Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

OMB No. 1545-0047

2015

Open to Public Inspection

A For the 2015 calendar year, or tax year beginning 07/01, **2015, and ending** 06/30, **20** 16

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

C Name of organization
CHESTER RIVER HOSPITAL CENTER

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
100 BROWN STREET

City or town, state or province, country, and ZIP or foreign postal code
CHESTERTOWN, MD 21620

D Employer identification number
52-0679694

E Telephone number
(410) 822-1000

G Gross receipts $ 64,485,289.

F Name and address of principal officer: KENNETH KOZEL
100 BROWN STREET CHESTERTOWN, MD 21620

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

H(b) Are all subordinates included? ☐ Yes ☐ No

If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

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

J Website: ▶ WWW.UMSHOREREGIONAL.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶ **L** Year of formation: 1935 **M** State of legal domicile: MD

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: CRH CTR, A MEMBER OF UMMS, IS AN INTEGRAL RURAL DELIVERY SYSTEM DEDICATED TO PROVIDING EXCELLENT AND CARING HEALTH SERVICES AND FACILITIES TO THE PEOPLE OF UPPER EASTERN SHORE.

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

3	Number of voting members of the governing body (Part VI, line 1a)	3	25.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	21.
5	Total number of individuals employed in calendar year 2015 (Part V, line 2a)	5	339.
6	Total number of volunteers (estimate if necessary)	6	129.
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	421,037.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	-21,923.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	1,329,486.	333,425.
9	Program service revenue (Part VIII, line 2g)	55,232,113.	56,079,811.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	445,453.	305,395.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	258,657.	256,956.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	57,265,709.	56,975,587.

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Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	0.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	23,501,547.	17,865,318.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	30,720,768.	33,601,114.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	54,222,315.	51,466,432.
19	Revenue less expenses. Subtract line 18 from line 12	3,043,394.	5,509,155.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	73,013,772.	74,264,736.
21	Total liabilities (Part X, line 26)	28,118,313.	25,407,086.
22	Net assets or fund balances. Subtract line 21 from line 20	44,895,459.	48,857,650.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date: 05/01/2017

▶ JOANNE HAHEY CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
FRANK GIARDINI	Frank S. Giardini	05/11/2017		P00532355

Firm's name ▶ GRANT THORNTON LLP — Firm's EIN ▶ 36-6055558

Firm's address ▶ 2001 MARKET STREET, SUITE 700 PHILADELPHIA, PA 19103 — Phone no. 215-561-4200

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2015)

Form **8868**
(Rev. January 2014)
Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File an Exempt Organization Return

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

OMB No. 1545-1709

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

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

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

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

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

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

Enter filer's identifying number, see instructions

Type or print	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
File by the due date for filing your return. See instructions.	CHESTER RIVER HOSPITAL CENTER	52-0679694
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	100 BROWN STREET	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
	CHESTERTOWN, MD 21620	

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

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 990-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 ▶ JOANNE HAHEY, 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 17, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

▶ ☐ calendar year 20 ____ or

▶ X tax year beginning 07/01, 20 15, and ending 06/30, 20 16.

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

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

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

Cumulative e-File History 2015	
FED	
Locator:	4221CV
Taxpayer Name:	Chester River Hospital Center
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	10/10/2016 16:30:09
Acknowledgement Date:	10/10/2016 16:57:19
Status:	Accepted
Submission ID:	23695320162845000025

- 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

Type or print

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

Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
CHESTER RIVER HOSPITAL CENTER	52-0679694
Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
100 BROWN STREET	
City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
CHESTERTOWN, MD 21620	

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

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

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

- The books are in the care of ▶ JOANNE HAHEY, 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 17 .

5 For calendar year _____ , or other tax year beginning 07/01 , 20 15 , and ending 06/30 , 20 16 .

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

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

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

Signature and Verification must be completed for Part II only.

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

Signature ▶ Frank S. Franchini Title ▶ TAX PRINCIPAL Date ▶ 01/31/2017

Cumulative e-File History 2015	
FED	
Locator:	4221CV
Taxpayer Name:	Chester River Hospital Center
Return Type:	990, 990 & 990T (Corp)
Submitted Date:	01/31/2017 10:01:52
Acknowledgement Date:	01/31/2017 10:27:21
Status:	Accepted
Submission ID:	23695320170315000010

Part III **Statement of Program Service Accomplishments**

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

1 Briefly describe the organization's mission:

AN ACUTE CARE HOSPITAL THAT SERVES THE RESIDENTS OF KENT AND QUEEN ANNE'S COUNTIES AND PORTIONS OF CAROLINE AND CECIL COUNTIES.

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 $ 47,596,931. including grants of $ 0.) (Revenue $ 55,766,184.)

CHESTER RIVER HOSPITAL CENTER IS A 40-BED HOSPITAL. IT IS SERVED BY APPROXIMATELY 200 ACTIVE AND CONSULTING STAFF PHYSICIANS REPRESENTING A WIDE ARRAY OF MEDICAL SPECIALTIES. THE COMMUNITY HOSPITAL, WHICH IS FULLY ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, PROVIDES INPATIENT MEDICAL SERVICES, 24-HOUR EMERGENCY CARE, SURGICAL SERVICES, OUTPATIENT DIAGNOSTIC SERVICES, LABORATORY SERVICES, REHABILITATION, AND ONCOLOGY TO SERVE THE LOCAL COMMUNITY'S NEEDS. THE HOSPITAL WAS ESTABLISHED IN 1935. IT IS STAFFED BY APPROXIMATELY 339 EMPLOYEES.

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 ▶ 47,596,931.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, 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*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		X
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments-other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	X	
c	Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	24a		X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a	X	
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a		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)? *If "Yes," complete Schedule R, Part V, line 2*	35b		
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O.	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	62		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0.		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	339		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)	2b		X	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?	9a			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O.	13a			
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

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

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a 25		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
b	Enter the number of voting members included in line 1a, above, who are independent	1b 21		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? . .	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6	X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9		X

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

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

Section C. Disclosure

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

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

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

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, address, and telephone number of the person who possesses the organization's books and records: ▶
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) JOHN DILLON	1.00									
CHAIRMAN	4.00	X		X				0.	156,000.	0.
(2) RICHARD LOEFFLER	1.00									
VICE CHAIRMAN	4.00	X		X				0.	0.	0.
(3) STUART BOUNDS, PHD	1.00									
SECRETARY	4.00	X		X				0.	0.	0.
(4) WAYNE L. GARDNER	1.00									
TREASURER	4.00	X		X				0.	0.	0.
(5) MYRA BUTLER	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(6) CHARLES CAPUTE	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(7) ART CECIL	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(8) ROBERT A. CHRENCIK	1.00									
DIRECTOR	49.00	X						0.	2,562,797.	23,637.
(9) JOSEPH J. CIOTOLA, M.D.	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(10) DEBORAH DAVIS, M.D.	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(11) KATHY DEOUDES	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(12) MARLENE FELDMAN	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(13) WAYNE HOWARD	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(14) MICHAEL D. JOYCE, M.D.	1.00									
DIRECTOR	4.00	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (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) KEITH MCMAHAN	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(16) DAVID MILLIGAN	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(17) WILLIAM NOLL	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(18) GEOFF OXNAM	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(19) MARTHA RUSSELL	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(20) C. DANIEL SAUNDERS	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(21) THOMAS STAUCH, M.D.	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(22) ROBERT SWAM	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(23) MYRON SZCZUKOWSKI	1.00									
DIRECTOR	4.00	X						0.	0.	0.
(24) JOHN W. ASHWORTH, III	1.00									
DIRECTOR	49.00	X						0.	780,732.	23,637.
(25) KENNETH KOZEL	20.00									
PRESIDENT/CEO	20.00	X		X				0.	576,657.	86,496.
1b Sub-total ▶								0.	2,718,797.	23,637.
c Total from continuation sheets to Part VII, Section A ▶								624,126.	2,929,164.	308,665.
d Total (add lines 1b and 1c) ▶								624,126.	5,647,961.	332,302.

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 ▶ 14

		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*	3	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*	4	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*	5		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 ▶ 7

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) JOANNE HAHEY	20.00									
CFO/SVP FINANCE	20.00			X				0.	387,553.	58,501.
(27) CHRISTOPHER J. PARKER	20.00									
CNO	20.00				X			0.	376,985.	22,522.
(28) KATHY C. ELLIOTT	40.00									
DIR. RN CLINICAL	0.					X		120,484.	0.	11,143.
(29) STEWART SEITZ	40.00									
DIR. SHORE NURSING & REHAB	0.					X		138,725.	0.	11,627.
(30) DEBORAH PIPPIN	40.00									
SITE COORDINATOR	0.					X		126,711.	0.	14,484.
(31) KENNETH PEREGOY	40.00									
CLINICAL PHARMACIST	0.					X		124,292.	0.	14,402.
(32) MICHAEL W. PARKER	40.00									
NURSE	0.					X		113,914.	0.	9,786.
(33) MARY JO KEEFE	0.									
FORMER VP/CNO	0.						X	0.	158,262.	21,053.
(34) SAMUEL P. MARINELLI, JR.	0.									
FORMER CFO	0.						X	0.	279,905.	21,307.
(35) JAMES E. ROSS	0.									
FORMER CEO/PRESIDENT	0.						X	0.	267,104.	0.
(36) SCOTT BURLESON	20.00									
FORMER COO	20.00						X	0.	101,966.	13,707.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 14

		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*	**3**	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*	**4**	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*	**5**		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
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d	333,425.			
	e	Government grants (contributions)	1e				
	f	All other contributions, gifts, grants, and similar amounts not included above	1f				
	g	Noncash contributions included in lines 1a-1f: $					
	h	**Total.** Add lines 1a-1f ▶		333,425.			
			Business Code				
Program Service Revenue	2a	PATIENT SERVICE REVENUE	623000	56,079,811.	55,658,774.	421,037.	
	b						
	c						
	d						
	e						
	f	All other program service revenue					
	g	**Total.** Add lines 2a-2f ▶		56,079,811.			
	3	Investment income (including dividends, interest, and other similar amounts) ▶		155,631.			155,631.
	4	Income from investment of tax-exempt bond proceeds ▶		0.			
	5	Royalties ▶		0.			
			(i) Real / (ii) Personal				
	6a	Gross rents	149,546.				
	b	Less: rental expenses					
	c	Rental income or (loss)	149,546.				
	d	Net rental income or (loss) ▶		149,546.			149,546.
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	7,659,466.				
	b	Less: cost or other basis and sales expenses	7,509,702.				
	c	Gain or (loss)	149,764.				
	d	Net gain or (loss) ▶		149,764.			149,764.
Other Revenue	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from fundraising events ▶		0.			
	9a	Gross income from gaming activities. See Part IV, line 19	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from gaming activities ▶		0.			
	10a	Gross sales of inventory, less returns and allowances	a				
	b	Less: cost of goods sold	b				
	c	Net income or (loss) from sales of inventory ▶		0.			
		Miscellaneous Revenue	**Business Code**				
	11a	CAFETERIA SALES	900099	67,721.	67,721.		
	b	MEDICAL RECORDS SALES	900099	16,084.	16,084.		
	c	MISC. REVENUE LAB SVCS	900099	4,575.	4,575.		
	d	All other revenue	900099	19,030.	19,030.		
	e	**Total.** Add lines 11a-11d ▶		107,410.			
	12	**Total revenue.** See instructions. ▶		56,975,587.	55,766,184.	421,037.	454,941.

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	0.			
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0.			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. 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	0.			
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	13,570,388.	12,186,208.	1,384,180.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,563,251.	1,403,799.	159,452.	
9 Other employee benefits	1,696,158.	1,523,150.	173,008.	
10 Payroll taxes	1,035,521.	929,898.	105,623.	
11 Fees for services (non-employees):				
a Management	0.			
b Legal	19,492.		19,492.	
c Accounting	0.			
d Lobbying	3,271.		3,271.	
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.) ATCH 2	11,517,812.	10,960,678.	557,134.	
12 Advertising and promotion	0.			
13 Office expenses	343,069.	308,076.	34,993.	
14 Information technology	0.			
15 Royalties	0.			
16 Occupancy	2,507,559.	2,251,788.	255,771.	
17 Travel	25,782.	23,152.	2,630.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	0.			
20 Interest	238,596.	189,811.	48,785.	
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	3,971,237.	3,566,171.	405,066.	
23 Insurance	936,172.	868,626.	67,546.	
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 SHORE REG. HLTH. SHARED SVCS	5,309,851.	4,768,246.	541,605.	
b MEDICAL SUPPLIES	4,866,890.	4,866,890.		
c BAD DEBT EXPENSE	2,773,694.	2,773,694.		
d REPAIRS & MAINTENANCE	707,999.	635,783.	72,216.	
e All other expenses	379,690.	340,961.	38,729.	
25 **Total functional expenses.** Add lines 1 through 24e	51,466,432.	47,596,931.	3,869,501.	
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0.			

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	3,276,223.	1	5,214,072.
	2	Savings and temporary cash investments	1,206,676.	2	227,171.
	3	Pledges and grants receivable, net	0.	3	0.
	4	Accounts receivable, net	6,312,191.	4	3,928,030.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0.	5	0.
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0.	6	0.
	7	Notes and loans receivable, net	0.	7	0.
	8	Inventories for sale or use	457,185.	8	699,137.
	9	Prepaid expenses and deferred charges	76,002.	9	63,212.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 71,549,806.			
	b	Less: accumulated depreciation — 10b: 43,813,798.	27,967,442.	10c	27,736,008.
	11	Investments - publicly traded securities	7,230,000.	11	6,098,000.
	12	Investments - other securities. See Part IV, line 11	7,383,000.	12	9,136,000.
	13	Investments - program-related. See Part IV, line 11	0.	13	0.
	14	Intangible assets	0.	14	0.
	15	Other assets. See Part IV, line 11	19,105,053.	15	21,163,106.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	73,013,772.	16	74,264,736.
Liabilities	17	Accounts payable and accrued expenses	7,477,911.	17	6,239,288.
	18	Grants payable	0.	18	0.
	19	Deferred revenue	0.	19	0.
	20	Tax-exempt bond liabilities	0.	20	0.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0.	21	0.
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0.	22	0.
	23	Secured mortgages and notes payable to unrelated third parties	0.	23	0.
	24	Unsecured notes and loans payable to unrelated third parties	0.	24	0.
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	20,640,402.	25	19,167,798.
	26	**Total liabilities.** Add lines 17 through 25	28,118,313.	26	25,407,086.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	41,947,528.	27	46,117,495.
	28	Temporarily restricted net assets	1,659,920.	28	1,452,144.
	29	Permanently restricted net assets	1,288,011.	29	1,288,011.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	44,895,459.	33	48,857,650.
	34	Total liabilities and net assets/fund balances	73,013,772.	34	74,264,736.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	56,975,587.
2	Total expenses (must equal Part IX, column (A), line 25)	2	51,466,432.
3	Revenue less expenses. Subtract line 2 from line 1	3	5,509,155.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	44,895,459.
5	Net unrealized gains (losses) on investments	5	-630,451.
6	Donated services and use of facilities	6	0.
7	Investment expenses	7	0.
8	Prior period adjustments	8	0.
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-916,513.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	48,857,650.

