGS CONDUCTED BY THE BALTIMORE CITY HEALTH DEPARTMENT AS A PART OF ITS HEALTHY BALTIMORE 2015 STUDY. THESE COMMUNITY MEMBERS DISCUSSED THEIR IDEAS OF WHAT WERE ISSUES WITHIN THE COMMUNITY. A SURVEY WAS ALSO TAKEN TO GAIN INPUT AS TO WHAT NEEDS THE COMMUNITY FELT WERE IMPORTANT. ADDITIONALLY DATA WAS OBTAINED FROM HEALTHY PEOPLE 2020, THE MARYLAND DHMH'S STATE HEALTH IMPROVEMENT PLAN (SHIP), BALTIMORE CITY HEALTH DEPARTMENT'S 2011 NEIGHBORHOOD PROFILES AND HEALTHY BALTIMORE 2015 AND INCLUDED TO PROVIDE NATIONAL AND LOCAL CONTEXT, DATA, AS WELL AS DIRECTION FOR THE ASSESSMENT.

UM REHAB & ORTHO SERVES A DIVERSE COMMUNITY, BOTH IN TERMS OF DIAGNOSIS,

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AS WELL AS LOCATION. AS A REHABILITATION SPECIALTY HOSPITAL, ADULT PATIENTS ARE TREATED FOR A VARIETY OF MUSCULOSKELETAL ISSUES SUCH AS TOTAL JOINT REPLACEMENT AND SPORTS MEDICINE, AND REHABILITATION ISSUES SUCH AS BRAIN INJURY, SPINAL CORD INJURY, STROKE, AND PAIN MANAGEMENT. THESE PATIENTS PRIMARILY COME FROM THE PREVIOUSLY DESCRIBED AREAS OF ANNE ARUNDEL, BALTIMORE AND HOWARD COUNTIES, AND BALTIMORE CITY.

HEALTH NEEDS IDENTIFIED THROUGH THE ASSESSMENT PROCESS INCLUDE CHRONIC DISEASE SUCH AS OBESITY AND ACCESS TO HEALTH CARE PROVISIONS. THERE ARE EXISTING HEALTH CARE FACILITIES AND RESOURCES WITHIN THE COMMUNITY AVAILABLE TO MEET THE COMMUNITY HEALTH NEEDS. THEY INCLUDE BUT ARE LIMITED TO: AMERICAN HEART ASSOCIATION, AMERICAN RED CROSS, BRAIN INJURY ASSOCIATION OF MARYLAND AND US AGAINST MS.

OUR HOSPITAL CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT THAT CONFORMS TO THE IRS DEFINITION IN JUNE OF 2012,
[HTTP://WWW.UMREHABORTHO.ORG/ABOUT/COMMUNITY-HEALTH-NEEDS-ASSESSMENT.HTM](http://www.umrehabortho.org/about/community-health-needs-assessment.htm)

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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.

OUR HOSPITAL ADOPTED AN IMPLEMENTATION STRATEGY THAT CONFORMS TO THE IRS
DEFINITIONS AND MAY BE FOUND AT
[HTTP://WWW.UMREHABORTHO.ORG/ABOUT/COMMUNITY-HEALTH-NEEDS-ASSESSMENT.HTM](http://www.umrehabortho.org/about/community-health-needs-assessment.htm)

ELIGIBILITY EDUCATION

SCHEDULE H, PART VI, LINE 3

FINANCIAL ASSISTANCE POLICY (FAP) OF THE UNIVERSITY OF MARYLAND
REHABILITATION & ORTHOPAEDIC INSTITUTE.

UNIVERSITY OF MARYLAND REHABILITATION & ORTHOPAEDIC INSTITUTE, AS A PART
OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM, PROVIDES HEALTHCARE
SERVICES TO THOSE IN NEED REGARDLESS OF AN INDIVIDUAL'S ABILITY TO PAY.
CARE MAY BE PROVIDED WITHOUT CHARGE, OR AT A REDUCED CHARGE, TO THOSE WHO
DO NOT HAVE INSURANCE, MEDICARE/MEDICAL ASSISTANCE COVERAGE, AND ARE
WITHOUT THE MEANS TO PAY. AN INDIVIDUAL'S ELIGIBILITY TO RECEIVE CARE
WITHOUT CHARGE, AT A REDUCED CHARGE, OR TO PAY FOR THEIR CARE OVER TIME
IS DETERMINED ON A CASE BY CASE BASIS.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 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.

WITHIN TWO DAYS FOLLOWING A PATIENT'S REQUEST FOR FINANCIAL ASSISTANCE SERVICES, APPLICATION FOR MEDICAL ASSISTANCE, OR BOTH, THE HOSPITAL MAKES A DETERMINATION OF PROBABLE ELIGIBILITY.

A LARGE PERCENTAGE OF THE UM REHAB & ORTHO PATIENTS ARE TRANSFERRED FROM THE SHOCK TRAUMA CENTER OR THE UNIVERSITY OF MARYLAND HOSPITAL. THOSE WHO DO NOT HAVE THE ABILITY TO PAY ARE NEVER TURNED AWAY AND ARE HELPED TO FIND RESOURCES TO COVER THE COSTS OF THEIR HOSPITAL STAY AND MEDICATIONS WITH THE ASSISTANCE OF UM REHAB & ORTHO'S INSTITUTE CASE MANAGERS. FOR PATIENTS WHO REQUIRE FINANCIAL ASSISTANCE, UM REHAB & ORTHO INSTITUTE HAS ENDOWMENT FUNDS AVAILABLE TO ASSIST PEOPLE WITHOUT RESOURCES WHO MAY NEED MEDICAL SUPPLIES OR MEDICATIONS. THIS ASSISTANCE IS AVAILABLE UPON REQUEST AND IS REVIEWED ON A CASE-BY-CASE BASIS.

INFORMATION REGARDING THE FINANCIAL ASSISTANCE POLICY AT UM REHAB & ORTHO INSTITUTE IS POSTED WITHIN THE HOSPITAL IN CLINIC AREAS AND BUSINESS AREAS WHERE ELIGIBLE PATIENTS ARE LIKELY TO BE PRESENT. PATIENTS ALSO

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RECEIVE INDIVIDUALIZED HELP IN OBTAINING SERVICES AND CARE SHOULD THEY NOT HAVE THE ABILITY TO PAY. INFORMATION REGARDING UM REHAB & ORTHO INSTITUTE FINANCIAL ASSISTANCE POLICY IS PROVIDED AT THE TIME OF PREADMISSION OR ADMISSION TO EACH PERSON WHO SEEKS SERVICES AT THE HOSPITAL, INCLUDING THE PATIENT HANDBOOK.

UM REHAB & ORTHO INSTITUTE MAKES EVERY EFFORT TO ENSURE THAT INFORMATION IS PROVIDED IN LANGUAGES THAT IS UNDERSTOOD BY THE TARGET POPULATION OF PATIENTS UTILIZING HOSPITAL SERVICES.

UM REHAB & ORTHO INSTITUTE MAKES EVERY EFFORT TO MAKE FINANCIAL ASSISTANCE INFORMATION AVAILABLE TO OUR PATIENTS INCLUDING, BUT NOT LIMITED TO:

- SIGNAGE IN MAIN ADMITTING AREAS OF THE HOSPITAL ARE POSTED IN ENGLISH AND SPANISH.
- INFORMATION SHEETS EXPLAINING FINANCIAL ASSISTANCE ARE MADE AVAILABLE

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IN ALL PATIENT CARE AREAS IN ENGLISH AND SPANISH.

- INFORMATION SHEETS ARE PROVIDED TO ALL PATIENTS AT THE TIME OF ADMISSION, EXPLAINING THE PROCESS FOR PAYMENT. IF PAYMENT CANNOT BE MADE, OPTIONS ARE EXPLAINED TO THE PATIENT.

- A DESCRIPTION OF THE FINANCIAL ASSISTANCE POLICY IS INCLUDED IN THE PATIENT HANDBOOK WHICH IS GIVEN TO ALL PATIENTS ADMITTED TO THE HOSPITAL.

POLICY

THIS POLICY APPLIES TO THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS)

FOLLOWING ENTITIES:

- UNIVERSITY OF MARYLAND MEDICAL CENTER (UMMC)
- UNIVERSITY OF MARYLAND REHABILITATION & ORTHOPAEDIC INSTITUTE
- UNIVERSITY SPECIALTY HOSPITAL (USH)
- UNIVERSITY OF MARYLAND ST. JOSEPH MEDICAL CENTER (UMSJMC)

UMMS IS COMMITTED TO PROVIDING FINANCIAL ASSISTANCE TO PERSONS WHO HAVE HEALTH CARE NEEDS AND ARE UNINSURED, UNDERINSURED, INELIGIBLE FOR A

Part VI Supplemental Information

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GOVERNMENT PROGRAM, OR OTHERWISE UNABLE TO PAY, FOR MEDICALLY NECESSARY
CARE BASED ON THEIR INDIVIDUAL FINANCIAL SITUATION.

IT IS THE POLICY OF THE UMMS ENTITIES TO PROVIDE FINANCIAL ASSISTANCE
BASED ON INDIGENCE OR HIGH MEDICAL EXPENSES FOR PATIENTS WHO MEET
SPECIFIED FINANCIAL CRITERIA AND REQUEST SUCH ASSISTANCE. THE PURPOSE OF
THE FOLLOWING POLICY STATEMENT IS TO DESCRIBE HOW APPLICATIONS FOR
FINANCIAL ASSISTANCE SHOULD BE MADE, THE CRITERIA FOR ELIGIBILITY, AND
THE STEPS FOR PROCESSING APPLICATIONS.

UMMS ENTITIES WILL PUBLISH THE AVAILABILITY OF FINANCIAL ASSISTANCE ON A
YEARLY BASIS IN THEIR LOCAL NEWSPAPERS AND WILL POST NOTICES OF
AVAILABILITY AT APPROPRIATE INTAKE LOCATIONS AS WELL AS THE BILLING
OFFICE. NOTICE OF AVAILABILITY WILL ALSO BE SENT TO PATIENTS TO PATIENT
WITH PATIENT BILLS. SIGNAGE IN KEY PATIENT ACCESS AREAS WILL BE MADE
AVAILABLE. A PATIENT BILLING AND FINANCIAL ASSISTANCE INFORMATION SHEET
WILL BE PROVIDED BEFORE DISCHARGE AND WILL BE AVAILABLE TO ALL PATIENTS
UPON REQUEST.

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FINANCIAL ASSISTANCE MAY BE EXTENDED WHEN A REVIEW OF A PATIENT'S INDIVIDUAL FINANCIAL CIRCUMSTANCES HAS BEEN CONDUCTED AND DOCUMENTED. THIS SHOULD INCLUDE A REVIEW OF THE PATIENT'S EXISTING MEDICAL EXPENSES AND OBLIGATIONS (INCLUDING ANY ACCOUNTS HAVING GONE TO BAD DEBT EXCEPT THOSE ACCOUNTS THAT HAVE GONE TO LAWSUIT AND A JUDGMENT HAS BEEN OBTAINED) AND ANY PROJECTED MEDICAL EXPENSES. FINANCIAL ASSISTANCE APPLICATIONS MAY BE OFFERED TO PATIENTS WHOSE ACCOUNTS ARE WITH A COLLECTION AGENCY AND MAY APPLY ONLY TO THOSE ACCOUNTS ON WHICH A JUDGMENT HAS NOT BEEN GRANTED.

UMMS RETAINS THE RIGHT IN ITS SOLE DISCRETION TO DETERMINE A PATIENT'S ABILITY TO PAY. ALL PATIENTS PRESENTING FOR EMERGENCY SERVICES WILL BE TREATED REGARDLESS OF THEIR ABILITY TO PAY. FOR EMERGENT/URGENT SERVICES, APPLICATIONS TO THE FINANCIAL CLEARANCE PROGRAM WILL BE COMPLETED, RECEIVED, AND EVALUATED RETROSPECTIVELY AND WILL NOT DELAY PATIENTS FROM RECEIVING CARE.

UNIVERSITY OF MARYLAND ST. JOSEPH MEDICAL CENTER (UMSJMC) ADOPTED THIS

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POLICY EFFECTIVE JUNE 1, 2013.

PROGRAM ELIGIBILITY

CONSISTENT WITH THEIR MISSION TO DELIVER COMPASSIONATE AND HIGH QUALITY HEALTHCARE SERVICES AND TO ADVOCATE FOR THOSE WHO DO NOT HAVE THE MEANS TO PAY FOR MEDICALLY NECESSARY CARE, UMMC, UMSJMC, JLK, AND USH HOSPITALS STRIVE TO ENSURE THAT THE FINANCIAL CAPACITY OF PEOPLE WHO NEED HEALTH CARE SERVICES DOES NOT PREVENT THEM FROM SEEKING OR RECEIVING CARE.

