

<b>Cumulative E-File History 2013</b>	
<b>Federal</b>	
Locator: 4228CV Taxpayer Name: SHORE HEALTH SYSTEM, INC. Return Type: 990, 990	
<b>Submitted Date</b>	5/12/2015 8:00:01 AM
<b>Acknowledgement Date</b>	5/12/2015 8:27:09 AM
<b>Status</b>	Accepted
<b>Submission ID</b>	23695320151325000006
<a href="#">Print</a>	<a href="#">Close</a>

Form **8879-EO**

# IRS e-file Signature Authorization for an Exempt Organization

OMB No 1545-1878

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

**2013**

Department of the Treasury  
Internal Revenue Service

Do not send to the IRS. Keep for your records.  
Information about Form 8879-EO and its instructions is at [www.irs.gov/form8879ec](http://www.irs.gov/form8879ec).

Name of exempt organization

Employer identification number

SHORE HEALTH SYSTEM, INC.

52-0610538

Name and title of officer

JOANNE HAHEY, CFO

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

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

1a	Form 990 check here	<input checked="" type="checkbox"/>	b	Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	<u>241629485.</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

ERO firm name

1 4 2 3 2

Enter five numbers, but do not enter all zeros

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 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

*Joanne Hahey*

Date

6/27/2013

## 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.

23005336605

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. 4183, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature

Date

**ERO Must Retain This Form - See Instructions**

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

Form 8879-EO (2013)

For Paperwork Reduction Act Notice, see back of form.

# Return of Organization Exempt From Income Tax

OMB No. 1545-0047

## 2013

**Open to Public Inspection**

Form **990**

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

▶ 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](http://www.irs.gov/form990).

Department of the Treasury  
Internal Revenue Service

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

<b>B</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	<b>C</b> Name of organization SHORE HEALTH SYSTEM, INC. Doing Business As Number and street (or P.O. box if mail is not delivered to street address) Room/suite 219 SOUTH WASHINGTON ST. City or town, state or province, country, and ZIP or foreign postal code EASTON, MD 21601		<b>D</b> Employer identification number 52-0610538
	<b>F</b> Name and address of principal officer: <u>KENNETH ROZET</u> 219 SOUTH WASHINGTON ST. EASTON, MD 21601		<b>E</b> Telephone number (410) 822-1000 EXT 5502
	<b>I</b> 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		<b>G</b> Gross receipts \$ <u>242,832,659.</u>
	<b>J</b> Website: ▶ <u>HTTP://UMSHOREREGIONAL.ORG/</u>		<b>H(a)</b> Is this a group return for subsidiaries? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>H(b)</b> Are all subsidiaries covered? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) <b>H(c)</b> Group exemption number ▶
<b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			<b>L</b> Year of formation: <u>1906</u> <b>M</b> State of legal domicile: <u>MD</u>

### Part I Summary

<b>Activities &amp; Governance</b>	1	Briefly describe the organization's mission or most significant activities: <u>SHORE HEALTH SYSTEM IS A REGIONAL, NOT-FOR-PROFIT NETWORK OF INPATIENT AND OUTPATIENT SERVICES WITH FACILITIES IN TALBOT, DORCHESTER, CAROLINE, AND QUEEN ANNE'S COUNTIES.</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	
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	25.
	5	Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5	20.
	6	Total number of volunteers (estimate if necessary)	6	2,028.
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	473.
	b Net unrelated business taxable income from Form 990-T, line 34	7b	7,170,911.	
			-389,298.	
<b>Revenue</b>	8	Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9	Program service revenue (Part VIII, line 2g)	1,175,085.	1,073,363.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	224,710,875.	231,762,966.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	6,260,294.	9,315,124.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	-550,380.	-521,968.
	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	231,595,874.	241,629,485.
	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)	106,988,248.	103,022,600.
		b Total fundraising expenses (Part IX, column (D), line 25) ▶	0	0
<b>Expenses</b>	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	104,596,660.	116,403,380.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	211,584,908.	219,425,980.
	19	Revenue less expenses. Subtract line 18 from line 12	20,010,966.	22,203,505.
<b>Net Assets or Fund Balances</b>	20	Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21	Total liabilities (Part X, line 26)	343,942,458.	370,246,091.
	22	Net assets or fund balances. Subtract line 21 from line 20	150,297,748.	149,049,498.
		193,644,710.	221,196,593.	

### 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.

<b>Sign Here</b>	Signature of officer Date <u>05/06/2015</u>		
	Type or print name and title JOANNE HAHFY CFO		
<b>Paid Preparer Use Only</b>	Print/Type preparer's name FRANK GTARDINI	Preparer's signature Date <u>05/06/2015</u>	Check <input type="checkbox"/> if self-employed <input type="checkbox"/> PTIN <u>P00532355</u>
	Firm's name ▶ GRANT THORNTON LLP	Firm's EIN ▶ 36-6055558	Phone no. 215-561-4200
	Firm's address ▶ 2001 MARKET STREET, SUITE 700 PHILADELPHIA, PA 19103		
May the IRS discuss this return with the preparer shown above? (see instructions) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			

For Paperwork Reduction Act Notice, see the separate instructions.

Form 990 (2013)

## Application for Extension of Time To File an Exempt Organization Return

OMB No. 1545-1709

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

<b>Type or print</b>  File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.  SHORE HEALTH SYSTEM, INC.	Employer identification number (EIN) or  52-0610538
	Number, street, and room or suite no. If a P.O. box, see instructions. 219 SOUTH WASHINGTON ST.	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. EASTON, MD 21601	

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 ▶ WALTER ZAJAC, CFO, 219 SOUTH WASHINGTON ST. EASTON, MD 21601

Telephone No. ▶ 410 822-1000 FAX No. ▶ \_\_\_\_\_

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

**1** I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 02/15, 20 15, 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, 20 13, and ending 06/30, 20 14.

**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

<b>3a</b> 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.	<b>3a</b>	\$	0
<b>b</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.	<b>3b</b>	\$	0
<b>c Balance due.</b> Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	<b>3c</b>	\$	0

**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.

Form **8868** (Rev. 1-2014)

**Cumulative e-File History 2013**

**Federal Extension3**

Locator:	4228CV
Taxpayer Name:	SHORE HEALTH SYSTEM, INC.
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	11/05/2014 08:39:33
Acknowledgement Date:	11/05/2014 08:57:41
Status:	Accepted
Submission ID:	23695320143095000040

- If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** and check this box  **X**.
- Note.** Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.
- If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** (on page 1).

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

Enter filer's identifying number, see instructions

<b>Type or print</b>  File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.  SHORE HEALTH SYSTEM, INC.	Employer identification number (EIN) or  52-0610538
	Number, street, and room or suite no. If a P.O. box, see instructions.  219 SOUTH WASHINGTON ST.	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.  EASTON, MD 21601	

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

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (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  WALTER ZAJAC, CFO, 219 SOUTH WASHINGTON ST. EASTON, MD 21601  
Telephone No.  410 822-1000 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

<b>8a</b> 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.	<b>8a</b> \$	0
<b>b</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.	<b>8b</b> \$	0
<b>c Balance Due.</b> Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	<b>8c</b> \$	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

<b>Cumulative e-File History 2013</b>	
<b>FED</b>	
Locator:	4228CV
Taxpayer Name:	SHORE HEALTH SYSTEM, INC.
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	02/06/2015 16:53:27
Acknowledgement Date:	02/06/2015 17:28:57
Status:	Rejected
Submission ID:	23695320150375000021
Submitted Date:	02/10/2015 16:23:28
Acknowledgement Date:	02/10/2015 16:57:37
Status:	Accepted
Submission ID:	23695320150415000007

**Part III Statement of Program Service Accomplishments**

Check if Schedule O contains a response or note to any line in this Part III  Yes  No

**1** Briefly describe the organization's mission:

TO EXCEL IN QUALITY CARE AND PATIENT SATISFACTION.

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

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

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

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

**4** Describe the 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 \$ 191,343,025. including grants of \$ ) (Revenue \$ 224,798,077. )

SEE SCHEDULE O

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

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

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

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

**4e** Total program service expenses 191,343,025.



**Part IV Checklist of Required Schedules**

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

**Part IV Checklist of Required Schedules (continued)**

		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	<b>Section 501(c)(3) and 501(c)(4) organizations.</b> 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	<b>Section 501(c)(3) organizations.</b> 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? <b>Note.</b> 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 number, description, and Yes/No checkboxes. Includes sections for backup withholding, employee reporting, foreign accounts, prohibited transactions, and charitable contributions.

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 4 columns: Question, Line Number, Yes, No. Rows include 1a (25), 1b (20), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

Table with 4 columns: Question, Line Number, Yes, No. Rows include 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: JOANNE HAHEY, CFO 219 SOUTH WASHINGTON ST. EASTON, MD 21601 410-822-1000

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) ROBERT CHRENCIK UMMS PRESIDENT/CEO	1.00 49.00	X						0	1,735,933.	246,647.
(2) JOHN DILLON BOARD CHAIRMAN	1.00 5.00	X		X				0	0	0
(3) RICHARD LOEFFLER BOARD VICE CHAIRMAN	1.00 4.00	X		X				0	0	0
(4) CHARLES CAPUTE BOARD MEMBER	1.00 5.00	X						0	0	0
(5) MARTHA RUSSELL BOARD TREASURER	1.00 4.00	X		X				0	0	0
(6) STUART BOUNDS BOARD SECRETARY	1.00 4.00	X		X				0	0	0
(7) JUDITH COOPER BOARD MEMBER	1.00 4.00	X						0	0	0
(8) CHARLES LEA, JR. BOARD MEMBER	1.00 4.00	X						0	0	0
(9) MARLENE FELDMAN BOARD MEMBER	1.00 4.00	X						0	0	0
(10) MICHAEL JOYCE, MD BOARD MEMBER	1.00 4.00	X						0	0	0
(11) KEITH MCMAHAN BOARD MEMBER	1.00 5.00	X						0	0	0
(12) DAVID MILLIGAN BOARD MEMBER	1.00 4.00	X						0	0	0
(13) NEIL MUFSON BOARD MEMBER	1.00 4.00	X						0	0	0
(14) JOHN ASHWORTH, III BOARD MEMBER	1.00 49.00	X						0	527,667.	20,501.

**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) JAMES PETERSON BOARD MEMBER	1.00 4.00	X					0	0	0	
16) ROBERT SWAM BOARD MEMBER	1.00 4.00	X					0	0	0	
17) WALTER ZAJAC VP OF FINANCE & BUDGET	30.00 20.00	X		X			259,952.	0	17,608.	
18) KENNETH KOZEL PRESIDENT/CEO	32.00 18.00	X		X			493,731.	0	84,119.	
19) DEBORAH DAVIS, MD BOARD MEMBER	1.00 4.00	X					0	0	0	
20) JOSEPH J. CIOTOLA, MD BOARD MEMBER	1.00 4.00	X					0	0	0	
21) EDWIN FRY BOARD MEMBER	1.00 4.00	X					0	0	0	
22) WAYNE L. GARDNER, SR. BOARD MEMBER	1.00 4.00	X					0	0	0	
23) C. DANIEL SAUNDERS, ESQ. BOARD MEMBER	1.00 4.00	X					0	0	0	
24) WILLIAM J. WASHINGTON BOARD MEMBER	1.00 4.00	X					0	0	0	
25) JOANNE HAHEY CFO (STARTED 4/24/2014)	32.00 18.00	X		X			0	0	0	
<b>1b Sub-total</b>							0	2,263,600.	267,148.	
<b>c Total from continuation sheets to Part VII, Section A</b>							3,272,400.	0	277,449.	
<b>d Total (add lines 1b and 1c)</b>							3,272,400.	2,263,600.	544,597.	

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 **65**

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 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 **32**

**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			
( 26) LUDWIG EGLSEDER III BOARD MEMBER	1.00 4.00	X					52,000.	0	0	
( 27) GERARD WALSH FORMER INTERIM CEO	45.00 5.00				X		379,500.	0	18,117.	
( 28) MICHAEL TOOKE, MD CMO	50.00 0				X		297,566.	0	13,884.	
( 29) CHRISTOPHER PARKER SVP- PAT CARE/CNO	48.00 2.00				X		314,030.	0	19,586.	
( 30) JONATHAN COOK VP/PHYSICAN SERVICES	40.00 10.00				X		206,488.	0	34,925.	
( 31) MICHAEL ZIMMERMAN VP/HR	50.00 0					X	180,757.	0	12,942.	
( 32) MICHAEL SILGEN VP/STRAT PLAN & BUS DEVELOP	50.00 0					X	298,108.	0	7,435.	
( 33) JOHN SAWYER LEAD MEDICAL PHYSICIST	40.00 0					X	179,160.	0	11,141.	
( 34) FRANCIS G. LEE VP-PHILANTHROPY	1.00 39.00					X	190,224.	0	32,170.	
( 35) PATTI WILLIS VP EXT RELATIONS & COMM	40.00 0					X	228,512.	0	17,283.	
( 36) PHYLLIS MATTHAI FORMER BOARD ASST. SECRETARY	0 0					X	44,583.	0	8,239.	
<b>1b Sub-total</b> . . . . .										
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .										
<b>d Total (add lines 1b and 1c)</b> . . . . .										

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 ▶ 65

	Yes	No
3 Did the organization list any <b>former</b> 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

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

**Part 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			
( 37) JOSEPH ROSS FORMER PRESIDENT/CEO	0 0						X	147,789.	0	0
<b>1b Sub-total</b> .....										
<b>c Total from continuation sheets to Part VII, Section A</b> .....										
<b>d Total (add lines 1b and 1c)</b> .....										

**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 **▶** 65

	Yes	No
<b>3</b> 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	
<b>4</b> 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	
<b>5</b> 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

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



**Part VIII Statement of Revenue**

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	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>						
	<b>b</b> Membership dues . . . . .	<b>1b</b>						
	<b>c</b> Fundraising events . . . . .	<b>1c</b>						
	<b>d</b> Related organizations . . . . .	<b>1d</b>	783,615.					
	<b>e</b> Government grants (contributions) . .	<b>1e</b>	280,491.					
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above .	<b>1f</b>	9,257.					
	<b>g</b> Noncash contributions included in lines 1a-1f: \$							
	<b>h Total.</b> Add lines 1a-1f . . . . .			1,073,363.				
<b>Program Service Revenue</b>	<b>Business Code</b>							
	<b>2a</b> PATIENT SERVICE REVENUE		621500	229,405,913.	222,363,755.	7,042,158.		
	<b>b</b> OTHER OPERATING REVENUE		900099	2,357,053.	2,357,053.			
	<b>c</b>							
	<b>d</b>							
	<b>e</b>							
	<b>f</b> All other program service revenue . . . . .							
<b>g Total.</b> Add lines 2a-2f . . . . .				231,762,966.				
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .			4,118,556.			4,118,556.	
	<b>4</b> Income from investment of tax-exempt bond proceeds . . .			0				
	<b>5</b> Royalties . . . . .			0				
	<b>6a</b> Gross rents . . . . .	(i) Real		690,815.				
		(ii) Personal						
		<b>b</b> Less: rental expenses . . . . .		1,203,174.				
		<b>c</b> Rental income or (loss) . . . . .		-512,359.				
	<b>d</b> Net rental income or (loss) . . . . .				-512,359.		-512,359.	
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities		4,980,937.				
		(ii) Other		215,631.				
		<b>b</b> Less: cost or other basis and sales expenses . . . . .						
		<b>c</b> Gain or (loss) . . . . .		4,980,937.	215,631.			
	<b>d</b> Net gain or (loss) . . . . .				5,196,568.	82,878.	132,753.	4,980,937.
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 . . . . .	<b>a</b>						
	<b>b</b> Less: direct expenses . . . . .	<b>b</b>						
<b>c</b> Net income or (loss) from fundraising events . . . . .				0				
<b>9a</b> Gross income from gaming activities. See Part IV, line 19 . . . . .	<b>a</b>							
<b>b</b> Less: direct expenses . . . . .	<b>b</b>							
<b>c</b> Net income or (loss) from gaming activities . . . . .				0				
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>a</b>							
<b>b</b> Less: cost of goods sold . . . . .	<b>b</b>							
<b>c</b> Net income or (loss) from sales of inventory . . . . .				0				
<b>Miscellaneous Revenue</b>			<b>Business Code</b>					
<b>11a</b> W/O SHORE HEALTH ENTERPRISES STOCK		900099		-4,000.		-4,000.		
<b>b</b> PHYSICIAN LOAN INTEREST		900099		25,102.	25,102.			
<b>c</b> CONTRIBUTIONS		900099		-30,711.	-30,711.			
<b>d</b> All other revenue . . . . .								
<b>e Total.</b> Add lines 11a-11d . . . . .				-9,609.				
<b>12 Total revenue.</b> See instructions . . . . .				241,629,485.	224,798,077.	7,170,911.	8,587,134.	

**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

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	(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 . . . . .	2,194,128.	1,865,009.	329,119.	
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 . . . . .	76,172,542.	68,485,218.	7,687,324.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) . . . . .	4,191,949.	3,808,963.	382,986.	
9 Other employee benefits . . . . .	14,486,829.	13,128,605.	1,358,224.	
10 Payroll taxes . . . . .	5,977,152.	5,212,100.	765,052.	
11 Fees for services (non-employees):				
a Management . . . . .	0			
b Legal . . . . .	559,459.		559,459.	
c Accounting . . . . .	2,625,851.		2,625,851.	
d Lobbying . . . . .	19,397.	19,397.		
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.) <u>ATCH 2</u>	25,397,763.	20,897,331.	4,500,432.	
12 Advertising and promotion . . . . .	976,210.	976,210.		
13 Office expenses . . . . .	2,219,404.	1,864,852.	354,552.	
14 Information technology . . . . .	7,204,771.	192,134.	7,012,637.	
15 Royalties . . . . .	0			
16 Occupancy . . . . .	5,907,625.	5,907,625.		
17 Travel . . . . .	201,898.	140,265.	61,633.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings . . . . .	0			
20 Interest . . . . .	3,440,042.	2,924,036.	516,006.	
21 Payments to affiliates . . . . .	0			
22 Depreciation, depletion, and amortization . . . . .	14,032,143.	13,163,257.	868,886.	
23 Insurance . . . . .	0			
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>BAD DEBT</u> . . . . .	11,979,040.	11,979,040.		
b <u>MEDICAL SUPPLIES</u> . . . . .	31,412,643.	31,412,643.		
c <u>RECRUITMENT</u> . . . . .	1,027,302.	879,942.	147,360.	
d <u>EXPENDITURES FOR FUND PURPOS</u> . . . . .	565,024.	565,024.		
e All other expenses . . . . .	8,834,808.	7,921,374.	913,434.	
<b>25 Total functional expenses.</b> Add lines 1 through 24e	219,425,980.	191,343,025.	28,082,955.	
<b>26 Joint costs.</b> 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
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing	13,479,877.	<b>1</b>	13,656,840.
	<b>2</b> Savings and temporary cash investments	0	<b>2</b>	0
	<b>3</b> Pledges and grants receivable, net	30,068,915.	<b>3</b>	19,564,821.
	<b>4</b> Accounts receivable, net	0	<b>4</b>	0
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	<b>5</b>	0
	<b>6</b> 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	<b>6</b>	0
	<b>7</b> Notes and loans receivable, net	0	<b>7</b>	0
	<b>8</b> Inventories for sale or use	3,921,181.	<b>8</b>	3,611,118.
	<b>9</b> Prepaid expenses and deferred charges	986,346.	<b>9</b>	1,454,899.
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 303,499,609.		
	<b>b</b> Less: accumulated depreciation	<b>10b</b> 172,767,808.	127,155,804.	<b>10c</b> 130,731,801.
	<b>11</b> Investments - publicly traded securities	30,412,563.	<b>11</b>	27,769,433.
	<b>12</b> Investments - other securities. See Part IV, line 11	30,054,000.	<b>12</b>	41,330,000.
	<b>13</b> Investments - program-related. See Part IV, line 11	0	<b>13</b>	0
	<b>14</b> Intangible assets	0	<b>14</b>	0
	<b>15</b> Other assets. See Part IV, line 11	107,863,772.	<b>15</b>	132,127,179.
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34)	343,942,458.	<b>16</b>	370,246,091.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses	28,938,870.	<b>17</b>	32,115,008.
	<b>18</b> Grants payable	0	<b>18</b>	0
	<b>19</b> Deferred revenue	3,034.	<b>19</b>	3,034.
	<b>20</b> Tax-exempt bond liabilities	0	<b>20</b>	0
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D	0	<b>21</b>	0
	<b>22</b> 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	<b>22</b>	0
	<b>23</b> Secured mortgages and notes payable to unrelated third parties	13,949,388.	<b>23</b>	12,371,947.
	<b>24</b> Unsecured notes and loans payable to unrelated third parties	0	<b>24</b>	0
	<b>25</b> 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	107,406,456.	<b>25</b>	104,559,509.
	<b>26 Total liabilities.</b> Add lines 17 through 25	150,297,748.	<b>26</b>	149,049,498.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here</b> <input checked="" type="checkbox"/> <b>and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets	165,187,364.	<b>27</b>	189,472,551.
	<b>28</b> Temporarily restricted net assets	14,600,816.	<b>28</b>	17,750,159.
	<b>29</b> Permanently restricted net assets	13,856,530.	<b>29</b>	13,973,883.
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here</b> <input type="checkbox"/> <b>and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building, or equipment fund		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds		<b>32</b>	
	<b>33</b> Total net assets or fund balances	193,644,710.	<b>33</b>	221,196,593.
	<b>34</b> Total liabilities and net assets/fund balances	343,942,458.	<b>34</b>	370,246,091.