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		X
	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?	2b	X	
	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.	2c	X	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	3b		

Form **990** (2015)

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ **Attach to Form 990 or Form 990-EZ.**

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

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization	**Employer identification number**
CHESTER RIVER HOSPITAL CENTER	52-0679694

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 (Form 990 or 990-EZ).)

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 in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.

a ☐ **Type I**. A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**

b ☐ **Type II**. A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated**. A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated**. A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

f Enter the number of supported organizations . . . . . ☐

g 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 (see instructions))	**(iv)** Is the organization listed in your governing document?		**(v)** Amount of monetary support (see instructions)	**(vi)** Amount of other support (see instructions)
			Yes	**No**		
(A)						
(B)						
(C)						
(D)						
(E)						
Total						

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2015 (line 6, column (f) divided by line 11, column (f)) . . . . . 14 %

15 Public support percentage from 2014 Schedule A, Part II, line 14 . . . . . 15 %

16a **33 1/3 % support test - 2015.** If the organization did not check the box on line 13, and line 14 is 33 1/3 % or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3 % support test - 2014.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3 % or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test - 2015.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2014.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2015 (line 8, column (f) divided by line 13, column (f))	15	%
16	Public support percentage from 2014 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2015** (line 10c, column (f) divided by line 13, column (f))	17	%
18	Investment income percentage from **2014** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2015.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3 %, and line 17 is not more than 33 1/3 %, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2014.** 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 Supporting Organizations

(Complete only if you checked a box in line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? *If "No," describe in* ***Part VI*** *how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* ***Part VI*** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes," and if you checked 11a or 11b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If "Yes," describe in* ***Part VI*** *how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.*	4b		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in* ***Part VI****, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).*	5a		
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in* ***Part VI.***	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If "Yes," provide detail in* ***Part VI.***	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* ***Part VI.***	9b		
c	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* ***Part VI.***	9c		
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)*	10b		

Part IV Supporting Organizations *(continued)*

			Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?			
a	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	11a		
b	A family member of a person described in (a) above?	11b		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in* ***Part VI.***	11c		

Section B. Type I Supporting Organizations

			Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *If "No," describe in* ***Part VI*** *how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.*	1		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in* ***Part VI*** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.*	2		

Section C. Type II Supporting Organizations

			Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? *If "No," describe in* ***Part VI*** *how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).*	1		

Section D. All Type III Supporting Organizations

			Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	1		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? *If "No," explain in* ***Part VI*** *how the organization maintained a close and continuous working relationship with the supported organization(s).*	2		
3	By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? *If "Yes," describe in* ***Part VI*** *the role the organization's supported organizations played in this regard.*	3		

Section E. Type III Functionally-Integrated Supporting Organizations

1 *Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (****see instructions****):*

a ☐ The organization satisfied the Activities Test. *Complete* ***line 2*** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* ***line 3*** *below.*

c ☐ The organization supported a governmental entity. *Describe in Part VI how you supported a government entity (see instructions).*

			Yes	No
2	Activities Test. ***Answer (a) and (b) below.***			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	2b		
3	Parent of Supported Organizations. ***Answer (a) and (b) below.***			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI*** *the role played by the organization in this regard.*	3b		

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970. **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	**1**		
2 Recoveries of prior-year distributions	**2**		
3 Other gross income (see instructions)	**3**		
4 Add lines 1 through 3	**4**		
5 Depreciation and depletion	**5**		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	**6**		
7 Other expenses (see instructions)	**7**		
8 Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	**8**		

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
a Average monthly value of securities	**1a**		
b Average monthly cash balances	**1b**		
c Fair market value of other non-exempt-use assets	**1c**		
d Total (add lines 1a, 1b, and 1c)	**1d**		
e Discount claimed for blockage or other factors (explain in detail in **Part VI**):			
2 Acquisition indebtedness applicable to non-exempt-use assets	**2**		
3 Subtract line 2 from line 1d	**3**		
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	**4**		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	**5**		
6 Multiply line 5 by .035	**6**		
7 Recoveries of prior-year distributions	**7**		
8 Minimum Asset Amount (add line 7 to line 6)	**8**		

Section C - Distributable Amount		Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	**1**	
2 Enter 85% of line 1	**2**	
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	**3**	
4 Enter greater of line 2 or line 3	**4**	
5 Income tax imposed in prior year	**5**	
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	**6**	

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).

Part V **Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations** *(continued)*

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	
4	Amounts paid to acquire exempt-use assets	
5	Qualified set-aside amounts (prior IRS approval required)	
6	Other distributions (describe in **Part VI**). See instructions.	
7	**Total annual distributions.** Add lines 1 through 6.	
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions.	
9	Distributable amount for 2015 from Section C, line 6	
10	Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2015	(iii) Distributable Amount for 2015
1	Distributable amount for 2015 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2015 (reasonable cause required-see instructions)			
3	Excess distributions carryover, if any, to 2015:			
a				
b				
c				
d	From 2013			
e	From 2014			
f	**Total** of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2015 distributable amount			
i	Carryover from 2010 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2015 from Section D, line 7: $			
a	Applied to underdistributions of prior years			
b	Applied to 2015 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2015, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6	Remaining underdistributions for 2015. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7	**Excess distributions carryover to 2016**. Add lines 3j and 4c.			
8	Breakdown of line 7:			
a				
b				
c	Excess from 2013			
d	Excess from 2014			
e	Excess from 2015			

Part VI **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 B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ **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*.**

OMB No. 1545-0047

2015

Name of the organization
CHESTER RIVER HOSPITAL CENTER

Employer identification number
52-0679694

Organization type (check one):

Filers of:	**Section:**
Form 990 or 990-EZ	[X] 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

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling $5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

[ ] For an organization described in section 501(c)(3) 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), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions 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 an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled 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 totaling $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 CHESTER RIVER HOSPITAL CENTER | **Employer identification number** 52-0679694

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		$ 333,425.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization CHESTER RIVER HOSPITAL CENTER | **Employer identification number** 52-0679694

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 CHESTER RIVER HOSPITAL CENTER

Employer identification number 52-0679694

Part III ***Exclusively* religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than $1,000 for the year from any one contributor.** 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)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

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2015

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

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

Name of organization	Employer identification number
CHESTER RIVER HOSPITAL CENTER	52-0679694

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)					

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

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

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

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

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.

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **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 separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	**(a)** 2012	**(b)** 2013	**(c)** 2014	**(d)** 2015	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		3,271.
j Total. Add lines 1c through 1i			3,271.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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."

1	Dues, assessments and similar amounts from members	**1**	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	**2a**	
b	Carryover from last year	**2b**	
c	Total	**2c**	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	**3**	
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?	**4**	
5	Taxable amount of lobbying and political expenditures (see instructions)	**5**	

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, lines 1 and 2 (see instructions); 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). MHA AND AHA ENGAGE IN MANY SUPPORT ACTIVITIES INCLUDING LOBBYING AND ADVOCATING FOR THEIR MEMBER HOSPITALS. THE MHA AND AHA REPORTED THAT 6.15% AND 22.12% OF MEMBER DUES WERE USED FOR LOBBYING PURPOSES AND AS SUCH, THE ORGANIZATION HAS REPORTED THIS AMOUNT ON SCHEDULE C, PART II-B AS LOBBYING ACTIVITIES.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

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

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

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

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

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

Part II Conservation Easements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 7.

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

☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of a historically important land area
☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

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

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

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

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

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

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

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

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part 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) Revenue 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 Revenue included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $

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

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

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

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

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

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☒ No

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

Part V Endowment Funds.

Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

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

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

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

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

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

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

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

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		475,591.		475,591.
b Buildings		36,153,697.	18,629,515.	17,524,182.
c Leasehold improvements				
d Equipment		33,935,078.	24,304,617.	9,630,461.
e Other		985,440.	879,666.	105,774.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ▶				27,736,008.

Schedule D (Form 990) 2015

Part VII Investments - Other Securities.
Complete if the organization answered "Yes" on 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	9,136,000.	FMV
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶	9,136,000.	

Part VIII Investments - Program Related.
Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

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

Part IX Other Assets.
Complete if the organization answered "Yes" on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) SELF INSURANCE	8,360,305.
(2) ECONOMIC INTEREST IN FND.	5,195,728.
(3) ASSETS LIMITED TO USE	4,642,508.
(4) OTHER RECEIVABLES	2,964,565.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	21,163,106.

Part X Other Liabilities.
Complete if the organization answered "Yes" on 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) MALPRACTICE	6,022,346.
(3) DUE TO UMMS	4,508,160.
(4) MINIMUM PENSION LIABILITY	3,348,546.
(5) OTHER - CURRENT LIABILITIES	2,479,545.
(6) ENVIRONMENTAL REMEDIATION	1,562,353.
(7) ADVANCES FROM THIRD PARTY PAYORS	778,030.
(8) OTHER - CREDIT PAT AR	468,818.
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	19,167,798.

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 [X]

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

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

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

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

Part 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

Part XIII Supplemental Information *(continued)*

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)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization
CHESTER RIVER HOSPITAL CENTER

Employer identification number
52-0679694

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) 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: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	3a	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☒ Other 500.0000 %	3b	X	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		X
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			308,196.		308,196.	.63
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			308,196.		308,196.	.63
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			44,808.		44,808.	.09
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)			7,080,090.	1,411,436.	5,668,654.	16.36
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			79,655.		79,655.	.16
j **Total.** Other Benefits			7,204,553.	1,411,436.	5,793,117.	16.61
k **Total.** Add lines 7d and 7j			7,512,749.	1,411,436.	6,101,313.	17.24

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			2,444.		2,444.	
3 Community support			7,526.		7,526.	.02
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			1,368.		1,368.	
7 Community health improvement advocacy			4,447.		4,447.	.01
8 Workforce development						
9 Other						
10 Total			15,785.		15,785.	.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?	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount 2 2,095,428.			
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit 3			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	25,315,378.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	26,805,278.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-1,489,900.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other		

Section C. Collection Practices

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

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

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

Part V Facility Information

Section A. Hospital Facilities (list in order of size, from largest to smallest - see instructions) How many hospital facilities did the organization operate during the tax year? 1 Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 CHESTER RIVER HOSPITAL CENTER 100 BROWN STREET CHESTERTOWN MD 21620 WWW.UMSHOREREGIONAL.ORG 14-002	X	X					X			1
2										
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group CHESTER RIVER HOSPITAL CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3	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 12	3	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 15			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	X	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		X
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): WWW. UMSHOREREGIONAL.ORG			
b	[ ] Other website (list url):			
c	[X] Made a paper copy available for public inspection without charge at the hospital facility			
d	[ ] Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 2015			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): WWW. UMSHOREREGIONAL.ORG			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	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)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? **$**			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group CHESTER RIVER HOSPITAL CENTER

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	X	
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.0000 % and FPG family income limit for eligibility for discounted care of 500.0000 %			
b	[X] Income level other than FPG (describe in Section C)			
c	[X] Asset level			
d	[X] Medical indigency			
e	[X] Insurance status			
f	[X] Underinsurance status			
g	[ ] Residency			
h	[X] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[ ] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Included measures to publicize the policy within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): WWW.UMSHOREREGIONAL.ORG			
b	[ ] The FAP application form was widely available on a website (list url):			
c	[X] A plain language summary of the FAP was widely available on a website (list url): WWW.UMSHOREREGIONAL.ORG			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	[X] Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[ ] Other (describe in Section C)			

Billing and Collections

17	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 all of the actions the hospital facility or other authorized party may take upon non-payment?	17	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	[ ] Reporting to credit agency(ies)			
b	[ ] Selling an individual's debt to another party			
c	[ ] Actions that require a legal or judicial process			
d	[ ] Other similar actions (describe in Section C)			
e	[X] None of these actions or other similar actions were permitted			

Part V Facility Information *(continued)*

Name of hospital facility or letter of facility reporting group CHESTER RIVER HOSPITAL CENTER

			Yes	No
19	Did the hospital facility or other authorized 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?	**19**		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Actions that require a legal or judicial process			
d	☐ Other similar actions (describe in Section C)			

20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (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)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required 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?	**21**	X	
	If "No," indicate why:			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ Other (describe in Section C)			

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

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

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

23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	**23**		X
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.	**24**		X

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

CHESTER RIVER HOSPITAL CENTER

SCHEDULE H, PART V, SECTION B

LINE 5 - SHORE REGIONAL HEALTH (SRH) CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FOR THE FIVE COUNTIES OF MARYLAND'S MID-SHORE: TALBOT, CAROLINE, QUEEN ANNE'S, DORCHESTER, AND KENT. THE COMMUNITY HEALTH NEEDS ASSESSMENT WAS COMPLETED ON MAY 12, 2015, ON WHICH DATE IT WAS APPROVED BY THE BOARD OF DIRECTORS AND IMPLEMENTED. THE HEALTH NEEDS OF OUR COMMUNITY WERE IDENTIFIED THROUGH A PROCESS WHICH INCLUDED COLLECTING AND ANALYZING PRIMARY AND SECONDARY DATA. IN PARTICULAR, THE CHNA INCLUDES PRIMARY DATA FROM TALBOT, CAROLINE, DORCHESTER, KENT, QUEEN ANNE'S HEALTH DEPARTMENTS AND THE COMMUNITY AT LARGE. ADDITIONALLY, SHORE REGIONAL 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 INCLUDES DATA COLLECTED FROM SURVEYS, ADVISORY GROUPS AND FROM OUR COMMUNITY OUTREACH AND EDUCATION SESSIONS.

SHORE REGIONAL HEALTH PARTICIPATES ON THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) SYSTEM COMMUNITY HEALTH IMPROVEMENT COMMITTEE TO STUDY DEMOGRAPHICS, ASSESS COMMUNITY HEALTH DISPARITIES, INVENTORY RESOURCES AND ESTABLISH COMMUNITY BENEFIT GOALS FOR BOTH SHORE REGIONAL HEALTH SYSTEM AND UMMS.