SPECIFIC EXCLUSIONS TO COVERAGE UNDER THE FINANCIAL ASSISTANCE PROGRAM INCLUDE THE FOLLOWING:

1. SERVICES PROVIDED BY HEALTHCARE PROVIDERS NOT AFFILIATED WITH UMMS HOSPITALS (E.G., DURABLE MEDICAL EQUIPMENT, HOME HEALTH SERVICES)
2. PATIENTS WHOSE INSURANCE PROGRAM OR POLICY DENIES COVERAGE FOR SERVICES BY THEIR INSURANCE COMPANY (E.G., HMO, PPO, OR WORKERS COMPENSATION), ARE NOT ELIGIBLE FOR THE FINANCIAL ASSISTANCE PROGRAM.

A. GENERALLY, THE FINANCIAL ASSISTANCE PROGRAM IS NOT AVAILABLE TO COVER SERVICES THAT ARE DENIED BY A PATIENT'S INSURANCE COMPANY; HOWEVER,

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EXCEPTIONS MAY BE MADE ON A CASE BY CASE BASIS CONSIDERING MEDICAL AND PROGRAMMATIC IMPLICATIONS.

3. UNPAID BALANCES RESULTING FROM COSMETIC OR OTHER NON-MEDICALLY NECESSARY SERVICES

4. PATIENT CONVENIENCE ITEMS

5. PATIENT MEALS AND LODGING

PATIENTS MAY BE INELIGIBLE FOR FINANCIAL ASSISTANCE FOR THE FOLLOWING REASONS:

1. REFUSAL TO PROVIDE REQUESTED DOCUMENTATION OR PROVIDE INCOMPLETE INFORMATION.

2. HAVE INSURANCE COVERAGE THROUGH AN HMO, PPO, WORKERS COMPENSATION, MEDICAID, OR OTHER INSURANCE PROGRAMS THAT DENY ACCESS TO THE MEDICAL CENTER DUE TO INSURANCE PLAN RESTRICTIONS/LIMITS.

3. FAILURE TO PAY CO-PAYMENTS AS REQUIRED BY THE FINANCIAL ASSISTANCE PROGRAM.

4. FAILURE TO KEEP CURRENT ON EXISTING PAYMENT ARRANGEMENTS WITH UMMS.

5. FAILURE TO MAKE APPROPRIATE ARRANGEMENTS ON PAST PAYMENT OBLIGATIONS OWED TO UMMS (INCLUDING THOSE PATIENTS WHO WERE REFERRED TO AN OUTSIDE

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COLLECTION AGENCY FOR A PREVIOUS DEBT).

6. REFUSAL TO BE SCREENED FOR OTHER ASSISTANCE PROGRAMS PRIOR TO
SUBMITTING AN APPLICATION TO THE FINANCIAL CLEARANCE PROGRAM.

7. REFUSAL TO DIVULGE INFORMATION PERTAINING TO A PENDING LEGAL LIABILITY
CLAIM

PATIENTS WHO BECOME INELIGIBLE FOR THE PROGRAM WILL BE REQUIRED TO PAY
ANY OPEN BALANCES AND MAY BE SUBMITTED TO A BAD DEBT SERVICE IF THE
BALANCE REMAINS UNPAID IN THE AGREED UPON TIME PERIODS.

PATIENTS WHO INDICATE THEY ARE UNEMPLOYED AND HAVE NO INSURANCE COVERAGE
SHALL BE REQUIRED TO SUBMIT A FINANCIAL ASSISTANCE APPLICATION UNLESS
THEY MEET PRESUMPTIVE FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA. IF THE
PATIENT QUALIFIES FOR COBRA COVERAGE, PATIENT'S FINANCIAL ABILITY TO PAY
COBRA INSURANCE PREMIUMS SHALL BE REVIEWED BY THE FINANCIAL
COUNSELOR/COORDINATOR AND RECOMMENDATIONS SHALL BE MADE TO SENIOR
LEADERSHIP. INDIVIDUALS WITH THE FINANCIAL CAPACITY TO PURCHASE HEALTH
INSURANCE SHALL BE ENCOURAGED TO DO SO, AS A MEANS OF ASSURING ACCESS TO

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HEALTH CARE SERVICES AND FOR THEIR OVERALL PERSONAL HEALTH.

COVERAGE AMOUNTS WILL BE CALCULATED BASED UPON 200-300% OF INCOME AS
DEFINED BY FEDERAL POVERTY GUIDELINES AND FOLLOWS THE SLIDING SCALE
INCLUDED IN ATTACHMENT A FOR A REDUCED COST OF CARE.

PRESUMPTIVE FINANCIAL ASSISTANCE

PATIENTS MAY ALSO BE CONSIDERED FOR PRESUMPTIVE FINANCIAL ASSISTANCE
ELIGIBILITY. THERE ARE INSTANCES WHEN A PATIENT MAY APPEAR ELIGIBLE FOR
FINANCIAL ASSISTANCE, BUT THERE IS NO FINANCIAL ASSISTANCE FORM ON FILE.
THERE IS ADEQUATE INFORMATION PROVIDED BY THE PATIENT OR THROUGH OTHER
SOURCES, WHICH PROVIDE SUFFICIENT EVIDENCE TO PROVIDE THE PATIENT WITH
FINANCIAL ASSISTANCE. IN THE EVENT THERE IS NO EVIDENCE TO SUPPORT A
PATIENT'S ELIGIBILITY FOR FINANCIAL ASSISTANCE, UMMS RESERVES THE RIGHT
TO USE OUTSIDE AGENCIES OR INFORMATION IN DETERMINING ESTIMATED INCOME
AMOUNTS FOR THE BASIS OF DETERMINING FINANCIAL ASSISTANCE ELIGIBILITY AND
POTENTIAL REDUCED CARE RATES. ONCE DETERMINED, DUE TO THE INHERENT NATURE
OF PRESUMPTIVE CIRCUMSTANCES, THE ONLY FINANCIAL ASSISTANCE THAT CAN BE

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GRANTED IS A 100% WRITE-OFF OF THE ACCOUNT BALANCE. PRESUMPTIVE FINANCIAL ASSISTANCE ELIGIBILITY SHALL ONLY COVER THE PATIENT'S SPECIFIC DATE OF SERVICE. PRESUMPTIVE ELIGIBILITY MAY BE DETERMINED ON THE BASIS OF INDIVIDUAL LIFE CIRCUMSTANCES THAT MAY INCLUDE:

- A. ACTIVE MEDICAL ASSISTANCE PHARMACY COVERAGE
- B. QMB COVERAGE/ SLMB COVERAGE
- C. PAC COVERAGE
- D. HOMELESSNESS
- E. MEDICAL ASSISTANCE AND MEDICAID MANAGED CARE PATIENTS FOR SERVICES PROVIDED IN THE ER BEYOND THE COVERAGE OF THESE PROGRAMS
- F. MEDICAL ASSISTANCE SPEND DOWN AMOUNTS
- G. ELIGIBILITY FOR OTHER STATE OR LOCAL ASSISTANCE PROGRAMS
- H. PATIENT IS DECEASED WITH NO KNOWN ESTATE
- I. PATIENTS THAT ARE DETERMINED TO MEET ELIGIBILITY CRITERIA ESTABLISHED UNDER FORMER STATE ONLY MEDICAL ASSISTANCE PROGRAM
- J. NON-US CITIZENS DEEMED NON-COMPLIANT
- K. NON-ELIGIBLE MEDICAL ASSISTANCE SERVICES FOR MEDICAL ASSISTANCE ELIGIBLE PATIENTS

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L. UNIDENTIFIED PATIENTS (DOE ACCOUNTS THAT WE HAVE EXHAUSTED ALL EFFORTS TO LOCATE AND/OR ID)

M. BANKRUPTCY, BY LAW, AS MANDATED BY THE FEDERAL COURTS.

SPECIFIC SERVICES OR CRITERIA THAT ARE INELIGIBLE FOR PRESUMPTIVE FINANCIAL ASSISTANCE INCLUDE:

A. PURELY ELECTIVE PROCEDURES (EXAMPLE - COSMETIC) ARE NOT COVERED UNDER THE PROGRAM.

B. UNINSURED PATIENTS SEEN IN THE EMERGENCY DEPARTMENT UNDER EMERGENCY PETITION WILL NOT BE CONSIDERED UNDER THE PRESUMPTIVE FINANCIAL ASSISTANCE PROGRAM UNTIL THE MARYLAND MEDICAID PSYCH PROGRAM HAS BEEN BILLED.

PROCEDURES

1. THERE ARE DESIGNATED PERSONS WHO WILL BE RESPONSIBLE FOR TAKING FINANCIAL ASSISTANCE APPLICATIONS. THESE STAFF CAN BE FINANCIAL COUNSELORS, PATIENT FINANCIAL RECEIVABLE COORDINATORS, CUSTOMER SERVICE REPRESENTATIVES, ETC.

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2. EVERY POSSIBLE EFFORT WILL BE MADE TO PROVIDE FINANCIAL CLEARANCE PRIOR TO DATE OF SERVICE. WHERE POSSIBLE, DESIGNATED STAFF WILL CONSULT VIA PHONE OR MEET WITH PATIENTS WHO REQUEST FINANCIAL ASSISTANCE TO DETERMINE IF THEY MEET PRELIMINARY CRITERIA FOR ASSISTANCE.

A. STAFF WILL COMPLETE AN ELIGIBILITY CHECK WITH THE MEDICAID PROGRAM FOR SELF PAY PATIENTS TO VERIFY WHETHER THE PATIENT HAS CURRENT COVERAGE.

B. PRELIMINARY DATA WILL BE ENTERED INTO A THIRD PARTY DATA EXCHANGE SYSTEM TO DETERMINE PROBABLY ELIGIBILITY. TO FACILITATE THIS PROCESS EACH APPLICANT MUST PROVIDE INFORMATION ABOUT FAMILY SIZE AND INCOME (AS DEFINED BY MEDICAID REGULATIONS). TO HELP APPLICANTS COMPLETE THE PROCESS, WE WILL PROVIDE AN APPLICATION THAT WILL LET THEM KNOW WHAT PAPERWORK IS REQUIRED FOR A FINAL DETERMINATION OF ELIGIBILITY.

C. APPLICATIONS INITIATED BY THE PATIENT WILL BE TRACKED, WORKED AND ELIGIBILITY DETERMINED WITHIN THE THIRD PARTY DATA AND WORKFLOW TOOL. A LETTER OF FINAL DETERMINATION WILL BE SUBMITTED TO EACH PATIENT THAT HAS FORMALLY REQUESTED FINANCIAL ASSISTANCE.

D. UPON RECEIPT OF THE PATIENT'S APPLICATION, THEY WILL HAVE TWENTY (20) DAYS TO SUBMIT THE REQUIRED DOCUMENTATION TO BE CONSIDERED FOR

Part VI Supplemental Information

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- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

ELIGIBILITY. IF NO DATA IS RECEIVED WITHIN THE 20 DAYS, A DENIAL LETTER WILL BE SENT NOTIFYING THAT THE CASE IS NOW CLOSED FOR INACTIVITY AND THE ACCOUNT WILL BE REFERRED TO BAD DEBT COLLECTION SERVICES IF NO FURTHER COMMUNICATION OR DATA IS RECEIVED FROM THE PATIENT. THE PATIENT MAY RE-APPLY TO THE PROGRAM AND INITIATE A NEW CASE IF THE ORIGINAL TIMELINE IS NOT ADHERED TO.

3. THERE WILL BE ONE APPLICATION PROCESS FOR UMMC, UMSJMC, JLK, AND USH.

THE PATIENT IS REQUIRED TO PROVIDE A COMPLETED FINANCIAL ASSISTANCE APPLICATION. IN ADDITION, THE FOLLOWING MAY BE REQUIRED:

- A. A COPY OF THEIR MOST RECENT FEDERAL INCOME TAX RETURN (IF MARRIED AND FILING SEPARATELY, THEN ALSO A COPY SPOUSE'S TAX RETURN); PROOF OF DISABILITY INCOME (IF APPLICABLE), PROOF OF SOCIAL SECURITY INCOME (IF APPLICABLE). IF UNEMPLOYED, REASONABLE PROOF OF UNEMPLOYMENT SUCH AS STATEMENT FROM THE OFFICE OF UNEMPLOYMENT INSURANCE, A STATEMENT FROM CURRENT SOURCE OF FINANCIAL SUPPORT, ETC ...
- B. A COPY OF THEIR MOST RECENT PAY STUBS (IF EMPLOYED) OR OTHER EVIDENCE OF INCOME.
- C. A MEDICAL ASSISTANCE NOTICE OF DETERMINATION (IF APPLICABLE).

Part VI Supplemental Information

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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.

D. COPY OF THEIR MORTGAGE OR RENT BILL (IF APPLICABLE), OR WRITTEN DOCUMENTATION OF THEIR CURRENT LIVING/HOUSING SITUATION.

4. A PATIENT CAN QUALIFY FOR FINANCIAL ASSISTANCE EITHER THROUGH LACK OF SUFFICIENT INSURANCE OR EXCESSIVE MEDICAL EXPENSES. ONCE A PATIENT HAS SUBMITTED ALL THE REQUIRED INFORMATION, THE FINANCIAL COUNSELOR WILL REVIEW AND ANALYZE THE APPLICATION AND FORWARD IT TO THE PATIENT FINANCIAL SERVICES DEPARTMENT FOR FINAL DETERMINATION OF ELIGIBILITY BASED ON UMMS GUIDELINES.