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	241,629,485.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	219,425,980.
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	22,203,505.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	193,644,710.
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	0
<b>6</b>	Donated services and use of facilities	<b>6</b>	0
<b>7</b>	Investment expenses	<b>7</b>	0
<b>8</b>	Prior period adjustments	<b>8</b>	0
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	5,348,378.
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	221,196,593.

**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
<b>2a</b>		X
<b>2b</b>	X	
<b>2c</b>	X	
<b>3a</b>		X
<b>3b</b>		

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

**Public Charity Status and Public Support**

OMB No. 1545-0047

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

**2013**

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](http://www.irs.gov/form990).

**Open to Public Inspection**

<b>Name of the organization</b> SHORE HEALTH SYSTEM, INC.	<b>Employer identification number</b> 52-0610538
--	---

**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)									
<b>Total</b>									

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule A (Form 990 or 990-EZ) 2013

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

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 Gross receipts from admissions, merchandise sold or services performed; 3 Gross receipts from activities that are not an unrelated trade or business; 4 Tax revenues levied for the organization's benefit; 5 The value of services or facilities furnished by a governmental unit; 6 Total. Add lines 1 through 5; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 7c Add lines 7a and 7b; 8 Public support (Subtract line 7c from line 6).

Section B. Total Support

Table with 7 columns: (a) 2009, (b) 2010, (c) 2011, (d) 2012, (e) 2013, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 10b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975; 10c Add lines 10a and 10b; 11 Net income from unrelated business activities not included in line 10b; 12 Other income. Do not include gain or loss from the sale of capital assets; 13 Total support. (Add lines 9, 10c, 11, and 12.)

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

Section C. Computation of Public Support Percentage

Table with 3 columns: Description, 2013, 2012. Row 15: Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f)). Row 16: Public support percentage from 2012 Schedule A, Part III, line 15.

Section D. Computation of Investment Income Percentage

Table with 3 columns: Description, 2013, 2012. Row 17: Investment income percentage for 2013 (line 10c, column (f) divided by line 13, column (f)). Row 18: Investment income percentage from 2012 Schedule A, Part III, line 17.

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.

19b 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](http://www.irs.gov/form990).

**Name of the organization**

SHORE HEALTH SYSTEM, INC.

**Employer identification number**

52-0610538

**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 SHORE HEALTH SYSTEM, INC.

Employer identification number  
52-0610538**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	MARYLAND HOSPITAL ASSOCIATION 6820 DEERPATH RD ELKRIDGE, MD 21075	\$ 80,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	DORCHESTER GENERAL HOSP FDTN PO BOX 939 CAMBRIDGE, MD 21613	\$ 143,976.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	MEMORIAL HOSPITAL FOUNDATION PO BOX 1846 EASTON, MD 21601	\$ 639,639.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	MD DEPT HLTH & MENTAL HYGIENE 201 W PRESTON ST BALTIMORE, MD 21201	\$ 123,797.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	UNIVERSITY OF MD, BALTIMORE 220 ARCH ST., 13TH FLOOR BALTIMORE, MD 21201	\$ 31,509.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	MD INSTITUTE EMERGENCY MEDICAL SERVICE 653 W PRATT ST BALTIMORE, MD 21201	\$ 22,177.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **SHORE HEALTH SYSTEM, INC.**

Employer identification number  
52-0610538

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	DORCHESTER COUNTY HEALTH DEPARTMENT 3 CEDAR ST CAMBRIDGE, MD 21613	\$ 22,008.	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.)

Name of organization **SHORE HEALTH SYSTEM, INC.**

Employer identification number

52-0610538

**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 SHORE HEALTH SYSTEM, INC.

Employer identification number  
52-0610538

**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](http://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 SHORE HEALTH SYSTEM, INC.	Employer identification number 52-0610538
---	--

**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.

<b>Limits on Lobbying Expenditures</b> (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
<b>1a</b>	Total lobbying expenditures to influence public opinion (grass roots lobbying) . . . . .														
<b>b</b>	Total lobbying expenditures to influence a legislative body (direct lobbying) . . . . .														
<b>c</b>	Total lobbying expenditures (add lines 1a and 1b) . . . . .														
<b>d</b>	Other exempt purpose expenditures . . . . .														
<b>e</b>	Total exempt purpose expenditures (add lines 1c and 1d) . . . . .														
<b>f</b>	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.														
<b>g</b>	Grassroots nontaxable amount (enter 25% of line 1f) . . . . .														
<b>h</b>	Subtract line 1g from line 1a. If zero or less, enter -0- . . . . .														
<b>i</b>	Subtract line 1f from line 1c. If zero or less, enter -0- . . . . .														
<b>j</b>	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.)

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

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

Table with columns (a) Yes/No and (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation...; 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 columns Yes/No. Rows include: 1 Were substantially all (90% or more) dues received nondeductible by members?; 2 Did the organization make only in-house lobbying expenditures of \$2,000 or less?; 3 Did the organization agree to 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 columns 1-5. Rows include: 1 Dues, assessments and similar amounts from members; 2 Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid); 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 1I

THE ORGANIZATION DOES NOT ENGAGE IN ANY DIRECT LOBBYING ACTIVITIES. THE ORGANIZATION PAYS MEMBERSHIP DUES TO THE MARYLAND HOSPITAL ASSOCIATION (MHA) AND THE AMERICAN HOSPITAL ASSOCIATION (AHA) AND AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION (AMRPA). MHA, AHA AND AMRPA ENGAGE IN MANY SUPPORT ACTIVITIES INCLUDING LOBBYING AND ADVOCATING FOR THEIR MEMBER HOSPITALS. THE MHA, AHA, AND AMRPA REPORTED THAT 6.22%, 23.65%, AND 37.0% RESPECTIVELY OF MEMBER DUES WERE USED FOR LOBBYING PURPOSES AND AS SUCH, THE ORGANIZATION HAS REPORTED THIS AMOUNT ON SCHEDULE C PART II-B LINE 1I AS LOBBYING ACTIVITIES.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

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

SHORE HEALTH SYSTEM, INC.

52-0610538

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

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

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate contributions to (during year), 3 Aggregate grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors... Yes No, 6 Did the organization inform all grantees...

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..., 3 Number of conservation easements modified..., 4 Number of states where property subject to conservation easement is located..., 5 Does the organization have a written policy..., 6 Staff and volunteer hours devoted..., 7 Amount of expenses incurred..., 8 Does each conservation easement reported on line 2(d) above satisfy the requirements..., 9 In Part XIII, describe how the organization reports 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. b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenues included in Form 990, Part VIII, line 1 (ii) Assets included in Form 990, Part X 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items: a Revenues included in Form 990, Part VIII, line 1 b Assets included in Form 990, Part X

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

Schedule D (Form 990) 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?

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

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?
b If "Yes," explain the arrangement in Part XIII and complete the following table:

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

- 2a Did the organization include an amount on Form 990, Part X, line 21?
b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII.

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

Table with 6 columns: (a) Current year, (b) Prior year, (c) Two years back, (d) Three years back, (e) Four years back. Rows: 1a 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 100.0000 %
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:

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

- (i) unrelated organizations
(ii) related organizations
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?
4 Describe in Part XIII the intended uses of the organization's endowment funds.

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

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

**Part VII Investments - Other Securities.**

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) ALTERNATIVE INVESTMENTS	41,330,000.	FMV
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶	41,330,000.	

**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)		
<b>Total.</b> (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) ASSETS WHOSE USE IS LIMITED	28,785,866.
(2) OTHER RECEIVABLES	16,089,283.
(3) ECONOMIC INTERESTS IN NET	
(4) ASSETS OF RELATED ORGANIZATION	74,781,815.
(5) INVESTMENT IN SUBSIDIARIES AND	
(6) OTHER ASSETS	11,824,440.
(7) SELF-INSURANCE TRUST	
(8) CURRENT POSITION	645,775.
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	132,127,179.

**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) ADVANCES FROM 3RD PARTY PAYORS	5,367,836.
(3) OTHER LIABILITIES	14,902,464.
(4) DUE TO UMMS	84,289,209.
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	104,559,509.

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 description, sub-row labels (2a-2d, 4a-4b), and total labels (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 description, sub-row labels (2a-2d, 4a-4b), and total labels (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)

## INTENDED USES OF ENDOWMENT FUNDS

SCHEDULE D, PART V, LINE 4

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

## LIABILITY FOR UNCERTAIN TAX POSITION (ASC 740)

SCHEDULE D, PART X, LINE 2

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

**SCHEDULE 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](http://www.irs.gov/form990).

Department of the Treasury  
Internal Revenue Service

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

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

**7 Financial Assistance and Certain Other Community Benefits at Cost**

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			5,375,018.		5,375,018.	2.45
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .						
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs . . . . .			5,375,018.		5,375,018.	2.45
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) . . . . .			1,391,010.	36,919.	1,354,091.	.62
<b>f</b> Health professions education (from Worksheet 5) . . . . .			633,801.		633,801.	.29
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .			5,864,318.	9,021.	5,855,297.	2.67
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			410,556.		410,556.	.19
<b>j Total.</b> Other Benefits . . . . .			8,299,685.	45,940.	8,253,745.	3.77
<b>k Total.</b> Add lines 7d and 7j. . . . .			13,674,703.	45,940.	13,628,763.	6.22

**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			5,299.		5,299.	
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			29,287.		29,287.	.01
7 Community health improvement advocacy			3,129.		3,129.	
8 Workforce development			53,244.		53,244.	.02
9 Other						
10 Total			90,959.		90,959.	.03

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

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

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME) . . . . .	111,319,242.
6 Enter Medicare allowable costs of care relating to payments on line 5 . . . . .	85,445,816.
7 Subtract line 6 from line 5. This is the surplus (or shortfall) . . . . .	25,873,426.
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? . . . . .	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 . . . . .	X	

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

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



**Part V Facility Information**

**Section A. Hospital Facilities**

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

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

Name, address, 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
<b>1</b> THE MEMORIAL HOSPITAL AT EASTON 219 S. WASHINGTON STREET EASTON MD 21601	X	X					X			
<b>2</b> DORCHESTER GENERAL HOSPITAL 300 BYRN STREET CAMBRIDGE MD 21613	X	X					X			
<b>3</b>										
<b>4</b>										
<b>5</b>										
<b>6</b>										
<b>7</b>										
<b>8</b>										
<b>9</b>										
<b>10</b>										

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 THE MEMORIAL HOSPITAL AT EASTON

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)

- 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.
a A definition of the community served by the hospital facility
b Demographics of the community
c Existing health care facilities and resources within the community that are available to respond to the health needs of the community
d How data was obtained
e The health needs of the community
f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
g The process for identifying and prioritizing community health needs and services to meet the community health needs
h The process for consulting with persons representing the community's interests
i Information gaps that limit the hospital facility's ability to assess the community's health needs
j Other (describe in Section C)
2 Indicate the tax year the hospital facility last conducted a CHNA: 20 1 2
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?
4 Was the hospital facility's CHNA conducted with one or more other hospital facilities?
5 Did the hospital facility make its CHNA report widely available to the public?
a Hospital facility's website (list url):
b Other website (list url):
c Available upon request from the hospital facility
d 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 Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA
b Execution of the implementation strategy
c Participation in the development of a community-wide plan
d Participation in the execution of a community-wide plan
e Inclusion of a community benefit section in operational plans
f Adoption of a budget for provision of services that address the needs identified in the CHNA
g Prioritization of health needs in its community
h Prioritization of services that the hospital facility will undertake to meet health needs in its community
i Other (describe in Section C)
7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA?
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)?
b 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? \$

Table with 3 columns: Question ID, Yes, No. Rows correspond to questions 1 through 8c.

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 DORCHESTER GENERAL 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) 2

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

- 1 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9.
a A definition of the community served by the hospital facility
b Demographics of the community
c Existing health care facilities and resources within the community that are available to respond to the health needs of the community
d How data was obtained
e The health needs of the community
f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
g The process for identifying and prioritizing community health needs and services to meet the community health needs
h The process for consulting with persons representing the community's interests
i Information gaps that limit the hospital facility's ability to assess the community's health needs
j Other (describe in Section C)
2 Indicate the tax year the hospital facility last conducted a CHNA: 20 1 2
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?
4 Was the hospital facility's CHNA conducted with one or more other hospital facilities?
5 Did the hospital facility make its CHNA report widely available to the public?
a Hospital facility's website (list url):
b Other website (list url):
c Available upon request from the hospital facility
d 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 Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA
b Execution of the implementation strategy
c Participation in the development of a community-wide plan
d Participation in the execution of a community-wide plan
e Inclusion of a community benefit section in operational plans
f Adoption of a budget for provision of services that address the needs identified in the CHNA
g Prioritization of health needs in its community
h Prioritization of services that the hospital facility will undertake to meet health needs in its community
i Other (describe in Section C)
7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA?
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)?
b 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? \$

Table with 3 columns: Question ID, Yes, No. Rows correspond to questions 1 through 8c.

**Part V Facility Information (continued)**

**Financial Assistance Policy** THE MEMORIAL HOSPITAL AT EASTON

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>9</b>	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? . . . . .	X	
<b>10</b>	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	
<b>11</b>	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	
<b>12</b>	Explained the basis for calculating amounts charged to patients? . . . . . If "Yes," indicate the factors used in determining such amounts (check all that apply):	X	
<b>a</b>	<input checked="" type="checkbox"/> Income level		
<b>b</b>	<input checked="" type="checkbox"/> Asset level		
<b>c</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>d</b>	<input checked="" type="checkbox"/> Insurance status		
<b>e</b>	<input checked="" type="checkbox"/> Uninsured discount		
<b>f</b>	<input checked="" type="checkbox"/> Medicaid/Medicare		
<b>g</b>	<input checked="" type="checkbox"/> State regulation		
<b>h</b>	<input type="checkbox"/> Residency		
<b>i</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>13</b>	Explained the method for applying for financial assistance? . . . . .	X	
<b>14</b>	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	
<b>a</b>	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
<b>b</b>	<input checked="" type="checkbox"/> The policy was attached to billing invoices		
<b>c</b>	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
<b>d</b>	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
<b>e</b>	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
<b>f</b>	<input checked="" type="checkbox"/> The policy was available on request		
<b>g</b>	<input type="checkbox"/> Other (describe in Section C)		

**Billing and Collections**

<b>15</b>	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	
<b>16</b>	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:		
<b>a</b>	<input type="checkbox"/> Reporting to credit agency		
<b>b</b>	<input type="checkbox"/> Lawsuits		
<b>c</b>	<input type="checkbox"/> Liens on residences		
<b>d</b>	<input type="checkbox"/> Body attachments		
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)		
<b>17</b>	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
<b>a</b>	<input type="checkbox"/> Reporting to credit agency		
<b>b</b>	<input type="checkbox"/> Lawsuits		
<b>c</b>	<input type="checkbox"/> Liens on residences		
<b>d</b>	<input type="checkbox"/> Body attachments		
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)		

**Part V Facility Information (continued)**

Financial Assistance Policy		DORCHESTER GENERAL HOSPITAL		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:					
<b>9</b>	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? . . . . .	<b>9</b>	X		
<b>10</b>	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.	<b>10</b>	X		
<b>11</b>	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.	<b>11</b>	X		
<b>12</b>	Explained the basis for calculating amounts charged to patients? . . . . . If "Yes," indicate the factors used in determining such amounts (check all that apply):	<b>12</b>	X		
<b>a</b>	<input checked="" type="checkbox"/> Income level				
<b>b</b>	<input checked="" type="checkbox"/> Asset level				
<b>c</b>	<input checked="" type="checkbox"/> Medical indigency				
<b>d</b>	<input checked="" type="checkbox"/> Insurance status				
<b>e</b>	<input checked="" type="checkbox"/> Uninsured discount				
<b>f</b>	<input checked="" type="checkbox"/> Medicaid/Medicare				
<b>g</b>	<input checked="" type="checkbox"/> State regulation				
<b>h</b>	<input type="checkbox"/> Residency				
<b>i</b>	<input type="checkbox"/> Other (describe in Section C)				
<b>13</b>	Explained the method for applying for financial assistance? . . . . .	<b>13</b>	X		
<b>14</b>	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):	<b>14</b>	X		
<b>a</b>	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website				
<b>b</b>	<input checked="" type="checkbox"/> The policy was attached to billing invoices				
<b>c</b>	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms				
<b>d</b>	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices				
<b>e</b>	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility				
<b>f</b>	<input checked="" type="checkbox"/> The policy was available on request				
<b>g</b>	<input type="checkbox"/> Other (describe in Section C)				
<b>Billing and Collections</b>					
<b>15</b>	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? . . . . .	<b>15</b>	X		
<b>16</b>	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:				
<b>a</b>	<input type="checkbox"/> Reporting to credit agency				
<b>b</b>	<input type="checkbox"/> Lawsuits				
<b>c</b>	<input type="checkbox"/> Liens on residences				
<b>d</b>	<input type="checkbox"/> Body attachments				
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)				
<b>17</b>	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:	<b>17</b>			X
<b>a</b>	<input type="checkbox"/> Reporting to credit agency				
<b>b</b>	<input type="checkbox"/> Lawsuits				
<b>c</b>	<input type="checkbox"/> Liens on residences				
<b>d</b>	<input type="checkbox"/> Body attachments				
<b>e</b>	<input type="checkbox"/> Other similar actions (describe in Section C)				

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

- 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 |
|---|-----------|-----|----|
| <b>19</b> 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? . . . . .<br>If "No," indicate why: | <b>19</b> | X   |    |
| <b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions   |           |     |    |
| <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing   |           |     |    |
| <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)   |           |     |    |
| <b>d</b> <input type="checkbox"/> Other (describe in Section C)   |           |     |    |

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

- |   |           |  |   |
|---|-----------|--|---|
| <b>20</b> 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.  |           |  |   |
| <b>a</b> <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged   |           |  |   |
| <b>b</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   |           |  |   |
| <b>c</b> <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged  |           |  |   |
| <b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)  |           |  |   |
| <b>21</b> 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? . . . . .<br>If "Yes," explain in Section C. | <b>21</b> |  | X |
| <b>22</b> 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? . . . . .<br>If "Yes," explain in Section C.   | <b>22</b> |  | X |

**Part V Facility Information (continued)** DORCHESTER GENERAL 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 |
|---|-----------|-----|----|
| <b>19</b> 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? . . . . .<br>If "No," indicate why: | <b>19</b> | X   |    |
| a <input 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)**

- |   |           |  |   |
|---|-----------|--|---|
| <b>20</b> 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)   |           |  |   |
| <b>21</b> 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? . . . . .<br>If "Yes," explain in Section C. | <b>21</b> |  | X |
| <b>22</b> 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? . . . . .<br>If "Yes," explain in Section C.   | <b>22</b> |  | 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.

THE MEMORIAL HOSPITAL AT EASTON

SCHEDULE H, PART V, SECTION B

LINE 3 - COMMUNICATION WITH LOCAL HEALTH DEPARTMENTS, PUBLIC SCHOOL SYSTEMS, CHURCH LEADERS, COMMITTEES, ADVISORY BOARDS, AND COMMUNITY WORKGROUPS ACTIVE IN IDENTIFYING REGIONAL HEALTH CARE NEEDS.

LINE 7 - ENVIRONMENTAL HEALTH NEEDS REQUIRING EXPERTISE AND RESOURCES BEYOND THE CAPABILITIES OF THE SYSTEM. MENTAL HEALTH AND MENTAL DISORDERS IS ADDRESSED THROUGH ANOTHER ORGANIZATION (MID SHORE MENTAL HEALTH SYSTEMS, INC.)

LINE 20D - CALCULATES AN APPROVED % OF FINANCIAL ASSISTANCE BASED ON INCOME AND % OF FEDERAL POVERTY LEVEL INCOME. THE PATIENT IS BILLED THE CHARGES LESS THE % OF FINANCIAL ASSISTANCE DETERMINED.

