

Return of Organization Exempt From Income Tax

2010

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

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

A For the 2010 calendar year, or tax year beginning **07/01, 2010**, and ending **06/30, 2011**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization FRANKLIN SQUARE HOSPITAL CENTER INC.			D Employer identification number 52-0608007
	Doing Business As MEDSTAR FRANKLIN SQUARE MEDICAL CENT			E Telephone number (410) 772-6719
	Number and street (or P.O. box if mail is not delivered to street address) 9000 FRANKLIN SQUARE DRIVE		Room/suite	
	City or town, state or country, and ZIP + 4 BALTIMORE, MD 21237			G Gross receipts \$ 452,953,180.
F Name and address of principal officer: ADRIENNE KIRBY 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237			H(a) Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527				
J Website: WWW.FRANKLINSQUARE.ORG				
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other <input type="checkbox"/>				
L Year of formation: 1898 M State of legal domicile: MD				

Part I Summary		Prior Year	Current Year
Activities & Governance	1 Briefly describe the organization's mission or most significant activities: MEDSTAR FRANKLIN SQUARE MEDICAL CENTER, A MEMBER OF MEDSTAR HEALTH, PROVIDES THE HIGHEST QUALITY HEALTHCARE AND EDUCATION TO OUR COMMUNITIES.		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	19.
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	14.
	5 Total number of individuals employed in calendar year 2010 (Part VII, line 2a)	5	3,858.
	6 Total number of volunteers (estimate if necessary)	6	400.
	7a Total gross unrelated business revenue from Part VIII, column (C), line 12	7a	0.
b Net unrelated business taxable income from Form 990-T, line 34	7b	0.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	4,212,704.	2,172,692.
	9 Program service revenue (Part VIII, line 2g)	428,134,103.	447,746,775.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	143,132.	27,046.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	6,863,857.	2,973,353.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	439,353,796.	452,919,866.
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)	206,636,133.	218,337,018.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b Total fundraising expenses (Part IX, column (D), line 25)	0.	0.
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24f)	201,552,463.	216,493,339.	
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	408,188,596.	434,830,357.	
19 Revenue less expenses. Subtract line 18 from line 12	31,165,200.	18,089,509.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year 279,516,026.	End of Year 310,161,018.
	21 Total liabilities (Part X, line 26)	72,667,918.	73,232,767.
	22 Net assets or fund balances. Subtract line 21 from line 20.	206,848,108.	236,928,251.

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 <i>Marc R. Berger</i>	Date 5/14/12
	Type or print name and title MARC R. BERGER AVP, TAXATION	

Paid Preparer Use Only	Print/Type preparer's name Scott Sherman	Preparer's signature <i>Scott Sherman</i>	Date 5/3/12	Check if self-employed <input type="checkbox"/>	PTIN P00451522
	Firm's name KPMG LLP	Firm's EIN 13-5565207	Phone no. 757-616-7000		
	Firm's address 440 MONTICELLO AVE, SUITE 1900 NORFOLK, VA 23510-2674				

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

Application for Extension of Time To File an Exempt Organization Return

▶ File a separate application for each return.

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

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

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

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

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

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

Type or print	Name of exempt organization FRANKLIN SQUARE HOSPITAL CENTER INC.	Employer identification number 52-0608007
	Number, street, and room or suite no. If a P.O. box, see instructions. 9000 FRANKLIN SQUARE DRIVE	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. BALTIMORE, MD 21237	

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

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

- The books are in the care of ▶ MARC BERGER

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

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

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 02/15, 2012, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

▶ calendar year 20____ or

▶ tax year beginning 07/01, 2010, and ending 06/30, 2011.