A. IF THE PATIENT'S APPLICATION FOR FINANCIAL ASSISTANCE IS DETERMINED TO BE COMPLETE AND APPROPRIATE, THE FINANCIAL

B. COORDINATOR WILL RECOMMEND THE PATIENT'S LEVEL OF ELIGIBILITY AND FORWARD FOR A SECOND AND FINAL APPROVAL.

I) IF THE PATIENT DOES QUALIFY FOR FINANCIAL ASSISTANCE, THE FINANCIAL COORDINATOR WILL NOTIFY CLINICAL STAFF WHO MAY THEN SCHEDULE THE PATIENT FOR THE APPROPRIATE HOSPITAL-BASED SERVICE.

II) IF THE PATIENT DOES NOT QUALIFY FOR FINANCIAL ASSISTANCE, THE FINANCIAL COORDINATOR WILL NOTIFY THE CLINICAL STAFF OF THE DETERMINATION

Part VI Supplemental Information

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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.

AND THE NON-EMERGENT/URGENT HOSPITAL-BASED SERVICES WILL NOT BE SCHEDULED.

(1) A DECISION THAT THE PATIENT MAY NOT BE SCHEDULED FOR HOSPITAL-BASED, NON-EMERGENT/URGENT SERVICES MAY BE RECONSIDERED BY THE FINANCIAL CLEARANCE EXECUTIVE COMMITTEE, UPON THE REQUEST OF A CLINICAL CHAIR.

5. EACH CLINICAL DEPARTMENT HAS THE OPTION TO DESIGNATE CERTAIN ELECTIVE PROCEDURES FOR WHICH NO FINANCIAL ASSISTANCE OPTIONS WILL BE GIVEN.

6. ONCE A PATIENT IS APPROVED FOR FINANCIAL ASSISTANCE, FINANCIAL ASSISTANCE COVERAGE MAY BE EFFECTIVE FOR THE MONTH OF DETERMINATION, UP TO 3 YEARS PRIOR, AND UP TO SIX (6) CALENDAR MONTHS IN TO THE FUTURE.

HOWEVER, THERE ARE NO LIMITATIONS ON THE FINANCIAL ASSISTANCE ELIGIBILITY PERIOD. EACH ELIGIBILITY PERIOD WILL BE DETERMINED ON A CASE-BY-CASE BASIS. IF ADDITIONAL HEALTHCARE SERVICES ARE PROVIDED BEYOND THE APPROVAL PERIOD, PATIENTS MUST REAPPLY TO THE PROGRAM FOR CLEARANCE. IN ADDITION, CHANGES TO THE PATIENT'S INCOME, ASSETS, EXPENSES OR FAMILY STATUS ARE EXPECTED TO BE COMMUNICATED TO THE FINANCIAL ASSISTANCE PROGRAM DEPARTMENT.

7. IF A PATIENT IS DETERMINED TO BE INELIGIBLE, ALL EFFORTS TO COLLECT

Part VI Supplemental Information

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CO-PAYS, DEDUCTIBLES OR A PERCENTAGE OF THE EXPECTED BALANCE FOR THE SERVICE WILL BE MADE PRIOR TO THE DATE OF SERVICE OR MAY BE SCHEDULED FOR COLLECTION ON THE DATE OF SERVICE.

8. A LETTER OF FINAL DETERMINATION WILL BE SUBMITTED TO EACH PATIENT WHO HAS FORMALLY SUBMITTED AN APPLICATION.

9. REFUND DECISIONS ARE BASED ON WHEN THE PATIENT WAS DETERMINED UNABLE TO PAY COMPARED TO WHEN THE PATIENT PAYMENTS WERE MADE. REFUNDS MAY BE ISSUED BACK TO THE PATIENT FOR CREDIT BALANCES, DUE TO PATIENT PAYMENTS, RESULTED FROM APPROVED FINANCIAL ASSISTANCE ON CONSIDERED BALANCE(S).

10. PATIENTS WHO HAVE ACCESS TO OTHER MEDICAL CARE (E.G., PRIMARY AND SECONDARY INSURANCE COVERAGE OR A REQUIRED SERVICE PROVIDER, ALSO KNOWN AS A CARVE-OUT), MUST UTILIZE AND EXHAUST THEIR NETWORK BENEFITS BEFORE APPLYING FOR THE FINANCIAL ASSISTANCE PROGRAM.

11. THE FINANCIAL ASSISTANCE PROGRAM WILL ACCEPT THE FACULTY PHYSICIANS, INC.'S (FPI) COMPLETED FINANCIAL ASSISTANCE APPLICATIONS IN DETERMINING ELIGIBILITY FOR THE UMMS FINANCIAL ASSISTANCE PROGRAM. THIS INCLUDES ACCEPTING FPI'S APPLICATION REQUIREMENTS.

12. THE FINANCIAL ASSISTANCE PROGRAM WILL ACCEPT ALL OTHER UNIVERSITY OF

Part VI Supplemental Information

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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.

MARYLAND MEDICAL SYSTEM HOSPITAL'S COMPLETED FINANCIAL ASSISTANCE APPLICATIONS IN DETERMINING ELIGIBILITY FOR THE PROGRAM. THIS INCLUDES ACCEPTING EACH FACILITY'S APPLICATION FORMAT.

13. THE FINANCIAL ASSISTANCE PROGRAM DOES NOT COVER SUPERVISED LIVING ACCOMMODATIONS AND MEALS WHILE A PATIENT IS IN THE DAY PROGRAM.

14. WHERE THERE IS A COMPELLING EDUCATIONAL AND/OR HUMANITARIAN BENEFIT, CLINICAL STAFF MAY REQUEST THAT THE FINANCIAL CLEARANCE EXECUTIVE COMMITTEE CONSIDER EXCEPTIONS TO THE FINANCIAL ASSISTANCE PROGRAM GUIDELINES, ON A CASE-BY-CASE BASIS, FOR FINANCIAL ASSISTANCE APPROVAL.

A. FACULTY REQUESTING FINANCIAL CLEARANCE/ASSISTANCE ON AN EXCEPTION BASIS MUST SUBMIT APPROPRIATE JUSTIFICATION TO THE FINANCIAL CLEARANCE EXECUTIVE COMMITTEE IN ADVANCE OF THE PATIENT RECEIVING SERVICES.

B. THE CHIEF MEDICAL OFFICER WILL NOTIFY THE ATTENDING PHYSICIAN AND THE FINANCIAL ASSISTANCE STAFF OF THE FINANCIAL CLEARANCE EXECUTIVE COMMITTEE DETERMINATION.

FINANCIAL HARDSHIP

THE AMOUNT OF UNINSURED MEDICAL COSTS INCURRED AT EITHER UMMC, UMSJMC,

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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.

JLK, OR USH WILL BE CONSIDERED IN DETERMINING A PATIENT'S ELIGIBILITY FOR THE FINANCIAL ASSISTANCE PROGRAM. THE FOLLOWING GUIDELINES ARE OUTLINED AS A SEPARATE, SUPPLEMENTAL DETERMINATION OF FINANCIAL ASSISTANCE, KNOWN AS FINANCIAL HARDSHIP. FINANCIAL HARDSHIP WILL BE OFFERED TO ALL PATIENTS WHO APPLY FOR FINANCIAL ASSISTANCE. MEDICAL FINANCIAL HARDSHIP ASSISTANCE IS AVAILABLE FOR PATIENTS WHO OTHERWISE DO NOT QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE PRIMARY GUIDELINES OF THIS POLICY, BUT FOR WHOM:

1) THEIR MEDICAL DEBT INCURRED AT OUR EITHER UMMC, UMSJMC, JLK, OR USH EXCEEDS 25% OF THE FAMILY ANNUAL HOUSEHOLD INCOME, WHICH IS CREATING MEDICAL FINANCIAL HARDSHIP; AND

2) WHO MEET THE INCOME STANDARDS FOR THIS LEVEL OF ASSISTANCE.

FOR THE PATIENTS WHO ARE ELIGIBLE FOR BOTH, THE REDUCED COST CARE UNDER THE PRIMARY FINANCIAL ASSISTANCE CRITERIA AND ALSO UNDER THE FINANCIAL HARDSHIP ASSISTANCE CRITERIA, UMMC, UMSJMC, JLK, AND USH WILL GRANT THE REDUCTION IN CHARGES THAT ARE MOST FAVORABLE TO THE PATIENT.

FINANCIAL HARDSHIP IS DEFINED AS FACILITY CHARGES INCURRED HERE AT EITHER

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UMMC, UMSJMC, JLK, OR USH FOR MEDICALLY NECESSARY TREATMENT BY A FAMILY HOUSEHOLD OVER A TWELVE (12) MONTH PERIOD THAT EXCEEDS 25% OF THAT FAMILY'S ANNUAL INCOME.

MEDICAL DEBT IS DEFINED AS OUT OF POCKET EXPENSES FOR THE FACILITY CHARGES INCURRED HERE AT UMMC, UMSJMC, JLK, OR USH FOR MEDICALLY NECESSARY TREATMENT.

ONCE A PATIENT IS APPROVED FOR FINANCIAL HARDSHIP ASSISTANCE, COVERAGE WILL BE EFFECTIVE STARTING THE MONTH OF THE FIRST QUALIFYING DATE OF SERVICE AND UP TO THE FOLLOWING TWELVE (12) CALENDAR MONTHS FROM THE APPLICATION EVALUATION COMPLETION DATE. EACH PATIENT WILL BE EVALUATED ON A CASE-BY-CASE BASIS FOR THE ELIGIBILITY TIME FRAME ACCORDING TO THEIR SPELL OF ILLNESS/EPISODE OF CARE. IT WILL COVER THE PATIENT AND THE IMMEDIATE FAMILY MEMBERS LIVING IN THE HOUSEHOLD FOR THE APPROVED REDUCED COST AND ELIGIBILITY PERIOD FOR MEDICALLY NECESSARY TREATMENT. COVERAGE SHALL NOT APPLY TO ELECTIVE OR COSMETIC PROCEDURES. HOWEVER, THE PATIENT OR GUARANTOR MUST NOTIFY THE HOSPITAL OF THEIR ELIGIBILITY AT THE TIME OF REGISTRATION OR ADMISSION. IN ORDER TO CONTINUE IN THE PROGRAM AFTER THE EXPIRATION OF EACH ELIGIBILITY APPROVAL PERIOD, EACH PATIENT MUST

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REAPPLY TO BE RECONSIDERED. IN ADDITION, PATIENTS WHO HAVE BEEN APPROVED FOR THE PROGRAM MUST INFORM THE HOSPITALS OF ANY CHANGES IN INCOME, ASSETS, EXPENSES, OR FAMILY (HOUSEHOLD) STATUS WITHIN 30 DAYS OF SUCH CHANGE(S).

ALL OTHER ELIGIBILITY, INELIGIBILITY, AND PROCEDURES FOR THE PRIMARY FINANCIAL ASSISTANCE PROGRAM CRITERIA APPLY FOR THE FINANCIAL HARDSHIP ASSISTANCE CRITERIA, UNLESS OTHERWISE STATED ABOVE.

ASSET CONSIDERATION

ASSETS ARE GENERALLY NOT CONSIDERED AS PART OF FINANCIAL ASSISTANCE ELIGIBILITY DETERMINATION UNLESS THEY ARE DEEMED SUBSTANTIAL ENOUGH TO COVER ALL OR PART OF THE PATIENT RESPONSIBILITY WITHOUT CAUSING UNDUE HARDSHIP. INDIVIDUAL PATIENT FINANCIAL SITUATIONS, SUCH AS THE ABILITY TO REPLENISH THE ASSET AND FUTURE INCOME POTENTIAL ARE TAKEN INTO CONSIDERATION WHENEVER ASSETS ARE CONSIDERED IN THE EVALUATION PROCESS.

1. UNDER THE CURRENT LEGISLATION, THE FOLLOWING ASSETS ARE EXEMPT FROM CONSIDERATION:

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A. THE FIRST \$10,000.00 OF MONETARY ASSETS FOR INDIVIDUALS, AND THE FIRST \$25,000.00 OF MONETARY ASSETS FOR HOUSEHOLD FAMILIES.

B. UP TO \$150,000.00 IN PRIMARY RESIDENCE EQUITY.

C. RETIREMENT ASSETS, REGARDLESS OF BALANCE, TO WHICH THE IRS HAS GRANTED PREFERENTIAL TAX TREATMENT AS A RETIREMENT ACCOUNT, INCLUDING BUT NOT LIMITED TO, DEFERRED COMPENSATION PLANS QUALIFIED UNDER THE IRS CODE OR NONQUALIFIED DEFERRED COMPENSATION PLANS. GENERALLY, THIS CONSISTS OF PLANS THAT ARE TAX EXEMPT AND/OR HAVE PENALTIES FOR EARLY WITHDRAWAL.

APPEALS

- PATIENTS WHOSE FINANCIAL ASSISTANCE APPLICATIONS ARE DENIED HAVE THE OPTION TO APPEAL THE DECISION.

- APPEALS CAN BE INITIATED VERBALLY OR WRITTEN.