LINE 22 - GROSS CHARGES FOR SERVICES ARE ALWAYS CHARGED AT THE SAME RATE WITHOUT DISCRIMINATION. GROSS CHARGES FOR SERVICES ARE ALWAYS BILLED, ANY ADJUSTMENT SUCH AS FINANCIAL ASSISTANCE IS APPLIED TO RESULT IN THE BALANCE DUE FOR PAYMENT.

DORCHESTER GENERAL HOSPITAL

SCHEDULE H, PART V, SECTION B

LINE 3 - COMMUNICATION WITH LOCAL HEALTH DEPARTMENTS, PUBLIC SCHOOL SYSTEMS, CHURCH LEADERS, COMMITTEES, ADVISORY BOARDS, AND COMMUNITY WORKGROUPS ACTIVE IN IDENTIFYING REGIONAL HEALTH CARE NEEDS.

LINE 7 - ENVIRONMENTAL HEALTH NEEDS REQUIRING EXPERTISE AND RESOURCES BEYOND THE CAPABILITIES OF THE SYSTEM. MENTAL HEALTH AND MENTAL DISORDERS IS ADDRESSED THROUGH ANOTHER ORGANIZATION (MID SHORE MENTAL HEALTH SYSTEMS, INC.)



**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.

LINE 20D - CALCULATES AN APPROVED % OF FINANCIAL ASSISTANCE BASED ON INCOME AND % OF FEDERAL POVERTY LEVEL INCOME. THE PATIENT IS BILLED THE CHARGES LESS THE % OF FINANCIAL ASSISTANCE DETERMINED.

LINE 22 - GROSS CHARGES FOR SERVICES ARE ALWAYS CHARGED AT THE SAME RATE WITHOUT DISCRIMINATION. GROSS CHARGES FOR SERVICES ARE ALWAYS BILLED, ANY ADJUSTMENT SUCH AS FINANCIAL ASSISTANCE IS APPLIED TO RESULT IN THE BALANCE DUE FOR PAYMENT.

**Part 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? 11

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

Schedule H (Form 990) 2013

**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)
<b>1</b> THE SHORE MEDICAL PAVILION 125 SHOREWAY DRIVE QUEENSTOWN MD 21658	DIAGNOSTIC & REHAB
<b>2</b>	
<b>3</b>	
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**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.

## CRITERIA FOR FREE OR DISCOUNTED CARE

SCHEDULE H, PART I, LINE 3C

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

## RELATED ORGANIZATION REPORT

SCHEDULE H, PART I, LINE 6A

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

**Part VI Supplemental Information**

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.

COST ATTRIBUTABLE TO A PHYSICAL CLINIC

SCHEDULE H, PART I, LINE 7G

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

COSTING METHODOLOGY

SCHEDULE H, PART I, LINE 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

**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.

ASSESSMENT.

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

(D)

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

MARYLAND'S UNIQUE ALL PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE

COMMUNITY BUILDING ACTIVITIES

SCHEDULE H, PART II

THROUGH A VARIETY OF COMMUNITY BUILDING ACTIVITIES, UM SHORE REGIONAL HEALTH PROMOTES HEALTH AND WELLNESS IN THE COMMUNITY IT SERVES. THESE

**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.

ACTIVITIES INCLUDE: ACTIVE ENGAGEMENT AND COLLABORATION WITH LOCAL HEALTH DEPARTMENTS, CHAMBERS OF COMMERCE, AND ORGANIZATIONS THAT WORK TO IMPROVE THE QUALITY OF LIFE FOR THE RESIDENTS OF THE MID-SHORE (TALBOT, CAROLINE, DORCHESTER, QUEEN ANNE'S, AND KENT COUNTIES) BECAUSE LOCAL ACTION IS ESSENTIAL TO PUBLIC HEALTH PROGRESS, UM SHORE REGIONAL HEALTH IS A KEY STAKEHOLDER IN THE MID-SHORE HEALTH IMPROVEMENT COALITION, A PARTNERSHIP OF PUBLIC SECTOR AGENCIES, HEALTH CARE PROVIDERS AND COMMUNITY-BASED PARTNERS. THE COALITION WAS FORMED IN DECEMBER 2011 IN RESPONSE TO A STATEWIDE HEALTH IMPROVEMENT PROCESS (SHIP). IN ADDITION TO PROVIDING THE COALITION WITH LEADERSHIP, A VARIETY OF CLINICAL AND NON-CLINICAL UM SRH ASSOCIATES SERVE ON VARIOUS COALITION WORKGROUPS.

THE WORK OF THE COALITION BEGAN BY REVIEWING AND PRIORITIZING OBJECTIVES IDENTIFIED BY THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE'S (DHMH) STATE HEALTH IMPROVEMENT PROCESS (SHIP). SHIP, LAUNCHED IN SEPTEMBER 2011, FOCUSES ON IMPROVING THE HEALTH OF MARYLAND RESIDENTS IN SIX VISION AREAS: HEALTHY BABIES, HEALTHY SOCIAL ENVIRONMENTS, SAFE PHYSICAL ENVIRONMENTS, INFECTIOUS DISEASE, CHRONIC DISEASE AND HEALTH

**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.

CARE ACCESS. UNDER SHIP'S UMBRELLA, THE COALITION DEVELOPS AND IMPLEMENTS STRATEGIES THAT WILL IMPROVE LOCAL PUBLIC HEALTH. THE COALITION DECIDED TO FOCUS ON THREE HEALTH PRIORITIES: (1) ADOLESCENT OBESITY, (2) ADOLESCENT TOBACCO USE, AND (3) DIABETES RELATED EMERGENCY DEPARTMENT VISITS.

THE COALITION FORMULATED AN ACTION PLAN THAT ARTICULATES SPECIFIC GOALS AND STRATEGIES FOR THE THREE HEALTH PRIORITIES. THROUGH COALITION WORKGROUPS AND COMMITTEES, REPRESENTATIVES FROM THE MID-SHORE COLLABORATE TO ASSESS LOCAL HEALTH NEEDS AND SERVICES; SHARE DATA AND OTHER RESOURCES; EXPLORE EVIDENCE-BASED HEALTH PRACTICES; AND ACQUIRE SUPPORT TO ENHANCE AND INITIATE HEALTH PROGRAMS THAT IMPACT TARGETED POPULATIONS AND COMMUNITIES. THE COALITION PLANS TO EFFECTIVELY LEVERAGE AND UTILIZE NEW AND EXISTING RESOURCES TO MEASURABLY IMPROVE THE HEALTH STATUS OF THE RESIDENTS OF THE MID-SHORE.

IN ADDITION TO BEING AN INTEGRAL PART OF THE MID-SHORE HEALTH IMPROVEMENT COALITION, UM SRH CONTINUES TO MAINTAIN OPEN COMMUNICATION WITH THE



**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.

HEALTH DEPARTMENTS OF TALBOT, CAROLINE, DORCHESTER, QUEEN ANNE'S, AND KENT COUNTIES, MID-SHORE MENTAL HEALTH SYSTEM, CHOPTANK COMMUNITY HEALTH SYSTEM, LOCAL GOVERNMENT AND SCHOOLS. UM SRH'S COMMUNITY OUTREACH PROGRAMS CAN BE FOUND IN COUNTY SCHOOLS, SENIOR CENTERS, COMMUNITY CENTERS AND CHURCHES THROUGHOUT THE MID-SHORE.

UM SRH'S DIRECTOR OF COMMUNITY OUTREACH PARTICIPATES IN COMMITTEES AND ADVISORY COUNCILS, PROMOTING CONTINUOUS DIALOGUE BETWEEN THE MEDICAL CENTER AND COMMUNITY STAKEHOLDERS. THIS PROVIDES OPPORTUNITIES FOR NEW IDEAS AND PROGRAMS TO BE EXCHANGED, ALLOWING UM SRH TO MAXIMIZE COMMUNITY OUTREACH EFFORTS.

UM SRH SEEKS INSIGHT FROM COMMUNITY MEMBERS ATTENDING EDUCATIONAL PROGRAMS THROUGH ITS OUTREACH EVENTS. PROGRAM PARTICIPANTS ARE ASKED TO COMPLETE A BRIEF SURVEY EVALUATION, PROVIDING FEEDBACK AND COMMENTS ABOUT THE PROGRAM THEY ATTENDED, AS WELL AS PROVIDING SUGGESTIONS FOR FUTURE PROGRAM TOPICS.

**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.

METHODOLOGY USED BY THE ORGANIZATION TO ESTIMATE BAD DEBT EXPENSE

SCHEDULE H, PART III, LINES 2 AND 3

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.

**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.

BAD DEBT EXPENSE FOOTNOTE ON AUDITED FINANCIAL STATEMENTS

SCHEDULE H, PART III, LINE 4

FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE CORPORATION ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR BAD DEBTS, ALLOWANCE FOR CONTRACTUAL ADJUSTMENTS, PROVISION FOR BAD DEBTS, AND CONTRACTUAL ADJUSTMENTS ON ACCOUNTS FOR WHICH THIRD-PARTY PAYOR HAS NOT YET PAID OR FOR PAYORS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF THE AMOUNTS DUE UNLIKELY. FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS OR BALANCES REMAINING AFTER THIRD-PARTY COVERAGE HAS ALREADY PAID, THE CORPORATION RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS HISTORICAL COLLECTIONS, WHICH INDICATES THAT MANY PATIENTS ULTIMATELY DO NOT PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE DISCOUNTED RATES AND THE AMOUNTS COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR BAD DEBTS. ALLOWANCE FOR BAD DEBTS.

**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.

MEDICARE COST REPORT

SCHEDULE H, PART III, LINE 8

ALLOWABLE COSTS ARE ESTIMATED RATIO OF COST TO CHARGE APPLIED TO GROSS CHARGES.

COLLECTION PRACTICES

SCHEDULE H, PART III, LINE 9B

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

**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.

SYSTEM WORKS WITH A BUSINESS PARTNER WHO WILL WORK WITH OUR PATIENTS TO ASSIST THEM WITH THE STATE ASSISTANCE PROGRAMS, WHICH IS FREE TO OUR PATIENTS. IF A PATIENT DOES NOT QUALIFY FOR MEDICAID OR ANOTHER PROGRAM, SHORE HEALTH SYSTEM OFFERS OUR FINANCIAL ASSISTANCE PROGRAM. SHORE HEALTH SYSTEM POSTS NOTICES OF OUR POLICY IN CONSPICUOUS PLACES THROUGHOUT THE HOSPITALS, HAS INFORMATION WITHIN OUR HOSPITAL BILLING BROCHURE, EDUCATES ALL NEW EMPLOYEES THOROUGHLY ON THE PROCESS DURING ORIENTATION, AND DOES A YEARLY RE-EDUCATION TO ALL EXISTING STAFF. ALL STAFF HAVE COPIES OF THE FINANCIAL ASSISTANCE APPLICATION, BOTH IN ENGLISH AND SPANISH, TO SUPPLY TO PATIENTS WHO WE DEEM, AFTER SCREENING, TO HAVE A NEED FOR ASSISTANCE. SHORE HEALTH SYSTEM HAS A DEDICATED FINANCIAL ASSISTANCE LIAISON TO WORK WITH OUR PATIENTS TO ASSIST THEM WITH THIS PROCESS AND EXPEDITE THE DECISION PROCESS.

COMMUNITY HEALTH CARE NEEDS ASSESSMENT

SCHEDULE H, PART VI, LINE 2

UM SHORE REGIONAL HEALTH (SHS) IN COLLABORATION WITH CHESTER RIVER HOSPITAL SYSTEM (CRHS) CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT

**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.

(CHNA) FOR THE FIVE COUNTIES OF MARYLAND'S MID-SHORE: TALBOT, CAROLINE, QUEEN ANNE'S, DORCHESTER, AND KENT. THE HEALTH NEEDS OF OUR COMMUNITY WERE IDENTIFIED THROUGH A PROCESS WHICH INCLUDED COLLECTING AND ANALYZING PRIMARY AND SECONDARY DATA. SHORE HEALTH SYSTEM, MEMORIAL HOSPITAL AT EASTON AND DORCHESTER GENERAL HOSPITAL STARTED THE PROCESS OF THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) ON 7/1/2012 AND COMPLETED THE PROCESS ON 5/22/2013. THE PLAN WAS PRESENTED AND APPROVED BY THE BOARD OF DIRECTORS ON MAY 22, 2013. IN PARTICULAR, THE CHNA INCLUDES PRIMARY DATA FROM TALBOT, CAROLINE, DORCHESTER, KENT, QUEEN ANNE'S HEALTH DEPARTMENTS AND THE COMMUNITY AT LARGE. ADDITIONALLY, SHORE HEALTH, IS A PARTICIPATING MEMBER OF THE MID-SHORE SHIP COALITION, WHERE WE ARE PARTNERING WITH OTHER COMMUNITY STAKEHOLDERS INVESTED IN IMPROVING THE COMMUNITY'S OVERALL HEALTH. MEMBERS OF THE MID-SHORE SHIP COALITION INCLUDE COMMUNITY LEADERS, COUNTY GOVERNMENT REPRESENTATIVES, LOCAL NON-PROFIT ORGANIZATIONS, LOCAL HEALTH PROVIDERS, AND MEMBERS OF THE BUSINESS COMMUNITY. FEEDBACK FROM CUSTOMERS INCLUDES DATA COLLECTED FROM SURVEYS, ADVISORY GROUPS AND FROM OUR COMMUNITY OUTREACH AND EDUCATION SESSIONS. SECONDARY DATA RESOURCES REFERENCED TO IDENTIFY COMMUNITY

**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.

HEALTH NEEDS INCLUDE COUNTY HEALTH RANKINGS

([HTTP://WWW.COUNTYHEALTHRANKINGS.ORG](http://www.countyhealthrankings.org)), MARYLAND DEPARTMENT OF HEALTH AND

MENTAL HYGIENE'S STATE HEALTH IMPROVEMENT PROCESS

(SHIP) ([HTTP://DHMH.MARYLAND.GOV/SHIP/](http://dhmh.maryland.gov/ship/)), THE MARYLAND CHARTBOOK OF

MINORITY HEALTH AND MINORITY HEALTH DISPARITIES

([HTTP://DHMH.MARYLAND.GOV/MHHD/DOCUMENTS/2NDRESOURCE\\_2009.PDF](http://dhmh.maryland.gov/mhhd/documents/2ndresource_2009.pdf)).

SHORE REGIONAL HEALTH PARTICIPATES ON THE UNIVERSITY OF MARYLAND MEDICAL

SYSTEM (UMMS) COMMUNITY BENEFITS WORKGROUP TO STUDY DEMOGRAPHICS, ASSESS

COMMUNITY HEALTH DISPARITIES, INVENTORY RESOURCES AND ESTABLISH COMMUNITY

BENEFIT GOALS FOR BOTH UM SHORE REGIONAL HEALTH AND UMMS.

UM SHORE REGIONAL HEALTH CONSULTED WITH COMMUNITY PARTNERS AND

ORGANIZATIONS TO DISCUSS COMMUNITY NEEDS RELATED TO HEALTH IMPROVEMENT

AND ACCESS TO CARE. THE FOLLOWING LIST OF PARTNER AGENCIES MEETS ON A

MONTHLY BASIS AS MEMBERS OF THE MID-SHORE SHIP COALITION:

- CHOPTANK COMMUNITY HEALTH SYSTEMS
- CAROLINE COUNTY MINORITY OUTREACH TECHNICAL ASSISTANCE
- TALBOT COUNTY LOCAL MANAGEMENT BOARD

**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.

- PARTNERSHIP FOR DRUG FREE DORCHESTER
- CAROLINE COUNTY COMMUNITY REPRESENTATIVE
- EASTERN SHORE AREA HEALTH EDUCATION CENTER
- KENT COUNTY MINORITY OUTREACH TECHNICAL ASSISTANCE
- YMCA OF THE CHESAPEAKE
- UNIVERSITY OF MD EXTENSION
- KENT COUNTY LOCAL MANAGEMENT BOARD
- KENT COUNTY DEPARTMENT OF JUVENILE SERVICES
- COALITION AGAINST TOBACCO USE
- MT. OLIVE AME CHURCH
- MID SHORE CORE SERVICE AGENCY
- ASSOCIATED BLACK CHARITIES
- QUEEN ANNE COUNTY HOUSING AND FAMILY SERVICES
- QUEEN ANNE COUNTY HEALTH DEPARTMENT
- DORCHESTER COUNTY HEALTH DEPARTMENT
- TALBOT COUNTY HEALTH DEPARTMENT
- CAROLINE COUNTY HEALTH DEPARTMENT
- EASTON MEMORIAL HOSPITAL



**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.

- CHESTER RIVER HOSPITAL

- MID-SHORE MENTAL HEALTH SYSTEMS

SHORE HEALTH AND CHESTER RIVER HEALTH HOSTED A SERIES OF COMMUNITY LISTENING FORUMS TO GATHER COMMUNITY INPUT FOR A REGIONALIZATION STUDY THAT EXPLORES THE BENEFITS OF A REGIONAL APPROACH TO PROVIDING HEALTH CARE FOR CAROLINE, DORCHESTER, KENT, QUEEN ANNE'S AND TALBOT COUNTIES. IN ADDITION, SHORE HEALTH MEETS QUARTERLY WITH MEMBERS OF THE LOCAL HEALTH DEPARTMENTS AND COMMUNITY LEADERS, INCLUDING:

- CHOPTANK COMMUNITY HEALTH SYSTEM: JOSEPH SHEEHAN
- HEALTH DEPARTMENTS: HEALTH OFFICERS
- MID SHORE MENTAL HEALTH SYSTEMS: HOLLY IRELAND
- EASTERN SHORE HOSPITAL CENTER: RANDY BRADFORD

IN ADDITION, THE FOLLOWING AGENCIES/ORGANIZATIONS ARE REFERENCED IN GATHERING INFORMATION AND DATA:

- MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
- MARYLAND DEPARTMENT OF PLANNING
- MARYLAND VITAL STATISTICS ADMINISTRATION
- HEALTHSTREAM, INC.

**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.

- COUNTY HEALTH RANKINGS

- MID SHORE COMPREHENSIVE ECONOMIC DEVELOPMENT STRATEGY CEDS

OUR CHNA IDENTIFIED THE FOLLOWING LIST OF PRIORITIES FOR OUR COMMUNITY:

- DIABETES

- HEART DISEASE

- CANCER

- BEHAVIORAL HEALTH

- ACCESS TO CARE

SEVERAL ADDITIONAL TOPIC AREAS WERE IDENTIFIED BY THE CHNA STEERING

COMMITTEE INCLUDING: SAFE HOUSING, TRANSPORTATION, AND SUBSTANCE ABUSE.

THE UNMET NEEDS NOT ADDRESSED BY SHS AND CRHS WILL CONTINUE TO BE

ADDRESSED BY KEY GOVERNMENTAL AGENCIES AND EXISTING COMMUNITY- BASED

ORGANIZATIONS. WHILE SHS AND CRHS WILL FOCUS THE MAJORITY OF OUR EFFORTS

ON THE IDENTIFIED PRIORITIES OUTLINED IN THE CHNA ACTION PLAN, WE WILL

REVIEW THE COMPLETE SET OF NEEDS IDENTIFIED IN THE CHNA FOR FUTURE

COLLABORATION AND WORK. THESE AREAS, WHILE STILL IMPORTANT TO THE HEALTH

OF THE COMMUNITY, WILL BE MET THROUGH OTHER HEALTH CARE ORGANIZATIONS

**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.

WITH OUR ASSISTANCE AS AVAILABLE.

SHORE HEALTH SYSTEM, MEMORIAL HOSPITAL AT EASTON AND DORCHESTER GENERAL HOSPITAL, PUBLICIZED THE CHNA VIA:

A. A WEBSITE

[HTTP://WWW.SHOREHEALTH.ORG/PDFS/2013-COMMUNITY-HEALTH-ACTION-PLAN.PDF](http://www.shorehealth.org/pdfs/2013-community-health-action-plan.pdf)

B. MADE AVAILABLE ON REQUEST AT THE HOSPITAL FACILITY

SHORE HEALTH SYSTEM, MEMORIAL HOSPITAL AT EASTON AND DORCHESTER GENERAL HOSPITAL, CONDUCTED ITS CHNA WITH THE FOLLOWING OTHER FACILITIES:

SHORE HEALTH SYSTEM (SHS) IN COLLABORATION WITH CHESTER RIVER HOSPITAL SYSTEM (CRHS) CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FOR THE FIVE COUNTIES OF MARYLAND'S MID-SHORE: TALBOT, CAROLINE, QUEEN ANNE'S, DORCHESTER, AND KENT.