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

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

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

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

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

Type or print File by the extended due date for filing your return. See instructions.	Name of exempt organization FRANKLIN SQUARE HOSPITAL CENTER INC.	Employer identification number 52-0608007
	Number, street, and room or suite no. If a P.O. box, see instructions. 9000 FRANKLIN SQUARE DRIVE	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. BALTIMORE, MD 21237	

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

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

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

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

- I request an additional 3-month extension of time until 05/15, 2012 .
- For calendar year _____, or other tax year beginning 07/01, 2010, and ending 06/30, 2011 .
- If the tax year entered in line 5 is for less than 12 months, check reason: Initial return Final return
 Change in accounting period
- State in detail why you need the extension **INFORMATION NECESSARY TO PREPARE A COMPLETE AND ACCURATE RETURN IS NOT YET AVAILABLE.**

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

Signature and Verification

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

Signature **▶**  Title **▶** CPA Date **▶** 11/16/11

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

ATTACHMENT 1

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

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

4 Describe the exempt purpose achievements for each of the organization's three largest program services by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses \$ 346,617,386. including grants of \$ 0.) (Revenue \$ 430,830,486.)

MEDSTAR FRANKLIN SQUARE MEDICAL CENTER'S LARGEST PROGRAM IS ACCESS TO AND THE PROVISION OF ACUTE HOSPITAL SERVICES TO THE COMMUNITIES OF EASTERN BALTIMORE COUNTY, MARYLAND AND THE SURROUNDING AREAS. IN ADDITION TO THE PROGRAM SERVICE EXPENSES LISTED ABOVE, MFSC INCURRED \$55.6M OF MANAGEMENT AND GENERAL EXPENSES IN PROVIDING SERVICES TO ITS COMMUNITIES. MFSC OFFERS CLINICAL SERVICES IN MEDICINE, SURGERY, ONCOLOGY, OBSTETRICS, CARDIOLOGY (INCLUDING ANGIOPLASTY), PEDIATRICS, GYNECOLOGY, AND PSYCHIATRY. FOR ADDITIONAL INFORMATION, SEE SCHEDULE O.

4b (Code:) (Expenses \$ 17,499,067. including grants of \$ 0.) (Revenue \$ 12,997,752.)

MEDSTAR FRANKLIN SQUARE MEDICAL CENTER PROVIDED \$17.5M IN SUBSIDIZED (MISSION DRIVEN) HEALTH SERVICES IN FISCAL 2011. THESE CRITICAL SERVICES, WHICH ARE DRIVEN BY COMMUNITY NEEDS, OPERATE AT A LOSS. THEY ADDRESS PRIORITIES PRIMARILY THROUGH DISEASE PREVENTION AND IMPROVEMENT OF HEALTH STATUS. SERVICES INCLUDE OPERATION AND MANAGEMENT OF THE FAMILY HEALTH CENTER, HOMELESS HEALTH SERVICES, PRIMARY CARE SERVICES, HOSPITALISTS, AND EMERGENCY AND TRAUMA SERVICES.

4c (Code:) (Expenses \$ 15,143,864. including grants of \$ 0.) (Revenue \$ 0.)

MEDSTAR FRANKLIN SQUARE MEDICAL CENTER PROVIDED \$15.1M IN HEALTH PROFESSIONS EDUCATION IN FISCAL YEAR 2011. THIS CATEGORY INCLUDES TRAINING IN GRADUATE MEDICAL EDUCATION, AND EDUCATION FOR PHYSICIANS, MEDICAL STUDENTS, NURSES, AND OTHER HEALTH PROFESSIONS.