- PATIENTS ARE ENCOURAGED TO SUBMIT ADDITIONAL SUPPORTING DOCUMENTATION JUSTIFYING WHY THE DENIAL SHOULD BE OVERTURNED.

- APPEALS ARE DOCUMENTED WITHIN THE THIRD PARTY DATA AND WORKFLOW TOOL.

THEY ARE THEN REVIEWED BY THE NEXT LEVEL OF MANAGEMENT ABOVE THE REPRESENTATIVE WHO DENIED THE ORIGINAL APPLICATION.

- IF THE FIRST LEVEL OF APPEAL DOES NOT RESULT IN THE DENIAL BEING

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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.

OVERTURNED, PATIENTS HAVE THE OPTION OF ESCALATING TO THE NEXT LEVEL OF MANAGEMENT FOR ADDITIONAL RECONSIDERATION.

- THE ESCALATION CAN PROGRESS UP TO THE CHIEF FINANCIAL OFFICER WHO WILL RENDER A FINAL DECISION.

- A LETTER OF FINAL DETERMINATION WILL BE SUBMITTED TO EACH PATIENT WHO HAS FORMALLY SUBMITTED AN APPEAL.

JUDGMENTS

IF A PATIENT IS LATER FOUND TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE AFTER A JUDGMENT HAS BEEN OBTAINED OR THE DEBT SUBMITTED TO A CREDIT REPORTING AGENCY, UMMC, UMSJMC, JLK, OR USH SHALL SEEK TO VACATE THE JUDGMENT AND/OR STRIKE THE ADVERSE CREDIT INFORMATION.

AND/OR STRIKE THE ADVERSE CREDIT INFORMATION.

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DESCRIPTION OF COMMUNITY SERVED

SCHEDULE H, PART VI, LINE 4

THE FOLLOWING INFORMATION DETAILS THE AREAS UM REHAB & ORTHO SERVES:

BALTIMORE CITY, MARYLAND

BALTIMORE CITY CONSISTS OF NINE GEOGRAPHICAL REGIONS: NORTHERN, NORTHWESTERN, NORTHEASTERN, WESTERN, CENTRAL, EASTERN, SOUTHERN, SOUTHWESTERN, AND SOUTHEASTERN. THE WEST BALTIMORE COMMUNITY IS NEAREST TO UM REHAB & ORTHO INSTITUTE, AND CONSISTS OF THE NORTHWESTERN, WESTERN, AND SOUTHWESTERN DISTRICTS. THE NORTHWESTERN DISTRICT, BOUNDED BY THE BALTIMORE COUNTY LINE ON ITS NORTHERN AND WESTERN BOUNDARIES, GWYNNS FALLS PARKWAY ON THE SOUTH AND PIMLICO ROAD ON THE EAST, IS HOME TO PIMLICO RACE COURSE, WHERE THE PREAKNESS STAKES TAKES PLACE EACH MAY, AND IS PRIMARILY RESIDENTIAL.

THE WESTERN DISTRICT, LOCATED WEST OF THE MAIN COMMERCIAL DISTRICT DOWNTOWN, IS THE HEART OF WEST BALTIMORE, BOUNDED BY GWYNNS FALLS PARKWAY, FREMONT AVENUE, AND BALTIMORE STREET. COPPIN STATE UNIVERSITY,

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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.

MONDAWMIN MALL, AND EDMONDSON VILLAGE, ALL LOCATED WITHIN THIS DISTRICT, HAVE BEEN HISTORIC CULTURAL AND ECONOMIC CENTERS OF THE CITY'S AFRICAN AMERICAN COMMUNITY.

THE SOUTHWESTERN DISTRICT IS BOUNDED BY BALTIMORE COUNTY TO THE WEST, BALTIMORE STREET TO THE NORTH, AND THE DOWNTOWN AREA TO THE EAST. ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF SOUTHWESTERN DISTRICT VARY.

DEMOGRAPHICS

ACCORDING TO THE 2010 U.S. CENSUS, THE LATEST DATA AVAILABLE, THERE WERE 621,342 PEOPLE RESIDING IN BALTIMORE, AN INCREASE OF .01% SINCE 2010. ACCORDING TO THE 2010 U.S. CENSUS, 29.6% OF THE POPULATION WAS NON-HISPANIC WHITE, 63.7% NON-HISPANIC BLACK OR AFRICAN AMERICAN, 0.4% NON-HISPANIC AMERICAN INDIAN AND ALASKA NATIVE, 2.3% NON-HISPANIC ASIAN, 0% FROM SOME OTHER RACE (NON-HISPANIC) AND 2.1% OF TWO OR MORE RACES (NON-HISPANIC). 4.2% OF BALTIMORE'S POPULATION WAS OF HISPANIC, LATINO, OR SPANISH ORIGIN. IN THE 1990S, THE US CENSUS REPORTED THAT BALTIMORE

Part VI Supplemental Information

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RANKED AS ONE OF THE LARGEST POPULATION LOSERS ALONGSIDE DETROIT AND WASHINGTON D.C., LOSING OVER 84,000 RESIDENTS BETWEEN 1990 AND 2000.

THE SAME REPORT ALSO ESTIMATED THESE PEOPLE LIVED IN A TOTAL OF 294,579 HOUSING UNITS. AGE RANGES WERE 22.4% UNDER 18 YEARS OLD, 11.8% AT AGE 65 OR OLDER, AND 65.8% FROM 18 TO 64 YEARS OLD. THE CITY'S ESTIMATED 2009 POPULATION OF 637,418 WAS 53.4% FEMALE.

A STATISTICAL ABSTRACT PREPARED BY THE U.S. CENSUS BUREAU ESTIMATED THE MEDIAN INCOME FOR A HOUSEHOLD IN THE CITY DURING 2009 AT \$38,458, WITH 20.9% OF THE POPULATION BELOW THE POVERTY LINE.

BALTIMORE COUNTY, MARYLAND

A PART OF THE BALTIMORE-WASHINGTON METROPOLITAN AREA, BALTIMORE COUNTY IS LOCATED IN THE NORTHERN PART OF THE STATE OF MARYLAND. IN 2010, THE COUNTY'S POPULATION WAS 805,029. COMPRISED OF APPROXIMATELY 598 SQUARE MILES, BALTIMORE COUNTY DOES NOT HAVE ANY INCORPORATED CITIES OR TOWNS

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AND IS DIVIDED INTO COUNCIL DISTRICTS. UM REHAB & ORTHO IS LOCATED ON THE SOUTHWESTERN BORDER OF DISTRICT 4 (RANDALLSTOWN/WOODLAWN/SECURITY) OF THE COUNTY AND BALTIMORE CITY.

DEMOGRAPHICS

ACCORDING TO THE 2010 CENSUS QUICKFACTS, THE LATEST DATA AVAILABLE, THE POPULATION AND DEMOGRAPHICS OF BALTIMORE COUNTY WERE AS FOLLOWS:

WHITE PERSONS COMPRISED 64.8 PERCENT OF THE POPULATION, WITH BLACK PERSONS ACCOUNTING FOR 27 PERCENT OF THE COUNTY'S POPULATION. AMERICAN INDIAN AND ALASKA NATIVE PERSONS MADE UP .04 PERCENT OF THE POPULATION, ASIAN POPULATION COMPRISED 5.4 PERCENT, WITH NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER AT .01 PERCENT. PERSONS REPORTING TWO OR MORE RACES MADE UP PERCENT OF BALTIMORE COUNTY'S POPULATION, PERSONS OF HISPANIC OR LATINO ORIGIN, TOTALED 4.6 PERCENT. THE PERCENT OF WHITE PERSONS, NOT HISPANIC WAS 61.4 PERCENT.

THERE WERE 315.127 HOUSEHOLDS OUT OF WHICH 30.20% HAD CHILDREN UNDER THE AGE OF 18 LIVING WITH THEM, 49.40% WERE MARRIED COUPLES LIVING TOGETHER,

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12.80% HAD A FEMALE HOUSEHOLDER WITH NO HUSBAND PRESENT, AND 33.80% WERE NON-FAMILIES. 27.30% OF ALL HOUSEHOLDS WERE MADE UP OF INDIVIDUALS AND 10.10% HAD SOMEONE LIVING ALONE WHO WAS 65 YEARS OF AGE OR OLDER. THE AVERAGE HOUSEHOLD SIZE WAS AND THE AVERAGE FAMILY SIZE WAS 3.00.

IN THE COUNTY THE POPULATION WAS SPREAD OUT WITH 23.60% UNDER THE AGE OF 18, 8.50% FROM 18 TO 24, 29.80% FROM 25 TO 44, 23.40% FROM 45 TO 64, AND 14.60% WHO WERE 65 YEARS OF AGE OR OLDER. THE MEDIAN AGE WAS 38 YEARS. FOR EVERY 100 FEMALES THERE WERE 90.00 MALES. FOR EVERY 100 FEMALES AGE 18 AND OVER, THERE WERE 86.00 MALES.

THE MEDIAN INCOME FOR A HOUSEHOLD IN THE COUNTY WAS \$65,411.00, AND THE MEDIAN INCOME FOR A FAMILY WAS \$59,998. MALES HAD A MEDIAN INCOME OF \$41,048 VERSUS \$31,426 FOR FEMALES. THE PER CAPITA INCOME FOR THE COUNTY WAS \$34,304.0. ABOUT 8.2% OF THE POPULATION WAS BELOW THE POVERTY LINE, INCLUDING 7.20% OF THOSE UNDER AGE 18 AND 6.50% OF THOSE AGED 65 OR OVER.

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HOWARD COUNTY, MARYLAND

HOWARD COUNTY IS LOCATED IN THE CENTRAL PART OF THE MARYLAND, BETWEEN
BALTIMORE AND WASHINGTON, D.C. IT IS CONSIDERED PART OF THE
BALTIMORE-WASHINGTON METROPOLITAN AREA.

ACCORDING TO THE 2010 U.S. CENSUS, THE LATEST DATA AVAILABLE, ITS
POPULATION WAS 299,430. ITS COUNTY SEAT IS ELLICOTT CITY. THE CENTER OF
POPULATION OF MARYLAND IS LOCATED ON THE COUNTY LINE BETWEEN HOWARD
COUNTY AND ANNE ARUNDEL COUNTY, IN THE UNINCORPORATED TOWN OF JESSUP.
DUE TO THE PROXIMITY OF HOWARD COUNTY'S POPULATION CENTERS TO BALTIMORE,
THE COUNTY HAS TRADITIONALLY BEEN CONSIDERED A PART OF THE BALTIMORE
METROPOLITAN AREA. RECENT DEVELOPMENT IN THE SOUTH OF THE COUNTY HAS LED
TO SOME REALIGNMENT TOWARDS THE WASHINGTON, D.C. MEDIA AND EMPLOYMENT
MARKETS. THE COUNTY IS ALSO HOME TO COLUMBIA, A MAJOR PLANNED COMMUNITY
OF 100,000 FOUNDED BY DEVELOPER JAMES ROUSE IN 1967.

HOWARD COUNTY IS FREQUENTLY CITED FOR ITS AFFLUENCE, QUALITY OF LIFE, AND
EXCELLENT SCHOOLS. FOR 2011, IT WAS RANKED THE FIFTH WEALTHIEST COUNTY BY

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MEDIAN HOUSEHOLD INCOME IN THE UNITED STATES BY THE U.S. CENSUS BUREAU.

MANY OF THE MOST AFFLUENT COMMUNITIES IN THE BALTIMORE-WASHINGTON METROPOLITAN AREA, SUCH AS CLARKSVILLE, GLENELG, GLENWOOD AND WEST FRIENDSHIP, ARE LOCATED ALONG THE ROUTE 32 CORRIDOR IN HOWARD COUNTY. THE MAIN POPULATION CENTER OF COLUMBIA/ELLCOTT CITY WAS NAMED 2ND AMONG MONEY MAGAZINE'S 2010 SURVEY OF "AMERICA'S BEST PLACES TO LIVE." HOWARD COUNTY'S SCHOOLS FREQUENTLY RANK FIRST IN MARYLAND AS MEASURED BY STANDARDIZED TEST SCORES AND GRADUATION RATES.

DEMOGRAPHICS

ACCORDING TO THE 2010 U.S. CENSUS, THE LATEST DATA AVAILABLE, WHITE PERSONS COMPRISED 62.3 PERCENT OF THE POPULATION OF HOWARD COUNTY. BLACK PERSONS MADE UP 18.1 PERCENT. ASIAN PERSON WERE 15.7 PERCENT OF THE POPULATION, AND AMERICAN INDIAN OR ALASKA NATIVES WERE 0.4 PERCENT OF THE POPULATION, PERSONS REPORTING TWO OR MORE RACES COMPRISED 3.6 PERCENT OF THE COUNTY'S POPULATION, AND PERSONS OF HISPANIC OR LATINO ORIGIN TOTALED 6.2 PERCENT OF THE POPULATION. THERE WERE NO REPORTED NATIVE HAWAIIAN OR

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PACIFIC ISLANDERS. MEDIAN HOUSEHOLD INCOME WAS REPORTED AT \$105,692 AND THE NUMBER OF PEOPLE LIVING BELOW THE POVERTY LEVEL WAS 4.5 PERCENT.