ELIGIBILITY EDUCATION

SCHEDULE H, PART VI, LINE 3

IT IS THE POLICY OF UM SHORE REGIONAL HEALTH TO WORK WITH OUR PATIENTS TO IDENTIFY AVAILABLE RESOURCES TO PAY FOR THEIR CARE. ALL PATIENTS PRESENTING AS SELF PAY AND REQUESTING CHARITY RELIEF FROM THEIR BILL WILL

**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.

BE SCREENED AT ALL POINTS OF ENTRY, FOR POSSIBLE COVERAGE THROUGH STATE PROGRAMS AND A PROBABLE DETERMINATION FOR COVERAGE FOR EITHER MEDICAL ASSISTANCE OR FINANCIAL ASSISTANCE (CHARITY CARE) FROM THE HOSPITAL IS IMMEDIATELY GIVEN TO THE PATIENT. THE PROCESS IS RESOURCE INTENSIVE AND TIME CONSUMING FOR PATIENTS AND THE HOSPITAL; HOWEVER, IF PATIENTS QUALIFY FOR ONE OF THESE PROGRAMS, THEN THEY WILL HAVE HEALTH BENEFITS THAT THEY WILL CARRY WITH THEM BEYOND THEIR CURRENT HOSPITAL BILLS, AND ALLOW THEM TO ACCESS PREVENTIVE CARE SERVICES AS WELL.

UM SHORE REGIONAL HEALTH WORKS WITH A BUSINESS PARTNER WHO WILL WORK WITH OUR PATIENTS TO ASSIST THEM WITH THE STATE ASSISTANCE PROGRAMS, WHICH IS FREE TO OUR PATIENTS.

IF A PATIENT DOES NOT QUALIFY FOR MEDICAID OR ANOTHER PROGRAM, UM SHORE REGIONAL HEALTH OFFERS OUR FINANCIAL ASSISTANCE PROGRAM. UM SHORE REGIONAL HEALTH POSTS NOTICES OF OUR POLICY IN CONSPICUOUS PLACES THROUGHOUT THE HOSPITALS- INCLUDING THE EMERGENCY DEPARTMENT, HAS INFORMATION WITHIN OUR HOSPITAL BILLING BROCHURE, EDUCATES ALL NEW

**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.

EMPLOYEES THOROUGHLY ON THE PROCESS DURING ORIENTATION, AND DOES A YEARLY RE- EDUCATION TO ALL EXISTING STAFF. ALL STAFF HAVE COPIES OF THE FINANCIAL ASSISTANCE APPLICATION, BOTH IN ENGLISH AND SPANISH, TO SUPPLY TO PATIENTS WHO WE DEEM, AFTER SCREENING, TO HAVE A NEED FOR ASSISTANCE. UM SHORE REGIONAL HEALTH HAS A DEDICATED FINANCIAL ASSISTANCE LIAISON TO WORK WITH OUR PATIENTS TO ASSIST THEM WITH THIS PROCESS AND EXPEDITE THE DECISION PROCESS.

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

- SHORE HEALTH PREPARES ITS FAP IN A CULTURALLY SENSITIVE MANNER, AT A READING COMPREHENSION LEVEL APPROPRIATE TO THE CBSA'S POPULATION, AND IN SPANISH.

**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.

- SHORE HEALTH POSTS ITS FAP AND FINANCIAL ASSISTANCE CONTACT INFORMATION IN ADMISSIONS AREAS, EMERGENCY ROOMS, AND OTHER AREAS OF FACILITIES IN WHICH ELIGIBLE PATIENTS ARE LIKELY TO PRESENT;

- SHORE HEALTH PROVIDES A COPY OF THE FAP AND FINANCIAL ASSISTANCE CONTACT INFORMATION TO PATIENTS OR THEIR FAMILIES AS PART OF THE INTAKE PROCESS;

- SHORE HEALTH PROVIDES A COPY OF THE FAP AND FINANCIAL ASSISTANCE CONTACT INFORMATION TO PATIENTS WITH DISCHARGE MATERIALS.

- A COPY OF SHORE HEALTH'S FAP ALONG WITH FINANCIAL ASSISTANCE CONTACT INFORMATION, IS PROVIDED IN PATIENT BILLS; AND/OR

- SHORE HEALTH DISCUSSES WITH PATIENTS OR THEIR FAMILIES THE AVAILABILITY OF VARIOUS GOVERNMENT BENEFITS, SUCH AS MEDICAID OR STATE PROGRAMS, AND ASSISTS PATIENTS WITH QUALIFICATION FOR SUCH PROGRAMS, WHERE APPLICABLE.

- AN ABBREVIATED STATEMENT REFERENCING SHORE HEALTH'S FINANCIAL ASSISTANCE POLICY, INCLUDING A PHONE NUMBER TO CALL FOR MORE INFORMATION, IS RUN ANNUALLY IN THE LOCAL NEWSPAPER (STAR DEMOCRAT).

**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.

## DESCRIPTION OF COMMUNITY SERVED

SCHEDULE H, PART VI, LINE 4

UM SHORE REGIONAL HEALTH'S SERVICE AREA IS DEFINED AS THE MARYLAND COUNTIES OF CAROLINE, DORCHESTER, TALBOT (PRIMARY SERVICE AREA); QUEEN ANNE'S AND KENT (SECONDARY SERVICE AREA). THE FIVE COUNTIES OF THE MID-SHORE COMPRISE 20% OF THE LANDMASS OF THE STATE OF MARYLAND AND 2% OF THE POPULATION. THE POPULATION OF THE FIVE COUNTIES IS JUST OVER 170,000. THE ENTIRE REGION HAS OVER 4,400 EMPLOYERS WITH NEARLY 45,000 WORKERS. ONLY 50 OF THOSE EMPLOYERS EMPLOY 100 OR MORE WORKERS. ALMOST 85% OF EMPLOYERS IN THIS RURAL REGION ARE MANUFACTURING FIRMS, WHICH REQUIRE WORKERS WITH HIGH-LEVEL TECHNOLOGY SKILLS AS WELL AS LOW-SKILLED WORKERS. ( - 9.62% ADULTS HAVE LESS THAN A 9TH GRADE EDUCATION AND ANOTHER 9.62% HAVE AN EDUCATION AT THE 9TH -12TH GRADE LEVEL BUT DO NOT HAVE A HIGH SCHOOL DIPLOMA). THE SERVICE INDUSTRY IS GROWING RAPIDLY AS THE LOCAL POPULATION SHIFTS TO INCLUDE MORE SENIOR ADULTS WHO RETIRE TO THIS BEAUTIFUL AREA OF THE STATE. ALTHOUGH THE SEAFOOD INDUSTRY CONTINUES TO BE IMPORTANT TO THE REGION IT IS FAST BECOMING AN ENDANGERED SPECIES.

**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.

THE MID-SHORE HAS A HIGHER PERCENTAGE OF POPULATION AGED 65 AND OLDER AS COMPARED TO MARYLAND OVERALL. TALBOT COUNTY HAS A 23.7 % RATE FOR THIS AGE GROUP. THIS CONCENTRATION IS DUE MAINLY TO INFLUX OF RETIREES. THE MID SHORE REGION HAS 26,203 MINORITY PERSONS, REPRESENTING 25.3% OF THE TOTAL POPULATION.

WHILE STEADY PROGRESS IS BEING MADE, THE MID-SHORE ECONOMY STILL FACES A MYRIAD OF CHALLENGES THAT INCLUDE LIMITED ACCESS TO AFFORDABLE HIGH SPEED BROADBAND SERVICES, A SHORTAGE OF AFFORDABLE HOUSING, AN INADEQUATE SUPPLY OF SKILLED WORKERS, LOW PER CAPITA INCOME, AND MORE LAYOFFS IN THE MANUFACTURING SECTOR. (SOURCE: MID SHORE COMPREHENSIVE ECONOMIC DEVELOPMENT STRATEGY CEDS)

IN TERMS OF HEALTHCARE, LARGE DISPARITIES EXIST BETWEEN BLACKS AND WHITES AS REPORTED BY THE OFFICE OF MINORITY HEALTH AND HEALTH DISPARITIES, DHMH. FOR EMERGENCY DEPARTMENT (ED) VISIT RATES FOR DIABETES, ASTHMA AND HYPERTENSION, THE BLACK RATES ARE TYPICALLY 3- TO 5 FOLD HIGHER THAN WHITE RATES. ADULTS AT HEALTHY WEIGHT METRIC IS LOWER (WORSE) FOR BLACKS



**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.

IN ALL THREE COUNTIES WHERE BLACK DATA COULD BE REPORTED. HEART DISEASE MORTALITY BLACK RATES ARE VARIOUSLY HIGHER OR LOWER COMPARED TO WHITE RATES IN INDIVIDUAL COUNTIES. IN CAROLINE, THE BLACK RATE IS LOWER THAN THE WHITE RATES NOT BECAUSE THE BLACK RATE IS PARTICULARLY LOW, BUT BECAUSE THE WHITE RATE IS UNUSUALLY HIGH. FOR CANCER MORTALITY, BLACK RATES EXCEED WHITE RATES IN DORCHESTER, KENT, QUEEN ANNE'S AND TALBOT. IN CAROLINE, BLACK RATES ARE LOWER, AGAIN BECAUSE OF A RATHER HIGH WHITE RATE. THE BLACK RATES AND WHITE RATES ARE BELOW THE STATE HEALTH IMPROVEMENT PROCESS (SHIP) GOALS. (SOURCE: [HTTP://WWW.DHMM.MARYLAND.GOV/SHIP](http://www.dhmm.maryland.gov/ship)).

COUNTY HEALTH RANKINGS FOR THE MID-SHORE COUNTIES ALSO REVEAL THE LARGE DISPARITIES BETWEEN COUNTIES FOR HEALTH OUTCOMES IN THE SERVICE AREA. OVERALL, QUEEN ANNE'S COUNTY RANKS 4TH; TALBOT COUNTY RANKS 6TH; DORCHESTER RANKS 21ST; CAROLINE RANKS 23RD (OUT OF 24 COUNTIES INCLUDING BALTIMORE CITY) IN HEALTH OUTCOMES THAT INDICATE THE OVERALL HEALTH OF THE COUNTY (SOURCE: [HTTP://WWW.COUNTYHEALTHRANKINGS.ORG/MARYLAND/ANNE-ARUNDEL/2013](http://www.countyhealthrankings.org/Maryland/Anne-Arundel/2013)).

**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.

MEMORIAL HOSPITAL AT EATON'S PRIMARY SERVICE AREA: 21601,21613,  
21629,21632,21655,21639,21643

DORCHESTER GENERAL HOSPITAL'S PRIMARY SERVICE AREA : 21613,21643,21631

COMMUNITY BENEFIT SERVICE AREA (CBSA) TARGET POPULATION: 170,000

TALBOT COUNTY

MALE: 47.7%, FEMALE: 52.3%

WHITE, NOT HISPANIC (NH): 81.4%

BLACK, NH: 12.8%

HISPANIC: 5.5%

ASIAN, NH: 1.2%

AMERICAN INDIAN, NH: 0.2%

MEDIAN AGE: 43.3

MEDIAN HOUSEHOLD INCOME: \$62,739

**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.

## DORCHESTER COUNTY

MALE: 47.7%, FEMALE: 52.3%

WHITE, NOT HISPANIC (NH): 67.6%

BLACK, NH: 27.7%

HISPANIC: 3.5%

ASIAN, NH: 0.9%

AMERICAN INDIAN, NH: 0.3%

MEDIAN AGE: 40.7

MEDIAN HOUSEHOLD INCOME: \$46,710

## CAROLINE COUNTY

MALE: 48.8%, FEMALE: 51.2%

WHITE, NOT HISPANIC (NH): 79.8%

BLACK, NH: 13.9%

HISPANIC: 5.5%

ASIAN, NH: 0.6

AMERICAN INDIAN, NH: 0.4

MEDIAN AGE: 37

**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.

MEDIAN HOUSEHOLD INCOME: \$59,689

QUEEN ANNE'S COUNTY

MALE: 49.7%, FEMALE: 50.3%

WHITE, NOT HISPANIC (NH): 88.7%

BLACK, NH: 6.9%

HISPANIC: 3.0%

ASIAN, NH: 1.0%

AMERICAN INDIAN, NH: 0.3

MEDIAN AGE: 38.8

MEDIAN HOUSEHOLD INCOME: \$83,958

(SOURCE: [HTTP://DHMH.MARYLAND.GOV/SHIP](http://DHMH.MARYLAND.GOV/SHIP))

PERCENTAGE OF HOUSEHOLDS WITH INCOMES BELOW THE FEDERAL POVERTY

GUIDELINES WITHIN THE CBSA:

TALBOT 7.7%, DORCHESTER 15.0%, CAROLINE 11.8%, QUEEN ANNE'S 6.3%

(SOURCE: [HTTP://QUICKFACTS.CENSUS.GOV/QFD/STATES/24/24041.HTML](http://QUICKFACTS.CENSUS.GOV/QFD/STATES/24/24041.HTML))

**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.

PERCENTAGE OF UNINSURED PEOPLE BY COUNTY WITHIN THE CBSA:

TALBOT 10.5%, DORCHESTER 11.87%, CAROLINE 14.58%, QUEEN ANNE'S 10.3%

(SOURCE: [HTTP://WWW.SEEDCO.ORG](http://www.seedco.org))

PERCENTAGE OF MEDICAID RECIPIENTS BY COUNTY WITHIN THE CBSA:

TALBOT 12.63%, DORCHESTER 23.30%, CAROLINE 22.17%, QUEEN ANNE'S 12.08%

LIFE EXPECTANCY BY COUNTY WITHIN THE CBSA:

TALBOT COUNTY: ALL RACES 80.5, WHITE 81.2, BLACK 77.1

DORCHESTER COUNTY: ALL RACES 77.6, WHITE 79.1, BLACK 73.7

CAROLINE COUNTY: ALL RACES 76.5, WHITE 76.8, BLACK 74.7

QUEEN ANNE'S COUNTY: ALL RACES 79.7, WHITE 80.0, BLACK 75.2

(SOURCE: [HTTP://DHMH.MARYLAND.GOV](http://dhmh.maryland.gov))

MORTALITY RATES BY COUNTY WITHIN THE CBSA (AGE -ADJUSTED RATES PER  
100,000 POPULATION):

TALBOT COUNTY: ALL RACES 1086.1, WHITE 1118.0, BLACK 1015.8

DORCHESTER COUNTY: ALL RACES 1106.0, WHITE 1163.3, BLACK 1008.4

**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.

CAROLINE COUNTY: ALL RACES 942.9, WHITE. 955.3, BLACK 980.6

QUEEN ANNE'S COUNTY: ALL RACES 800.6, WHITE 800.3, BLACK 1077.9

(SOURCE: MARYLAND VITAL STATISTICS ANNUAL REPORT 2011, VITAL STATISTICS ADMINISTRATION, MARYLAND DHMH)

PROPORTION OF COUNTY RESTAURANTS THAT ARE FAST FOOD RESTAURANTS:

TALBOT COUNTY: 37%

DORCHESTER COUNTY: 60%

CAROLINE COUNTY: 58%

QUEEN ANNE'S COUNTY: 45%

LIMITED ACCESS TO HEALTHY FOOD (PERCENTAGES OF THE POPULATION WHO ARE LOW INCOME AND DO NOT LIVE CLOSE TO A GROCERY STORE):

TALBOT COUNTY: 2%

DORCHESTER COUNTY: 3%

CAROLINE COUNTY: 2%

QUEEN ANNE'S COUNTY: 3%

(SOURCE: URL: [HTTP://WWW.COUNTYHEALTHRANKINGS.ORG/MARYLAND/2013](http://www.countyhealthrankings.org/Maryland/2013))

**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.

QUALITY OF HOUSING:

TOTAL HOUSING UNITS:

TALBOT COUNTY: 19,645

DORCHESTER COUNTY: 16,574

CAROLINE COUNTY: 13,469

QUEEN ANNE'S COUNTY: 20,303

HOME OWNERSHIP RATE:

TALBOT COUNTY: 72.6%

DORCHESTER COUNTY: 69.8%

CAROLINE COUNTY: 74.2%

QUEEN ANNE'S COUNTY: 86.0%

CAROLINE COUNTY. THERE IS A LACK OF SECTION 8 RENTAL ASSISTANCE HOUSING IN CAROLINE COUNTY. AT THE PRESENT TIME, ONLY ABOUT ONE- THIRD OF THE DEMAND HAS BEEN FILLED.

**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.

DORCHESTER COUNTY. HOUSING IN DORCHESTER COUNTY, EVEN THOUGH RELATIVELY LOW-PRICED, IS NOT NECESSARILY MORE AFFORDABLE DUE TO THE RELATIVELY LOW INCOME OF COUNTY RESIDENTS. COMPARED TO THE SURROUNDING COUNTIES, THE HOUSING STOCK IS OLDER, FEWER HOMES ARE OWNER- OCCUPIED, MORE HOUSEHOLDS ARE LOW TO MODERATE INCOME, AND MORE HOUSING LACKS COMPLETE PLUMBING. THE LACK OF MOVE-UP HOUSING IN THE COUNTY IS SEEN AS A DETERRENT TO ATTRACTING BUSINESS. DORCHESTER COUNTY HAS A RELATIVELY WEAK HOUSING MARKET LINKED TO THE WEAK ECONOMY. IN ADDITION, THE DISPROPORTIONATE AMOUNT OF THE COUNTY'S ELDERLY POPULATION DICTATES THE NEED FOR MORE MODEST PRICED HOMES FOR THE PERSONS IN THIS AGE CATEGORY.

COUNTY-WIDE, JUST OVER 31.5 PERCENT OF HOUSING WAS RENTER OCCUPIED IN 2010 WITH A RENTER RATE FOR INCORPORATED TOWNS NEARING 50 PERCENT. IN 2010, 18.3 PERCENT OF THE COUNTY'S HOUSING UNITS WERE VACANT. THIS IS A MUCH HIGHER PERCENTAGE THAN FOR ADJOINING COUNTIES. PROBLEMS ASSOCIATED WITH DORCHESTER COUNTY HOUSING INCLUDE THE FOLLOWING:

- HIGH HOUSING COSTS COMPARED TO INCOME



**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.

- SIGNIFICANT NUMBER OF HOMES IN POOR PHYSICAL CONDITION

- OWNER OCCUPANCY LEVEL FOR HOUSING UNITS IN CAMBRIDGE AT LESS THAN 50 PERCENT

- MARKET DEMAND FOR RURAL SUBDIVISIONS COUPLED WITH DISINCENTIVES FOR HOUSING DEVELOPMENTS IN TOWNS ARE RESULTING IN INCREASING HOUSING DEVELOPMENT IN THE UNINCORPORATED AREA OF THE COUNTY.

TALBOT COUNTY. THE HOUSING ISSUES IN TALBOT COUNTY ARE COMPLEX PRIMARILY BECAUSE OF THE EXTREME DISPARITY OF INCOME LEVELS IN THE COUNTY. LIMITED ENTREPRENEURIAL AND JOB OPPORTUNITIES KEEP THE MODERATE INCOME WAGE EARNERS FROM HOME OWNERSHIP. HABITAT FOR HUMANITY AND NEW EASTON TOWN COUNCIL INITIATIVES NOW REQUIRE DEVELOPERS TO ADDRESS LOW TO MODERATE INCOME, AFFORDABLE HOME OWNERSHIP OPPORTUNITIES AS PART OF ANY NEW HOUSING DEVELOPMENT STRATEGY. THE NET EFFECT WILL NOT BE KNOWN FOR SEVERAL YEARS. THERE IS NO SHORTAGE OF HIGH END HOUSING OPTIONS. MIDDLE INCOME AFFORDABLE HOUSING REMAINS A COUNTY WIDE ISSUE.

TALBOT COUNTY HAD THE FOURTH SMALLEST NUMBER OF PERSONS PER HOUSEHOLD 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.
- 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.

THE STATE IN 2000 (2.32) HOWEVER 40% OF PUBLIC HOUSING REMAINS  
INEXPLICABLY VACANT. RENTAL PROPERTY IS EXORBITANT AND OFTEN REQUIRES  
UNRELATED FAMILIES TO SHARE SPACE. APARTMENTS REPRESENT 85% OF THE RENTAL  
PROPERTY. FAILURE OF CODE ENFORCEMENT ALLOWS RENTALS TO REMAIN IN A STATE  
OF DISREPAIR. MUCH OF THE SUBSTANDARD HOUSING IS IN SMALL RURAL POCKETS.