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

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

4e Total program service expenses 379,260,317.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 1a through 14b regarding Form 1096, Form W-2G, gaming winnings, Form W-3, foreign accounts, prohibited transactions, and contributions.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members... 1b Enter the number of voting members... 2 Did any officer, director, trustee, or key employee have a family relationship... 3 Did the organization delegate control over management duties... 4 Did the organization make any significant changes to its governing documents... 5 Did the organization become aware during the year of a significant diversion of the organization's assets?... 6 Does the organization have members or stockholders?... 7a Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?... 7b Are any decisions of the governing body subject to approval by members, stockholders, or other persons?... 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body? b Each committee with authority to act on behalf of the governing body?... 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

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Does the organization have local chapters, branches, or affiliates? b If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization?... 11a Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form? b Describe in Schedule O the process, if any, used by the organization to review this Form 990. 12a Does the organization have a written conflict of interest policy? If "No," go to line 13 b Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts? c Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done 13 Does the organization have a written whistleblower policy? 14 Does the organization have a written document retention and destruction policy? 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 b Other officers or key employees of the organization 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? b If "Yes," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken steps to safeguard the organization's exempt status with respect to such arrangements?

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 (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply. [] Own website [] Another's website [X] Upon request
19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: MARC BERGER, 5565 STERRETT PLACE, 5TH FLOOR, COLUMBIA, MD 21044 410-772-6719

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
ATTACHMENT 3										
(1) HATEM S ABDO MD DIRECTOR	1.00	X					0.	0.	0.	
(2) KHALID AL-TALIB MD DIRECTOR	1.00	X					0.	0.	0.	
(3) MOHAMMAD M ALABRASH MD DIRECTOR	1.00	X					11,667.	0.	0.	
(4) MICHAEL L DIETRICH DIRECTOR	1.00	X					0.	0.	0.	
(5) DEBRA B DOYLE DIRECTOR	1.00	X					0.	0.	0.	
(6) ELIZABETH S GLENN DIRECTOR	1.00	X					0.	0.	0.	
(7) IRA GUBERNICK MD DIRECTOR	1.00	X					23,333.	0.	0.	
(8) CLIFFORD M JOHNSON JR DIRECTOR	1.00	X					0.	0.	0.	
(9) COLLEEN LOPRESTO DIRECTOR	1.00	X					0.	0.	0.	
(10) VINCENT MARTORANA DPM DIRECTOR	1.00	X					0.	0.	0.	
(11) PATRICIA R NORMAN DIRECTOR	1.00	X					0.	0.	0.	
(12) CHARLES PICCININI DIRECTOR	1.00	X					0.	0.	0.	
(13) KENNETH A SAMET DIRECTOR	1.00	X					0.	3,125,094.	132,265.	
(14) RICHARD W SINGLE SR DIRECTOR	1.00	X					0.	0.	0.	
(15) MICHAEL D SUTER MD DIRECTOR	1.00	X					0.	0.	0.	
(16) DEBORAH M TURNER DIRECTOR	1.00	X					0.	0.	0.	

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

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(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			
(17) THOMAS S WINTZ DIRECTOR	1.00	X					0.	0.	0.	
(18) ADRIENNE KIRBY PRESIDENT	40.00	X		X			355,177.	0.	4,882.	
(19) GEORGE J JABAJI MD DIRECTOR	1.00	X					32,089.	0.	0.	
(20) ANTHONY SCLAMA VICE PRESIDENT	40.00			X			487,274.	0.	17,946.	
(21) ROBERT LALLY VICE PRESIDENT	40.00			X			345,081.	0.	36,044.	
(22) LAWRENCE STRASSNER VICE PRESIDENT	40.00				X		221,219.	0.	10,297.	
(23) GLENN VISBEEN SENIOR VICE PRESIDENT	40.00				X		306,790.	0.	15,706.	
(24) YVONNE OTTAVIANO CHIEF	40.00					X	404,428.	0.	17,986.	
(25) WILLIAM MCGUIRE PHYSICIAN DIR SERVICE LINE FSH	40.00					X	479,099.	0.	7,995.	
(26) WILLIAM WATERFIELD CHIEF	40.00					X	395,542.	0.	17,472.	
(27) SAMUEL SMITH MEDICAL DIRECTOR	40.00					X	395,777.	0.	22,944.	
(28) ALBERT FLEISHER PHYSICIAN	40.00					X	444,999.	0.	16,717.	
1b Sub-total							3,902,475.	3,125,094.	300,254.	
c Total from continuation sheets to Part VII, Section A ATTACHMENT 2							0.	1,060,335.	38,378.	
d Total (add lines 1b and 1c)							3,902,475.	4,185,429.	338,632.	