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

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 QUARTERLY BASIS AS MEMBERS OF THE MID-SHORE SHIP COALITION (BELOW IS MEMBERSHIP ROSTER, REPRESENTATIVE VARIES DEPENDING UPON TOPIC/AGENDA AND AVAILABILITY):

- CHOPTANK COMMUNITY HEALTH SYSTEMS, DR. JONATHAN MOSS, CMO
- CAROLINE COUNTY MINORITY OUTREACH TECHNICAL ASSISTANCE, JANET FOUNTAIN, PROGRAM MANAGER
- TALBOT COUNTY LOCAL MANAGEMENT BOARD DONNA HACKER, EXECUTIVE DIRECTOR
- PARTNERSHIP FOR DRUG FREE DORCHESTER, DONALD HALL, PROGRAM DIRECTOR
- CAROLINE COUNTY COMMUNITY REPRESENTATIVE, MARGARET JOPP, FAMILY NURSE PRACTITIONER
- EASTERN SHORE AREA HEALTH EDUCATION CENTER, JAKE FREGO, EXECUTIVE DIRECTOR
- KENT COUNTY MINORITY OUTREACH TECHNICAL ASSISTANCE, DORA BEST, PROGRAM COORDINATOR
- YMCA OF THE CHESAPEAKE, DEANNA HARRELL, EXECUTIVE DIRECTOR
- UNIVERSITY OF MD EXTENSION, ALY VALENTINE, EXECUTIVE DIRECTOR
- KENT COUNTY LOCAL MANAGEMENT BOARD, HOPE CLARK, EXECUTIVE DIRECTOR
- KENT COUNTY DEPARTMENT OF JUVENILE SERVICES, WILLIAM CLARK, DIRECTOR
- COALITION AGAINST TOBACCO USE, CAROLYN BROOKS, MEMBER
- MT. OLIVE AME CHURCH, REV. MARY WALKER
- MID- SHORE MENTAL HEALTH SYSTEMS, HOLLY IRELAND LCSW-C, EXECUTIVE DIRECTOR
- ASSOCIATED BLACK CHARITIES, ASHYRIA DOTSON, PROGRAM DIRECTOR

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

- QUEEN ANNE COUNTY HOUSING AND FAMILY SERVICES, MIKE CLARK, EXECUTIVE DIRECTOR

- QUEEN ANNE COUNTY HEALTH DEPARTMENT, JOSEPH CIOTOLA MD

- DORCHESTER COUNTY HEALTH DEPARTMENT, ROGER L. HARRELL, HEALTH OFFICER

- TALBOT COUNTY HEALTH DEPARTMENT, FREDIA WADLEY MD, HEALTH OFFICER

- CAROLINE COUNTY HEALTH DEPARTMENT, DR. LELAND SPENCER, HOUSE OFFICER

- SRH, KATHLEEN MCGRATH, REGIONAL DIRECTOR OF OUTREACH

- SRH, WILLIAM ROTH, REGIONAL DIRECTOR - CARE TRANSITIONS

SHORE REGIONAL HEALTH HOSTED A SERIES OF COMMUNITY LISTENING FORUMS IN CAROLINE, DORCHESTER, KENT, QUEEN ANNE'S AND TALBOT COUNTIES TO GATHER COMMUNITY INPUT. IN ADDITION, SHORE REGIONAL HEALTH MEETS QUARTERLY WITH MEMBERS OF THE LOCAL HEALTH DEPARTMENTS AND COMMUNITY LEADERS, INCLUDING:

- CHOPTANK COMMUNITY HEALTH SYSTEM: JOSEPH SHEEHAN, CEO, JONATHAN MOSS, CMO

- HEALTH DEPARTMENTS HEALTH OFFICERS:

- LELAND SPENCER, M.D. KENT COUNTY AND CAROLINE COUNTY

- ROGER L. HARRELL, MHA, DORCHESTER COUNTY HEALTH DEPARTMENT

- JOSEPH CIOTOLA MD -DHMH QUEEN ANNE'S COUNTY

- FREDIA WADLEY MD, TALBOT COUNTY HEALTH DEPARTMENT

- MID SHORE MENTAL HEALTH SYSTEMS, HOLLY IRELAND, EXECUTIVE DIRECTOR

- EASTERN SHORE HOSPITAL CENTER: RANDY BRADFORD, CEO

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

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.
- COUNTY HEALTH RANKINGS
- MID SHORE COMPREHENSIVE ECONOMIC DEVELOPMENT STRATEGY CEDS

CHNA CONDUCTED WITH OTHER HOSPITAL FACILITIES

LINE 6A - SHORE REGIONAL HEALTH (SRH) CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FOR THE UM SRH NETWORK WHICH SERVES THE MID-SHORE REGION: UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT CHESTERTOWN (SMC AT CHESTERTOWN), THE UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT DORCHESTER (SMC AT DORCHESTER), AND THE UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT EASTON (SMC AT EASTON).

LINE 6B - SHORE REGIONAL HEALTH (SRH) COMMUNITY HEALTH NEEDS ASSESSMENT WAS NOT CONDUCTED WITH ONE OR MORE ORGANIZATIONS.

SIGNIFICANT NEEDS ADDRESSED IN CHNA

LINE 11 - ALL PRIMARY HEALTH NEEDS ARE BEING ADDRESSED TO THE EXTENT THAT AVAILABLE RESOURCES AND CLINICAL EXPERTISE ALLOW. THE COMMUNITY BENEFITS PLAN IS ABLE TO ADEQUATELY ADDRESS HEART DISEASE, CANCER, DIABETES,

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

HYPERTENSION, HIGH CHOLESTEROL, ISSUES ASSOCIATED WITH AGING POPULATION.

NUTRITION, WEIGHT MANAGEMENT/OBESITY IS ADDRESSED THROUGH EDUCATIONAL

CLASSES AND/OR SEMINARS. TOBACCO USE/SMOKING AND ALCOHOL/BINGE

DRINKING/UNDERAGE DRINKING ARE BEING ADDRESSED BY OTHER COUNTY AGENCIES

AND ORGANIZATIONS AND THROUGH PARTNERSHIPS, INCLUDING THE COUNTY HEALTH

DEPARTMENTS.

SHORE REGIONAL HEALTH HOSPITALS DO NOT POSSESS THE RESOURCES AND

EXPERTISE REQUIRED FOR ENVIRONMENTAL HEALTH CONCERNS AND ISSUES. MENTAL

HEALTH IS BEING ADDRESSED THROUGH THE MID-SHORE MENTAL HEALTH SYSTEMS,

INC., WHICH IS A PRIVATE, NOT-FOR-PROFIT ORGANIZATION SERVING THE FIVE

MID-SHORE COUNTIES: CAROLINE DORCHESTER, KENT, QUEEN ANNE'S AND TALBOT.

SEVERAL ADDITIONAL TOPIC AREAS WERE IDENTIFIED BY THE COMMUNITY HEALTH

PLANNING COUNCIL INCLUDING: SAFE HOUSING, TRANSPORTATION, AND SUBSTANCE

ABUSE. THE UNMET NEEDS NOT ADDRESSED BY UMC AT EATON, UMC AT DORCHESTER,

UMC AT CHESTERTOWN WILL CONTINUE TO BE ADDRESSED BY KEY GOVERNMENTAL

AGENCIES AND EXISTING COMMUNITY- BASED ORGANIZATIONS. WHILE SHORE

REGIONAL HEALTH HOSPITALS 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.

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

LINE 13 - THE FINANCIAL ASSISTANCE POLICY EXPLAINS SEVERAL ELIGIBILITY CRITERIA, INCLUDING PARTICIPATION IN MEDICAID/MEDICARE PROGRAMS AS WELL AS ELIGIBILITY UNDER VARIOUS STATE REGULATIONS. IN COMPLIANCE WITH THE NEW IRC SECTION 501(R) REGULATIONS UMMS HAS UPDATED THEIR FINANCIAL ASSISTANCE POLICY TO ENSURE ITS COMPLIANCE WITH IRS REGULATIONS.

LINE 22D - ALL PATIENTS ARE CHARGED STATE REGULATED RATES, REGARDLESS OF THEIR ABILITY TO PAY.

LINE 24 - THE STATE OF MARYLAND IS A UNIQUE STATE IN REGARD TO THE PROVISION OF HEALTH CARE SERVICES AND THEIR RELATED CHARGES BY HOSPITALS. ALL HOSPITAL CHARGES PROCESSED TO ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, ARE SET THROUGH MARYLAND'S HEALTH SERVICES COST COMMISSION. ACCORDINGLY, ALL HOSPITAL CHARGES ARE NOT GROSS CHARGES AS DEFINED BY THE IRS UNDER INTERNAL REVENUE CODE SECTION 501(R)(5)(B). ALL HOSPITAL CHARGES PROCESSED TO ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, ARE SET THROUGH MARYLAND'S HEALTH SERVICES COST COMMISSION. ACCORDINGLY, ALL HOSPITAL CHARGES ARE NOT GROSS CHARGES AS DEFINED BY THE IRS UNDER INTERNAL REVENUE CODE SECTION 501(R)(5)(B). INTERNAL REVENUE CODE SECTION 501(R)(5)(B).

Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

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

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

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

RELATED ORGANIZATION REPORT

SCHEDULE H, PART I, LINE 6A

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

COSTING METHODOLOGY

PART I, LINE 7A, COLUMNS (D)

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

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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 ASSESSMENT.

PART I, LINE 7F COLUMN (C) AND (D)

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

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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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 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.

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

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

COMMUNITY BUILDING ACTIVITIES

PART II

SHORE REGIONAL HEALTH'S ORGANIZATION'S MISSION AND VISION STATEMENTS SET THE FRAMEWORK FOR THE COMMUNITY BENEFIT PROGRAM. AS UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH EXPANDS THE REGIONAL HEALTH CARE NETWORK, WE HAVE EXPLORED AND RENEWED OUR MISSION, VISION AND VALUES TO REFLECT A CHANGING HEALTH CARE ENVIRONMENT AND OUR COMMUNITIES' NEEDS. WITH INPUT FROM PHYSICIANS, TEAM MEMBERS, PATIENTS, HEALTH OFFICERS, COMMUNITY LEADERS, VOLUNTEERS AND OTHER STAKEHOLDERS, THE BOARD OF UM SHORE REGIONAL HEALTH HAS ADOPTED A FIVE-YEAR STRATEGIC PLAN.

THE STRATEGIC PLAN SUPPORTS OUR MISSION, CREATING HEALTHIER COMMUNITIES TOGETHER, AND OUR VISION, TO BE THE REGION'S LEADER IN PATIENT CENTERED HEALTH CARE. OUR GOAL IS TO PROVIDE QUALITY HEALTH CARE SERVICES THAT ARE COMPREHENSIVE, ACCESSIBLE, AND CONVENIENT, AND THAT ADDRESS THE NEEDS OF OUR PATIENTS, THEIR FAMILIES AND OUR WIDER COMMUNITIES.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

BAD DEBT EXPENSE

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.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, LINES 2 AND 4

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.

IN 2014, MARYLAND'S WAIVER WITH MEDICARE WAS RENEGOTIATED AND UPDATED TO REFLECT THE CURRENT HEALTHCARE ENVIRONMENT. UNDER THIS NEW WAIVER, SEVERAL CRITERIA WERE ESTABLISHED TO MONITOR THE SUCCESS OF THE SYSTEM IN CONTROLLING HEALTHCARE COSTS AND THE CONTINUANCE OF THE WAIVER ITSELF:

1. REVENUE GROWTH PER CAPITA
2. MEDICARE HOSPITAL REVENUE PER BENEFICIARY
3. MEDICARE ALL PROVIDER REVENUE GROWTH PER BENEFICIARY
4. MEDICARE READMISSION RATES
5. HOSPITAL ACQUIRED CONDITION RATE

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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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

PART III, LINE 8

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

IN 2014, MARYLAND'S WAIVER WITH MEDICARE WAS RENEGOTIATED AND UPDATED TO REFLECT THE CURRENT HEALTHCARE ENVIRONMENT. UNDER THIS NEW WAIVER, SEVERAL CRITERIA WERE ESTABLISHED TO MONITOR THE SUCCESS OF THE SYSTEM IN CONTROLLING HEALTHCARE COSTS AND THE CONTINUANCE OF THE WAIVER ITSELF:

1. REVENUE GROWTH PER CAPITA
2. MEDICARE HOSPITAL REVENUE PER BENEFICIARY
3. MEDICARE ALL PROVIDER REVENUE GROWTH PER BENEFICIARY
4. MEDICARE READMISSION RATES
5. HOSPITAL ACQUIRED CONDITION RATE

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

COLLECTION PRACTICES

PART III, LINE 9B

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

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

Part VI Supplemental Information

Provide the following information.

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2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PROCESS.

COMMUNITY HEALTH CARE NEEDS ASSESSMENT

PART VI, LINE 2

SHORE REGIONAL HEALTH HAS A PROCESS TO ASSESS THE HEALTH CARE NEEDS IN THE COMMUNITY THROUGH ESTABLISHMENT OF THE COMMUNITY HEALTH PLANNING COUNCIL. THE UM SRH COMMUNITY HEALTH PLANNING COUNCIL SERVES AS THE LEAD TEAM TO CONDUCT THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WITH INPUT FROM THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) COMMUNITY HEALTH IMPROVEMENT COMMITTEE, COMMUNITY LEADERS, THE PUBLIC, HEALTH EXPERTS, AND THE 5 HEALTH DEPARTMENTS THAT SERVE THE MID-SHORE. THE UM SRH COMMUNITY HEALTH PLANNING COUNCIL ADOPTED THE 6-STEP COMPREHENSIVE ASSESSMENT PROCESS DEVELOPED BY THE ASSOCIATION FOR COMMUNITY HEALTH IMPROVEMENT (ACHI).

THE ASSESSMENT PROCESS:

-DEVELOP A COMPREHENSIVE PROFILE OF HEALTH STATUS, QUALITY OF CARE AND CARE MANAGEMENT INDICATORS FOR RESIDENTS OF THE MID-SHORE AREA OVERALL

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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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 BY COUNTY.

-IDENTIFY A SET OF PRIORITY HEALTH NEEDS (PUBLIC HEALTH AND HEALTH CARE)

FOR FOLLOW-UP.

-PROVIDE RECOMMENDATIONS ON STRATEGIES THAT CAN BE UNDERTAKEN BY HEALTH

PROVIDERS, PUBLIC HEALTH, COMMUNITIES, POLICY MAKERS AND OTHERS TO FOLLOW

UP ON THE INFORMATION PROVIDED, SO AS TO IMPROVE THE HEALTH STATUS OF

MID-SHORE RESIDENTS.