THE TALBOT COUNTY HOUSING ROUNDTABLE, A COALITION OF ORGANIZATIONS AND  
INDIVIDUALS FORMED TO ASSESS AND RECOMMEND AFFORDABLE HOUSING POLICY FOR  
TALBOT COUNTY, AND THE LOCAL AND COUNTY COUNCILS ARE EXPLORING AVENUES TO  
SIGNIFICANTLY ADDRESS QUALITY OF LIFE ISSUES THROUGH BETTER HOUSING  
OPTIONS. ON THE DRAWING BOARD ARE ZONING AND DESIGN STANDARDS THAT  
INCREASE THE MIX OF USES AND HOUSING TYPES; MANDATED MODERATELY PRICED  
DWELLINGS AS PART OF ALL NEW DEVELOPMENTS; EMPLOYER- ASSISTED HOUSING,  
CREATION OF HOUSING TRUST FUNDS SOLELY TO BUILD AFFORDABLE HOMES IN LOW,  
MODERATE AND MIDDLE INCOME BRACKETS AND CREATING NONPROFIT, SEMI-PUBLIC  
DEVELOPERS AND OTHER FINANCIERS OF AFFORDABLE HOUSING.

(SOURCE: MIDSHORE COMPREHENSIVE ECONOMIC DEVELOPMENT STRATEGY CEDS

SOURCE: [HTTP://WWW.MIDSHORE.ORG/REPORTS](http://www.midshore.org/reports))

**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.

ACCESS TO TRANSPORTATION WITHIN THE CBSA:

TRANSIT SERVICES IN THE THREE COUNTY AREAS ARE PROVIDED UNDER CONTRACT BY DELMARVA COMMUNITY TRANSIT. SERVICES INCLUDE MEDICAL AND SENIOR CITIZEN DEMAND SERVICES AND FIXED ROUTE COUNTY AND REGIONAL SERVICE. WHILE MOST OF THE REGION IS SERVED BY THE FIXED ROUTES, THERE ARE GAPS IN COVERAGE IN THE LESS POPULATED AREAS OF THE COUNTIES. THE REGIONAL SYSTEM, MARYLAND UPPER SHORE TRANSIT (MUST), PROVIDES LOW COST AND SEAMLESS SERVICE FOR THE GENERAL PUBLIC FROM KENT ISLAND TO OCEAN CITY WITH CONVENIENT FREE TRANSFER POINTS AT KEY LOCATIONS ON THE SHORE. MUST IS A COORDINATED EFFORT OF SEVERAL UPPER SHORE AGENCIES AND GOVERNMENTS TO PROVIDE A REGIONAL TRANSIT SYSTEM FOR KENT, QUEEN ANNE'S, TALBOT, CAROLINE, AND DORCHESTER COUNTIES. TRANSIT SERVICES ARE PROVIDED BY QUEEN ANNE'S COUNTY RIDE (OPERATED BY THE COUNTY) AND DELMARVA COMMUNITY TRANSIT (DCT), A PRIVATE COMPANY UNDER CONTRACT TO THE COUNTIES. THE SYSTEM ALSO INCLUDES SHORE TRANSIT, WHICH PROVIDES SCHEDULED ROUTES ON THE LOWER SHORE. THE MTA AND THE MARYLAND DEPARTMENT

**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.

OF HUMAN RESOURCES HAVE PROVIDED FUNDING. OVERALL MANAGEMENT OF THE REGIONAL SYSTEM IS THE RESPONSIBILITY OF THE TRANSPORTATION ADVISORY GROUP (TAG). THE COUNTY COMMISSIONERS OF THE FIVE UPPER SHORE COUNTIES APPOINT THE MEMBERS OF THE TAG.

(SOURCE: MID SHORE COMPREHENSIVE ECONOMIC DEVELOPMENT STRATEGY CEDS(REVISED MARCH 2012) [HTTP://WWW.MIDSHORE.ORG/REPORTS](http://www.midshore.org/reports))

ANNUAL AVERAGE CBSA UNEMPLOYMENT RATE:

TALBOT 6.4%, DORCHESTER 9.4%, CAROLINE 7.7%, QUEEN ANNE'S 6.1%

(SOURCE: MARYLAND DEPARTMENT OF LABOR, LICENSING & REGULATION, JULY 2013.)

ACCESS TO QUALITY HEALTH CARE:

HOSPITALS: UM SHORE REGIONAL HEALTH

PENINSULA REGIONAL MEDICAL CENTER

ANNE ARUNDEL MEDICAL CENTER

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC): CHOPTANK COMMUNITY HEALTH

(SOURCE: [HTTP://WWW.DHMM.STATE.MD/US/GETTHEHEALTHCARE/FQHC.PDF](http://www.dhmm.state.md/us/getthehealthcare/fqhc.pdf))

**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.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC): CHOPTANK COMMUNITY HEALTH

(SOURCE: [HTTP://WWW.DHMH.STATE.MD/US/GETTHEHEALTHCARE/FQHC.PDF](http://www.dhmm.state.md/us/getthehealthcare/fqhc.pdf))

PROMOTING THE HEALTH OF THE COMMUNITY

SCHEDULE H, PART VI, LINE 5

THE ANALYSIS OF LOCAL DATA INDICATED THAT DIABETES, HEART DISEASE, CANCER, BEHAVIORAL HEALTH AND ACCESS TO CARE WERE ALL HEALTH IMPROVEMENT PRIORITIES FOR THE MID-SHORE. AFTER CAREFUL REVIEW OF COUNTY HEALTH DATA, THE MID-SHORE SHIP COALITION PRIORITIZED THE POTENTIAL HEALTH IMPROVEMENT AREAS AND DECIDED TO FOCUS THE COALITION'S EFFORTS ON THREE AREAS: (1) ADOLESCENT OBESITY, (2) ADOLESCENT TOBACCO USE, AND (3) DIABETES RELATED EMERGENCY DEPARTMENT VISITS. THE COALITION IS COMMITTED TO EXAMINING WHAT EVIDENCE-BASED INITIATIVES CAN IMPROVE THE COUNTY'S HEALTH IN THESE THREE AREAS RELATED TO RACIAL, ETHNIC AND OTHER DEMOGRAPHIC AND GEOGRAPHIC-RELATED HEALTH DISPARITIES.

MARYLAND'S STATE HEALTH IMPROVEMENT PROCESS (SHIP) PROVIDES A FRAMEWORK FOR CONTINUAL PROGRESS TOWARD A HEALTHIER MARYLAND. MARYLAND'S STATE

**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.

HEATH IMPROVEMENT PROCESS (SHIP) BEGAN WITH NATIONAL, STATE AND LOCAL DATA BEING REVIEWED AND ANALYZED BY THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DHMH) OFFICE OF POPULATION HEALTH AS WELL AS BY THE 5 DEPARTMENTS OF HEALTH (TALBOT, CAROLINE, DORCHESTER, QUEEN ANNE'S, KENT). IT HAS THREE MAIN COMPONENTS: ACCOUNTABILITY, LOCAL ACTION AND PUBLIC ENGAGEMENT.

SHIP INCLUDES 39 MEASURES THAT PROVIDE A FRAMEWORK TO IMPROVE THE HEALTH OF MARYLAND RESIDENTS. TWENTY-EIGHT OF THE MEASURES HAVE BEEN IDENTIFIED AS CRITICAL RACIAL/ETHNIC HEALTH DISPARITIES. EACH MEASURE HAS A DATA SOURCE AND A TARGET, AND WHERE POSSIBLE, CAN BE ASSESSED AT THE COUNTY LEVEL.

UM SRH'S PRIORITIES ARE ALIGNED WITH THE MARYLAND STATE HEALTH IMPROVEMENT PROCESS VISION AREAS AND THOSE OBJECTIVES OUTLINED BY THE LOCAL HEALTH IMPROVEMENT COALITION.

UM SRH'S PRIORITIES:

1. CHRONIC DISEASES (OBESITY, HEART DISEASE, DIABETES AND CANCER)

**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.

2. WELLNESS AND ACCESS

3. REDUCING ED VISITS DUE TO CHRONIC DISEASE

4. ACCESS TO CARE

SEVERAL ADDITIONAL TOPIC AREAS WERE IDENTIFIED BY THE CHNA STEERING COMMITTEE INCLUDING: SAFE HOUSING, TRANSPORTATION, AND SUBSTANCE ABUSE. THE UNMET NEEDS NOT ADDRESSED BY UM SRH WILL CONTINUE TO BE ADDRESSED BY KEY GOVERNMENTAL AGENCIES AND EXISTING COMMUNITY- BASED ORGANIZATIONS. WHILE UM SRH WILL FOCUS THE MAJORITY OF OUR EFFORTS ON THE IDENTIFIED PRIORITIES OUTLINED IN THE CHNA ACTION PLAN, WE WILL REVIEW THE COMPLETE SET OF NEEDS IDENTIFIED IN THE CHNA FOR FUTURE COLLABORATION AND WORK. THESE AREAS, WHILE STILL IMPORTANT TO THE HEALTH OF THE COMMUNITY, WILL BE MET THROUGH OTHER HEALTH CARE ORGANIZATIONS WITH OUR ASSISTANCE AS AVAILABLE.

INITIATIVE 1

IDENTIFIED NEED: REDUCE EMERGENCY DEPARTMENT VISITS DUE TO DIABETES,

**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.

HYPERTENSION.

HOSPITAL INITIATIVE: SHORE WELLNESS PARTNERS (SWP)

PRIMARY OBJECTIVE OF INITIATIVE/METRICS THAT WILL BE USED TO EVALUATE THE RESULTS: SHORE WELL PARTNERS IS A UNIQUE PROGRAM THAT PROVIDES A CONTINUUM OF CARE, FOCUSING ON PREVENTIVE CARE TO IMPROVE THE ABILITY OF PATIENTS AND FAMILIES TO WORK TOGETHER TO REDUCE EMERGENCY DEPARTMENT VISITS AND READMISSIONS. THE PROGRAM IS DESIGNED FOR AT-RISK FAMILIES AND INDIVIDUALS WHO DO NOT HAVE SUFFICIENT RESOURCES AND ARE NOT ELIGIBLE FOR OTHER IN-HOME SERVICES. WELLNESS PARTNERS HELPS PATIENTS WITH DISEASE MANAGEMENT AND LIFE SKILLS SO THAT THEY CAN CONTINUE TO LIVE IN THEIR OWN HOMES. THE SERVICE IS PROVIDED BY SHORE HEALTH SYSTEM AT NO CHARGE FOR THOSE WHO QUALIFY.

OBJECTIVES:

- MANAGING PHYSICAL HEALTH PROBLEMS
- CONNECTION WITH OTHER COMMUNITY SERVICES



**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.

- DIETARY EDUCATION
- HOME SAFETY EVALUATIONS
- SAFE MEDICINE USE
- EDUCATION ON SPECIFIC ILLNESS AND TREATMENTS
- EMOTIONAL SUPPORT
- MONITORING CLIENT PROGRESS THROUGH HOME VISITS OR PHONE CALLS

SINGLE OF MULTI-YEAR INITIATIVE TIME PERIOD: MULTI-YEAR INITIATIVE  
BEGINNING IN 2011.

KEY PARTNERS AND/OR HOSPITALS IN INITIATIVE DEVELOPMENT AND/OR  
IMPLEMENTATION: MEMBERS OF THE SHORE WELLNESS PARTNERS TEAM INCLUDE  
ADVANCED PRACTICE NURSES AND MEDICAL SOCIAL WORKERS. THESE SPECIALISTS  
WORK WITH PATIENTS, CAREGIVERS, AND PRIMARY CARE PROVIDERS (SOMETIMES  
CARE IS PROVIDED IN THE PATIENT'S HOME). SHORE WELLNESS PARTNERS IS A  
PARTNER IN THE HEZ FOR DORCHESTER AND CAROLINE COUNTIES. DETAILED  
INFORMATION FOR THE HEZ MODEL, COMPETENT CARE CONNECTIONS CAN BE FOUND  
AT: [HTTP://DHMH.ORG](http://DHMH.ORG)

**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.

EVALUATION DATES: JULY 1, 2013 THROUGH JUNE 30 2014.

EVALUATION OF OUTCOMES: (1) # OF REFERRALS TO SERVICE ;( 2) # OF PATIENTS  
ON SERVICE WITH SHORE WELLNESS PARTNERS; (3) COMPARISON OF ALL CAUSE  
READMISSIONS FOR FY14

OUTCOMES (PROCESS AND IMPACT MEASURES INCLUDED):

NUMBER OF REFERRALS = 305

NUMBER OF ACTIVE PATIENTS=232

THERE WAS A 52% REDUCTION IN HOSPITAL ADMISSIONS FOR CLIENTS ON SERVICE  
WITH SWP FOR 0-6 MONTHS, WHICH REPRESENTED 84% OF THE SWP CLIENTS IN FY  
2014. THIS ADMISSION REDUCTION IS SIMILAR TO THE GLENDENING-NAPOLI,  
DOWLING, PULVION, BAILLARGEON AND RAIMER (2012) STUDY THAT FOUND A 53%  
DECREASE IN HOSPITAL ADMISSIONS.

BASED ON FY 2014 HISTORY, THERE WAS AN 8% MEAN ED VISIT AND A 30% MEAN  
HOSPITAL VISIT RATE DECREASE FOR CLIENTS WITH SWP GREATER THAN 6 MONTHS.

**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.

FY14 SATISFACTION SURVEY, WHICH HAD A 29% RESPONSE RATE, SWP CLIENTS WERE HIGHLY SATISFIED WITH THE PROGRAM. ONE HUNDRED PERCENT OF THE CLIENTS SURVEYED RATED THE PROGRAM 10 ON A 0 - 10 SCALE WITH 0 BEING THE WORST SERVICE POSSIBLE AND 10 REPRESENTING THE BEST SERVICE POSSIBLE. MEDICATION MANAGEMENT, VITAL SIGNS MONITORING, AND EMOTIONAL SUPPORT WERE HIGHLY RATED ASPECTS OF THE PROGRAM.

CONTINUATION OF INITIATIVE: YES, EXPANSION OF SWP AS PART OF THE HEZ GRANT

TOTAL COST OF INITIATIVE \$467,268 (INCLUDES STAFF SALARY AND SUPPLIES DOES NOT INCLUDE INDIRECT OVERHEAD)

DIRECT OFFSETTING REVENUE FROM RESTRICTED GRANTS HEZ GRANT: \$35,289.  
\$485,341 (INCLUDES STAFF SALARY AND SUPPLIES DOES NOT INCLUDE INDIRECT OVERHEAD)

INITIATIVE 2

**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.

IDENTIFIED NEED: CARDIOVASCULAR DISEASE, CRITICAL CARE ACCESS TO  
EMERGENCY MEDICATIONS PREVENTS TERMINAL OUTCOMES FOR PATIENTS (ADVANCED  
CARDIAC LIFE SUPPORT)

HOSPITAL INITIATIVE: (A) ANTI-THROMBOSIS CLINIC; (B): EMS MEDICATION  
PROGRAMS

PRIMARY OBJECTIVE OF INITIATIVE/METRICS THAT WILL BE USED TO EVALUATE THE  
RESULTS:

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

B). SHORE REGIONAL HEALTH PROVIDE EMERGENCY MANAGEMENT MEDICATIONS TO  
THE LOCAL AMBULANCE SERVICES SO THAT ADVANCED CARDIAC LIFE SUPPORT MAY BE  
INITIATED IN THE FIELD.

**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.

KEY PARTNERS AND/OR HOSPITALS IN INITIATIVE DEVELOPMENT AND/OR IMPLEMENTATION:

- A) SHORE HEALTH PHARMACY SERVICES
- B) SHORE HEALTH PHARMACY, EMS

SINGLE OF MULTI-YEAR INITIATIVE TIME PERIOD: MULTI-YEAR INITIATIVE.

HOW WERE THE OUTCOMES EVALUATED?

1. # OF PATIENTS ENROLLED
2. TIME TO THERAPEUTIC INTERNATIONAL NORMALIZED RATIO (INR)
3. % OF TIME WITH THERAPEUTIC INR'S
4. # UNEXPECTED ADVERSE EVENTS ASSOCIATED WITH ORAL ANTICOAGULATION

OUTCOMES (PROCESS AND IMPACT MEASURES INCLUDED):

CLINIC MANAGES GREATER THAN 1,000 PATIENTS

UMC AT EASTON 11,684 PATIENT ENCOUNTERS

UMC AT EASTON AVERAGE # OF PATIENTS SERVED, 932

AVERAGE TIME TO THERAPEUTIC INR IS 4.3 DAYS (NATIONAL AVERAGE IS 5.8

**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.

DAYS)

76.15% PATIENTS WERE MAINTAINED WITH THERAPEUTIC RANGE >90% TIME

(NATIONAL AVERAGE IS 58%)

4.7% INCIDENCE OF MAJOR HEMORRHAGIC EVENTS (LITERATURE REPORTS RATE OF

5-8.1%)

UMC AT CHESTERTOWN 4,285 ENCOUNTERS

UMC AT CHESTERTOWN AVERAGE # OF PATIENTS SERVED, 259

AVERAGE TIME TO THERAPEUTIC INR IS 4.5 DAYS (NATIONAL AVERAGE IS 5.8

DAYS)

68.9% PATIENTS WERE MAINTAINED WITH THERAPEUTIC RANGE >90% TIME (NATIONAL

AVERAGE IS 58%)

2.5% ADVERSE EVENTS

CONTINUATION OF INITIATIVES: YES.

COST OF INITIATIVE: UMC AT EASTON \$185,918, UMC AT CHESTERTOWN

\$100,509 (INCLUDES STAFF SALARY AND SUPPLIES DOES NOT INCLUDE INDIRECT

OVERHEAD)

**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.

INITIATIVE 3

IDENTIFIED NEED : CRITICAL CARE ACCESS TO EMERGENCY MEDICATIONS PREVENTS

TERMINAL OUTCOMES FOR PATIENTS

HOSPITAL INITIATIVE: EMS MEDICATION PROGRAMS

PRIMARY OBJECTIVE: SHORE REGIONAL HEALTH PROVIDES EMERGENCY MANAGEMENT

MEDICATIONS TO THE LOCAL AMBULANCE SERVICES SO THAT ADVANCED CARDIAC LIFE

SUPPORT THAT MAY BE INITIATED IN THE FIELD

SINGLE OR MULTI-YEAR INITIATIVE TIME PERIOD: MULTI-YEAR/ONGOING

KEY PARTNERS IN DEVELOPMENT AND/OR IMPLEMENTATION:

SHORE REGIONAL HEALTH PHARMACY, LOCAL EMS UNITS AND THE STATE OF MARYLAND

INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEM

HOW WERE THE OUTCOMES EVALUATED?

**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.

DECREASE DEATH AND DISABILITY RELATED TO CRITICAL ILLNESSES WHERE EARLY INTERVENTION IS POSSIBLE AND PROVEN TO BE OF BENEFIT

- UMC AT EASTON AND DORCHESTER # OF PATIENTS SERVED, 10,000
- UMC AT CHESTERTOWN # OF PATIENTS SERVED, 2,500

OUTCOMES (INCLUDE PROCESS AND IMPACT MEASURES):

EARLY INTERVENTIONS BY EMS, SERVED 12,500 PERSONS.

SUCCESSFUL FIELD RESUSCITATION AND TREATMENT OF PATIENTS THROUGH EARLY INTERVENTION AS ENCOUNTERED BY LOCAL EMS SERVICES.

PROVIDING ACCESS TO EMERGENCY MEDICATION IS AN ESSENTIAL COMPONENT OF THE EARLY INTERVENTION PROTOCOLS.