ANNE ARUNDEL COUNTY, MARYLAND

ANNE ARUNDEL COUNTY IS LOCATED IN THE STATE OF MARYLAND. ACCORDING TO THE 2010 U.S. CENSUS, THE LATEST DATA AVAILABLE ITS POPULATION WAS 550,488. THE COUNTY FORMS PART OF THE BALTIMORE-WASHINGTON METROPOLITAN AREA. THE FOLLOWING INFORMATION PROVIDES DEMOGRAPHIC DATA PERTAINING TO ANNE ARUNDEL COUNTY.

DEMOGRAPHICS

WHITE PERSONS COMPRISED 76.9 PERCENT OF THE COUNTY'S POPULATION. BLACK PERSONS TOTALED 16.1PERCENT. AMERICAN INDIAN AND ALASKA NATIVES MADE UP 0.4 PERCENT OF THE COUNTY'S POPULATION, WHILE ASIAN PERSONS TOTALED 3.7 PERCENT, NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDERS MADE UP 0.1 PERCENT. THOSE REPORTING TWO OR MORE RACES TOTALED 2.8 PERCENT AND THOSE

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REPORTING HISPANIC OR LATINO ORIGIN MADE UP 6.6PERCENT OF THE POPULATION.

MEDIAN HOUSEHOLD INCOME OF ANNE ARUNDEL COUNTY RESIDENTS WAS REPORTED AT

\$85,690. PERSONS LIVING BELOW THE POVERTY LEVEL WERE 5.5 PERCENT.

SOURCE: US CENSUS BUREAU QUICK FACTS 2010

SIGNIFICANT DEMOGRAPHIC CHARACTERISTICS AND SOCIAL DETERMINANTS OF THE COMMUNITY BENEFIT SERVICE AREA THAT ARE RELEVANT TO THE NEEDS OF THE COMMUNITY ARE AS FOLLOWS: (FOR PURPOSES OF THIS SECTION, SOCIAL DETERMINANTS ARE FACTORS THAT CONTRIBUTE TO A PERSON'S CURRENT STATE OF HEALTH.)

1. TARGET POPULATION

BALTIMORE CITY 621,342: MALE 47.1 %; FEMALE 52.9%

ANNE ARUNDEL COUNTY 550,448: MALE 49.4%; FEMALE 50.6%

BALTIMORE COUNTY 817,455: MALE 47.3%; FEMALE 52.7%

HOWARD COUNTY 299,430: MALE 49.1%; FEMALE 50.9%

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2. MEDIAN HOUSEHOLD INCOME

BALTIMORE CITY - \$40,100.00

ANNE ARUNDEL COUNTY - \$85,690.00

BALTIMORE COUNTY - \$65,411.00

HOWARD COUNTY - \$105,692.00

SOURCE: US CENSUS 2010

3. PERCENTAGE OF HOUSEHOLDS WITH INCOMES BELOW THE FEDERAL POVERTY

GUIDELINES

BALTIMORE CITY - 23.4 %

ANNE ARUNDEL COUNTY - 5.9%

BALTIMORE COUNTY - 8.5%

HOWARD COUNTY - 4.4 %

SOURCE: 2012 AMERICAN COMMUNITY SURVEY- US CENSUS

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4. MARYLAND MEDICAL INSURANCE STATISTICS

UNINSURED RESIDENTS - 10 %

HMO ENROLLMENT - 1, 742, 980

ANNUAL EMPLOYEE PREMIUM IN MD EMPLOYER-SPONSORED PLAN (AFTER EMPLOYER

CONTRIBUTION:) \$1115

AVERAGE HOSPITAL COST PER INPATIENT DAY (BEFORE INSURANCE) - \$2,485

SOURCE: KAISER FAMILY FOUNDATION 2013

5. PERCENTAGE OF MEDICAID RECIPIENTS

BALTIMORE CITY - 14.6%

ANNE ARUNDEL COUNTY - 8%

BALTIMORE COUNTY - 21.9%

HOWARD COUNTY - 6.6%

6. LIFE EXPECTANCY

FEMALES

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BALTIMORE - 76.5

ANNE ARUNDEL COUNTY - 80.7

BALTIMORE COUNTY - 80.6

HOWARD COUNTY - 83

MALES

BALTIMORE - 67.8

ANNE ARUNDEL COUNTY - 75.9

BALTIMORE COUNTY - 75.5

HOWARD COUNTY - 79.8

SOURCE: WORLIDLIFEEXPECTANCY.COM

7. MORTALITY RATES

ANNE ARUNDEL COUNTY: RANKS 8TH OUT OF 24 MARYLAND JURISDICTIONS.

BALTIMORE CITY: RANKS 24TH OUT OF 24 MARYLAND JURISDICTIONS.

BALTIMORE COUNTY: RANKS 14TH OUT OF 24 MARYLAND JURISDICTIONS.

HOWARD COUNTY: RANKS 2ND OUT OF 24 MARYLAND JURISDICTIONS.

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SOURCE: COUNTYHEALTHRANKINGS.ORG 2013

SOURCE: COUNTY HEALTH RANKINGS AND ROADMAPS 2010AVAILABLE

8. OTHER CHARACTERISTICS AND DETERMINANTS

A. ACCESS TO HEALTHY FOOD: ADULT OBESITY BY COUNTY IS AS FOLLOWS: ANNE ARUNDEL COUNTY 28%, BALTIMORE CITY 31%, BALTIMORE COUNTY 27% AND HOWARD COUNTY ARE 25%.

B. EDUCATION: PERCENTAGE OF HIGH SCHOOL GRADUATES IN EACH OF THE CBSA COUNTIES IS ANNE ARUNDEL - 82%, BALTIMORE CITY - 61%, BALTIMORE COUNTY -80%, HOWARD COUNTY - 89%

SOURCE: US CENSUS BUREAU, 2010 CENSUS PL94-171 RELEASE

PROMOTING THE HEALTH OF THE COMMUNITY

SCHEDULE H, PART VI, LINE 5

THE FOLLOWING INFORMATION HIGHLIGHTS THE INITIATIVES UM REHAB & ORTHO HAS UNDERTAKEN TO MEET THE MAJOR HEALTH NEEDS PERTINENT TO UM REHAB & ORTHO'S

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SPECIALTY PATIENT POPULATION AND IDENTIFIED IN HEALTHY BALTIMORE 2015, MARYLAND'S STATE HEALTH IMPROVEMENT PLAN (SHIP) AND IN THE UMMS MARKET RESEARCH SURVEY. THESE INITIATIVES HAVE ALSO BEEN IDENTIFIED IN UM REHAB & ORTHO'S 2012 COMMUNITY HEALTH NEEDS ASSESSMENT AND DETAILED BELOW:

INITIATIVE 1

HEART DISEASE: REDUCE DEATHS FROM HEART DISEASE BY ENCOURAGING DISABLED COMMUNITY MEMBERS TO PARTICIPATE IN SPORTS AND TO KEEP AS PHYSICALLY FIT AS POSSIBLE, IN ORDER TO REDUCE OBESITY AND OTHER HEALTH RISK FACTORS. SUFFICIENT EVIDENCE NOW EXISTS TO RECOMMEND THAT ADULTS WITH DISABILITIES SHOULD ALSO GET REGULAR PHYSICAL ACTIVITY. THE ADAPTED SPORTS FESTIVAL OFFERS OPPORTUNITIES TO PARTICIPATE IN HAND CYCLING, BOCCE BALL, WHEELCHAIR BASKETBALL, A WHEELCHAIR SLALOM COURSE, SCUBA DIVING, ADAPTED GOLF AND QUAD RUGBY. THE FESTIVAL WAS CREATED TO HELP DISABLED ADULTS FIGHT OBESITY, HEART DISEASE, AND DIABETES. APPROXIMATELY 125 COMMUNITY MEMBERS PARTICIPATED IN THE ADAPTED SPORTS EVENTS.

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THIS EVENT MARKED THE FIFTH YEAR OF THE INITIATIVE. CURRENT AND FORMER PATIENTS, AS WELL AS INDIVIDUALS WITH DISABILITIES LIVING IN THE COMMUNITY, ATTENDED THE EVENT AND WERE ENCOURAGED TO PARTICIPATE IN A RANGE OF RECREATIONAL ACTIVITIES. ALL ACTIVITIES WERE SUPERVISED BY TRAINED STAFF, TAKING INTO ACCOUNT INDIVIDUAL NEEDS AND ABILITIES. EQUIPMENT WAS ADAPTED AS NECESSARY AND PATIENTS WERE ENCOURAGED TO UTILIZE NEWLY DEVELOPED SKILLS AND TECHNIQUES ACQUIRED THROUGH REHABILITATION.

INITIATIVE 2

CHRONIC OBESITY: REDUCE THE PROPORTION OF CHILDREN AND ADOLESCENTS WHO ARE CONSIDERED OBESE BY PROVIDING SPORTS PHYSICALS AND CARE TO HIGH SCHOOL STUDENTS WHO PARTICIPATE IN SPORTS ACTIVITIES. STUDIES SHOW THAT REGULAR PHYSICAL ACTIVITY REDUCES RISK OF DEPRESSION, DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE, OBESITY, STROKE, AND CERTAIN KINDS OF

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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CANCER. YET, THE 2008 PHYSICAL ACTIVITY GUIDELINES ADVISORY COMMITTEE NOTES THAT DATA FROM VARIOUS NATIONAL SURVEILLANCE PROGRAMS CONSISTENTLY SHOW MOST ADULTS AND YOUTH IN THE U.S. DO NOT MEET CURRENT PHYSICAL ACTIVITY RECOMMENDATIONS, --45% TO 50% OF ADULTS AND 35.8% OF HIGH SCHOOL STUDENTS SAY THEY GET THE RECOMMENDED AMOUNTS OF MODERATE TO VIGOROUS PHYSICAL ACTIVITY.

MANY HIGH SCHOOL STUDENTS IN THE BALTIMORE AND HOWARD COUNTY COMMUNITIES DO NOT HAVE A PRIMARY CARE PHYSICIAN AND SOME DO NOT HAVE THE RESOURCES TO SEE A DOCTOR TO OBTAIN A PHYSICAL IN ORDER TO PARTICIPATE IN SPORTS. THE ATHLETIC TRAINERS AT UM REHAB & ORTHO, AS WELL AS MANY OF THE SPORTS MEDICINE PHYSICIANS, DONATE THEIR TIME EACH SUMMER TO PROVIDE AN OPPORTUNITY FOR STUDENTS TO SEE A PHYSICIAN AT THEIR SCHOOL AND OBTAIN A

MANY OF THESE STUDENTS TO REMAIN ACTIVE IN ORDER TO REDUCE OBESITY. ADDITIONALLY, THE PHYSICIANS AND /OR RESIDENTS IN THE SPORTS MEDICINE PROGRAM DONATE THEIR TIME TO ATTEND ATHLETIC CONTESTS AS TEAM PHYSICIANS FOR VARIOUS SCHOOLS.

Part VI Supplemental Information

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PARENTS AND STUDENTS REQUEST THAT THEY CAN BRING/ARRANGE FOR THEIR STUDENTS TO ATTEND THESE LOW COST OR FREE PHYSICALS; 148 STUDENTS WERE SCREENED.

INITIATIVE 3

HEALTHCARE ACCESS - REDUCE THE PROPORTION OF INDIVIDUALS WHO ARE UNABLE TO AFFORD TO SEE A DOCTOR BY HELPING THOSE EXPERIENCING A LIFE-CHANGING EVENT, AND/OR THEIR LOVED ONES TO BE ABLE TO ADAPT TO THEIR NEW EXPERIENCE WITH THE AID OF SUPPORT GROUPS.

UM REHAB & ORTHO PROVIDES EDUCATION, SERVES AS AN ADVOCATE AND SUPPORTS THE DISABILITY POPULATIONS WITHIN ITS CONTINUUM OF CARE. DURING FY 2014, UM REHAB & ORTHO PROVIDED AND FACILITATED MONTHLY SUPPORT GROUPS FOR BRAIN INJURY, STROKE, SPINAL CORD INJURY, AMPUTEE, CAREGIVERS', TOTAL JOINT REPLACEMENT, TRAUMA SURVIVORS' PROGRAMS AND MULTIPLE SCLEROSIS . IN

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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ADDITION TO MONTHLY GROUPS UM REHAB & ORTHO HELD AN AMPUTEE WALKING CLINIC.

EACH GROUP MEETS MONTHLY OR BI-MONTHLY, DEPENDING UPON NEEDS OF THE GROUP. LENGTH OF MEETING VARIES FROM 1 - 2 HOURS. A TOTAL OF 1,092 VISIT TO THE SUPPORT GROUPS. A TOTAL OF 118 ATTENDEES CAME TO THE WALKING CLINIC.

INITIATIVE 4

ACCESS TO DENTAL CARE: TO INCREASE THE PROPORTION OF CHILDREN AND ADOLESCENTS IN NEED WHO RECEIVE DENTAL CARE BY PROVIDING EDUCATION TO CHILDREN AND ADULTS WHO HAVE LIMITED ACCESS TO ORAL HEALTH CARE. STAFF VISITED AREA SCHOOLS TO INSTRUCT STUDENTS ON ORAL CARE, AS WELL AS PARTICIPATED IN COMMUNITY HEALTH FAIRS.