-PROVIDE ACCESS TO THE DATA AND ASSISTANCE TO STAKEHOLDERS WHO ARE

INTERESTED IN USING IT.THE COMMUNITY HEALTH PLANNING COUNCIL RECOMMENDED

AND DEVELOPED POLICIES, PROGRAMS AND SERVICES THAT CARRY OUT THE MISSION

OF UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH TO ENHANCE THE HEALTH OF

LOCAL COMMUNITIES. THE COUNCIL REPORTS THROUGH AND PROVIDES REGULAR

UPDATES TO SENIOR LEADERSHIP AND THE BOARD STRATEGIC PLANNING COMMITTEE.

ULTIMATELY THE COMMUNITY HEALTH PLANNING COUNCIL DETERMINES THE COMMUNITY

BENEFIT ACTIVITIES TO BE DELIVERED BY SHORE REGIONAL HEALTH TO THE

COMMUNITY BASED ON BEST USE OF RESOURCES AND AREAS OF EXPERTISE.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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ELIGIBILITY EDUCATION

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 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.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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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.

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 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

Part VI Supplemental Information

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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.

-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

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POLICY, INCLUDING A PHONE NUMBER TO CALL FOR MORE INFORMATION, IS RUN

ANNUALLY IN THE LOCAL NEWSPAPER (STAR DEMOCRAT)

HOSPITAL FINANCIAL ASSISTANCE POLICY

SHORE REGIONAL HEALTH IS COMMITTED TO ENSURING THAT UNINSURED PATIENTS

WITHIN ITS SERVICE AREA WHO LACK FINANCIAL RESOURCES HAVE ACCESS TO

MEDICALLY NECESSARY HOSPITAL SERVICES. IF YOU ARE UNABLE TO PAY FOR

MEDICAL CARE, YOU MAY QUALIFY FOR FREE OR REDUCED COST MEDICALLY

NECESSARY CARE IF YOU HAVE NO OTHER INSURANCE OPTIONS OR SOURCES OF

PAYMENT INCLUDING MEDICAL ASSISTANCE, LITIGATION OR THIRD-PARTY

LIABILITY.

SHORE REGIONAL HEALTH MEETS OR EXCEEDS THE LEGAL REQUIREMENTS BY

PROVIDING FINANCIAL ASSISTANCE TO THOSE INDIVIDUALS IN HOUSEHOLDS BELOW

200% OF THE FEDERAL POVERTY LEVEL AND REDUCED COST-CARE UP TO 300% OF THE

FEDERAL POVERTY LEVEL.

PATIENTS' RIGHTS

Part VI Supplemental Information

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SHORE REGIONAL HEALTH WILL WORK WITH THEIR UNINSURED PATIENTS TO GAIN AN

UNDERSTANDING OF EACH PATIENT'S FINANCIAL RESOURCES.

-THEY WILL PROVIDE ASSISTANCE WITH ENROLLMENT IN PUBLICLY-FUNDED

ENTITLEMENT PROGRAMS (E.G. MEDICAID) OR OTHER CONSIDERATIONS OF FUNDING

THAT MAY BE AVAILABLE FROM OTHER CHARITABLE ORGANIZATIONS.

-IF YOU DO NOT QUALIFY FOR MEDICAL ASSISTANCE, OR FINANCIAL ASSISTANCE,

YOU MAY BE ELIGIBLE FOR AN EXTENDED PAYMENT PLAN FOR YOUR HOSPITAL

MEDICAL BILLS.

-IF YOU BELIEVE YOU HAVE BEEN WRONGLY REFERRED TO A COLLECTION AGENCY,

YOU HAVE THE RIGHT TO CONTACT THE HOSPITAL TO REQUEST ASSISTANCE. (SEE

CONTACT INFORMATION BELOW).

PATIENTS' OBLIGATIONS

SHORE REGIONAL HEALTH BELIEVES THAT ITS PATIENTS HAVE PERSONAL

RESPONSIBILITIES RELATED TO THE FINANCIAL ASPECTS OF THEIR HEALTHCARE

NEEDS. OUR PATIENTS ARE EXPECTED TO:

-COOPERATE AT ALL TIMES BY PROVIDING COMPLETE AND ACCURATE INSURANCE &

FINANCIAL INFORMATION

Part VI Supplemental Information

Provide the following information.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

-PROVIDE REQUESTED DATA TO COMPLETE MEDICAID APPLICATIONS IN A TIMELY

MANNER.

-MAINTAIN COMPLIANCE WITH ESTABLISHED PAYMENT PLAN TERMS.

-NOTIFY US IMMEDIATELY AT THE NUMBER LISTED BELOW OF ANY CHANGES IN

CIRCUMSTANCES.

CONTACTS:

CALL 410-822-1000 X1020 OR TOLL FREE 1-800-876-3364 WITH QUESTIONS

CONCERNING:

-YOUR HOSPITAL BILL

-YOUR RIGHTS AND OBLIGATIONS WITH REGARDS TO YOUR HOSPITAL BILL

-HOW TO APPLY FOR MARYLAND MEDICAID

-HOW TO APPLY FOR FREE OR REDUCED CARE

FOR INFORMATION ABOUT MARYLAND MEDICAL ASSISTANCE

CONTACT YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES

1-800-332-6347 TTY 1-800-925-4434

OR VISIT: WWW.DHR.STATE.MD.US

Part VI Supplemental Information

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PHYSICIAN CHARGES ARE NOT INCLUDED IN HOSPITALS BILLS AND ARE BILLED

SEPARATELY BY THE PHYSICIAN.

DESCRIPTION OF COMMUNITY SERVED

PART VI, LINE 4

SITUATED ON MARYLAND'S EASTERN SHORE, UNIVERSITY OF MARYLAND SHORE

REGIONAL HEALTH'S THREE HOSPITALS, SHORE MEDICAL CENTER AT EASTON (SMC AT

EASTON), SHORE MEDICAL CENTER AT DORCHESTER (SMC AT DORCHESTER), SHORE

MEDICAL CENTER AT CHESTERTOWN (SMC AT CHESTERTOWN) ARE NOT FOR PROFIT

HOSPITALS OFFERING A COMPLETE RANGE OF INPATIENT AND OUTPATIENT SERVICES

TO OVER 170,000 PEOPLE THROUGHOUT THE MID-SHORE OF MARYLAND.

SHORE REGIONAL HEALTH'S SERVICE AREA IS DEFINED AS THE MARYLAND COUNTIES

OF CAROLINE, DORCHESTER, TALBOT, QUEEN ANNE'S AND KENT. THE FIVE COUNTIES

OF THE MID-SHORE COMPRISE 20% OF THE LANDMASS OF THE STATE OF MARYLAND

AND 2% OF THE POPULATION.

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SMC AT EASTON IS SITUATED AT THE CENTER OF THE MID-SHORE AREA AND THUS SERVES A LARGE RURAL GEOGRAPHICAL AREA (ALL 5 COUNTIES OF THE MID-SHORE). SMC AT DORCHESTER IS LOCATED APPROXIMATELY 18 MILES FROM EASTON AND PRIMARILY SERVES DORCHESTER COUNTY AND PORTIONS OF CAROLINE COUNTY. UMC AT CHESTERTOWN LOCATED IN CHESTERTOWN, IN KENT COUNTY MERGED WITH SHORE REGIONAL HEALTH IN JULY 2013. SMC AT CHESTERTOWN SERVES THE RESIDENTS OF KENT COUNTY, PORTIONS OF QUEEN ANNE'S AND CAROLINE COUNTIES AND THE SURROUNDING AREAS.

SHORE REGIONAL HEALTH'S SERVICE AREA HAS A HIGHER PERCENTAGE OF POPULATION AGED 65 AND OLDER AS COMPARED TO MARYLAND OVERALL. TALBOT COUNTY HAS A 27.2% RATE FOR THIS AGE GROUP AND KENT COUNTY HAS 25.3% OF ITS RESIDENTS AGE 65 YEARS OR OLDER. THESE RATES ARE 65% HIGHER THAN MARYLAND'S PERCENTAGE, AND HIGHER THAN OTHER RURAL AREAS IN THE STATE BY ALMOST A QUARTER. TODAY, MORE THAN TWO-THIRDS OF ALL HEALTH CARE COSTS ARE FOR TREATING CHRONIC ILLNESSES. AMONG HEALTH CARE COSTS FOR OLDER AMERICANS, 95% ARE FOR CHRONIC DISEASES. THE COST OF PROVIDING HEALTH CARE FOR ONE PERSON AGED 65 OR OLDER IS THREE TO FIVE TIMES HIGHER THAN

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THE COST FOR SOMEONE YOUNGER THAN 65.

SOURCE:HTTP://WWW.CDC.GOV/FEATURES/AGINGANDHEALTH/STATE_OF_AGING_AND_HEALT

H_IN_AMERICA_2013.PDF HOFFMAN C, RICE D, SUNG HY. PERSONS WITH CHRONIC

CONDITIONS: THEIR PREVALENCE AND COSTS. JAMA. 1996;276(18):1473-1479

COUNTY HEALTH RANKINGS FOR THE MID-SHORE COUNTIES ALSO REVEAL THE LARGE

DISPARITIES BETWEEN COUNTIES FOR HEALTH OUTCOMES IN THE SERVICE AREA. THE

MID-SHORE REGION HAS 26,203 MINORITY PERSONS, REPRESENTING 25.3% OF THE

TOTAL POPULATION. IN TERMS OF HEALTHCARE, LARGE DISPARITIES EXIST BETWEEN

BLACK OR AFRICAN AMERICANS 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 OR

AFRICAN AMERICAN RATES ARE TYPICALLY 3- TO 5 FOLD HIGHER THAN WHITE

RATES. ADULTS AT A HEALTHY WEIGHT IS LOWER (WORSE) FOR BLACK OR AFRICAN

AMERICANS IN ALL THREE COUNTIES WHERE BLACK OR AFRICAN AMERICAN DATA

COULD BE REPORTED. HEART DISEASE MORTALITY BLACK OR AFRICAN AMERICAN

RATES ARE VARIOUSLY HIGHER OR LOWER COMPARED TO WHITE RATES IN INDIVIDUAL

COUNTIES. IN CAROLINE, THE BLACK OR AFRICAN AMERICAN RATE IS LOWER THAN

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THE WHITE RATES NOT BECAUSE THE BLACK OR AFRICAN AMERICAN RATE IS

PARTICULARLY LOW, BUT BECAUSE THE WHITE RATE IS UNUSUALLY HIGH. FOR

CANCER MORTALITY, BLACK OR AFRICAN AMERICAN RATES EXCEED WHITE RATES IN

DORCHESTER, KENT, QUEEN ANNE'S AND TALBOT. IN CAROLINE, BLACK OR AFRICAN

AMERICAN RATES ARE LOWER, AGAIN BECAUSE OF A RATHER HIGH WHITE RATE. THE

BLACK OR AFRICAN AMERICAN RATES AND WHITE RATES ARE BELOW THE STATE

HEALTH IMPROVEMENT PROCESS (SHIP) GOALS.

SOURCE: HTTP://WWW.DHMH.MARYLAND.GOV/SHIP.

HTTP://DHMH.MARYLAND.GOV/MHHD/DOCUMENTS/MARYLAND-BLACK-OR-AFRICAN-AMERICAN

-DATA-REPORT-DECEMBER-2013.PDF

COUNTY RANKINGS:

HTTP://WWW.COUNTYHEALTHRANKINGS.ORG/APP/MARYLAND/2016/COUNTY/SNAPSHOTS/

MARYLAND STATE HEALTH IMPROVEMENT PROCESS, HTTP://DHMH.MARYLAND.GOV/SHIP

AND ITS COUNTY HEALTH PROFILES 2013

QUEEN ANNE

HEALTH OUTCOMES: 6

Part VI Supplemental Information

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LENGTH OF LIFE: 5

QUALITY OF LIFE: 8

HEALTH FACTORS: 5

HEALTH BEHAVIORS: 7

CLINICAL CARE: 12

SOCIAL & ECONOMIC FACTORS: 6

PHYSICAL ENVIRONMENT: 4

TALBOT

HEALTH OUTCOMES: 8

LENGTH OF LIFE: 8

QUALITY OF LIFE: 8

HEALTH FACTORS: 7

HEALTH BEHAVIORS: 6

CLINICAL CARE: 3

SOCIAL & ECONOMIC FACTORS: 11

PHYSICAL ENVIRONMENT: 3

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KENT

HEALTH OUTCOMES: 18

LENGTH OF LIFE: 20

QUALITY OF LIFE: 19

HEALTH FACTORS: 13

HEALTH BEHAVIORS: 13

CLINICAL CARE: 5

SOCIAL & ECONOMIC FACTORS: 15

PHYSICAL ENVIRONMENT: 1

DORCHESTER

HEALTH OUTCOMES: 21

LENGTH OF LIFE: 16

QUALITY OF LIFE: 23

HEALTH FACTORS: 21

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HEALTH BEHAVIORS: 20

CLINICAL CARE: 22

SOCIAL & ECONOMIC FACTORS: 22

PHYSICAL ENVIRONMENT: 16

CAROLINE

HEALTH OUTCOMES: 23

LENGTH OF LIFE: 23

QUALITY OF LIFE: 16

HEALTH FACTORS: 22

HEALTH BEHAVIORS: 22

CLINICAL CARE: 24

SOCIAL & ECONOMIC FACTORS: 19

PHYSICAL ENVIRONMENT: 15

PATIENT POPULATION AT RISK FOR READMISSION

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HIGH UTILIZERS WERE IDENTIFIED ACROSS ALL SHORE REGIONAL HEALTH

FACILITIES: SMCE, SMCD, SMCC, AND SECQ

HIGH UTILIZERS WERE DEFINED IN FISCAL YEAR 2015 AS HAVING 2 OR MORE

INPATIENT OR OBSERVATIONS GREATER THAN 24 HOURS IN THE YEAR AND EXCLUDED

PEDIATRIC (0-17) PATIENTS AND MORTALITIES. HIGH UTILIZERS WERE ALSO

IDENTIFIED GEOGRAPHICALLY BY THE FOLLOWING SERVICE AREA ZIP CODES:

21601,21613,21620,21629,21663,21655,21661,21643,21632,21660,21617,21678,21

651,21673,21623,21625,21631,21639,21666,21668. THE HIGH UTILIZER PATIENT

POPULATION THAT WAS IDENTIFIED IS THE MEDICARE POPULATION.