CONTINUATION OF INITIATIVE

THE INITIATIVE IS CONTINUING

TOTAL COST OF INITIATIVE: UMC AT EASTON AND DORCHESTER \$121,553, UMC AT CHESTERTOWN \$36,554

INITIATIVE 4, 5, 6



**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.

IDENTIFIED NEED: CANCER MORTALITY

HOSPITAL INITIATIVE: A) SHORE REGIONAL BREAST OUTREACH; (B): SHORE REGIONAL BREAST CENTER WELLNESS FOR WOMEN PROGRAM; (C) PROSTATE CANCER SCREENING

PRIMARY OBJECTIVE OF INITIATIVE/METRICS THAT WILL BE USED TO EVALUATE THE RESULTS:

- A) 1. INCREASE THE NUMBER OF WOMEN SURVIVING BREAST CANCER BY DIAGNOSING THEM AT AN EARLIER STAGE THROUGH EDUCATION AND PROMOTION OF PREVENTATIVE MEASURES AND EARLY DETECTION.
2. DIAGNOSE AFRICAN AMERICAN WOMEN AT EARLIER STAGES OF BREAST CANCER, EQUIVALENT TO CAUCASIAN WOMEN.
3. EDUCATE LATINA WOMEN IN BREAST SELF EXAMINATION WITH THE ASSISTANCE OF A TRANSLATOR.
- B) THE PROGRAM SERVES AS A POINT OF ACCESS INTO CARE FOR AGE AND RISK SPECIFIC MAMMOGRAPHY SCREENING, CLINICAL BREAST EXAM, AND GENETIC TESTING FOR BREAST CANCER BASELINE/STRATEGIES/OUTCOMES: OFFERED NO COST

**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.

MAMMOGRAMS TO ELIGIBLE WOMEN: THOSE UNDER THE AGE OF 40 AND OVER 65WHO  
 HAVE NO INSURANCE AND LATINA WOMEN OF ALL AGES WHO WILL BE SCREENED  
 ANNUALLY THEREAFTER. THOSE WOMEN NEEDING FURTHER DIAGNOSTIC TESTS OR WHO  
 NEED TREATMENT FOR BREAST CANCER WILL BE ENROLLED IN THE STATE OF  
 MARYLAND DIAGNOSIS AND TREATMENT PROGRAM THROUGH THE CASE MANAGER.  
 C) PROVIDE MEN IN THE MID SHORE, THE OPPORTUNITY TO OBTAIN A FREE  
 PROSTATE CANCER SCREENING WHICH INCLUDES BLOOD TEST AND EXAM BY A  
 COMPETENT PHYSICIAN

SINGLE OF MULTI-YEAR INITIATIVE TIME PERIOD: ALL INITIATIVES ARE  
 MULTI-YEAR INITIATIVES

KEY PARTNERS AND/OR HOSPITALS IN INITIATIVE DEVELOPMENT AND/OR  
 IMPLEMENTATION: COUNTY DEPARTMENTS OF HEALTH, SHORE COMPREHENSIVE  
 UROLOGY, TALBOT COUNTY NAACP, MOTA

EVALUATION OF OUTCOMES: A): # OF WOMEN EDUCATED; CORRELATION OF TUMOR  
 REGISTRY DATA WITH OUTREACH EVENTS, SCREENINGS. (B): ONGOING DATA

**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.

COLLECTION REPORTED MONTHLY TO CAPTURE TOTAL NUMBER SEEN WITH BREAKDOWN BY RACE; INCREASE BREAST SCREENING LEVELS AMONG UNINSURED AND UNDERINSURED WOMEN. (C) # OF SCREENINGS AND EXAMS PROVIDED.

OUTCOMES (PROCESS AND IMPACT MEASURES INCLUDED):

A): SHORE REGIONAL BREAST OUTREACH INCREASED THE COMMUNITY'S AWARENESS OF BREAST CANCER PREVENTION, DETECTION AND TREATMENTS; SERVED 2,421 PERSON AT 74 COMMUNITY EVENTS, 17 PROFESSIONAL PRESENTATIONS; THE STAGE AT DIAGNOSIS AS REPORTED BY THE TUMOR REGISTRY FOR THE CANCER CENTER INDICATES WOMEN ARE BEING DIAGNOSED AT EARLY STAGES OF THE DISEASE, AND THAT THERE IS NO DISTINCTION BETWEEN THE ETHNIC GROUPS IN OUR COMMUNITY.

B): WELLNESS FOR WOMEN PROGRAM

- 177 PATIENT SCREENINGS
- AFRICAN AMERICAN NEW PATIENTS SEEN, 9, VOLUME DOWN 12%
- HISPANIC NEW PATIENTS, 24, VOLUME UP 37.5%
- CAUCASIAN NEW PATIENTS, 7, VOLUME DOWN 42%

SHORE REGIONAL BREAST CENTER CASE WORKER: 1,552 PATIENT VISITS.

- 37 WERE DIAGNOSED WITH BREAST CANCER

**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.

- 264 TOTAL OF PATIENTS HAD CASE MANAGEMENT

C): INCREASED AWARENESS AND DETECTION OF PROSTATE CANCER; PROVIDED ACCESS TO SCREENINGS TO UNDERSERVED PERSONS OF COMMUNITY; 81 CLIENTS WERE SERVED. ALL RESULTS ARE REVIEWED BY THE SCREENING PHYSICIAN. RESULTS ARE MAILED TO THE PARTICIPANT.

CONTINUATION OF INITIATIVE: YES.

COST OF INITIATIVE IN FY14: A. \$25,000 (INCLUDES STAFF SALARY AND SUPPLIES DOES NOT INCLUDE INDIRECT OVERHEAD); B. \$45,543 (INCLUDES STAFF SALARY AND SUPPLIES DOES NOT INCLUDE INDIRECT OVERHEAD); C \$1,400 (INCLUDES STAFF SALARY AND SUPPLIES DOES NOT INCLUDE INDIRECT OVERHEAD)

INITIATIVE 7, 8

IDENTIFIED NEED: REDUCE ED VISITS FROM DIABETES; IMPROVE MANAGEMENT OF DIABETES; REDUCE INCIDENCE OF DIABETES

**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.

HOSPITAL INITIATIVE: A) DIABETES EDUCATION, (B) SHORE KIDS CAMP

PRIMARY OBJECTIVE OF INITIATIVE/METRICS THAT WILL BE USED TO EVALUATE THE

RESULTS: THE PRIMARY OBJECTIVES OF THE (A) DIABETES EDUCATION PROGRAMS

ARE: IMPROVE HEALTH THROUGH BETTER MANAGEMENT OF DIABETES; INCREASE

KNOWLEDGE OF RISK FACTORS FOR DIABETES, HEART DISEASE AND STROKE AND HOW

TO IMPROVE HEALTH WITH REGULAR EXERCISE AND NUTRITION; PROVIDE SUPPORT

FOR DIABETES PATIENTS AND THEIR FAMILIES (B) PROVIDE CHILDREN WITH

LEARNING AND NETWORKING EXPERIENCE WHO HAVE DIABETES OR ASTHMA; PREVENT

HOSPITALIZATION OF CHILDREN ATTENDING THE CAMP.

SINGLE OF MULTI-YEAR INITIATIVE TIME PERIOD: MULTI-YEAR INITIATIVE.

KEY PARTNERS AND/OR HOSPITALS IN INITIATIVE DEVELOPMENT AND/OR

IMPLEMENTATION: GRASONVILLE COMMUNITY SENIOR CENTER, UM CENTER FOR

DIABETES AND ENDOCRINOLOGY, CAROLINE COUNTY SCHOOLS, AMERICAN DIABETES

ASSOCIATION

EVALUATION OF OUTCOMES: # OF PARTICIPANTS WHO REACH GOALS; # 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.
- 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.

PARTICIPANTS; PRE AND POST SEMINAR SURVEY

OUTCOMES (PROCESS AND IMPACT MEASURES INCLUDED):

DIABETES 101:

- 25 PARTICIPANTS ATTENDED 2 HOUR SESSION TO INCREASE THEIR KNOWLEDGE ON MANAGING THEIR DIABETES.
- GOALS WERE SET AND MONITORED.
- ALL PARTICIPANTS MADE PROGRESS TO MEET GOALS.

DIABETES SUPPORT GROUP:

8-10 PATIENTS ATTEND MONTHLY DIABETES SUPPORT GROUP. ATTENDEES AND THEIR FRIENDS AND FAMILY MEET TO DISCUSS DIABETES: CONCERNS, PROBLEMS, AND CHALLENGES. FACILITATOR PROVIDES HEALTH EDUCATION AND ACCURATE INFORMATION.

EDUCATION ON DIABETES FOR HIGH SCHOOL STUDENTS:

150 STUDENTS ATTENDED EDUCATIONAL SEMINARS. QUIZ GIVEN TO ASSESS AWARENESS OF SUGAR IN FOODS. 95% NOT AWARE OF AMOUNT OF SUGAR IN FOOD PRIOR TO SEMINAR. EDUCATION ON READING FOOD LABELS AND MAKING HEALTHY CHOICES PROVIDED TO ATTENDEES.

**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.

CONTINUATION OF INITIATIVE: YES, PROGRAMS WILL CONTINUE

COST OF INITIATIVE IN FY13: \$3,493 (INCLUDES STAFF SALARY AND SUPPLIES

DOES NOT INCLUDE INDIRECT OVERHEAD)

SHORE KIDS CAMP

EVALUATION OF OUTCOMES: TRACK THE ATTENDEES FOR ONE YEAR AFTER ATTENDING

CAMP FOR HOSPITALIZATIONS DUE TO COMPLICATIONS FROM DIABETES OR ASTHMA

OUTCOMES (PROCESS AND IMPACT MEASURES INCLUDED):

10 CHILDREN ATTENDED; ONLY 1 CHILD HOSPITALIZED WITH DIABETES

COMPLICATIONS IN FOLLOWING YEAR

CONTINUATION OF INITIATIVE: YES.

COST OF INITIATIVE IN FY13: SHORE KIDS CAMP: \$9,600 (INCLUDES STAFF SALARY

**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.

AND SUPPLIES DOES NOT INCLUDE INDIRECT OVERHEAD). DIRECT OFFSETTING

REVENUE FROM RESTRICTED GRANTS: \$804

INITIATIVE 9

IDENTIFIED NEED: PRE-DIABETES AND DIABETES AWARENESS, PREVENTION, AND  
MANAGEMENT

- REDUCE ED VISITS FROM DIABETES
- REDUCE INCIDENCE OF DIABETES
- IMPROVE MANAGEMENT OF DIABETES

HOSPITAL INITIATIVE: ANNUAL EDUCATION INITIATIVE FOR AMERICAN DIABETES  
MONTH, HELD EACH YEAR IN NOVEMBER.

- SUPPORT GROUPS JULY 2013 -JUNE 2014; 10-15 ATTENDEES EACH MONTH
- GROCERY STORE TOUR - APRIL 23, 2014;10 PARTICIPANTS
- RADIO SHOW - OCTOBER 7, 2013; 200+ LISTENERS

PRIMARY OBJECTIVE: THE PRIMARY OBJECTIVE OF THIS ANNUAL EDUCATIONAL  
INITIATIVE IS TO EDUCATE THE COMMUNITY ABOUT DIABETES, INCLUDING RISK



**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.

FACTORS AND TO RAISE AWARENESS ABOUT LIFESTYLE CHANGES THAT CAN PREVENT ONSET OF TYPE 2 DIABETES. KENT COUNTY HAS A HIGH INCIDENCE OF DIABETES, ESPECIALLY IN THE AFRICAN AMERICAN/BLACK COMMUNITY. SRH DIABETES NURSE/CDE PROVIDES COMMUNITY OUTREACH TO CHURCH GROUPS AND OTHER COMMUNITY ORGANIZATIONS ABOUT DIABETES. SRH HAS A COMPREHENSIVE EDUCATIONAL AND LIFESTYLE-CHANGE PROGRAM CALLED "MANAGING YOUR DIABETES," WHICH IS LED BY THE DIABETES NURSE/EDUCATOR. SRH DIABETES NURSE/EDUCATOR ALSO FACILITATES THE FREE MONTHLY DIABETES SUPPORT GROUP.

SINGLE OR MULTI-YEAR INITIATIVE TIME PERIOD: MULTI-YEAR AND ONGOING

KEY PARTNERS: SHORE MEDICAL CENTER AT CHESTERTOWN, UNIVERSITY OF MARYLAND CENTER FOR DIABETES AND ENDOCRINOLOGY HOSTS/SPONSORS THIS YEARLY PROGRAM, MOTA (MINORITY OUTREACH TECHNICAL ASSISTANCE) FOR ANNUAL COMMUNITY HEALTH FAIR (SEPTEMBER 28, 2013), LOCAL GROCERY STORES, CHURCHES AND COMMUNITY GROUPS.

**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.

HOW WERE THE OUTCOMES EVALUATED? OUTCOMES ARE EVALUATED BY REVIEWING  
NUMBER OF PARTICIPANTS AND ALL PARTICIPANTS ARE PROVIDED WITH OPPORTUNITY  
FOR PRE-DIABETES SCREENING AND ACCESS TO GLUCOSE SCREENING, AS WELL AS  
OPPORTUNITY TO PARTICIPATE IN SUPPORT GROUPS.

OUTCOMES (INCLUDE PROCESS AND IMPACT MEASURES)  
THE ANNUAL EVENT ON NOVEMBER 26, 2013 HAD 20 ATTENDEES. EACH PARTICIPANT  
PROVIDED WITH: EDUCATIONAL MATERIALS ABOUT DIABETES, NUTRITION AND  
WEIGHT MANAGEMENT INFORMATION; FREE GLUCOSE SCREENING VOUCHERS PROVIDED.  
PARTNERING WITH THE LOCAL GROCERY STORES, THE CDE AND DIETICIAN OFFERED  
THREE "HEALTHY EATING OPTIONS AND NUTRITION TIPS" ON APRIL 23, 2014; 10  
COMMUNITY MEMBERS PARTICIPATED. FREE GLUCOSE SCREENING VOUCHERS  
PROVIDED.

LIFESTYLE SCREENINGS WERE PROVIDED AT EDUCATIONAL EVENTS AND HEALTH  
FAIRS, INCLUDING:

-COMMUNITY HEALTH FAIR, WORTON COMMUNITY CENTER, WORTON, MARYLAND;

SEPTEMBER 28, 2013

-SENIOR SUMMIT HEALTH FAIR, CENTREVILLE, MARYLAND; MAY 16, 2014

**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.

-HOMEPORTS AGING SYMPOSIUM, CHESTERTOWN, MARYLAND; APRIL 15, 2014

CONTINUATION OF INITIATIVE: YES, ALL LISTED INITIATIVES ARE CONTINUING.

TOTAL COST OF INITIATIVE: \$2,400 (INCLUDES STAFF SALARY AND SUPPLIES  
DOES NOT INCLUDE INDIRECT OVERHEAD)

INITIATIVE 10

IDENTIFIED NEED: RESOURCES, HEALTH CARE PROGRAMS, ACCESS TO CARE FOR  
AGING POPULATION

HOSPITAL INITIATIVE: LEAD SPONSOR AND PARTNER IN LOCAL "HOME PORTS ANNUAL  
AGING SYMPOSIUM" AN EVENT THAT FOCUSED ON AGING ISSUES AND TRENDS, AND  
PROMOTING AGING IN PLACE.

PRIMARY OBJECTIVE: KENT COUNTY IS UNIQUE IN THAT 22% OF ITS RESIDENTS ARE  
65 YEARS OR OLDER, WHICH IS 65% HIGHER THAN THE STATE OF MARYLAND'S

**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.

PERCENTAGE, MAKING KENT COUNTY ONE OF THE OLDEST, AGING POPULATIONS IN THE MARYLAND. AS PEOPLE LIVE LONGER, AGING WELL IS A CHALLENGE AND HOSPITALS NEED TO BE PREPARED. SHORE MEDICAL CENTER AT CHESTERTOWN HAS MADE IT A PRIORITY TO MEET THE GROWING NEEDS OF AN AGING ADULT POPULATION BY SUPPORTING AND PARTICIPATING IN THE ANNUAL HOMEPORTS AGING SYMPOSIUM, AS WELL AS OTHER HEALTH FAIRS AND COMMUNITY ACTIVITIES AIMED AT EDUCATING THE UNDERSERVED AND DIVERSE ADULT POPULATION.

THE AGING SYMPOSIUM, "HEALTHY AGING- A COMMUNITY PERSPECTIVE" ON APRIL 15, 2014, PRESENTED STRATEGIES THAT PROMOTE A HEALTHIER SENIOR POPULATION, INTERVENTIONS FOR PROTECTING OLDER ADULTS FROM FINANCIAL EXPLOITATION, ESTATE PLANNING, AGING IN PLACE, LONG TERM CARE OPTIONS, RESOURCES AND SUPPORT SERVICES AVAILABLE FOR CAREGIVERS, AND MORE. SHORE MEDICAL CENTER AT CHESTERTOWN WILL CONTINUE TO PARTICIPATE IN PROGRAMS THAT FOCUS ON THE AGING POPULATION AND PLANS TO EXPLORE AND DEVELOP NEW AGING SERVICE DELIVERY MODELS TO IMPROVE PATHWAYS BETWEEN HOSPITALS AND POST-DISCHARGE AND/OR SPECIALTY 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.

ADDITIONAL HEALTH FAIRS AND AGING-RELATED EVENTS INCLUDING:

- COMMUNITY HEALTH FAIR, SEPTEMBER 28, 2013; 150 ATTENDEES
- QUEEN ANNE'S COUNTY ANNUAL SENIOR SUMMIT, MAY 16, 2014; 300 ATTENDEES

THE FOLLOWING EDUCATIONAL MATERIALS, INFORMATION AND FREE SCREENINGS ON

THE TOPICS WERE PROVIDED, INCLUDING:

- HIGH BLOOD PRESSURE AND HEART DISEASE
- DIABETES
- CANCER
- HOSPICE SERVICES AND PALLIATIVE CARE
- OBESITY, EXERCISE AND NUTRITION
- FREE BLOOD PRESSURE SCREENINGS

SINGLE OR MULTI-YEAR INITIATIVE TIME PERIOD: MULTI-YEAR INITIATIVE AND ONGOING

KEY PARTNERS: SHORE REGIONAL HEALTH SYSTEM/UM SHORE MEDICAL CENTER AT CHESTERTOWN (LOCAL HOSPITAL IN KENT COUNTY MARYLAND)

- UM CHESTER RIVER HOME CARE & HOSPICE

**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.

- KENT COUNTY'S HOMEPORTS  
 - KENT COUNTY HEALTH DEPART  
 - UPPER SHORE AGING  
 - KENT COUNTY COMMISSION ON AGING  
 - UNIVERSITY OF MARYLAND MEDICAL SYSTEM/UNIVERSITY OF MARYLAND SCHOOL OF  
 MEDICINE

HOW WERE THE OUTCOMES EVALUATED? OUTCOMES ARE EVALUATED BY NUMBER OF  
 COMMUNITY MEMBERS ATTENDING THE ANNUAL EVENT. ALL ATTENDEES ARE PROVIDED  
 WITH EDUCATIONAL MATERIALS ON A VARIETY OF APPROPRIATE TOPICS RELATED TO  
 THE AGING POPULATION. OPPORTUNITIES FOR FREE HEALTH SCREENINGS ARE  
 PROVIDED.

OUTCOMES (INCLUDE PROCESS AND IMPACT MEASURES): SHORE MEDICAL CENTER AT  
 CHESTERTOWN SUPPORTED AND PARTICIPATED IN THE 2014 AGING SYMPOSIUM AND  
 PROVIDED:

- \$3500 OF SPONSORSHIP SUPPORT
- CLINICAL STAFF AND EXPERTS FOR PRESENTATIONS AND OUTBREAK SESSIONS ON A

**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.

VARIETY OF HEALTH CARE TOPICS AND TRENDS

- DISPLAYS AND EDUCATIONAL MATERIALS ON HIGH BLOOD PRESSURE, HEART DISEASE, DIABETES, CANCER, UROLOGICAL ISSUES, HOSPICE SERVICES, PALLIATIVE CARE, LONG TERM CARE, SLEEP HYGIENE, OBESITY, EXERCISE AND NUTRITION; WOUND CARE
- FREE BLOOD PRESSURE SCREENINGS; BMI SCREENINGS; BONE DENSITY SCREENINGS
- THERE WERE 100 ATTENDEES. PARTICIPANTS WERE PROVIDED WITH A SURVEY AND DATA/ FEEDBACK WAS COLLECTED ON THE PRESENTATIONS, DISPLAYS, EDUCATIONAL MATERIALS AND THE BREAKOUT SESSIONS.

CONTINUATION OF INITIATIVE: YES, ALL LISTED INITIATIVES ARE CONTINUING.

TOTAL COST OF INITIATIVE: \$9,580

INITIATIVE 11

**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.

IDENTIFIED NEED: HEART DISEASE, HIGH BLOOD PRESSURE, HYPERTENSION,  
OBESITY

- REDUCE DEATHS FROM HEART DISEASE
- REDUCE HYPERTENSION-RELATED EMERGENCY DEPARTMENT VISITS
- INCREASE THE % OF ADULTS WHO ARE AT A HEALTHY WEIGHT

HOSPITAL INITIATIVE: FREE ANNUAL HEART DISEASE EDUCATION EVENT: FEBRUARY  
24, 2014.

THIS PROGRAM OCCURS EVERY FEBRUARY IN HONOR OF AMERICAN HEART MONTH.

SUPPORT GROUPS: MENDED HEARTS MEETING, FEBRUARY 24, 2014; 50 ATTENDEES AT  
SPECIAL MEETING.

RADIO SHOWS ON FEBRUARY 7, 2014; 200+ LISTENERS

TRANSITIONS CARE PROGRAM - CHF (CONGESTIVE HEART FAILURE) FREE CLINIC  
FORMERLY KNOWN AS (FOR FY 12 AND FY13; RENAMED IN FY14): CHESTER RIVER  
HOSPITAL "TAKING CHARGE OF YOUR HEART" CHF FREE OUTPATIENT CLINIC

PRIMARY OBJECTIVE: FREE ANNUAL HEART DISEASE EDUCATION EVENT: FEBRUARY  
24, 2014.