THE DENTAL CLINIC STAFF HAS FORMED RELATIONSHIPS WITH DENTAL PRACTICES THROUGHOUT MARYLAND SO THAT ALL PATIENTS HAVE RESOURCES TO DENTAL CARE

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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THEY NEED AVAILABLE TO THEM PRIOR TO ARRIVING FOR AN APPOINTMENT.

MOST AREA SCHOOLS, HOSPITALS, PRIMARY CARE AND DENTAL PRACTICES

THROUGHOUT THE STATE OF MARYLAND CANNOT TREAT SPECIAL NEEDS CHILDREN AND

ADULTS. THE UM REHAB & ORTHO DENTAL CLINIC SAW 9467 PATIENTS INCLUDING

DISABLED AND /OR LOW INCOME ADULTS AND CHILDREN IN FY 2014. DENTAL CLINIC

STAFF DISTRIBUTED INFORMATION ON DENTAL CARE TO 323 INDIVIDUALS DURING

SCHOOL VISITS AND HEALTH FAIRS.

BALTIMORE CITY COMMUNITY GROUP STAKEHOLDERS FELT ACCESS TO CARE, POVERTY

AND MENTAL HEALTH ISSUES WERE UNADDRESSED. OTHER UNADDRESSED NEEDS

IDENTIFIED INCLUDE CANCER, MENTAL HEALTH ISSUES, HIV/AIDS, STDS, AND

ASTHMA/LUNG DISEASE.

THE MEMBERS OF THE UMMS COMMUNITY HEALTH OUTREACH AND ADVOCACY TEAM WILL

CONTINUE TO MEET AND DISCUSS THE ITEMS THAT ARE CURRENTLY NOT BEING

ADDRESSED BY SYSTEM HOSPITALS AND DETERMINE IF PROGRAMS AND RESOURCES CAN

BE ALLOCATED TO ASSIST IN THOSE UNADDRESSED AREAS. CURRENTLY AREAS ARE

Part VI Supplemental Information

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BEING ADDRESSED AS RESOURCES ALLOW. MANY OF THE HEALTH NEEDS MENTIONED
IN THE FIRST PARAGRAPH ARE MET THROUGH UMMS COMMUNITY OUTREACH EFFORTS,
DESCRIBED IN THE COMMUNITY BENEFITS IMPLEMENTATION PLAN SECTION.

AVAILABLE RESOURCES TO ASSIST IN THE UNADDRESSED IDENTIFIED NEEDS

INCLUDE:

- BALTIMORE CITY HEALTH DEPARTMENT
- BALTIMORE CITY GOVERNMENT
- ANNE ARUNDEL COUNTY GOVERNMENT
- BALTIMORE COUNTY GOVERNMENT
- HOWARD COUNTY GOVERNMENT
- STATE OF MARYLAND (GOVERNMENTAL AGENCIES)
- U.S. HEALTH AND HUMAN SERVICES DEPARTMENT
- HOUSING OFFICE (HUD)

V. PHYSICIANS

AS REQUIRED UNDER HG§19-303, PROVIDE A WRITTEN DESCRIPTION OF GAPS IN THE
AVAILABILITY OF SPECIALIST PROVIDERS, INCLUDING OUTPATIENT SPECIALTY

Part VI Supplemental Information

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CARE, TO SERVE THE UNINSURED CARED FOR BY THE HOSPITAL.

GAP COVERAGE

THE UM REHAB & ORTHO IS A SPECIALTY HOSPITAL THAT OFFERS TOTAL JOINT SURGERY, NON-OPERATIVE MANAGEMENT OF BACK PAIN, THE LATEST MINIMALLY INVASIVE TECHNIQUES FOR SHOULDER SURGERY, INTEGRATIVE MEDICINE, AND LEADERSHIP IN SPORTS MEDICINE AND PEDIATRIC ORTHOPAEDICS. THE HOSPITAL'S EXPERT STAFF TREATS A FULL RANGE OF REHABILITATIVE ISSUES RESULTING FROM STROKE, SPINAL CORD INJURIES, TRAUMATIC BRAIN INJURIES AND NEUROLOGICAL DISORDERS.

AS AN ORTHOPAEDIC AND REHABILITATION SPECIALTY HOSPITAL, UM REHAB & ORTHO DOES NOT HAVE AN EMERGENCY DEPARTMENT. IT IS CLASSIFIED AS A LEVEL IV EMERGENCY SERVICE FACILITY. APPROPRIATE REFERRAL TO AN ACUTE CARE FACILITY CAPABLE OF PROVIDING CONTINUED EMERGENCY SERVICES ARE MADE IF NECESSARY VISITORS AND OUTPATIENTS WHO SUFFER CARDIOPULMONARY ARREST WILL HAVE EMERGENCY CARE INITIATED BY THE CODE BLUE TEAM AND THEN WILL BE TRANSPORTED TO AN EMERGENCY ROOM VIA 911.

Part VI Supplemental Information

Provide the following information.

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ALL INPATIENTS REQUIRING TREATMENT BY THE CODE BLUE TEAM WILL BE TRANSPORTED, WITH MONITORING, TO THE INTENSIVE CARE UNIT AT UM REHAB & ORTHO AT THE DISCRETION OF THE TEAM LEADER. IN CONSULTATION, THE INTENSIVIST AND SERVICE ATTENDING WILL MAKE THE DETERMINATION REGARDING PATIENT TRANSPORT TO A TERTIARY CARE FACILITY.

UM REHAB & ORTHO HAS A RAPID RESPONSE TEAM THAT WILL RESPOND TO CALLS REGARDING VISITORS/PATIENTS WHO NEED EMERGENT CARE OR RAPID MANAGEMENT OUTSIDE OF THE CRITICAL CARE SETTING. THE RAPID RESPONSE TEAM CONSISTS OF A RESPIRATORY THERAPIST, REGISTERED NURSE, INTENSIVIST (DAY SHIFT ONLY) AND HOSPITALIST.

1. IF YOU LIST PHYSICIAN SUBSIDIES IN YOUR DATA IN CATEGORY C OF THE CB INVENTORY SHEET, PLEASE INDICATE THE CATEGORY OF SUBSIDY, AND EXPLAIN WHY THE SERVICES WOULD NOT OTHERWISE BE AVAILABLE TO MEET PATIENT DEMAND. THE CATEGORIES INCLUDE: HOSPITAL-BASED PHYSICIANS WITH WHOM THE HOSPITAL HAS AN EXCLUSIVE CONTRACT; NON-RESIDENT HOUSE STAFF AND HOSPITALISTS; COVERAGE OF EMERGENCY DEPARTMENT CALL; PHYSICIAN PROVISION OF FINANCIAL

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ASSISTANCE TO ENCOURAGE ALIGNMENT WITH THE HOSPITAL FINANCIAL ASSISTANCE
POLICIES; AND PHYSICIAN RECRUITMENT TO MEET COMMUNITY NEED.

AFFILIATED HEALTH CARE SYSTEM ROLES

SCHEDULE H, PART VI, LINE 6

THE JAMES LAWRENCE KERNAN HOSPITAL IS A PART OF THE UNIVERSITY OF
MARYLAND MEDICAL SYSTEM (UMMS) AND PARTICIPATES ON THE UMMS COMMUNITY
HEALTH OUTREACH AND ADVOCACY TEAM. UMMS CREATED THE UNIVERSITY OF
MARYLAND COMMUNITY HEALTH OUTREACH AND ADVOCACY TEAM TO ADDRESS THE
HEALTH CARE NEEDS OF THE WEST BALTIMORE COMMUNITY. THE GROUP IS
COMPRISED OF COMMUNITY OUTREACH MANAGEMENT AND STAFF, SOCIAL WORKERS,
DIRECTORS, VICE PRESIDENTS, AND PHYSICIANS FROM UMMS SYSTEM HOSPITALS.
THE GROUP DETERMINES WHAT NEEDS ARE ADDRESSED AS WELL AS COMMUNITY
INVOLVEMENT AND ACTIVITIES EACH YEAR. UMMC PARTICIPATES IN THIS ADVOCACY
TEAM AND REPRESENTATIVES IN ADDITION TO THE IDENTIFIED UMMS PRIORITIES,
KERNAN SENIOR LEADERS AND COMMUNITY OUTREACH STAFF MEET TO DETERMINE
ANNUAL GOALS AND ACTIVITIES. KERNAN, IN PARTNERSHIP WITH UMMS, WAS A
MAJOR PARTICIPANT AND SPONSOR IN MAJOR ANNUAL OUTREACH EFFORTS.

Part VI Supplemental Information

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STATE FILING OF COMMUNITY BENEFIT REPORT

SCHEDULE H, PART VI, LINE 7

MARYLAND

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ Attach to Form 990. ▶ See separate instructions.

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

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Name of the organization

JAMES LAWRENCE KERNAN HOSPITAL, INC.

Employer identification number

52-0591639

Part I Questions Regarding Compensation

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

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

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

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including 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 checked="" type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input checked="" 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) 2013

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 ROBERT A CHRENCIK TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	1,173,854.	543,595.	18,484.	236,346.	10,301.	1,982,580.	0
2 HEMA PATEL, MD HOSPITALIST	(i)	225,997.	0	323.	11,556.	14,683.	252,559.	0
	(ii)	0	0	0	0	0	0	0
3 KAREN E. DOYLE DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	214,168.	41,763.	21,766.	8,567.	13,676.	299,940.	0
4 MICHAEL R. JABLONOVER CEO	(i)	286,856.	67,039.	52,439.	10,200.	13,676.	430,210.	0
	(ii)	0	0	0	0	0	0	0
5 W. W. AUGUSTIN, III CFO	(i)	207,868.	27,732.	23,786.	8,533.	10,301.	278,220.	0
	(ii)	0	0	0	0	0	0	0
6 JUANITA D. ROBBINS COO	(i)	162,652.	30,330.	797.	21,207.	1,230.	216,216.	0
	(ii)	0	0	0	0	0	0	0
7 JOHN STRAUMANIS SVP-CMO	(i)	227,797.	25,622.	9,081.	30,281.	14,683.	307,464.	0
	(ii)	0	0	0	0	0	0	0
8 LORI PATRIA MANAGER- AMBULATORY	(i)	120,682.	20,760.	137.	6,291.	14,683.	162,553.	0
	(ii)	0	0	0	0	0	0	0
9 LOBNA ZADA DENTAL CLINICAL CHIEF	(i)	185,301.	15,049.	705.	9,406.	6,497.	216,958.	0
	(ii)	0	0	0	0	0	0	0
10 THOMAS MERKLE HOSPITALIST	(i)	172,648.	0	122.	8,840.	10,301.	191,911.	0
	(ii)	0	0	0	0	0	0	0
11 NORBERT ROBINSON DIR-PHARMACY	(i)	141,984.	21,332.	174.	7,356.	14,683.	185,529.	0
	(ii)	0	0	0	0	0	0	0
12 MARGARET BEATTY RN - STAFFING & RESOURCE	(i)	145,640.	0	124.	4,010.	6,212.	155,986.	0
	(ii)	0	0	0	0	0	0	0
13 CHERYL D. LEE VP - CNO	(i)	183,021.	17,267.	2,807.	24,050.	6,212.	233,357.	0
	(ii)	0	0	0	0	0	0	0
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.

HEALTH OR SOCIAL CLUB DUES OR INITIATION FEES

SCHEDULE J, PART I, LINE 1A

UMMS EXECUTIVES RECEIVE A BENEFIT PACKAGE WHICH MAY BE USED TOWARDS HEALTH CLUB DUES OR OTHER HEALTH MAINTENANCE PROGRAMS. SUCH BENEFITS ARE CAPPED AT \$7,000, \$5,000 OR \$3,000 DEPENDING ON JOB TITLE AS DESCRIBED IN THE PROGRAM DOCUMENTS.

SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN

SCHEDULE J, PART I, LINE 4B

DURING THE FISCAL YEAR ENDED JUNE 30, 2014, CERTAIN OFFICERS AND KEY EMPLOYEES PARTICIPATED IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN. THE INDIVIDUALS LISTED BELOW HAVE NOT VESTED IN THE PLAN THEREFORE THE ACCRUED CONTRIBUTION TO THE PLAN FOR THE FISCAL YEAR IS REPORTED ON SCHEDULE J, PART II, COLUMN C, RETIREMENT AND OTHER DEFERRED COMPENSATION: ROBERT A. CHRENCIK, JUANITA D. ROBBINS, JOHN STRAUMANIS & CHERYL D. LEE.

DURING THE FISCAL YEAR, ENDED JUNE 30, 2014, CERTAIN OFFICERS AND KEY

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.

EMPLOYEES PARTICIPATED IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN. THE INDIVIDUALS LISTED BELOW HAVE VESTED IN THE PLAN IN A PRIOR YEAR, THEREFORE THE CONTRIBUTIONS TO THE PLAN FOR THE FISCAL YEAR ARE REPORTED AS TAXABLE COMPENSATION AND REPORTED ON SCHEDULE J, PART II, LINE B(III), OTHER REPORTABLE COMPENSATION: MICHAEL R. JABLONOVER, W.W. AUGUSTIN III, AND KAREN DOYLE.