THE MEDICARE HIGH UTILIZERS (1,136 UNIQUE PATIENTS) CREATED $42.9 MILLION

IN TOTAL CHARGES, NEARLY HALF OF ALL TOTAL CHARGES OF ALL MEDICARE

BENEFICIARIES IN THE SHORE REGIONAL HEALTH SYSTEM. OF THE 1,136 MEDICARE

HIGH UTILIZERS NEARLY 60% HAD A MENTAL HEALTH AND OR SUBSTANCE ABUSE

DIAGNOSIS ALONG WITH CHRONIC DISEASE(S) DIAGNOSIS. THIS DATA CONFIRMS

THE EARLIER CHNA STUDIES AND SHIP STUDIES THAT MENTAL AND BEHAVIORAL

HEALTH RESOURCES ARE IN SHORT SUPPLY. MEDICARE HIGH UTILIZERS WERE

Part VI Supplemental Information

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FOLLOWED BY; DUAL ELIGIBLES 466 PATIENTS ACROSS THE HEALTH SYSTEM WITH

TOTAL CHARGES OF $19.5 MILLION AND MEDICAID PATIENTS 362 AGAIN ACROSS THE

SHORE HEALTH SYSTEM WITH TOTAL CHARGES OF $10.9 MILLION.

AT SHORE OUR GOAL IS TO TRANSFORM OUR DELIVERY MODELS FROM A FOCUS ON

INPATIENT CARE TO A FOCUS ON BUILDING HEALTHY COMMUNITIES THROUGH

ENHANCING OUR OUTPATIENT SERVICES, OUR COORDINATION WITH EXISTING

COMMUNITY HEALTH PROVIDERS, AND WHEN NEEDED, OUR DIRECT COORDINATION AND

MANAGEMENT OF THE CHRONIC CARE OF OUR MOST COMPLEX PATIENTS.

SOURCE: REVIEW OF HOSPITAL DISCHARGE DATE

PROMOTING THE HEALTH OF THE COMMUNITY

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)

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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 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

Part VI Supplemental Information

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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 DISEASE MANAGEMENT (OBESITY, HYPERTENSION, DIABETES,

SMOKING)

2. BEHAVIORAL HEALTH

3. ACCESS TO CARE

4. CANCER

5. OUTREACH & EDUCATION (PREVENTIVE CARE, SCREENINGS, HEALTH LITERACY)

INITIATIVE 1

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IDENTIFIED NEED: CHRONIC DISEASE MANAGEMENT

HOSPITAL INITIATIVE

SHORE WELLNESS PARTNERS (SWP) PROVIDES COMMUNITY CASE MANAGEMENT, AT NO CHARGE, TO COMMUNITY MEMBERS WHO MEET THE ELIGIBILITY CRITERIA

PRIMARY OBJECTIVES

SHORE WELLNESS 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. DESIGNED FOR AT-RISK FAMILIES AND INDIVIDUALS WHO DO NOT HAVE SUFFICIENT RESOURCES AND ARE NOT ELIGIBLE FOR OTHER IN-HOME SERVICES. SHORE 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 REGIONAL HEALTH AT NO CHARGE FOR THOSE WHO QUALIFY.

OBJECTIVES:

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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-MANAGING PHYSICAL HEALTH PROBLEMS

-CONNECTION WITH OTHER COMMUNITY SERVICES

-DIETARY EDUCATION

-HOME SAFETY EVALUATIONS

-SAFE MEDICINE USE

-EDUCATION ON SPECIFIC ILLNESS AND TREATMENTS

-EMOTIONAL SUPPORT

-MONITORING CLIENT PROGRESS THROUGH HOME VISITS OR PHONE CALLS

KEY COLLABORATORS: 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.MARYLAND.GOV/HEALTHENTERPRISEZONES/SITEPAGES/HOME.

Part VI Supplemental Information

Provide the following information.

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OUTCOMES:

OBJECTIVE 1: ENROLL ELIGIBLE PATIENT

METRIC:

1. NEW CLIENTS = 159

2. NUMBER OF PATIENT VISITS = 1,538

OBJECTIVE 2: REDUCE READMISSIONS AND ED VISITS

PATIENT WITH NO READMISSION

33/56, 59%

PATIENT WITHOUT READMIT OR ED VISITS

25/56, 45%

PATIENTS WITH ED VISIT BUT NO READMISSION

8/56, 14%

PATIENTS WITH 1 RE-HOSPITALIZATION

8/56, 14%

PATIENTS WITH 2-3 RE-HOSPITALIZATIONS

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2/56, 3.6%

PATIENTS WITH 4 OR MORE RE-HOSPITALIZATIONS

0/56, 0%

PATIENTS WITH ED VISIT(S) AND HOSPITALIZATIONS

4/56, 7%

INITIATIVE 2

IDENTIFIED NEED: CARDIOVASCULAR CARE

-CHRONIC DISEASE MANAGEMENT

-REDUCTION IN ED VISITS

THE ANTITHROMBOSIS CLINIC IS DESIGNED TO PROVIDE DEDICATED HEALTH CARE

MONITORING FOR THOSE PATIENT RECEIVING CHRONIC WARFARIN THERAPY. WARFARIN

THERAPY IS REPORTED WIDELY IN THE MEDICAL LITERATURE AS HAVING

SIGNIFICANT MORBIDITIES ASSOCIATED WITH LONG-TERM THERAPY.

VIGILANT MONITORING IS NECESSARY TO AVOID THESE COMPLICATIONS. THIS

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CLINIC PROVIDES AT NO CHARGE CLOSE MONITORING OF THESE PATIENTS WITH

DEDICATED, KNOWLEDGEABLE STAFF. THROUGH CLOSE MONITORING, EDUCATION, AND

CONTINUOUS FOLLOW-UP, THE RISKS ASSOCIATED WITH LONG TERM ANTICOAGULATION

ARE GREATLY REDUCED.

PRIMARY OBJECTIVE OF THE INITIATIVE:

METRIC 1: TOTAL NUMBER OF PEOPLE REACHED BY THE INITIATIVE WITHIN THE

TARGET POPULATION

UMC AT CHESTERTOWN 293 PATIENT SERVED

UMC AT EASTON 1,511 PATIENTS SERVED

METRIC 2: IMPROVED OUTCOMES

TIME IN THERAPEUTIC RANGE IS 77% COMPARED TO 'USUAL NON-CLINIC CARE' OF

40-50%. BASED ON ANALYSIS OF THE LITERATURE, THIS HIGHER RATE OF TIME IN

THERAPEUTIC RANGE COMPARED TO USUAL CARE RESULTS IN APPROXIMATELY A 39%

REDUCTION IN RELATIVE RISK OF STROKE, A 40% REDUCTION IN RELATIVE RISK

FOR MAJOR BLEEDING, AND A 69% REDUCTION IN RELATIVE RISK OF MORTALITY FOR

OUR COMMUNITY.

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KEY COLLABORATORS: PARTICIPATING HOSPITAL STAFF, SHORE REGIONAL HEALTH

PHARMACY SERVICES

IMPACT/OUTCOME OF HOSPITAL INITIATIVE:

UMC AT EASTON

-15,792 PATIENT ENCOUNTERS OCCURRED DURING THIS PERIOD

-AVERAGE # PATIENTS SERVED 1211.8 PATIENTS

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

-76.15% PATIENTS WERE MAINTAINED WITHIN 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

-4,445 PATIENT ENCOUNTERS OCCURRED DURING THIS PERIOD

-AVERAGE # PATIENTS SERVED 268 PATIENTS

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

DAYS)

-68.9% PATIENTS WERE MAINTAINED WITHIN THERAPEUTIC RANGE >90% TIME

(NATIONAL AVERAGE IS 58%)

-2.5% ADVERSE EVENTS NOTED REQUIRING HOSPITALIZATION

EVALUATION OF OUTCOMES: INDICATORS SHOW A BETTER THAN NATIONAL AVERAGE

THERAPEUTIC RANGE FOR PATIENTS IN THE PROGRAM AND BETTER THAN AVERAGE

TIME TO THERAPEUTIC INR THAN NATIONAL AVERAGE LEADING TO A REDUCTION OF

HOSPITAL ENCOUNTERS RELATED TO OVER ANTICOAGULATION OR UNDER

ANTICOAGULATION.

INITIATIVE 3

IDENTIFIED NEED: CARDIOVASCULAR DISEASE, CRITICAL CARE ACCESS TO

EMERGENCY MEDICATIONS PREVENTS TERMINAL OUTCOMES FOR PATIENTS (ADVANCED

CARDIAC LIFE SUPPORT)

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HOSPITAL INITIATIVE: LOCAL EMS UNITS AND THE STATE OF MARYLAND INSTITUTE

FOR EMERGENCY MEDICAL SERVICES SYSTEM COLLABORATE TO DETERMINE MEDICATION

PROTOCOLS APPROPRIATE FOR FIELD ADMINISTRATION AS WELL AS NECESSARY PAR

LEVELS PER AMBULANCE CREW.

KEY COLLABORATORS: SHORE REGIONAL HEALTH PHARMACY, LOCAL EMS UNITS AND

THE STATE OF MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEM

PRIMARY OBJECTIVE: DECREASE DEATH AND DISABILITY RELATED TO CRITICAL

ILLNESSES WHERE EARLY INTERVENTION IS POSSIBLE AND PROVEN TO BE OF

BENEFIT PATIENT OUTCOME.

METRICS:

-PROVIDING ACCESS TO EMERGENCY MEDICATION IS AN ESSENTIAL COMPONENT OF

THE EARLY INTERVENTION PROTOCOLS.

-SUCCESSFUL FIELD RESUSCITATION AND TREATMENT OF PATIENTS THROUGH EARLY

INTERVENTION AS ENCOUNTERED BY LOCAL EMS SERVICES.

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OUTCOME:

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

-UMC AT CHESTERTOWN # OF PATIENTS SERVED, 2,500

EMS PROVIDERS PROVIDED EMERGENCY MEDICAL CARE TO RESIDENTS OF OUR

SURROUNDING COMMUNITIES. SRH'S ACTIVE PARTICIPATION IN THIS SYSTEM

THROUGH THE PROVISION OF EMERGENCY MEDICATIONS NEEDED TO CARE FOR THESE

CRITICALLY ILL PATIENTS IN THE FIELD, HAVE DEMONSTRATED THAT EARLY

INTERVENTION SAVES LIVES.

HTTP://WWW.NCBI.NLM.NIH.GOV/PUBMED/

INITIATIVE 4, 5, 6

IDENTIFIED NEED: CANCER MORTALITY

HOSPITAL INITIATIVE: A) SHORE REGIONAL BREAST OUTREACH; (B): SHORE

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REGIONAL BREAST CENTER WELLNESS FOR WOMEN PROGRAM; (C) PROSTATE CANCER

SCREENING

PRIMARY OBJECTIVE OF INITIATIVE/METRICS 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

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

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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

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

IMPLEMENTATION: COUNTY DEPARTMENTS OF HEALTH, SHORE COMPREHENSIVE

UROLOGY, TALBOT COUNTY NAACP, MOTA

METRICS: A): # OF WOMEN EDUCATED; CORRELATION OF TUMOR REGISTRY DATA

WITH OUTREACH EVENTS, SCREENINGS. (B): ONGOING DATA 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.

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.

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OUTCOME:

6,632 LIVES TOUCHED (SOME EVENTS INCLUDED BOTH COMMUNITY AND PROFESSIONAL

AUDIENCES)

59 COMMUNITY EVENTS

19 PROFESSIONAL PRESENTATIONS

B): WFW SCREENINGS:

OUTCOMES:

INCREASED BREAST SCREENING LEVELS AMONG UNINSURED AND UNDERINSURED

WOMEN.

WFW SCREENINGS:

201 PATIENTS SEEN (3% DECREASE)

-NEW AA VOLUME DOWN 56%

-NEW HISPANIC VOLUME DOWN 59%

-NEW CAUCASIAN VOLUME DOWN 15%

SHORE REGIONAL BREAST CENTER CASE WORKER

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-1876 PATIENT VISITS

-67 DIAGNOSED WITH BREAST CANCER

-376 PATIENT'S CASE MANAGED

3 OF 35 (9%) CASE MANAGED (NEW DIAGNOSIS)

173 OF 376 WITH ONGOING BREAST CANCER (46%)

203 OF 376 WITH NEGATIVE DIAGNOSTIC EVALUATION (54%)

C): THIS INITIATIVE IS OPEN TO ALL MEN, BUT FOCUSED OUTREACH IS ON AREAS

OF COUNTY WITH A HIGH PERCENTAGE OF AFRICAN AMERICAN /BLACK POPULATION.

SPIRITUAL LEADERS AND CHURCHES ARE CONTACTED AND ENGAGED, AND REQUESTED

TO ENCOURAGE THEIR CONGREGATIONS AND COMMUNITIES TO PARTICIPATE.

OUTCOME:

INCREASED AWARENESS AND DETECTION OF PROSTATE CANCER. PROVIDED ACCESS TO

SCREENINGS TO UNDERSERVED PERSONS OF COMMUNITY.

80 MEN ATTENDED EDUCATION SEMINAR. 23 MEN WERE SCREENED, 3 FOUND TO HAVE

SUSPICIOUS TUMOR.

ALL RESULTS REVIEWED AND HAD FOLLOWED UP WITH THEIR PRIMARY PHYSICIAN.

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INITIATIVE 7, 8

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

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

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

-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

METRIC:

NUMBER OF EVENTS AND PARTICIPANTS

KEY PARTNERS: GRASONVILLE COMMUNITY SENIOR CENTER, UM CENTER FOR DIABETES AND ENDOCRINOLOGY, CAROLINE COUNTY SCHOOLS, AMERICAN DIABETES ASSOCIATION

Part VI Supplemental Information

Provide the following information.

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METRICS: # OF PARTICIPANTS WHO REACH GOALS; # OF PARTICIPANTS; PRE AND

POST SEMINAR SURVEY

OUTCOMES:

DIABETES EDUCATION SERIES 'ASK THE DIETITIAN':

30 PARTICIPANTS ATTENDED 1 HOUR SESSION TO INCREASE THEIR KNOWLEDGE ON

MANAGING THEIR DIABETES. ALL PARTICIPANTS MADE PROGRESS ON DEVELOPING

STRATEGIES TO IMPROVE NUTRITIONAL HEALTH AND HEALTHY LIFESTYLES

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

SHORE KIDS CAMP

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

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CAMP FOR HOSPITALIZATIONS DUE TO COMPLICATIONS FROM DIABETES OR ASTHMA

OUTCOMES (PROCESS AND IMPACT MEASURES INCLUDED):

OUTCOMES:

9 CHILDREN ATTENDED-

NONE OF THE CHILDREN WHO ATTENDED CAMP WERE REPORTED TO BE HOSPITALIZED

WITH DIABETES COMPLICATIONS IN FOLLOWING YEAR

CHILDREN WHO ATTEND CAMP REPORT FEELING 'LESS ALONE' IN THEIR MANAGEMENT

OF THEIR DISEASE.