THE ANNUAL HEART DISEASE EDUCATION EVENT FOR FY14 FOCUSED ON EDUCATING



**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.

THE COMMUNITY ABOUT WHAT IS HEART DISEASE WITH SPECIAL EMPHASIS ON IDENTIFYING CARDIAC RISK FACTORS.

THE EVENT IS FREE AND FEATURES SPEAKERS THAT INCLUDE A COMMUNITY CARDIAC REHAB NURSE; AND HOSPITAL DIETICIAN. THIS YEAR'S SPEAKER DISCUSSED HEART DISEASE AND CARDIAC RISK FACTORS; HEALTHIER LIFESTYLE CHOICES WERE EMPHASIZED. THE DISCUSSION ALSO TOUCHED ON CONGESTIVE HEART FAILURE (CHF). MEMBERS OF MENDED HEARTS SUPPORT GROUP WERE IN ATTENDANCE.

DISCUSSION TOPICS AND EDUCATIONAL MATERIALS INCLUDE HEART DISEASE, HIGH CHOLESTEROL, HIGH BLOOD PRESSURE, AND OBESITY/LIFESTYLE CHOICES. SPECIAL ATTENTION IS GIVEN TO EDUCATING ABOUT PREVENTATIVE MEASURES, INCLUDING A HEALTHY DIET AND EXERCISE. FREE BLOOD PRESSURE SCREENINGS PROVIDED AT EVENTS AND THROUGHOUT THE COMMUNITY DURING THE YEAR, INCLUDING THE FOLLOWING:

- COMMUNITY HEALTH FAIR, WORTON COMMUNITY CENTER, WORTON, MARYLAND; SEPTEMBER 28, 2013
- SENIOR SUMMIT HEALTH FAIR, CENTREVILLE, MARYLAND; MAY 16, 2014
- HOMEPORTS AGING SYMPOSIUM, CHESTERTOWN, MARYLAND; APRIL 15, 2014

**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.

MENDED HEARTS SUPPORT GROUP INFORMATION PROVIDED.

TRANSITIONS CARE PROGRAM - CHF (CONGESTIVE HEART FAILURE) FREE CLINIC

CONGESTIVE HEART FAILURE (CHF) IS A VERY SERIOUS PROBLEM AND IS ONE OF THE MEDICAL CONDITIONS RESPONSIBLE FOR THE HIGHEST RATES OF HOSPITALIZATIONS IN THE US.

THE MEDICAL CENTER AT CHESTERTOWN'S APPROACH TO DEALING WITH CHF IS TO IMPROVE THE MANAGEMENT OF THIS CHRONIC DISEASE, WITH AN OVERARCHING GOAL TO INCREASE PATIENTS' QUALITY OF LIFE, LOWER READMISSIONS AND OTHER HEALTH COMPLICATIONS, WHILE INCREASING PATIENTS' UNDERSTANDING AND KNOWLEDGE.

THE PROGRAM IS MANAGED BY A NURSE, IN COLLABORATION WITH THE HEALTH SYSTEM'S HOME HEALTH GROUP. PATIENTS WITH CHF ARE EVALUATED, MANAGED AND TREATED IN A COMFORTABLE AND FRIENDLY ENVIRONMENT. PROGRESS IS TRACKED.

EACH PATIENT ENROLLED IN THE PROGRAM RECEIVES:

**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.

- PATIENT/FAMILY FOCUSED EDUCATION
- INDIVIDUAL BINDER
- SCALE TO TRACK WEIGHT

NUTRITION COUNSELING

SINGLE OR MULTI-YEAR INITIATIVE TIME PERIOD: MULTI-YEAR AND ONGOING

KEY PARTNERS: FREE ANNUAL HEART DISEASE EDUCATION EVENT: FEBRUARY 24, 2014.

- THE UM SHORE MEDICAL CENTER AT CHESTERTOWN IS THE HOST/SPONSOR OF THIS ANNUAL INITIATIVE.
- HOSPITAL'S CARDIAC REHAB NURSES PROVIDE ADDITIONAL HEALTH AND EXERCISE INFORMATION AND FREE BLOOD PRESSURE SCREENINGS.
- HOSPITAL'S DIETICIAN PROVIDES INFORMATION ON HEART HEALTHY EATING.
- THE MENDED HEARTS SUPPORT GROUP EXHIBITS AT EVENT.
- LOCAL GROCERY STORES (FOR GROCERY STORE TOURS; OFFERED APRIL 23, 2014).
- TRANSITIONS CARE PROGRAM - CHF (CONGESTIVE HEART FAILURE) FREE CLINIC

**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.

- THE MEDICAL CENTER AT CHESTERTOWN'S CARDIAC REHAB DEPARTMENT, DIETARY DEPARTMENT AND HOME HEALTH DEPARTMENT.

HOW WERE THE OUTCOMES EVALUATED? FREE ANNUAL HEART DISEASE EDUCATION EVENT: FEBRUARY 24, 2014.

ATTENDEES ARE PROVIDED WITH EDUCATIONAL MATERIALS AND INFORMATION, AS WELL AS OPPORTUNITY TO PARTICIPATE IN FREE EDUCATIONAL PROGRAMS AND SUPPORT GROUPS AND FREE BLOOD PRESSURE SCREENINGS TO HELP ASSESS/ IDENTIFY CARDIAC RISK FACTORS.

TRANSITIONS CARE PROGRAM - CHF (CONGESTIVE HEART FAILURE) FREE CLINIC OUTCOMES ARE EVALUATED BY REVIEWING NUMBER OF PATIENTS ENROLLED IN THE PROGRAM AND NUMBER OF PATIENTS WHO COMPLETE THE PROGRAM.

OUTCOMES (INCLUDE PROCESS AND IMPACT MEASURES): FREE ANNUAL HEART DISEASE EDUCATION EVENT: FEBRUARY 24, 2014.

**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.

THE ANNUAL HEART DISEASE EVENT PROVIDED:

- A TOTAL OF 50 COMMUNITY MEMBERS ATTENDED THE FEBRUARY 24, 2014 EVENT.
- PARTICIPANTS WERE PROVIDED WITH EDUCATIONAL MATERIALS ABOUT HEART DISEASE AND HEALTHY LIFESTYLE CHOICES, WITH EMPHASIS ON HEALTHY WEIGHT MANAGEMENT.
- FREE BLOOD PRESSURE SCREENINGS PROVIDED.
- HEART-HEALTHY SNACKS AND REFRESHMENTS PROVIDED, ALONG WITH HEART HEALTHY RECIPES.
- INFORMATION ABOUT FREE, GROCERY STORE TOURS INCLUDED (OFFERED IN APRIL 2014).

TRANSITIONS CARE PROGRAM - CHF (CONGESTIVE HEART FAILURE) FREE CLINIC  
 THE MEDICAL CENTER AT CHESTERTOWN'S TRANSITIONS CARE CHF FREE OUTPATIENT  
 CLINIC OPERATES WITHIN THE CARDIAC REHAB CENTER. THE PROGRAM WAS LAUNCHED  
 IN FY12 AND HAS CONTINUED THROUGH FY14.

- THERE ARE CURRENTLY 6 PATIENTS IN THE PROGRAM, SEEN THREE TIMES EACH WEEK.
- THE INTERMEDIATE TERM OUTCOME, TO BE TRACKED AND MEASURED OVER 1-5

**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.

YEARS, IS THE OVERALL DECREASE OF PATIENTS' HOSPITALIZATIONS AND READMISSIONS.

- THE SHORT TERM OUTCOME INDICATOR, TO BE TRACKED AND MEASURED, IS PARTICIPATION IN HEART FAILURE PROGRAM, AS WELL AS ATTENDANCE OF EXERCISE AND /OR EDUCATION CLASS.

CONTINUATION OF INITIATIVE: YES, ALL LISTED INITIATIVES ARE CONTINUING.

TOTAL COST OF INITIATIVE: \$5,600

INITIATIVE 12

IDENTIFIED NEED : LACK OF DENTAL CARE/ACCESS FOR PEDIATRIC POPULATION

- INCREASE THE PROPORTION OF INDIVIDUALS RECEIVING DENTAL CARE

HOSPITAL INITIATIVE: UMC AT CHESTERTOWN BECAME PART OF THE CHILDREN'S REGIONAL ORAL HEALTH CONSORTIUM (CROC) IN 2010 TO PROVIDE SERVICES TO CHILDREN OF LOW-INCOME FAMILIES AND RACIAL/ETHNIC MINORITY CHILDREN, WHO

**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.

REQUIRE GENERAL ANESTHESIA FOR THEIR DENTAL CARE.

PRIMARY OBJECTIVE: THE PRIMARY OBJECTIVE FOR THE PEDIATRIC DENTAL PROGRAM AT CHESTER RIVER HOSPITAL IS TO PROVIDE AND IMPROVE ACCESS TO MARYLAND RURAL ORAL HEALTH SERVICES. THE PROGRAM PROVIDES DENTAL CARE TO CHILDREN OF LOW-INCOME FAMILIES, AS WELL AS ADULTS WHO HAVE SPECIAL NEEDS AND PREGNANT WOMEN.

DENTAL DISEASE IS ONE OF THE MOST COMMON UNMET HEALTH TREATMENT NEED IN CHILDREN ON THE EASTERN SHORE OF MARYLAND. CHILDREN IN MARYLAND HAVE THREE TIMES THE NATIONAL AVERAGE OF UNTREATED TOOTH DECAY, WITH CHILDREN ON THE EASTERN SHORE HAVING THE HIGHEST PERCENTAGE IN THE STATE. THE MAJORITY OF THE EASTERN SHORE IS CONSIDERED DENTALLY UNDERSERVED, WITH BARRIERS TO ACCESS DENTAL CARE FOR LOW-INCOME FAMILIES AND RACIAL/ETHNIC MINORITIES.

AS PART OF CROC, CHESTER RIVER HOSPITAL PROVIDES SURGICAL FACILITIES AND EQUIPMENT FOR HOSPITAL-BASED PEDIATRIC DENTAL CASES TO KENT AND QUEEN ANNE'S COUNTY RESIDENTS.

TRANSPORTATION IS A BARRIER, SO TRANSPORTATION IS PROVIDED BY CHESTER RIVER HOSPITAL'S PEDIATRIC PROGRAM PASSENGER VAN.

**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.

SINGLE OR MULTI-YEAR INITIATIVE TIME PERIOD: MULTI-YEAR AND ONGOING

KEY PARTNERS: SRH, EASTERN SHORE AREA HEALTH EDUCATION CENTER, CHOPTANK  
COMMUNITY HEALTH SYSTEM, KENT COUNTY HEALTH DEPARTMENT, MARYLAND DHMH,  
MARYLAND HEALTHY SMILES, DR. MARGARET MCGRATH, DR. JEAN CARLSON,

HOW WERE THE OUTCOMES EVALUATED? OUTCOMES ARE EVALUATED BY NUMBER OF  
PATIENTS SERVED BY THIS PROGRAM.

OUTCOMES (INCLUDE PROCESS AND IMPACT MEASURES): THE PEDIATRIC DENTAL  
PROGRAM AT CHESTER RIVER HOSPITAL PROVIDED RESTORATIVE CARE, BOTH MINOR  
AND MAJOR, TO 60 PEDIATRIC PATIENTS FOR 740 TOTAL TEETH TREATED  
CONTINUATION OF INITIATIVE: YES, ALL LISTED INITIATIVES ARE CONTINUING.

TOTAL COST OF INITIATIVE: \$22,111 (DOES NOT INCLUDE INDIRECT OVERHEAD)

INITIATIVE 13



**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.

IDENTIFIED NEED: UNDERAGE DRINKING AND BINGE DRINKING AND DRUG/ SUBSTANCE  
ABUSE, DISTRACTED DRIVING

- INCREASE LIFE EXPECTANCY; REDUCE ALCOHOL-IMPAIRED DRIVING FATALITIES

HOSPITAL INITIATIVE: PARTNERSHIP WITH LOCAL RESET PROGRAM, WHICH SERVES  
THE 5-COUNTY AREA, INCLUDING SHORE REGIONAL MEDICAL CENTER AT  
CHESTERTOWN'S PSA OF KENT COUNTY

PRIMARY OBJECTIVE: THE PRIMARY OBJECTIVE OF THIS INITIATIVE IS TO PROVIDE  
THE YOUTH OF OUR COMMUNITY WITH INFORMATION ABOUT THE RISKS OF UNDERAGE  
CONSUMPTION OF ALCOHOL, BINGE DRINKING AND DRUG/SUBSTANCE ABUSE, AS WELL  
AS DISTRACTED DRIVING AND NOT PRACTICING SAFE DRIVING (I.E.: TEXTING,  
CELL PHONE USE, WEARING SEATBELTS).

THE RESET PROGRAM IS AN EARLY INTERVENTION/ALTERNATIVE SENTENCING  
EDUCATION PROGRAM TARGETED AT "AT-RISK" TEENS AND YOUNG ADULTS, AGED  
13-24 YEARS. SHORE MEDICAL CENTER AT CHESTERTOWN IS AN ANNUAL PARTNER AND  
SPONSOR. THE RESET PROGRAM UTILIZES THE HOSPITAL'S EMERGENCY DEPARTMENT  
AND ED CLINICAL STAFF TO ASSIST WITH EDUCATIONAL INSTRUCTION AND

**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.

EMERGENCY SIMULATION, AND INCLUDES PRESENTATIONS/LECTURES FROM PHYSICIANS AND EMERGENCY DEPARTMENT STAFF. THIS INTERACTIVE EDUCATIONAL PROGRAM SHOWS YOUTH THE CONSEQUENCES OF POOR CHOICES AND RISKY BEHAVIORS. THE RESET PROGRAM OCCURS MONTHLY.

RESET PROGRAM: [HTTP://TERRYOBER.WEEBLY.COM/RESET-PROGRAM.HTML](http://TERRYOBER.WEEBLY.COM/RESET-PROGRAM.HTML)

SINGLE OR MULTI-YEAR INITIATIVE TIME PERIOD; MULTI-YEAR INITIATIVE AND ONGOING

KEY PARTNERS: EMERGENCY DEPARTMENT, EMERGENCY DEPARTMENT STAFF AT SHORE MEDICAL CENTER AT CHESTERTOWN, COMMUNITY PHYSICIANS, TERRY OBER, RESET PROGRAM COORDINATOR.

SHORE MEDICAL CENTER AT CHESTERTOWN SUPPLIED THE USE OF ITS ED AND CLINICAL STAFF FOR THE EDUCATIONAL INSTRUCTION, ALONG WITH THE USE OF ITS CONFERENCE CENTER AND EDUCATION CENTER.

HOW WERE THE OUTCOMES EVALUATED? OUTCOMES ARE EVALUATED BY REVIEWING

**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.

NUMBER OF STUDENTS ENROLLED AND PARTICIPATING IN PROGRAM.

OUTCOMES (INCLUDE PROCESS AND IMPACT MEASURES):

EACH YEAR 75-100 RESET PROGRAM "STUDENTS" PARTICIPATE FROM MID-SHORE

COUNTIES, INCLUDING KENT. THE PROGRAM PROVIDES:

- INTERACTIVE AND EDUCATIONAL INSTRUCTION TO SHOW YOUTH CONSEQUENCES OF POOR CHOICES AND RISKY BEHAVIORS
- ADDRESSES ALCOHOL, BINGE DRINKING, DRUG/SUBSTANCE ABUSE AND DISTRACTED DRIVING (TEXTING, CELL PHONE USE, SEATBELTS)
- STUDENTS PARTICIPATE IN MOCK ACCIDENT AND SHOW WHAT A PERSON EXPERIENCES FORM AMBULANCE THROUGH EMERGENCY DEPARTMENT AND THEN LIFE POST-REHAB AND/OR DEATH.
- RECIDIVISM RATE 10% AMONG STUDENTS WHO SUCCESSFULLY COMPLETE PROGRAM

CONTINUATION OF INITIATIVE: YES, ALL LISTED INITIATIVES ARE CONTINUING.

TOTAL COST OF INITIATIVE: \$2,066

**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.

## AFFILIATED HEALTH CARE SYSTEM ROLES

SCHEDULE H, PART VI, LINE 6

THE UNIVERSITY OF MARYLAND MEDICAL CENTER IS AN 800-BED TEACHING HOSPITAL IN BALTIMORE AND THE FLAGSHIP INSTITUTION OF THE 12-HOSPITAL UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS). AS A NATIONAL AND REGIONAL REFERRAL CENTER FOR TRAUMA, CANCER CARE, NEUROCARE, CARDIAC CARE, WOMEN'S AND CHILDREN'S HEALTH AND PHYSICAL REHABILITATION, UMMC TREATS PATIENTS WHO ARE REFERRED NATIONALLY AND REGIONALLY FOR EXPERTISE IN TIME-SENSITIVE CRITICAL CARE MEDICINE. UMMC ALSO HAS ONE OF THE LARGEST SOLID ORGAN TRANSPLANT PROGRAMS IN THE COUNTRY, PERFORMING MORE THAN 400 ABDOMINAL AND THORACIC TRANSPLANTS A YEAR. ALL PHYSICIANS ON STAFF AT THE MEDICAL CENTER ARE FACULTY PHYSICIANS OF THE UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE. AS PART OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM, THE MEDICAL CENTER PARTICIPATES IN THE UMMS COMMUNITY HEALTH OUTREACH AND ADVOCACY TEAM TO VALIDATE DATA AND INFORMATION FROM OTHER UMMS HOSPITALS AND COLLABORATE ON LARGE SYSTEM-WIDE EVENTS AND INITIATIVES. SEVERAL UMMS-SPONSORED EVENTS THAT THE MEDICAL CENTER PARTNERS WITH OTHER UMMS' HOSPITALS INCLUDE: SPRING INTO GOOD HEALTH, FROM THE HEART, AND TAKE A

**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.

LOVED ONE TO THE DOCTOR TODAY.

THE UMMC RETAINS ITS STRATEGIC COMMUNITY OUTREACH PRIORITIES WHILE COLLABORATING WITH OTHER UMMS HOSPITALS. THE MEDICAL CENTER ESPECIALLY COLLABORATES WITH THE BALTIMORE-BASED HOSPITALS (UNIVERSITY OF MARYLAND MIDTOWN CAMPUS, FORMERLY MARYLAND GENERAL, MT WASHINGTON PEDIATRIC HOSPITAL, AND UNIVERSITY OF MARYLAND REHABILITATION AND ORTHOPEDIC INSTITUTE, FORMERLY KERNAN HOSPITAL). SEVERAL MEMBERS OF THE UMMC COMMUNITY OUTREACH TEAM ARE MEMBERS OF THE UMMS COMMUNITY ADVOCACY AND UMMS COMMUNITY BENEFITS TEAMS. INFORMATION AND COLLABORATIVE OPPORTUNITIES ARE DISCUSSED IN ALL FORUMS. IN MOST INSTANCES, THE UMMC PROVIDES CLINICAL EXPERTISE IN MANY SPECIALTY FIELDS AS WELL STAFF SUPPORT AND RESOURCES FOR LARGER SYSTEM-WIDE PROGRAMMING WHILE RETAINING FOCUS ON OUR KEY COMMUNITY STRATEGIC PRIORITIES.

**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.

COMMUNITY BENEFIT REPORT STATE FILINGS

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](http://www.irs.gov/form990).