NON FIXED COMPENSATION

SCHEDULE J, PART I, LINE 7

BONUSES PAID ARE BASED ON A NUMBER OF VARIABLES INCLUDING BUT NOT LIMITED TO INDIVIDUAL GOAL ACHIEVEMENTS AS WELL AS ORGANIZATION OPERATION ACHIEVEMENTS. THE FINAL DETERMINATION OF THE BONUS AMOUNT IS DETERMINED AND APPROVED BY THE BOARD AS PART OF THE OVERALL COMPENSATION REVIEW OF THE OFFICERS AND KEY EMPLOYEES.

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

2013

**Open to Public
Inspection**

Name of the organization

JAMES LAWRENCE KERNAN HOSPITAL, INC.

Employer identification number

52-0591639

MEMBERS OR STOCKHOLDERS

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

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (UMMS) IS THE SOLE MEMBER OF JAMES LAWRENCE KERNAN HOSPITAL (JLK). UMMS MAY ELECT ONE OR MORE BOARD MEMBERS OF THE GOVERNING BODY AND ALL DECISIONS OF THE GOVERNING BODY MUST BE APPROVED BY UMMS.

FORM 990 REVIEW PROCESS

FORM 990, PART VI, LINE 11B

THE I.R.S. FORM 990 IS PREPARED AND REVIEWED BY THE ACCOUNTING FIRM OF GRANT THORNTON. ACCOUNTING PERSONNEL IN FINANCE SHARED SERVICES AT THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM GATHER THE INFORMATION NEEDED TO COMPLETE THE RETURN AND INPUT THE DATA INTO THE GRANT THORNTON TAX ORGANIZER. WHEN ALL DATA HAS BEEN ENTERED, THE INFORMATION IS SUBMITTED TO GRANT THORNTON FOR IMPORTATION INTO THEIR TAX SOFTWARE. AT THIS POINT, GRANT THORNTON STAFF MEMBERS REVIEW THE DATA, ASK FOR ADDITIONAL INFORMATION IF NEEDED AND PREPARE THE TAX RETURN. EACH RETURN IS REVIEWED AT SEVERAL LEVELS AT GRANT THORNTON INCLUDING THE TAX PARTNER. AFTER THEIR REVIEW PROCESS, A DRAFT RETURN IS SENT TO THE ACCOUNTING STAFF AT UMMS FOR AN IN-HOUSE REVIEW.

UPON COMPLETION OF THE IN-HOUSE REVIEW, GRANT THORNTON IS INSTRUCTED TO MAKE ANY NECESSARY CHANGES AND TO PREPARE THE FINAL TAX RETURN. THE FINAL RETURN UNDERGOES ANOTHER REVIEW BY THE ACCOUNTING STAFF AT FINANCE

Name of the organization JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number 52-0591639
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SHARED SERVICES AND IS ALSO REVIEWED BY THE ACCOUNTING MANAGER, THE DIRECTOR OF FINANCIAL REPORTING, THE VICE PRESIDENT OF FINANCE AND THE CFO, WHO SIGNS THE RETURN. PRIOR TO FILING THE I.R.S. FORM 990, THE ORGANIZATION'S BOARD CHAIRMAN, TREASURER, AUDIT COMMITTEE CHAIRMAN, EXECUTIVE COMMITTEE CHAIRMAN OR OTHER MEMBER OF THE BOARD WITH SIMILAR AUTHORITY WILL REVIEW THE I.R.S. FORM 990. AT THE DISCRETION OF THE REVIEWING BOARD MEMBER, SUCH MEMBER WILL BRING ANY ISSUES OR QUESTIONS RELATED TO THE COMPLETED I.R.S. FORM 990 TO THE ATTENTION OF THE BOARD. NOTWITHSTANDING THE ABOVE, A BOARD RESOLUTION IS NOT REQUIRED FOR THE FILING OF THE ORGANIZATION'S I.R.S. FORM 990. EACH BOARD MEMBER IS PROVIDED WITH A COPY OF THE FINAL I.R.S. FORM 990 BEFORE FILING.

CONFLICT OF INTEREST POLICY MONITORING & ENFORCEMENT
FORM 990, PART VI, LINE 12C

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

A QUESTIONNAIRE WHICH DISCLOSES POTENTIAL CONFLICTS OF INTEREST IS DISTRIBUTED ANNUALLY TO ALL OFFICERS, DIRECTORS AND KEY EMPLOYEES. THE GENERAL COUNSEL OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (UMMSC) REVIEWS THE RESPONSES FOR UMMSC AND JAMES LAWRENCE KERNAN HOSPITAL. THE CEO OR CFO OF EACH OF THE OTHER ENTITIES IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM REVIEWS THE RESPONSES FOR THOSE ENTITIES.

Name of the organization JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number 52-0591639
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THE GENERAL COUNSEL, IN CONSULTATION WITH THE AUDIT COMMITTEE, IF NECESSARY, WOULD DETERMINE IF A CONFLICT OF INTEREST EXISTED FOR UMMSC OR JAMES LAWRENCE KERNAN HOSPITAL. WITH RESPECT TO THE OTHER ENTITIES IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM, THE GENERAL COUNSEL MAY BE CALLED FOR CONSULT. IF SO, THE GENERAL COUNSEL MAY CONSULT THE AUDIT COMMITTEE, IF NECESSARY.

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

ALL INVITATIONS FOR BIDS, PROPOSALS OR SOLICITATIONS FOR OFFERS INCLUDE THE FOLLOWING PROVISION: ANY VENDOR, SUPPLIER OR CONTRACTOR MUST DISCLOSE ANY ACTUAL OR POTENTIAL TRANSACTION WITH ANY ORGANIZATION OFFICER, DIRECTOR, EMPLOYEE OR MEMBER OF THE MEDICAL STAFF, INCLUDING FAMILY MEMBERS WITHIN FIVE DAYS OF THE TRANSACTION. FAILURE TO COMPLY WITH THIS PROVISION IS A MATERIAL BREACH OF AGREEMENT.

IN ADDITION, A BOARD DISCLOSURE REPORT IS FILED WITH THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION ON AN ANNUAL BASIS SHOWING ANY BUSINESS TRANSACTIONS BETWEEN THE BOARD MEMBERS AND THE ORGANIZATION.

Name of the organization JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number 52-0591639
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PROCESS FOR DETERMINING COMPENSATION

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

THE ORGANIZATION DETERMINES THE EXECUTIVE COMPENSATION PAID TO ITS EXECUTIVES IN THE FOLLOWING MANNER PRESCRIBED IN THE I.R.S. REGULATIONS: EXECUTIVE COMPENSATION PACKAGES ARE DETERMINED BY A COMMITTEE OF THE BOARD THAT IS COMPOSED ENTIRELY OF BOARD MEMBERS WHO HAVE NO CONFLICT OF INTEREST. THE COMMITTEE ACQUIRES CREDIBLE COMPARABILITY MARKET DATA CONCERNING THE COMPENSATION PACKAGES OF SIMILARLY SITUATED EXECUTIVES. THE COMMITTEE CAREFULLY REVIEWS THAT DATA, THE EXECUTIVE'S PERFORMANCE AND THE PROPOSED COMPENSATION PACKAGES DURING THE DECISION MAKING PROCESS. THE COMMITTEE MEMORIALIZES ITS DELIBERATIONS IN DETAILED MINUTES REVIEWED AND ADOPTED AT THE NEXT-FOLLOWING MEETING. THE COMMITTEE SEEKS AN OPINION OF COUNSEL THAT IT HAS MET THE REQUIREMENTS OF THE I.R.S. INTERMEDIATE SANCTIONS REGULATIONS. THIS PROCESS IS USED TO DETERMINE THE COMPENSATION PACKAGES FOR ALL MANAGEMENT EMPLOYEES FROM THE VICE PRESIDENT LEVEL AND UP.

HOW DOCUMENTS ARE MADE AVAILABLE TO THE PUBLIC

FORM 990, PART VI, LINE 19

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

REQUESTS FOR FORM 990 AND FORM 1023: A REQUESTOR SEEKING TO REVIEW

Name of the organization JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number 52-0591639
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AND/OR OBTAIN A COPY OF THE ORGANIZATION'S IRS FORM 990 OR FORM 1023 AS FILED WITH THE INTERNAL REVENUE SERVICE, INCLUDING ALL SCHEDULES AND ATTACHMENTS, MAY APPEAR IN PERSON OR SUBMIT A WRITTEN REQUEST. THE MOST RECENT THREE YEARS OF IRS FORM 990 MAY BE REQUESTED. IF THE REQUESTER APPEARS IN PERSON, THE INDIVIDUAL IS DIRECTED TO THE OFFICE OF THE CHIEF FINANCIAL OFFICER FOR THE ORGANIZATION AND THE FORM 990 AND/OR FORM 1023 ARE MADE AVAILABLE FOR INSPECTION. THE INDIVIDUAL IS PERMITTED TO REVIEW THE RETURN, TAKE NOTES AND REQUEST A COPY. IF REQUESTED, A COPY IS PROVIDED ON THE SAME DAY. A NOMINAL FEE IS CHARGED FOR MAKING THE COPIES. THE ORGANIZATION MAY HAVE AN EMPLOYEE PRESENT DURING THE PUBLIC INSPECTION OF THE DOCUMENT. WRITTEN REQUESTS FOR AN ENTITY'S FORM 990 OR FORM 1023 ARE DIRECTED IMMEDIATELY TO THE OFFICE OF THE CHIEF FINANCIAL OFFICER FOR THE ORGANIZATION. THE REQUESTED COPIES ARE MAILED WITHIN 30 DAYS OF THE REQUEST. REPRODUCTION FEES AND MAILING COSTS ARE CHARGED TO THE REQUESTOR.

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

TAX EXEMPT BOND ISSUE

PART IV, LINE 24A

PURSUANT TO A MASTER LOAN AGREEMENT DATED JUNE 20, 1991 (THE "MASTER LOAN

Name of the organization JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number 52-0591639
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AGREEMENT"), AS AMENDED, THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (THE "CORPORATION") AND SEVERAL OF ITS SUBSIDIARIES HAVE ISSUED DEBT THROUGH THE MARYLAND HEALTH AND HIGHER EDUCATION FACILITY AUTHORITY (THE "AUTHORITY"). AS SECURITY FOR THE PERFORMANCE OF THE BOND OBLIGATION UNDER THE MASTER LOAN AGREEMENT, THE AUTHORITY MAINTAINS A SECURITY INTEREST IN THE REVENUE OF THE OBLIGORS. THE MASTER LOAN AGREEMENT CONTAINS CERTAIN RESTRICTIVE COVENANTS. THESE COVENANTS REQUIRE THAT RATES AND CHARGES BE SET AT CERTAIN LEVELS, LIMIT INCURRENCE OF ADDITIONAL DEBT, REQUIRE COMPLIANCE WITH CERTAIN OPERATING RATIOS AND RESTRICT THE DISPOSITION OF ASSETS. THE OBLIGATED GROUP UNDER THE MASTER LOAN AGREEMENT INCLUDES THE CORPORATION, THE JAMES LAWRENCE KERNAN HOSPITAL, INC., MARYLAND GENERAL HOSPITAL, INC., BALTIMORE WASHINGTON MEDICAL CENTER, INC., SHORE HEALTH SYSTEM, INC., CHESTER RIVER HOSPITAL CENTER, INC., CIVISTA MEDICAL CENTER, INC., UNIVERSITY OF MARYLAND ST. JOSEPH MEDICAL CENTER, LLC, UPPER CHESAPEAKE MEDICAL CENTER, INC., HARFORD MEMORIAL HOSPITAL, INC. AND THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM FOUNDATION, INC. EACH MEMBER OF THE OBLIGATED GROUP IS JOINTLY AND SEVERALLY LIABLE FOR THE REPAYMENT OF THE OBLIGATIONS UNDER THE MASTER LOAN AGREEMENT OF THE CORPORATION'S \$1,457,870,000 OF OUTSTANDING AUTHORITY BONDS ON JUNE 30, 2014. ALL OF THE BONDS WERE ISSUED IN THE NAME OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND ARE REPORTED ON SCHEDULE K OF ITS FORM 990.

HOURS ON RELATED ENTITIES

PART VII, SECTION A, COLUMN (B)

THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) IS A MULTI-ENTITY HEALTH

Name of the organization JAMES LAWRENCE KERNAN HOSPITAL, INC.	Employer identification number 52-0591639
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CARE SYSTEM THAT INCLUDES 11 ACUTE CARE HOSPITALS, 1 ACUTE CARE HOSPITAL OWNED IN A JOINT VENTURE ARRANGEMENT AND VARIOUS SUPPORTING ENTITIES. A NUMBER OF INDIVIDUALS PROVIDE SERVICES TO VARIOUS ENTITIES WITHIN THE SYSTEM. IN GENERAL, THE OFFICERS AND KEY EMPLOYEES OF UMMS AVERAGE IN EXCESS OF 40 HOURS PER WEEK SERVING THE DIFFERENT ENTITIES THAT COMPRISE UMMS.