PARENTS REPORT A 'FEELING OF RELIEF TO HAVE THIS TIME THAT THEIR CHILD

CAN HAVE FUN WHILE UNDER THE PROFESSIONAL CARE OF NURSES.'

INITIATIVE 9

IDENTIFIED NEED: PROGRAMS FOR AGING POPULATION

-REDUCE ED VISITS FROM DIABETES

-REDUCE INCIDENCE OF DIABETES

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-IMPROVE MANAGEMENT OF DIABETES

HOSPITAL INITIATIVE: LEAD SPONSOR: PARTNER IN LOCAL A) 'HOME PORTS ANNUAL AGING SYMPOSIUM' AN EVENT THAT FOCUSED ON AGING ISSUES AND TRENDS, AND PROMOTING AGING IN PLACE. (B) QUEEN ANNE'S COUNTY ANNUAL SENIOR SUMMIT, A HEALTH FAIR AND AGING-RELATED EVENT

PRIMARY OBJECTIVE: AS PEOPLE LIVE LONGER, AGING WELL IS A CHALLENGE AND HOSPITALS NEED TO BE PREPARED. 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 PERCENTAGE, MAKING KENT COUNTY ONE OF THE OLDEST, AGING POPULATIONS IN THE MARYLAND. 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 EVENTS, AS WELL AS OTHER HEALTH FAIRS AND COMMUNITY ACTIVITIES AIMED AT EDUCATING THE UNDERSERVED AND DIVERSE ADULT POPULATION.

SHORE MEDICAL CENTER WILL CONTINUE TO PARTICIPATE IN PROGRAMS THAT FOCUS

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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.

HEALTH FAIRS AND AGING-RELATED EVENTS INCLUDING:

-QUEEN ANNE'S COUNTY ANNUAL SENIOR SUMMIT, MAY 2016; 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

KEY PARTNERS:

-SHORE REGIONAL HEALTH SYSTEM

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-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

METRICS: 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: SHORE REGIONAL HEALTH IS THE LEAD SPONSOR IN QA SENIOR SUMMIT: 18 CLINICAL STAFF AND EXPERTS FROM SRH ON A 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

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NUTRITION; WOUND CARE

-FREE BLOOD PRESSURE SCREENINGS; BMI SCREENINGS; PULMONARY LUNG FUNCTION

SCREENINGS

THERE WERE 200 -300 ATTENDEES. PARTICIPANTS WERE PROVIDED WITH A SURVEY

ON THE PRESENTATIONS, DISPLAYS, EDUCATIONAL MATERIALS AND THE BREAKOUT

SESSIONS. PARTICIPANTS FOUND INFORMATION USEFUL.

INITIATIVE 10

IDENTIFIED NEED: MOBILE INTEGRATED COMMUNITY HEALTH PROGRAM. ADDRESS THE

ISSUE OF FRAGMENTATION OF ACCESS TO HEALTH CARE AMONG MEDICALLY FRAGILE

RESIDENTS WHO FREQUENTLY CALL 911 FOR NON-LIFE THREATENING MEDICAL

REASONS.

HOSPITAL INITIATIVE: MOBILE INTEGRATED COMMUNITY HEALTH PROGRAM

PRIMARY OBJECTIVE:

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-TO IMPROVE HEALTH OUTCOMES AMONG CITIZENS OF THE COUNTY THROUGH

MULTI-AGENCY, INTEGRATED, AND INTERVENTION-BASED HEALTHCARE

-TO PROVIDE MECHANISMS FOR CITIZENS TO HAVE BETTER ACCESS TO HEALTHCARE

AND TO ENHANCE INDIVIDUAL HEALTH OUTCOMES

KEY PARTNERS:

-QUEEN ANNE'S COUNTY DEPARTMENT OF EMERGENCY SERVICES

-QUEEN ANNE'S COUNTY DEPARTMENT OF HEALTH

-MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEMS (MIEMSS)

-UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH

-QUEEN ANNE'S COUNTY COMMISSIONERS

-QUEEN ANNE'S COUNTY ADDICTIONS & PREVENTION SERVICES

-QUEEN ANNE'S COUNTY AREA AGENCY ON AGING

-DEPARTMENT OF HEALTH AND MENTAL HYGIENE

-ZOLL MEDICAL CORPORATION

OUTCOMES:

THE MICH PROGRAM FOCUSES ON INDIVIDUALS WHO HAVE UTILIZED 911 SERVICES

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FIVE INSTANCES OR MORE WITHIN A SIX-MONTH PERIOD OR WHO HAVE BEEN

IDENTIFIED BY EMS PROVIDERS AND/OR HOSPITAL STAFF AS BEING AT HIGH OR

MODERATE RISK FOR DECLINING PHYSICAL AND MENTAL HEALTH. INDIVIDUALS WHO

QUALIFY FOR THE PROGRAM CAN PARTICIPATE VOLUNTARILY AT NO COST, GIVING

THEM ACCESS TO A HEALTH CARE TEAM WHO PROVIDE A SCHEDULED HOME VISIT.

METRIC:

TOTAL NUMBER OF PEOPLE REACHED BY THE INITIATIVE WITHIN THE TARGET

POPULATION

NUMBER OF REFERRALS

REDUCTION IN 911 CALLS

189 CONNECTIONS WERE MADE DURING 63 VISITS TO ENROLLED PARTICIPANTS IN

THE PROGRAM.

REFERRALS TO:

-SAFETY ASSISTANCE 61

-GENERAL HEALTH EDUCATION 26

-CASE MANAGEMENT 18

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-BEHAVIORAL HEALTH 8

-SUBSTANCE ABUSE 8

-HOME CARE/HOME HEALTH 22

-HOUSING/SHELTER 6

-NUTRITION ASSISTANCE 6

-ENERGY ASSISTANCE 5

-PRIMARY CARE REFERRAL 5

-TRANSPORTATION 5

-DENTAL SERVICES 4

-DURABLE MEDICAL EQUIP 4

-SPECIALIST REFERRAL 4

-PRESCRIPTION DRUG ASST. 2

-PROTECTIVE SERVICES 1

-HEALTH INS REF. 1

-LIFE LIMITING ILLNESS 1

-VETERANS BENEFITS 1

TOTAL 911 CALL REDUCTION:29%

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AVERAGE PER PATIENT 911 CALL REDUCTION: 15%

TOTAL NUMBER OF ED VISITS AVOIDED: 136

THE RESULTS OF SATISFACTION SURVEY ARE AS FOLLOWS:

QUESTIONS:

1. AFTER THE MICH VISIT, I FEEL BETTER EQUIPPED TO MANAGE MY PERSONAL HEALTH (68% AGREE/STRONGLY AGREE)

2. DID THE MICH STAFF ADEQUATELY EXPLAIN THE SERVICES (88% AGREE/STRONGLY AGREE)

3. DO YOU FEEL AS THOUGH YOUR QUALITY OF LIFE IMPROVED AFTER THE MICH VISIT (60% AGREE/STRONGLY AGREE)

4. WERE THE SERVICES REFERRED APPROPRIATE FOR YOUR NEEDS (84% AGREE/STRONGLY AGREE)

5. WOULD YOU RECOMMEND MICH TO OTHERS (88% AGREE/STRONGLY AGREE)

INITIATIVE 11

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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: LACK OF DENTAL CARE/ACCESS FOR PEDIATRIC POPULATION

REDUCE DEATHS FROM HEART DISEASE

HOSPITAL INITIATIVE: PEDIATRIC DENTAL PROGRAM. 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 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. THE ORAL HEALTH PROGRAM'S OBJECTIVES ARE:

-INCREASE ACCESS TO ORAL HEALTHCARE

-PROVIDE ORAL HEALTHCARE SERVICES

-INCREASE UTILIZATION OF SERVICES

-IMPROVE ORAL HEALTH OUTCOMES

-IMPROVE ORAL HEALTH LITERACY

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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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.

-REDUCE BARRIERS TO ACCESSING CARE

-RAISE AWARENESS ABOUT ORAL HEALTH

-ADAPT AND IMPLEMENT PROMISING AND EVIDENCE-BASED APPROACHES

-BUILD NETWORKS OF ORAL HEALTH PARTNERS IN COMMUNITIES

KEY PARTNERS:

-CHESTER RIVER HEALTH/HOSPITAL

-EASTERN SHORE AREA HEALTH EDUCATION CENTER

-CHOPTANK COMMUNITY HEALTH SYSTEM

-SHORE REGIONAL HEALTH SYSTEM

-KENT COUNTY HEALTH DEPARTMENT

-MARYLAND DHMH

-MARYLAND HEALTHY SMILES

-DR. MARGARET MCGRATH

-DR. JEAN CARLSON

IMPACT/OUTCOME OF HOSPITAL INITIATIVE: DENTAL DISEASE IS ONE OF THE MOST

COMMON UNMET HEALTH TREATMENT NEED IN CHILDREN ON THE EASTERN SHORE OF

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

MARYLAND. 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.

OUTCOMES (INCLUDE PROCESS AND IMPACT MEASURES): THE PEDIATRIC DENTAL

PROGRAM AT UM AT CHESTERTOWN PROVIDED RESTORATIVE CARE, BOTH MINOR AND

MAJOR, TO 68 PEDIATRIC PATIENTS.

INITIATIVE 12

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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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: DRUG/ SUBSTANCE ABUSE

HOSPITAL INITIATIVE: UM SRH PARTNERSHIP WITH RECOVERY FOR SHORE (RFS)

PROGRAM, PROMOTES RECOVERY THROUGH ADVOCACY, EDUCATION AND SUPPORT

PRIMARY OBJECTIVE: THE PRIMARY OBJECTIVE OF THIS INITIATIVE IS TO:

-RAISE THE AWARENESS ABOUT ADDICTION AND RECOVERY

-REDUCE THE STIGMA ABOUT ADDICTION AND MENTAL DISORDERS

-ADVOCACY FOR THOSE IN RECOVERY

-ENGAGE IN COMMUNITY ACTIVITIES THAT CELEBRATE RECOVERY AND WELLNESS

KEY PARTNERS:

-CAROLINE COUNSELING CENTER

-CAROLINE COUNTY PREVENTION SERVICES

-CHESAPEAKE TREATMENT SERVICES

-CHESAPEAKE VOYAGERS, INC.

-CIRCUIT COURT OF TALBOT COUNTY, PROBLEM SOLVING COURT

-COMMUNITY NEWSPAPER PROJECT (CHESTERTOWN SPY AND TALBOT SPY)

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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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 ADDICTIONS PROGRAM

-DRI-DOCK RECOVERY AND WELLNESS CENTER

-KENT COUNTY DEPARTMENT OF HEALTH ADDICTION SERVICES

-MID SHORE MENTAL HEALTH SYSTEMS, INC.

-QUEEN ANNE'S COUNTY DEPARTMENT OF HEALTH - ADDICTIONS TREATMENT AND PREVENTION SERVICES

-UNIVERSITY OF MARYLAND SHORE BEHAVIORAL HEALTH OUTPATIENT ADDICTIONS

-TALBOT ASSOCIATION OF CLERGY AND LAITY

-TALBOT COUNTY HEALTH DEPARTMENT ADDICTIONS PROGRAM (TCAP) AND PREVENTION

-PAROLE AND PROBATION

-TALBOT PARTNERSHIP FOR ALCOHOL AND OTHER DRUG ABUSE PREVENTION

-UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH

-WARWICK MANOR BEHAVIORAL HEALTH

IMPACT/OUTCOME OF HOSPITAL INITIATIVE:

RFP EVENTS AND PROGRAMS:

PARTICIPATION IN 15-20 COMMUNITY EVENTS RAISING AWARENESS AND PROVIDING

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.

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SUPPORT THOSE AFFECTED BY SUBSTANCE ABUSE, SERVING 5 COUNTIES OF

MID-SHORE, INCLUDING:

-OUT OF THE DARKNESS, SUICIDE PREVENTION

-ADVOCACY FOR NALOXONE, LEGISLATIVE FORUMS IN CENTREVILLE AND CAMBRIDGE

-ADDRESS ALCOHOL, BINGE DRINKING, DRUG/SUBSTANCE ABUSE THROUGH

PARTNERSHIPS LISTED ABOVE

-SPONSOR PEER SUPPORT PROGRAMS

-INDICATORS SUGGEST THE QUALITY OF LIFE FOR THE TARGET POPULATION OF

THOSE IN LONG-TERM RECOVERY FROM ALCOHOL OR OTHER DRUG ADDICTION,

IMPROVED AS A RESULT OF THE SUPPORT AND ADVOCACY PROVIDED BY RFS

PROGRAMS.

INITIATIVE 13

IDENTIFIED NEED: CHRONIC DISEASE -SHORE POST-ACUTE CARE CLINIC

HOSPITAL INITIATIVE: SPACC SERVES: HIGH UTILIZING PATIENTS WHO ARE NOT

CONNECTED TO ONGOING PRIMARY CARE

Part VI Supplemental Information

Provide the following information.

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2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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CHRONICALLY ILL PATIENTS WITH TYPICAL, LONG STANDING COMBINATIONS OF

DIABETES, CHF, COPD, AND/OR KIDNEY DISEASE WHO ARE PRESCRIBED BETWEEN 5

AND 15 MEDICATIONS

RURAL PATIENTS WITH LONG TRAVEL TIMES TO CARE PROVIDERS AND WHO OFTEN DO

NOT HAVE ACCESS TO INFORMATION TECHNOLOGY RESOURCES

PATIENTS WITH SUB-ACUTE MENTAL ILLNESS, SOCIAL ISOLATION, AND/OR LIMITED

FAMILY SUPPORT WHO NEED ASSISTANCE IN MAKING HEALTHCARE DECISIONS THAT

PROVIDE THE BEST CARE IN THE BEST VENUE.

PRIMARY OBJECTIVE:

-IDENTIFY FAILURES IN HOSPITAL DISCHARGE PROCESS TO IMPROVE PROCESSES AND

IDENTIFY FOLLOW-UP NEEDS FROM COMMUNITY RESOURCES

-REDUCE READMISSIONS DURING THE TRANSITIONAL PERIOD RELATED TO CHRONIC

DISEASE MANAGEMENT

-DIABETES-RELATED READMISSION/REVISITS

-CONGESTIVE HEART FAILURE-RELATED READMISSIONS/REVISITS

-HYPERTENSION-RELATED READMISSIONS/REVISITS

Part VI Supplemental Information

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-COPD-RELATED READMISSIONS/REVISITS

-CHRONIC KIDNEY DISEASE-RELATED READMISSIONS/REVISITS

-PROVIDE ASSESSMENT OF DIETARY STATUS AND EDUCATIONAL NEEDS

-PROVIDE ASSESSMENT OF SAFE MEDICATION USE/EDUCATIONAL NEEDS/FINANCIAL

ASSISTANCE NEEDS

-PROVIDE TRANSITIONAL CASE MANAGEMENT SERVICES

KEY PARTNERS: COMMUNITY RESOURCES WILL BE ENGAGED AS APPROPRIATE BASED ON

PATIENT-SPECIFIC NEEDS. MULTIPLE HEALTH CARE REFERRALS MAY BE GENERATED

IN ORDER TO PROVIDE THE SAFEST PATIENT CARE.