OMB No. 1545-0047

**2013**

**Open to Public  
Inspection**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

**Part I Questions Regarding Compensation**

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

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

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

**2** Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all 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
<b>1b</b>	X	
<b>2</b>	X	
<b>4a</b>	X	
<b>4b</b>	X	
<b>4c</b>		X
<b>5a</b>		X
<b>5b</b>		X
<b>6a</b>		X
<b>6b</b>		X
<b>7</b>	X	
<b>8</b>		X
<b>9</b>		

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 CHRENCIK UMMS PRESIDENT/CEO	(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 JOHN ASHWORTH, III BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	370,396.	91,000.	66,271.	10,200.	10,301.	548,168.	0
3 GERARD WALSH FORMER INTERIM CEO	(i)	266,092.	75,295.	38,113.	10,200.	7,917.	397,617.	0
	(ii)	0	0	0	0	0	0	0
4 WALTER ZAJAC VP OF FINANCE & BUDGET	(i)	193,240.	39,834.	26,878.	7,967.	9,641.	277,560.	0
	(ii)	0	0	0	0	0	0	0
5 PHYLLIS MATTHAI FORMER BOARD ASST.SECRETARY	(i)	38,586.	5,881.	116.	2,809.	5,430.	52,822.	0
	(ii)	0	0	0	0	0	0	0
6 KENNETH KOZEL PRESIDENT/CEO	(i)	369,119.	101,250.	23,362.	71,250.	12,869.	577,850.	0
	(ii)	0	0	0	0	0	0	0
7 MICHAEL TOOKE, MD CMO	(i)	186,835.	80,133.	30,598.	7,617.	6,267.	311,450.	0
	(ii)	0	0	0	0	0	0	0
8 CHRISTOPHER PARKER SVP- PAT CARE/CNO	(i)	207,881.	65,416.	40,733.	8,722.	10,864.	333,616.	0
	(ii)	0	0	0	0	0	0	0
9 MICHAEL ZIMMERMAN VP/HR	(i)	121,962.	41,820.	16,975.	5,022.	7,920.	193,699.	0
	(ii)	0	0	0	0	0	0	0
10 JONATHAN COOK VP/PHYSICAN SERVICES	(i)	162,717.	40,747.	3,024.	22,071.	12,854.	241,413.	0
	(ii)	0	0	0	0	0	0	0
11 MICHAEL SILGEN VP/STRAT PLAN & BUS DEVELOP	(i)	115,605.	32,536.	149,967.	4,624.	2,811.	305,543.	57,950.
	(ii)	0	0	0	0	0	0	0
12 JOHN SAWYER LEAD MEDICAL PHYSICIST	(i)	178,793.	0	367.	10,713.	428.	190,301.	0
	(ii)	0	0	0	0	0	0	0
13 FRANCIS G. LEE VP-PHILANTHROPY	(i)	150,811.	32,550.	6,863.	20,150.	12,020.	222,394.	0
	(ii)	0	0	0	0	0	0	0
14 PATTI WILLIS VP EXT RELATIONS & COMM	(i)	154,321.	48,139.	26,052.	6,419.	10,864.	245,795.	0
	(ii)	0	0	0	0	0	0	0
15 JOSEPH ROSS FORMER PRESIDENT/CEO	(i)	0	0	147,789.	0	0	147,789.	0
	(ii)	0	0	0	0	0	0	0
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 OR \$3,000 DEPENDING ON JOB TITLE AS DESCRIBED IN THE PROGRAM DOCUMENTS.

## SEVERANCE OR CHANGE OF CONTROL PAYMENTS

SCHEDULE J, PART I, LINE 4A

JOSEPH ROSS RECEIVED SEVERANCE PAYMENTS TOTALING \$147,789.

## 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:

**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.

- ROBERT CHRENCIK
- MICHAEL SILGEN
- JONATHAN COOK
- KENNETH KOZEL

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 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, COLUMN B(III), OTHER REPORTABLE COMPENSATION:

- MICHAEL ZIMMERMAN
- PATTI WILLIS
- JOSEPH P. ROSS (TERM 4/1/11)
- JOHN ASHWORTH

**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.

- WALTER ZAJAC

- GERARD WALSH

CHRISTOPHER PARKER

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 INDIVIDUAL LISTED BELOW HAS VESTED IN THE PLAN IN THE REPORTING TAX YEAR. THEREFORE, THE FULL VALUE OF THE PLAN, INCLUDING ANY CONTRIBUTIONS TO THE PLAN FOR THE CURRENT FISCAL YEAR, IS REPORTED AS TAXABLE COMPENSATION AND REPORTED ON SCHEDULE J, PART II, LINE B(III), OTHER REPORTABLE COMPENSATION. PRIOR YEAR CONTRIBUTIONS TO THE PLAN WERE PREVIOUSLY REPORTED ON FORM 990 AND ARE INDICATED ON SCHEDULE J, PART II, COLUMN (F).

MICHAEL TOOKE MD

NON-FIXED PAYMENTS

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

**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.

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 L**  
**(Form 990 or 990-EZ)**

**Transactions With Interested Persons**

OMB No. 1545-0047

**2013**

Department of the Treasury  
Internal Revenue Service

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**  
▶ **Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.**  
▶ **Information about Schedule L (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

**Open To Public Inspection**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

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

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

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

**Part II Loans to and/or From Interested Persons.**

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

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

**Part III Grants or Assistance Benefiting Interested Persons.**

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

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

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

Schedule L (Form 990 or 990-EZ) 2013

**Part IV Business Transactions Involving Interested Persons.**

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) BONNIE ZAJAC	WALTER ZAJAC-SPOUSE	74,282.	COMPENSATION FOR FYE 2014		X
(2) KARYN WALSH	GERARD WALSH-SPOUSE	24,075.	COMPENSATION FOR FYE 2014		X
(3) JOSHUA ZIMMERMAN	MICHAEL ZIMMERMAN-SON	32,422.	COMPENSATION FOR FYE 2014		X
(4) RONALD MEAKER	CHRISTOPHER PARKER-SPOUSE	30,567.	COMPENSATION FOR FYE 2014		X
(5) WAYNE L. GARDNER, SR.	BEST CARE AMBULANCE	185,679.	PAYMENT TO COMPANY		X
(6)					
(7)					
(8)					
(9)					
(10)					

**Part V Supplemental Information**

Provide additional information for responses to questions on Schedule L (see instructions).

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

Department of the Treasury  
Internal Revenue Service

**Supplemental Information to Form 990 or 990-EZ**

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

OMB No. 1545-0047

**2013**

**Open to Public  
Inspection**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

NOTE REGARDING REORGANIZATION

EFFECTIVE JULY 1, 2013, THE OPERATIONS OF SHORE HEALTH AND CHESTER RIVER WERE COMBINED AND RENAMED SHORE REGIONAL HEALTH. THIS WAS ACCOMPLISHED THROUGH MERGING CERTAIN ENTITIES WITHIN THE SYSTEMS.

PROGRAM SERVICE ACCOMPLISHMENTS

FORM 990, PART III, LINE 4A

SHORE HEALTH SYSTEM, INC. IS A 191 LICENSED BED COMMUNITY HOSPITAL PROVIDING A FULL RANGE OF INPATIENT AND OUTPATIENT CLINICAL SERVICES TO THE MARYLAND MID-SHORE AREA; INCLUDING GENERAL HOSPITAL, EMERGENCY, AND SPECIALIZED SERVICES AS WELL AS OUTPATIENT CENTERS FOR PRIMARY CARE, DIAGNOSTICS, TREATMENT, EDUCATION, AND REHABILITATION. THE SYSTEM OFFERS FREE EDUCATION PROGRAMS AND SERVICES TO PROMOTE HEALTH AWARENESS IN THE COMMUNITY. DURING FY 2014, THE SYSTEM PROVIDED CARE FOR 11,474 INPATIENTS RESULTING IN 46,020 DAYS OF PATIENT CARE, TREATED 70,423 PATIENTS IN THE ER, AND PERFORMED 9,073 SURGERIES IN THE OR. THE SYSTEM'S ANCILLARY SERVICE DEPARTMENTS REALIZED 507,862 OUTPATIENT ENCOUNTERS. HOME HEALTH/HOSPICE SERVICES WERE PROVIDED TO 1,713 PATIENTS IN 27,724 NURSING VISITS. THE SYSTEMS MISSION STATEMENT IS "TO EXCEL IN QUALITY CARE AND PATIENT SATISFACTION". ITS STRATEGIC PRINCIPLE IS "EXCEPTIONAL CARE, EVERY DAY", AND ITS VALUES STATEMENT IS "EVERY INTERACTION WITH ANOTHER IS AN OPPORTUNITY TO CARE". AS A PART OF ITS MISSION, THE SYSTEM PROVIDES CHARITY CARE TO PATIENTS UNABLE TO PAY, PROVIDING \$10.2 MILLION OF CHARITY CARE IN FY 2014.

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

MEMBERS OR STOCKHOLDERS

FORM 990, PART VI, LINE 6

UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (UMMS) IS THE SOLE MEMBER OF SHORE HEALTH SYSTEM, INC. 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 SHARED SERVICES AND IS ALSO REVIEWED BY THE ACCOUNTING MANAGER, THE DIRECTOR OF



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

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

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

## PROCESS FOR DETERMINING COMPENSATION

FORM 990, PART VI, LINE 15A AND 15B

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

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

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

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

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

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

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

DEEMED PROPRIETARY AND NOT SUBJECT TO DISCLOSURE UPON REQUEST. HOWEVER, SPECIFIC PROVISIONS OF FEDERAL AND STATE LAW REQUIRE THE ORGANIZATION TO DISCLOSE CERTAIN LIMITED FINANCIAL AND TAX DATA UPON A SPECIFIC REQUEST FOR THAT INFORMATION. REQUESTS FOR FORM 990 AND FORM 1023: A REQUESTOR SEEKING TO REVIEW AND/OR OBTAIN A COPY OF THE ORGANIZATION'S I.R.S. 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 I.R.S. 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

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

POLICY WILL BE PROVIDED TO THE PUBLIC AT THE DISCRETION OF MANAGEMENT.

HOURS NARRATIVE

FORM 990, PART VII, SECTION A, COLUMN B

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

OTHER CHANGES IN NET ASSETS

FORM 990, PART XI, LINE 9

CHANGE IN BENEFICIAL INTEREST	\$9,274,491
CHANGE IN INVESTMENT OF SUB.	\$205,080
BOND SWAP TERM W/O	\$(323,454)
EQUITY TRF.	\$(12,003,881)
DONATED CAPITAL	\$9,400,000
SWAP COSTS	\$(1,206,862)
ROUNDING-AUDITED STMTS	\$3,004
	-----
TOTAL	\$5,348,378

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

TAX EXEMPT BONDS

PART IV, LINE 24A

PURSUANT TO A MASTER LOAN AGREEMENT DATED JUNE 20, 1991 (THE "MASTER LOAN AGREEMENT"), AS AMENDED, THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (THE "CORPORATION") AND SEVERAL OF ITS SUBSIDIARIES HAVE ISSUED DEBT THROUGH THE MARYLAND HEALTH AND HIGHER EDUCATION FACILITY AUTHORITY (THE "AUTHORITY"). AS SECURITY FOR THE PERFORMANCE OF THE BOND OBLIGATION UNDER THE MASTER LOAN AGREEMENT, THE AUTHORITY MAINTAINS A SECURITY INTEREST IN THE REVENUE OF THE OBLIGORS. THE MASTER LOAN AGREEMENT CONTAINS CERTAIN RESTRICTIVE COVENANTS. THESE COVENANTS REQUIRE THAT RATES AND CHARGES BE SET AT CERTAIN LEVELS, LIMIT INCURRENCE OF ADDITIONAL DEBT, REQUIRE COMPLIANCE WITH CERTAIN OPERATING RATIOS AND RESTRICT THE DISPOSITION OF ASSETS.

THE OBLIGATED GROUP UNDER THE MASTER LOAN AGREEMENT INCLUDES THE CORPORATION, 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 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.

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

ATTACHMENT 1

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

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
MARYLAND EMERGENCY MEDICINE NETWORK 110 SOUTH PACA ST. 6TH FLOOR STE. 200 BALTIMORE, MD 21201	PHYSICIAN SERVICES	1,912,415.
TIDEWATER ANESTHESIA ASSOCIATES PA PO BOX 1208 EASTON, MD 21601	PHYSICIAN SERVICES	1,449,996.
INNOVATIVE HEALTH SERVICES PO BOX 778 EASTON, MD 21601	MANAGEMENT FEES	921,339.
LABCORP OF AMERICA PO BOX 12140 BURLINGTON, NC 27217	LAB SERVICES	780,469.
SODEXO CO. PO BOX 536922 ATLANTA, GA 30353	CAFETERIA SERVICES	1,763,872.

ATTACHMENT 2FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	(A) <u>TOTAL FEES</u>	(B) <u>PROGRAM SERVICE EXP.</u>	(C) <u>MANAGEMENT AND GENERAL</u>	(D) <u>FUNDRAISING EXPENSES</u>
PHYSICIAN EXPENSES	7,884,652.	7,832,652.	52,000.	
OTHER SERVICES	2,899,797.	2,536,397.	363,400.	
CORPORATE OFFICE EXPENSE ALLOC	2,141,444.		2,141,444.	
BAD DEBT COLLECTION	2,329,519.	2,329,519.		
OTHER EXPENSES	10,142,351.	8,198,763.	1,943,588.	
TOTALS	<u>25,397,763.</u>	<u>20,897,331.</u>	<u>4,500,432.</u>	

**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](http://www.irs.gov/form990).**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

(a) Name, address, and EIN (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) 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) BALTIMORE WASHINGTON MEDICAL SYSTEM, INC. 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)	11C	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](http://www.irs.gov/form990).**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

(a) Name, address, and EIN (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](http://www.irs.gov/form990).**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

(a) Name, address, and EIN (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, I 827 LINDEN AVENUE BALTIMORE, MD 21201 52-1175337	HEALTHCARE	MD	501(C)(3)	11B	UMMSC		X
(2) MARYLAND GENERAL HOSPITAL INC 827 LINDEN AVENUE BALTIMORE, MD 21201 52-0591667	HEALTHCARE	MD	501(C)(3)	03	MGHS		X
(3) CARE HEALTH SERVICES INC 219 SOUTH WASHINGTON STREET EASTON, MD 21601 52-1510269	HEALTHCARE	MD	501(C)(3)	09	SHS	X	
(4) DORCHESTER GENERAL HOSPITAL FOUNDATION 219 SOUTH WASHINGTON STREET EASTON, MD 21601 52-1703242	FUNDRAISING	MD	501(C)(3)	11D	SHS	X	
(5) MEMORIAL HOSPITAL FOUNDATION INC 219 SOUTH WASHINGTON STREET EASTON, MD 21601 52-1282080	FUNDRAISING	MD	501(C)(3)	11A	SHS	X	
(6) SHORE CLINICAL FOUNDATION INC 219 SOUTH WASHINGTON STREET EASTON, MD 21601 52-1874111	HEALTHCARE	MD	501(C)(3)	03	SHS	X	
(7) JAMES LAWRENCE KERNAN HOSP ENDOW FD 2200 KERNAN DRIVE BALTIMORE, MD 21207 23-7360743	FUNDRAISING	MD	501(C)(3)	11B	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](http://www.irs.gov/form990).**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

(a) Name, address, and EIN (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 HOSPITAL INC 2200 KERNAN DRIVE BALTIMORE, MD 21207 52-0591639	HEALTHCARE	MD	501(C)(3)	03	UMMSC		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	UMMSC		X
(4) UNIVERSITY OF MARYLAND CHARLES REGIONAL PO BOX 1070 LA PLATA, MD 20646 52-2155576	HEALTHCARE	MD	501(C)(3)	11C	UMMSC		X
(5) CIVISTA MEDICAL CENTER, INC. PO BOX 1070 LA PLATA, MD 20646 52-0445374	HEALTHCARE	MD	501(C)(3)	03	CIVHS		X
(6) CHARLES REGIONAL MEDICAL CENTER FOUNDATI PO BOX 1070 LA PLATA, MD 20646 52-1414564	FUNDRAISING	MD	501(C)(3)	11A	CIVHS		X
(7) CHARLES REGIONAL MEDICAL CENTER AUXILIAR 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](http://www.irs.gov/form990).**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

(a) Name, address, and EIN (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. 52-1681044 7601 OSLER DRIVE TOWSON, MD 21204	FUNDRAISING	MD	501(C)(3)	11A	UMMSC		X
(2) HARMFORD 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)**

**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](http://www.irs.gov/form990).**

Name of the organization

SHORE HEALTH SYSTEM, INC.

Employer identification number

52-0610538

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

(a) Name, address, and EIN (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, IN 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, I 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					X			X	
(2) BALTIMORE WASHINGTON IMAGING, 301 HOSPITAL DRIVE	HEALTHCARE	MD	N/A					X			X	
(3) CENTRAL MARYLAND RADIOLOGY ONC 10710 CHARTER DRIVE	HEALTHCARE	MD	N/A					X			X	
(4) INNOVATIVE HEALTH LLC 52-19972 29165 CANVASBACK DRIVE, SUITE	BILLING	MD	SHS	RELATED	665,000.	326,500.		X			X	50.0000
(5) NAH/SUNRISE OF SEVERNA PARK LL 301 HOSPITAL DRIVE	HEALTHCARE	MD	N/A					X			X	
(6) NORTH ARUNDEL SENIOR LIVING LL 301 HOSPITAL DRIVE	HEALTHCARE	MD	N/A					X			X	
(7) SHIPLEY'S IMAGING CENTER LLC 5 22 SOUTH GREENE STREET	HEALTHCARE	MD	N/A					X			X	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) ARUNDEL PHYSICIANS ASSOCIATES, INC. 52-1992649 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	N/A	C CORP					X
(2) BALTIMORE WASHINGTON HEALTH ENTERPRISES, 52-1936656 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	N/A	C CORP					X
(3) BW PROFESSIONAL SERVICES, INC. 52-1655640 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	N/A	C CORP					X
(4) UNIV OF MARYLAND CHARLES REGIONAL CARE P 52-2176314 PO BOX 1070 LA PLATA, MD 20646	HEALTHCARE	MD	N/A	C CORP					X
(5) UNIVERSITY MIDTOWN PROF CENTER, A CONDO 52-1891126 827 LINDEN AVENUE BALTIMORE, MD 21201	REAL ESTATE	MD	N/A	C CORP					X
(6) SHORE HEALTH ENTERPRISES, INC. 52-1363201 219 SOUTH WASHINGTON STREET EASTON, MD 21601	REAL ESTATE	MD	N/A	C CORP			100.0000		X
(7) NA EXECUTIVE BUILDING CONDO ASSN, INC. NONE 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	REAL ESTATE	MD	N/A	C CORP					X

**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					X			X	
(2) O'DEA MEDICAL ARTS LIMITED PAR 7601 OSLER DRIVE	RENTAL	MD	N/A					X			X	
(3) ADVANCED IMAGING AT ST. JOSEPH 7601 OSLER DRIVE	HEALTHCARE	MD	N/A					X			X	
(4) UCHS/UMMS REAL ESTATE TRUST 27 520 UPPER CHESAPEAKE DR.	HOLD LAND	MD	N/A					X			X	
(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	CJ	N/A	C CORP					X
(2) UMMS SELF INSURANCE TRUST ----- 52-6315433 22 SOUTH GREENE STREET BALTIMORE, MD 21201	INSURANCE	MD	N/A	TRUST					X
(3) UPPER CHESAPEAKE INSURANCE COMPANY, LTD. ----- 98-0468438 P.O. BOX 1109 GRAND CAYMAN, GRAND CAYMAN ISLANDS CJ	CAPTIVE INSURANCE	CJ	N/A	LTD					X
(4) UPPER CHESAPEAKE HEALTH VENTURES, INC. ----- 52-2031264 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HEALTHCARE	MD	N/A	C CORP					X
(5) UPPER CHESAPEAKE MEDICAL CENTER LAND CON ----- 77-0674478 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	REAL ESTATE	MD	N/A	C CORP					X
(6) UPPER CHESAPEAKE MEDICAL OFFICE BUILDING ----- 52-1946829 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	REAL ESTATE	MD	N/A	C CORP					X
(7) UPPER CHESAPEAKE MGMT SVCS ORG, INC. ----- 52-1946025 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	MANAGEMENT SVCS	MD	N/A	C CORP					X

**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
<b>1</b> 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?		
<b>a</b> Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity	X	
<b>b</b> Gift, grant, or capital contribution to related organization(s)	X	
<b>c</b> Gift, grant, or capital contribution from related organization(s)	X	
<b>d</b> Loans or loan guarantees to or for related organization(s)		X
<b>e</b> Loans or loan guarantees by related organization(s)	X	
<b>f</b> Dividends from related organization(s)		X
<b>g</b> Sale of assets to related organization(s)		X
<b>h</b> Purchase of assets from related organization(s)		X
<b>i</b> Exchange of assets with related organization(s)		X
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s)	X	
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s)	X	
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s)	X	
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s)		X
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	X	
<b>o</b> Sharing of paid employees with related organization(s)	X	
<b>p</b> Reimbursement paid to related organization(s) for expenses	X	
<b>q</b> Reimbursement paid by related organization(s) for expenses	X	
<b>r</b> Other transfer of cash or property to related organization(s)	X	
<b>s</b> Other transfer of cash or property from related organization(s)		X

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) SHORE CLINICAL FOUNDATION	A	74,353.	FMV
(2) DORCHESTER GENERAL HOSPITAL FOUNDATION	C	143,976.	FMV
(3) MEMORIAL HOSPITAL FOUNDATION	C	639,639.	FMV
(4) CARE HEALTH SERVICES	N	452,808.	FMV
(5) MEMORIAL HOSPITAL FOUNDATION	N	329,394.	FMV
(6) SHORE CLINICAL FOUNDATION	N	658,176.	FMV



**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).

---