RECONCILIATION OF NET ASSETS

FORM 990, PART XI, LINE 9

UNREALIZED GAIN	\$1,309,994
CHANGE IN ECONOMIC INTEREST OF UMMS FOUNDATION	\$363,722
CHANGE IN ECONOMIC INTEREST OF KERNAN ENDOWMENT	\$3,148,858

TOTAL OTHER CHANGES IN NET ASSETS \$4,822,574

ATTACHMENT 1990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
TURNER CONSTRUCTION 1500 SPRING GARDEN STREET PHILADELPHIA, PA 19130	CONSTRUCTION MGMT	1,372,693.
ARAMARK HEALTHCARE FOOD LOCKBOX 25271 NETWORK PLACE CHICAGO, IL 60673-1252	FOOD SERVICES	1,312,843.
ARAMARK CORPORATION PO BOX 651009 CHARLOTTE, NC 28265	ENVIRONMENTAL SRVC	1,025,267.
MEDI-PHYSICS INC DBA GE HEALTHCARE PO BOX 640200 PITTSBURGH, PA 15264-3458	MEDICAL SERVICES	1,004,761.
BALTIMORE ULTRASOUND 3814 EAST JOPPA ROAD BALTIMORE, MD 21236	MEDICAL SERVICES	227,345.

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

- ▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**
- ▶ **Attach to Form 990.** ▶ **See separate instructions.**
- ▶ **Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.**

Name of the organization

JAMES LAWRENCE KERNAN HOSPITAL, INC.

Employer identification number

52-0591639

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) SHIPLEY'S PHYSICAL THERAPY CENTER, LLC 52-2061788 2200 KERNAN DRIVE BALTIMORE, MD 21207	HEALTHCARE	MD	612,000.	3,000.	JLK
(2) UM REHAB INSTITUTE OF SOUTHERN MARYLAND 2200 KERNAN DRIVE BALTIMORE, MD 20207	HEALTHCARE	MD			JLK
(3) -----					
(4) -----					
(5) -----					
(6) -----					

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

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

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

Schedule R (Form 990) 2013

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

- ▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**
- ▶ **Attach to Form 990.** ▶ **See separate instructions.**
- ▶ **Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.**

Name of the organization

JAMES LAWRENCE KERNAN HOSPITAL, INC.

Employer identification number

52-0591639

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) SHIPLEYS CHOICE MEDICAL PARK INC 04-3643849 22 SOUTH GREENE STREET BALTIMORE, MD 21201	REAL ESTATE	MD	501(C)(2)		NCC		X
(2) CHESTER RIVER HEALTH FOUNDATION INC 52-1338861 100 BROWN STREET CHESTERTOWN, MD 21620	FUNDRAISING	MD	501(C)(3)	08	CRHS		X
(3) UNIV OF MD SHORE REGIONAL HEALTH, INC 52-2046500 100 BROWN STREET CHESTERTOWN, MD 21620	HEALTHCARE	MD	501(C)(3)	11A	UMMSC		X
(4) CHESTER RIVER HOSPITAL CENTER 52-0679694 100 BROWN STREET CHESTERTOWN, MD 21620	HEALTHCARE	MD	501(C)(3)	03	CRHS		X
(5) CHESTER RIVER MANOR INC 52-6070333 200 MORGNEC ROAD CHESTERTOWN, MD 21620	HEALTHCARE	MD	501(C)(3)	09	CRHS		X
(6) MARYLAND GENERAL CLINICAL PRACTICE GROUP 52-1566211 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	11B	MGHS		X
(7) MARYLAND GENERAL COMM HEALTH FOUNDATION 52-2147532 827 LINDEN AVENUE BALTIMORE, MD 21201	FUNDRAISING	MD	501(C)(3)	11C	MGHS		X

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

Schedule R (Form 990) 2013

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

- ▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**
- ▶ **Attach to Form 990.** ▶ **See separate instructions.**
- ▶ **Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.**

Name of the organization

JAMES LAWRENCE KERNAN HOSPITAL, INC.

Employer identification number

52-0591639

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) UNIVERSITY OF MARYLAND MIDTOWN HEALTH, 52-1175337 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	11B	UMMSC		X
(2) MARYLAND GENERAL HOSPITAL INC 52-0591667 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	03	MGHS		X
(3) CARE HEALTH SERVICES INC 52-1510269 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTHCARE	MD	501(C)(3)	09	SHS		X
(4) DORCHESTER GENERAL HOSPITAL FOUNDATION 52-1703242 219 SOUTH WASHINGTON STREET EASTON, MD 21601	FUNDRAISING	MD	501(C)(3)	11D	SHS		X
(5) MEMORIAL HOSPITAL FOUNDATION INC 52-1282080 219 SOUTH WASHINGTON STREET EASTON, MD 21601	FUNDRAISING	MD	501(C)(3)	11A	SHS		X
(6) SHORE CLINICAL FOUNDATION INC 52-1874111 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTHCARE	MD	501(C)(3)	03	SHS		X
(7) SHORE HEALTH SYSTEM INC 52-0610538 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTHCARE	MD	501(C)(3)	03	UMMSC		X

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

Schedule R (Form 990) 2013

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

- ▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**
- ▶ **Attach to Form 990.** ▶ **See separate instructions.**
- ▶ **Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.**

Name of the organization: **JAMES LAWRENCE KERNAN HOSPITAL, INC.**
Employer identification number: **52-0591639**

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) JAMES LAWRENCE KERNAN HOSP ENDOW FD 2200 KERNAN DRIVE BALTIMORE, MD 21207 23-7360743	FUNDRAISING	MD	501(C)(3)	11B	JLK HOSPITAL		X
(2) UMMS FOUNDATION, INC. 22 SOUTH GREENE STREET BALTIMORE, MD 21201 52-2238893	FUNDRAISING	MD	501(C)(3)	11A	UMMSC		X
(3) UNIVERSITY OF MD MEDICAL SYSTEM CORP 22 SOUTH GREENE STREET BALTIMORE, MD 21201 52-1362793	HEALTHCARE	MD	501(C)(3)	03	N/A		X
(4) CIVISTA HEALTH, INC. PO BOX 1070 LA PLATA, MD 20646 52-2155576	HEALTHCARE	MD	501(C)(3)	11C	CIVHS		X
(5) CIVISTA MEDICAL CENTER, INC. PO BOX 1070 LA PLATA, MD 20646 52-0445374	HEALTHCARE	MD	501(C)(3)	03	CIVHS		X
(6) CIVISTA HEALTH FOUNDATION PO BOX 1070 LA PLATA, MD 20646 52-1414564	FUNDRAISING	MD	501(C)(3)	11A	CIVHS		X
(7) CIVISTA HEALTH AUXILIARY PO BOX 1070 LA PLATA, MD 20646 52-1131193	FUNDRAISING	MD	501(C)(3)	11A	CIVHS		X

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

Schedule R (Form 990) 2013

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
- ▶ Attach to Form 990. ▶ See separate instructions.
- ▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization

JAMES LAWRENCE KERNAN HOSPITAL, INC.

Employer identification number

52-0591639

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) UNIV OF MD ST. JOSEPH FOUNDATION, INC. 52-1682964 7601 OSLER DRIVE TOWSON, MD 21204	FUNDRAISING	MD	501(C)(3)	11A	UMMSC		X
(2) HARFORD MEMORIAL HOSPITAL, INC. 52-0591484 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HEALTHCARE	MD	501(C)(3)	03	UMUCHS		X
(3) UCH LEGACY FUNDING CORPORATION 52-0882914 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	FUNDRAISING	MD	501(C)(3)	11A	UMUCHS		X
(4) UM UPPER CHESAPEAKE HEALTH SYSTEM, INC. 52-1398513 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HEALTHCARE	MD	501(C)(3)	11C; III-FI	UMUCHS		X
(5) UPPER CHESAPEAKE HEALTH FOUNDATION, INC. 52-1398507 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	FUNDRAISING	MD	501(C)(3)	11A	UMUCHS		X
(6) UPPER CHESAPEAKE MEDICAL CENTER, INC. 52-1253920 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HEALTHCARE	MD	501(C)(3)	03	UMUCHS		X
(7) UPPER CHESAPEAKE MEDICAL SERVICES, INC. 52-1501734 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HEALTHCARE	MD	501(C)(3)	09	UMUCHS		X

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

Schedule R (Form 990) 2013

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
- ▶ Attach to Form 990. ▶ See separate instructions.
- ▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2013

**Open to Public
Inspection**

Name of the organization

JAMES LAWRENCE KERNAN HOSPITAL, INC.

Employer identification number

52-0591639

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) UPPER CHESAPEAKE PROPERTIES, INC. 52-1907237 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	REAL ESTATE	MD	501(C)(2)		UMUCHS		X
(2) UPPER CHES RESIDENTIAL HOSPICE HOUSE, INC 26-0737028 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HOSPICE	MD	501(C)(3)	07	UMUCHS		X
(3) UPPER CHESAPEAKE/ST. JOSEPH HOME CARE, 52-1229742 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HOME CARE	MD	501(C)(3)	09	UMUCHS		X
(4) -----							
(5) -----							
(6) -----							
(7) -----							

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

Schedule R (Form 990) 2013

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) ARUNDEL PHYSICIANS ASSOCIATES 301 HOSPITAL DRIVE	HEALTHCARE	MD	N/A									99.0000
(2) BALTIMORE WASHINGTON IMAGING, 301 HOSPITAL DRIVE	HEALTHCARE	MD	N/A									65.0000
(3) NAH/SUNRISE OF SEVERNA PARK LL 301 HOSPITAL DRIVE	HEALTHCARE	MD	N/A									50.0000
(4) NORTH ARUNDEL SENIOR LIVING LL 301 HOSPITAL DRIVE	HEALTHCARE	MD	N/A									99.0000
(5) INNOVATIVE HEALTH LLC 52-19972 29165 CANVASBACK DRIVE, SUITE	BILLING	MD	N/A									50.0000
(6) CENTRAL MARYLAND RADIOLOGY ONC 10710 CHARTER DRIVE	HEALTHCARE	MD	N/A									50.0000
(7) SHIPLEY'S IMAGING CENTER LLC 5 22 SOUTH GREENE STREET	HEALTHCARE	MD	N/A									50.0000

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) ARUNDEL PHYSICIANS ASSOCIATES ----- 52-1992649 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	N/A	C CORP			100.0000		
(2) BALTIMORE WASHINGTON HEALTH ENTERPRISES, ----- 52-1936656 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	N/A	C CORP			100.0000		
(3) BW PROFESSIONAL SERVICES, INC. ----- 52-1655640 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	N/A	C CORP			100.0000		
(4) UNIV OF MARYLAND CHARLES REGIONAL CARE P ----- 52-2176314 PO BOX 1070 LA PLATA, MD 20646	HEALTHCARE	MD	N/A	C CORP			100.0000		
(5) UNIVERSITY MIDTOWN PROF CENTER, A CONDOM ----- 52-1891126 827 LINDEN AVENUE BALTIMORE, MD 21201	REAL ESTATE	MD	N/A	C CORP			100.0000		
(6) SHORE HEALTH ENTERPRISES, INC. ----- 52-1363201 219 SOUTH WASHINGTON STREET EASTON, MD 21601	REAL ESTATE	MD	N/A	C CORP			100.0000		
(7) NA EXECUTIVE BUILDING CONDO ASSN, INC. ----- 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	REAL ESTATE	MD	N/A	C CORP			100.0000		

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) UNIVERSITYCARE LLC 52-1914892 22 SOUTH GREENE STREET	HEALTHCARE	MD	N/A									90.0000
(2) O'DEA MEDICAL ARTS LIMITED PAR 7601 OSLER DRIVE	RENTAL	MD	N/A									74.0000
(3) ADVANCED IMAGING AT ST. JOSEPH 7601 OSLER DRIVE	HEALTHCARE	MD	N/A									51.0000
(4) UCHS/UMMS REAL ESTATE TRUST 27 520 UPPER CHESAPEAKE DR	REAL ESTATE	MD	N/A									80.0000
(5) -----												
(6) -----												
(7) -----												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) TERRAPIN INSURANCE COMPANY ----- 98-0129232 P.O. BOX 1109 GRAND CAYMAN, KY1-1102	INSURANCE	0	N/A	C CORP			50.0000		
(2) UMMS SELF INSURANCE TRUST ----- 52-6315433 22 SOUTH GREENE STREET BALTIMORE, MD 21201	INSURANCE	MD	N/A	TRUST			50.0000		
(3) UPPER CHESAPEAKE INSURANCE COMPANY ----- 98-0468438 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	INSURANCE	MD	N/A	TRUST			100.0000		
(4) UPPER CHESAPEAKE HEALTH VENTURES, INC. ----- 52-2031264 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HEALTHCARE	MD	N/A	C CORP			100.0000		
(5) UPPER CHESAPEAKE MEDICAL CENTER LAND CON ----- 77-0674478 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	REAL ESTATE	MD	N/A	C CORP			100.0000		
(6) UPPER CHESAPEAKE MEDICAL OFFICE BUILDING ----- 52-1946829 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	REAL ESTATE	MD	N/A	C CORP			100.0000		
(7) -----									

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

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

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

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

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

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

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

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

Part VII **Supplemental Information**

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