PHYSICIAN PRACTICES (OWNED BY HOSPITAL/HEALTH SYSTEM)

PHYSICIAN PRACTICES (NOT WHOLLY OR PARTIALLY OWNED BY THE HOSPITAL)

RETAIL PHARMACIES

HOME HEALTH

IMPACT/OUTCOME OF HOSPITAL INITIATIVE:

THE PROGRAM SERVES 300 PATIENTS PER MONTH

Part VI Supplemental Information

Provide the following information.

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ON A MONTHLY BASIS AVOIDS 7-15 HOSPITAL DAYS PER 1000 DAYS OF PATIENT

LIFE.

*THE PROGRAMS IS VERY NEW, FEB. 2016, AND IT WILL 12 -18 MONTHS OF DATA

TO EVALUATE OUTCOMES. DEVELOPMENT OF DASHBOARDS TO DETERMINE

EFFECTIVENESS OF CLINIC, INVOLVEMENT OF COMMUNITY RESOURCES AND

SATISFACTION FOR THE CLINIC IS UNDERWAY.

INITIATIVE 14

IDENTIFIED NEED: BEHAVIORAL HEALTH

HOSPITAL INITIATIVE: THE BEHAVIORAL HEALTH BRIDGE CLINIC SERVES PATIENTS

DISCHARGED FROM THE BEHAVIORAL HEALTH INPATIENT UNIT WHO ARE UNABLE TO

ACCESS PSYCHIATRIC CARE FROM COMMUNITY DUE TO SHORTAGE OF PSYCHIATRIC

PROVIDERS.

Part VI Supplemental Information

Provide the following information.

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2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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KEY PARTNERS:

-PHYSICIAN PRACTICES

-LOCAL HEALTH DEPTS.

IMPACT/OUTCOME OF HOSPITAL INITIATIVE:

THE PROGRAM SERVED 274 PATIENTS, OCT.2015-JUNE 2016

PATIENTS ARE FOLLOWED IMMEDIATELY UPON DISCHARGE WITHOUT ANY BREAK IN

THEIR CARE OR SUPPORT. THE PROGRAM WORKS TOWARDS ESTABLISHING THE PATIENT

WITH A LONG TERM, ONGOING PROVIDER OF PSYCHIATRIC/BEHAVIORAL; HEALTH

CARE.

*THE PROGRAMS IS VERY NEW, AND WILL TAKE 12 MONTHS TO DEMONSTRATE A

SIGNIFICANT IMPACT. THERE IS NO HARD DATA FOR THE VAST MAJORITY OF THE

WORK WE HAVE DONE TO DATE.

AFFILIATED HEALTH CARE SYSTEM ROLES

SCHEDULE H, PART VI, LINE 6

AS PART OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS), THE

Part VI Supplemental Information

Provide the following information.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

UNIVERSITY OF MARYLAND MEDICAL CENTER UNDERSTANDS THAT HEALTH CARE GOES BEYOND THE WALLS OF THE HOSPITAL AND INTO THE COMMUNITY IT SERVES. UMMS HOSPITALS ARE COMMITTED TO STRENGTHENING THEIR NEIGHBORING COMMUNITIES. IN DOING SO, THE UMMC ASSESSES THE COMMUNITY'S HEALTH NEEDS, IDENTIFIES KEY PRIORITIES, AND RESPONDS WITH SERVICES, PROGRAMS AND INITIATIVES WHICH MAKE A POSITIVE, SUSTAINED IMPACT ON THE HEALTH OF THE COMMUNITY. WITH REPRESENTATION FROM ALL UMMS HOSPITALS, THE MEDICAL SYSTEM'S COMMUNITY HEALTH IMPROVEMENT COUNCIL COORDINATES THE EFFECTIVE AND EFFICIENT UTILIZATION AND DEPLOYMENT OF RESOURCES FOR COMMUNITY-BASED ACTIVITIES AND EVALUATES HOW SERVICES AND ACTIVITIES MEET TARGETED COMMUNITY NEEDS WITHIN DEFINED GEOGRAPHIC AREAS. THE UNIVERSITY OF MARYLAND MEDICAL CENTER IS COMMITTED TO HEALTH EDUCATION, ADVOCACY, COMMUNITY PARTNERSHIPS, AND ENGAGING PROGRAMS WHICH FOCUS ON HEALTH AND WELLNESS WITH THE GOAL OF ELIMINATING HEALTH CARE DISPARITIES IN OUR 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.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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" on Form 990, Part IV, line 23.**
▶ **Attach to Form 990.**
▶ **Information about Schedule J (Form 990) and its instructions is at *www.irs.gov/form990*.**

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization: CHESTER RIVER HOSPITAL CENTER

Employer identification number: 52-0679694

Part I Questions Regarding Compensation

		Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.		
	☐ First-class or charter travel		
	☐ Travel for companions		
	☐ Tax indemnification and gross-up payments		
	☐ Discretionary spending account		
	☐ Housing allowance or residence for personal use		
	☐ Payments for business use of personal residence		
	☒ Health or social club dues or initiation fees		
	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain **1b**	X	
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? **2**	X	
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.		
	☒ Compensation committee		
	☐ Independent compensation consultant		
	☐ Form 990 of other organizations		
	☐ Written employment contract		
	☒ Compensation survey or study		
	☒ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:		
a	Receive a severance payment or change-of-control payment? **4a**	X	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b**	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement? **4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.		
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5–9.		
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:		
a	The organization? **5a**		X
b	Any related organization? **5b**		X
	If "Yes" to line 5a or 5b, describe in Part III.		
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:		
a	The organization? **6a**		X
b	Any related organization? **6b**		X
	If "Yes" on line 6a or 6b, describe in Part III.		
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described on lines 5 and 6? If "Yes," describe in Part III **7**	X	
8	Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III **8**		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? **9**		

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 on 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 in column (B) reported as deferred on prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	JOHN DILLON	(i)	0.	0.	0.	0.	0.	0.	0.
	CHAIRMAN	(ii)	0.	0.	156,000.	0.	0.	156,000.	0.
2	ROBERT A. CHRENCIK	(i)	0.	0.	0.	0.	0.	0.	0.
	DIRECTOR	(ii)	1,254,208.	1,054,693.	253,896.	10,600.	13,037.	2,586,434.	0.
3	JOHN W. ASHWORTH, III	(i)	0.	0.	0.	0.	0.	0.	0.
	DIRECTOR	(ii)	511,790.	169,396.	99,546.	10,600.	13,037.	804,369.	0.
4	KENNETH KOZEL	(i)	0.	0.	0.	0.	0.	0.	0.
	PRESIDENT/CEO	(ii)	402,489.	157,973.	16,195.	77,147.	9,349.	663,153.	0.
5	JOANNE HAHEY	(i)	0.	0.	0.	0.	0.	0.	0.
	CFO/SVP FINANCE	(ii)	275,539.	96,494.	15,520.	45,309.	13,192.	446,054.	0.
6	CHRISTOPHER J. PARKER	(i)	0.	0.	0.	0.	0.	0.	0.
	CNO	(ii)	248,288.	85,185.	43,512.	10,369.	12,153.	399,507.	0.
7	STEWART SEITZ	(i)	137,997.	0.	728.	4,986.	6,641.	150,352.	0.
	DIR. SHORE NURSING & REHAB	(ii)	0.	0.	0.	0.	0.	0.	0.
8	MARY JO KEEFE	(i)	0.	0.	0.	0.	0.	0.	0.
	FORMER VP/CNO	(ii)	140,500.	17,004.	758.	9,790.	11,263.	179,315.	0.
9	SAMUEL P. MARINELLI, JR	(i)	0.	0.	0.	0.	0.	0.	0.
	FORMER CFO	(ii)	204,038.	47,581.	28,286.	8,449.	12,858.	301,212.	0.
10	JAMES E. ROSS	(i)	0.	0.	0.	0.	0.	0.	0.
	FORMER CEO/PRESIDENT	(ii)	0.	0.	267,104.	0.	0.	267,104.	0.
11	SCOTT BURLESON	(i)	0.	0.	0.	0.	0.	0.	0.
	FORMER COO	(ii)	90,776.	10,971.	219.	2,869.	10,838.	115,673.	0.
12		(i)							
		(ii)							
13		(i)							
		(ii)							
14		(i)							
		(ii)							
15		(i)							
		(ii)							
16		(i)							
		(ii)							

Part III Supplemental Information

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

HEALTH OR SOCIAL CLUB DUES OR INITIATION FEES

SCHEDULE J, PART I, LINE 1A

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

SEVERANCE PAYMENT OR CHANGE OF CONTROL PAYMENT

SCHEDULE J, PART I, LINE 4A

DURING THE FISCAL YEAR ENDED JUNE 30, 2016, CERTAIN OFFICERS AND KEY EMPLOYEES HAVE RECEIVED SEVERANCE PAYMENTS. THESE AMOUNTS ARE REPORTABLE AS TAXABLE COMPENSATION AND REPORTED ON SCHEDULE J, PART II, LINE B(III), OTHER REPORTABLE COMPENSATION. THE INDIVIDUAL AND AMOUNT ARE LISTED BELOW:

JAMES E. ROSS $250,191

SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN

SCHEDULE J, PART I, LINE 4B

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.

DURING THE FISCAL YEAR ENDED JUNE 30, 2016, 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:

KENNETH KOZEL

JOANNE HAHEY

DURING THE FISCAL YEAR ENDED JUNE 30, 2016, 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, LINE B(III), OTHER REPORTABLE 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.

JOHN W. ASHWORTH

CHRISTOPHER PARKER

ROBERT CHRENCIK

SAMUEL MARINELLI

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 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)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

▶ **Attach to Form 990 or Form 990-EZ.**

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

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Open To Public Inspection

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

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Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) 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	(d) Corrected? 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? To	(d) Loan to or from the organization? From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	(g) In default? No	(h) Approved by board or committee? Yes	(h) Approved by board or committee? No	(i) Written agreement? Yes	(i) Written agreement? No
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
Total	. . . . . ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

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

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

Part IV Business Transactions Involving Interested Persons.

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

	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	(e) Sharing of organization's revenues? No
(1)	C. DANIEL SAUNDERS	SPOUSE EMPLOYED	88,070.	COMPENSATION FOR FYE 2016		X
(2)	CHRISTOPHER PARKER	SPOUSE EMPLOYED	32,260.	COMPENSATION FOR FYE 2016		X
(3)	WAYNE GARDNER	PAYMENT TO THE COMPANY	47,298.	BEST CARE AMBULANCE		X
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						

Part V Supplemental Information

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

C. DANIEL SAUNDERS

C. DANIEL SAUNDERS' SPOUSE IS EMPLOYED AND PAID BY CHESTER RIVER HOSPITAL CENTER. HER FY2016 COMPENSATION WAS $88,070.

CHRISTOPHER PARKER

CHRISTOPHER PARKER'S SPOUSE IS EMPLOYED AND PAID BY CHESTER RIVER HOSPITAL CENTER AND COMPENSATION WAS $32,260.

WAYNE GARDNER

WAYNE GARDNER, DIRECTOR, IS PRESIDENT OF BEST CARE AMBULANCE. THE COMPANY PROVIDES AMBULANCE SERVICE FOR CHESTER RIVER HOSPITAL CENTER. CRHC'S TOTAL PAYMENT TO THE VENDOR WAS $47,298.

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.

MEMBERS OR STOCKHOLDERS

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

CHESTER RIVER HEALTH SYSTEM, INC. AND THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION MAY ELECT MEMBERS AND APPROVE DECISIONS OF CHESTER RIVER HOSPITAL CENTER.

FORM 990 REVIEW PROCESS

FORM 990, PART VI, LINE 11B

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

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

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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 FINANCIAL REPORTING, THE VICE PRESIDENT OF FINANCE AND THE CFO, WHO SIGNS THE RETURN.

PRIOR TO FILING THE IRS FORM 990, THE ORGANIZATION'S BOARD CHAIRMAN, TREASURER, AUDIT COMMITTEE CHAIRMAN, EXECUTIVE COMMITTEE CHAIRMAN OR OTHER MEMBER OF THE BOARD WITH SIMILAR AUTHORITY WILL REVIEW THE IRS FORM 990. AT THE DISCRETION OF THE REVIEWING BOARD MEMBER, SUCH MEMBER WILL BRING ANY ISSUES OR QUESTIONS RELATED TO THE COMPLETED IRS FORM 990 TO THE ATTENTION OF THE BOARD.

NOTWITHSTANDING THE ABOVE, A BOARD RESOLUTION IS NOT REQUIRED FOR THE FILING OF THE ORGANIZATION'S IRS FORM 990. EACH BOARD MEMBER IS PROVIDED WITH A COPY OF THE FINAL IRS FORM 990 BEFORE FILING.

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

THE ORGANIZATION'S OFFICERS, DIRECTORS, EMPLOYEES AND MEDICAL STAFF MEMBERS, AS APPLICABLE, SHALL DISCLOSE CONFLICTS OF INTEREST OR POTENTIAL CONFLICTS OF INTEREST BETWEEN THEIR PERSONAL INTERESTS AND THE INTERESTS

Name of the organization: CHESTER RIVER HOSPITAL CENTER

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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.

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

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

ALL INVITATIONS FOR BIDS, PROPOSALS OR SOLICITATIONS FOR OFFERS INCLUDE

Name of the organization: CHESTER RIVER HOSPITAL CENTER

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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.

PROCESS FOR DETERMINING COMPENSATION
FORM 990, PART VI, LINE 15A & 15B

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

EXECUTIVE COMPENSATION PACKAGES ARE DETERMINED BY A COMMITTEE OF THE BOARD THAT IS COMPOSED ENTIRELY OF BOARD MEMBERS WHO HAVE NO CONFLICT OF INTEREST. THE COMMITTEE ACQUIRES CREDIBLE COMPARABILITY MARKET DATA CONCERNING THE COMPENSATION PACKAGES OF SIMILARLY SITUATED EXECUTIVES. THE COMMITTEE CAREFULLY REVIEWS THAT DATA, THE EXECUTIVE'S PERFORMANCE AND THE PROPOSED COMPENSATION PACKAGES DURING THE DECISION MAKING PROCESS. THE COMMITTEE MEMORIALIZES ITS DELIBERATIONS IN DETAILED MINUTES REVIEWED AND ADOPTED AT THE NEXT-FOLLOWING MEETING.

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

REQUESTS FOR FORM 990 AND FORM 1023:

A REQUESTOR SEEKING TO REVIEW AND/OR OBTAIN A COPY OF THE ORGANIZATION'S IRS FORM 990 OR FORM 1023 AS FILED WITH THE INTERNAL REVENUE SERVICE, INCLUDING ALL SCHEDULES AND ATTACHMENTS, MAY APPEAR IN PERSON OR SUBMIT A WRITTEN REQUEST. THE MOST RECENT THREE YEARS OF IRS FORM 990 MAY BE REQUESTED. IF THE REQUESTER APPEARS IN PERSON, THE INDIVIDUAL IS DIRECTED TO THE OFFICE OF THE CHIEF FINANCIAL OFFICER FOR THE ORGANIZATION AND THE FORM 990 AND/OR FORM 1023 ARE MADE AVAILABLE FOR INSPECTION.

THE INDIVIDUAL IS PERMITTED TO REVIEW THE RETURN, TAKE NOTES AND REQUEST A COPY. IF REQUESTED, A COPY IS PROVIDED ON THE SAME DAY. A NOMINAL FEE

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IS CHARGED FOR MAKING THE COPIES. THE ORGANIZATION MAY HAVE AN EMPLOYEE PRESENT DURING THE PUBLIC INSPECTION OF THE DOCUMENT.

WRITTEN REQUESTS FOR AN ENTITY'S FORM 990 OR FORM 1023 ARE DIRECTED IMMEDIATELY TO THE OFFICE OF THE CHIEF FINANCIAL OFFICER FOR THE ORGANIZATION. THE REQUESTED COPIES ARE MAILED WITHIN 30 DAYS OF THE REQUEST. REPRODUCTION FEES AND MAILING COSTS ARE CHARGED TO THE REQUESTOR.

CONFLICT OF INTEREST POLICY AND GOVERNING DOCUMENTS:

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

HOURS ON RELATED ENTITIES

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

Name of the organization: CHESTER RIVER HOSPITAL CENTER

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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	(733,671)
CHANGE IN PENSION BENEFITS	(412,652)
FUNDING PPE	229,810
TOTAL OTHER CHANGE IN NET ASSETS	(916,513)

ATTACHMENT 1

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
MD EMERGENCY MEDICINE NETWORK 110 S. PAC ST., 6TH FL., STE. 200 BALTIMORE, MD 21201	PHYSICIAN SERVICES	2,785,023.
MD INPATIENT CARE SPECIALISTS 6934 AVIATION BLVD., STE. A GLEN BURNIE, MD 21061	PHYSICIAN SERVICES	725,000.
HEALTHCARE SERVICES GROUP 3220 TILLMAN DRIVE BENSALEM, PA 19020	ENVIRONMENTAL SVC	553,786.
LABCORP OF AMERICA P.O. BOX 2270 BURLINGTON, NC 27216	LABORATORY SERVICES	198,906.
ROI ELIGIBILITY SVCS. CORP. 1920 GREENSPRING DRIVE, STE. 200 TIMONIUM, MD 21093	COLLECTION RECOVERY	161,774.

ATTACHMENT 2

Name of the organization: CHESTER RIVER HOSPITAL CENTER

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ATTACHMENT 2 (CONT'D)

FORM 990, PART IX - OTHER FEES

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
CONTRACT PHYSICIAN SVCS	5,434,465.	5,434,465.		
SHARED SERVICES	3,839,355.	3,447,741.	391,614.	
CONTRACTED SERVICES	904,975.	812,668.	92,307.	
PURCHASED SVCS MEDICAL	621,233.	621,233.		
OTHER	717,784.	644,571.	73,213.	
TOTALS	11,517,812.	10,960,678.	557,134.	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ **Attach to Form 990.**

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

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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	(g) Section 512(b)(13) controlled entity? No
(1) BALTIMORE WASHINGTON EMERGENCY PHYS INC 52-1756326 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	501(C)(3)	11A	UWBWMS		X
(2) BALTIMORE WASHINGTON HEALTHCARE SERVICES 52-1830243 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	501(C)(3)	11A	UWBWMS		X
(3) BALTIMORE WASHINGTON MEDICAL CENTER INC 52-0689917 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	501(C)(3)	03	UWBWMS		X
(4) UM BALTIMORE WASHINGTON MEDICAL SYSTEM, 52-1830242 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	501(C)(3)	11A	UWBWMS		X
(5) BW MEDICAL CENTER FOUNDATION INC 52-1813656 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	FUNDRAISING	MD	501(C)(3)	11C	UWBWMS		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)		UWBWMS		X

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ **Attach to Form 990.**

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

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Open to Public Inspection

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

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	(g) Section 512(b)(13) controlled entity? No
(1) CHESTER RIVER HEALTH FOUNDATION INC 52-1338861 100 BROWN STREET CHESTERTOWN, MD 21620	FUNDRAISING	MD	501(C)(3)	08	UMSRH		X
(2) UNIV OF MD SHORE REGIONAL HEALTH,INC 52-2046500 100 BROWN STREET CHESTERTOWN, MD 21620	HEALTHCARE	MD	501(C)(3)	11A	UMMSC		X
(3) CHESTER RIVER MANOR INC 52-6070333 200 MORGNEC ROAD CHESTERTOWN, MD 21620	HEALTHCARE	MD	501(C)(3)	09	UMSRH		X
(4) MARYLAND GENERAL CLINICAL PRACTICE GROUP 52-1566211 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	11B	UMSRH		X
(5) MARYLAND GENERAL COMM HEALTH FOUNDATION 52-2147532 827 LINDEN AVENUE BALTIMORE, MD 21201	FUNDRAISING	MD	501(C)(3)	11C	UMMTH		X
(6) UNIVERSITY OF MARYLAND MIDTOWN HEALTH, I 52-1175337 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	11B	UMMSC		X
(7) MARYLAND GENERAL HOSPITAL INC 52-0591667 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	03	UMMTH		X

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

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	(g) Section 512(b)(13) controlled entity? No
(1) CARE HEALTH SERVICES INC 52-1510269 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTHCARE	MD	501(C)(3)	09	UMSRH		X
(2) DORCHESTER GENERAL HOSPITAL FOUNDATION 52-1703242 219 SOUTH WASHINGTON STREET EASTON, MD 21601	FUNDRAISING	MD	501(C)(3)	11D	UMSRH		X
(3) MEMORIAL HOSPITAL FOUNDATION INC 52-1282080 219 SOUTH WASHINGTON STREET EASTON, MD 21601	FUNDRAISING	MD	501(C)(3)	11A	UMSRH		X
(4) UNIVERSITY OF MARYLAND COMMUNITY MEDICAL 52-1874111 22 SOUTH GREENE STREET BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	03	UMMSC		X
(5) SHORE HEALTH SYSTEM INC 52-0610538 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTHCARE	MD	501(C)(3)	03	UMMSC		X
(6) JAMES LAWRENCE KERNAN HOSP ENDOW FD 23-7360743 2200 KERNAN DRIVE BALTIMORE, MD 21207	FUNDRAISING	MD	501(C)(3)	11B	UMMSC		X
(7) JAMES LAWRENCE KERNAN HOSPITAL INC 52-0591639 2200 KERNAN DRIVE BALTIMORE, MD 21207	HEALTHCARE	MD	501(C)(3)	03	UMMSC		X

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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(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	(g) Section 512(b)(13) controlled entity? No
(1) UMMS FOUNDATION, INC. 52-2238893 22 SOUTH GREENE STREET BALTIMORE, MD 21201	FUNDRAISING	MD	501(C)(3)	11A	UMMSC		X
(2) UNIVERSITY OF MD MEDICAL SYSTEM CORP 52-1362793 22 SOUTH GREENE STREET BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	03	N/A		X
(3) UNIVERSITY OF MARYLAND CHARLES REGIONAL 52-2155576 PO BOX 1070 LA PLATA, MD 20646	HEALTHCARE	MD	501(C)(3)	11C	UMMSC		X
(4) CIVISTA MEDICAL CENTER, INC. 52-0445374 PO BOX 1070 LA PLATA, MD 20646	HEALTHCARE	MD	501(C)(3)	03	CIVHS		X
(5) CHARLES REGIONAL MEDICAL CENTER FOUNDATI 52-1414564 PO BOX 1070 LA PLATA, MD 20646	FUNDRAISING	MD	501(C)(3)	11A	UMCRH		X
(6) CHARLES REGIONAL MEDICAL CENTER AUXILIAR 52-1131193 PO BOX 1070 LA PLATA, MD 20646	FUNDRAISING	MD	501(C)(3)	11A	UMCRH		X
(7) UNIV OF MD ST. JOSEPH FOUNDATION, INC 52-1681044 7601 OSLER DRIVE TOWSON, MD 21204	FUNDRAISING	MD	501(C)(3)	11A	UMMSC		X

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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52-0679694

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	(g) Section 512(b)(13) controlled entity? No
(1) HARFORD MEMORIAL HOSPITAL, INC. 52-0591484 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HEALTHCARE	MD	501(C)(3)	03	UMUCHS		X
(2) UCH LEGACY FUNDING CORPORATION 52-0882914 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	FUNDRAISING	MD	501(C)(3)	11A	UMUCHS		X
(3) 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
(4) UPPER CHESAPEAKE HEALTH FOUNDATION, INC. 52-1398507 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	FUNDRAISING	MD	501(C)(3)	11A	UMUCHS		X
(5) UPPER CHESAPEAKE MEDICAL CENTER, INC. 52-1253920 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HEALTHCARE	MD	501(C)(3)	03	UMUCHS		X
(6) UPPER CHESAPEAKE MEDICAL SERVICES, INC. 52-1501734 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HEALTHCARE	MD	501(C)(3)	09	UMUCHS		X
(7) UPPER CHESAPEAKE PROPERTIES, INC. 52-1907237 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	REAL ESTATE	MD	501(C)(2)		UMUCHS		X

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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▶ **Attach to Form 990.**

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OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization

CHESTER RIVER HOSPITAL CENTER

Employer identification number

52-0679694

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	(g) Section 512(b)(13) controlled entity? No
(1) UPPER CHES RESIDENTIAL HOSPICE HOUSE, IN 26-0737028 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HOSPICE	MD	501(C)(3)	07	UMUCHS		X
(2) UPPER CHESAPEAKE/ST. JOSEPH HOME CARE, I 52-1229742 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HOSPICE	MD	501(C)(3)	09	UMUCHS		X
(3) UMSJ HEALTH SYSTEM, LLC 46-0797956 7601 OSLER DRIVE TOWSON, MD 21204	HEALTHCARE	MD	501(C)(3)	11A	UMMSC		X
(4)							
(5)							
(6)							
(7)							

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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) ARUNDEL PHYSICIANS ASSOCIATES 301 HOSPITAL DRIVE GLEN BURNIE	HEALTHCARE	MD	N/A					X			X	
(2) BALTIMORE WASHINGTON IMAGING, 301 HOSPITAL DRIVE GLEN BURNIE	HEALTHCARE	MD	N/A					X			X	
(3) INNOVATIVE HEALTH LLC 52-19972 29165 CANVASBACK DRIVE, SUITE	BILLING	MD	N/A					X			X	
(4) CENTRAL MARYLAND RADIOLOGY ONC 10710 CHARTER DRIVE COLUMBIA,	HEALTHCARE	MD	N/A					X			X	
(5) UNIVERSITYCARE LLC 52-1914892 22 SOUTH GREENE STREET BALTIMO	HEALTHCARE	MD	N/A					X			X	
(6) O'DEA MEDICAL ARTS LIMITED PAR 7601 OSLER DRIVE TOWSON, MD 21	RENTAL	MD	N/A					X			X	
(7) ADVANCED IMAGING AT ST. JOSEPH 7601 OSLER DRIVE TOWSON, MD 21	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	(i) 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 CONDOM 52-1891126 827 LINDEN AVENUE BALTIMORE, MD 21201	REAL ESTATE	MD	N/A	C CORP					X
(6) NA EXECUTIVE BUILDING CONDO ASSN, INC. 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	REAL ESTATE	MD	N/A	C CORP					X
(7) TERRAPIN INSURANCE COMPANY 98-0129232 P.O. BOX 1109 GRAND CAYMAN, CJ KY1-1102	INSURANCE	CJ	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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) UCHS/UMMS REAL ESTATE TRUST 27 520 UPPER CHESAPEAKE DR BEL AI	REAL ESTATE	MD	N/A					X			X	
(2) UNIVERSITY OF MARYLAND CHARLES PO BOX 1070 LAPLATA, MD 20646	HEALTHCARE	MD	N/A					X			X	
(3)												
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1) UMMS SELF INSURANCE TRUST 52-6315433 22 SOUTH GREENE STREET BALTIMORE, MD 21201	INSURANCE	MD	UMMS	TRUST					X
(2) UPPER CHESAPEAKE INSURANCE COMPANY 98-0468438 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	INSURANCE	MD	UMUCHS	TRUST					X
(3) UPPER CHESAPEAKE HEALTH VENTURES, INC. 52-2031264 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	HEALTHCARE	MD	UMUCHS	C CORP					X
(4) UPPER CHESAPEAKE MEDICAL CENTER LAND CON 77-0674478 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	REAL ESTATE	MD	UC MED CRT	C CORP					X
(5) UPPER CHESAPEAKE MEDICAL OFFICE BUILDING 52-1946829 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014	REAL ESTATE	MD	UC HLTH VENT	C CORP					X
(6) UNIVERSITY OF MARYLAND HEALTH ADVANTAGE, 46-1411902 22 SOUTH GREENE STREET BALTIMORE, MD 21201	INSURANCE	MD	UMMS	C CORP					X
(7) UNIVERSITY OF MARYLAND HEALTH PARTNERS, 45-2815803 22 SOUTH GREENE STREET BALTIMORE, MD 21201	INSURANCE	MD	UMMS	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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" 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	(i) No
(1) UNIVERSITY OF MARYLAND MEDICAL SYSTEM HE 45-2815722 22 SOUTH GREENE STREET BALTIMORE, MD 21201	INSURANCE	MD	UMMS	C CORP					X
(2) SHORE ORTHOPEDICS, INC. 37-1817260 219 S. WASHINGTON STREET EASTON, MD 21601	HEALTHCARE	MD	SHS	C CORP					X
(3)									
(4)									
(5)									
(6)									
(7)									

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

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

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

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

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

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

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

Part VII **Supplemental Information**

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