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 in reportable compensation from the organization **▶ 178**

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 4		

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 **▶ 34**

Part VIII Statement of Revenue

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514	
Contributions, gifts, grants and other similar amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c	95,451.			
	d	Related organizations	1d				
	e	Government grants (contributions) . .	1e				
	f	All other contributions, gifts, grants, and similar amounts not included above .	1f	2,077,241.			
	g	Noncash contributions included in lines 1a-1f: \$					
	h	Total. Add lines 1a-1f		2,172,692.			
Program Service Revenue			Business Code				
	2a	<u>NET PATIENT SERVICE REVENUE</u>	621300	443,828,238.	443,828,238.		
	b	<u>PHARMACY</u>	900099	3,864,337.	3,864,337.		
	c	<u>HEALTH EDUCATION</u>	900099	54,200.	54,200.		
	d						
	e						
	f	All other program service revenue					
g	Total. Add lines 2a-2f		447,746,775.				
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)		13,341.		13,341.	
	4	Income from investment of tax-exempt bond proceeds . . .		0.			
	5	Royalties		0.			
	6a	Gross Rents	(i) Real				
			(ii) Personal				
				374,013.			
				0.			
	b	Less: rental expenses					
	c	Rental income or (loss)		374,013.			
	d	Net rental income or (loss)		374,013.		374,013.	
	7a	Gross amount from sales of assets other than inventory	(i) Securities				
			(ii) Other				
				13,705.			
	b	Less: cost or other basis and sales expenses					
	c	Gain or (loss)		13,705.			
	d	Net gain or (loss)		13,705.		13,705.	
8a	Gross income from fundraising events (not including \$ <u>95,451.</u> of contributions reported on line 1c). See Part IV, line 18	a	26,182.				
b	Less: direct expenses	b	33,314.				
c	Net income or (loss) from fundraising events		-7,132.		-7,132.		
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	<u>REBATE INCOME</u>	900099	1,337,847.		1,337,847.		
b	<u>PARKING LOT REVENUE</u>	812930	156,120.		156,120.		
c	<u>NSABP REVENUE</u>	900099	156,019.		156,019.		
d	All other revenue	900099	956,486.		956,486.		
e	Total. Add lines 11a-11d		2,606,472.				
12	Total revenue. See instructions		452,919,866.	447,746,775.	0.	3,000,399.	

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns.

All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21 . . .	0.			
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22	0.			
3 Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	1,867,505.	1,782,630.	84,875.	
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	177,793,162.	160,648,542.	17,144,620.	
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions).	4,163,920.	3,764,599.	399,321.	
9 Other employee benefits	22,257,444.	20,122,951.	2,134,493.	
10 Payroll taxes	12,254,987.	11,229,550.	1,025,437.	
11 Fees for services (non-employees):				
a Management	25,720,380.	0.	25,720,380.	
b Legal	210,324.	1,225.	209,099.	
c Accounting	0.			
d Lobbying	0.			
e Professional fundraising services. See Part IV, line 17	0.			
f Investment management fees	0.			
g Other	39,947,118.	37,703,836.	2,243,282.	
12 Advertising and promotion	1,715,013.	97,751.	1,617,262.	
13 Office expenses	3,514,936.	2,299,497.	1,215,439.	
14 Information technology	90,007.	76,212.	13,795.	
15 Royalties	0.			
16 Occupancy	1,612,439.	1,612,501.	-62.	
17 Travel	495,146.	406,742.	88,404.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	67,590.	61,767.	5,823.	
20 Interest	10,049,727.	10,049,727.	0.	
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	18,638,121.	18,638,121.	0.	
23 Insurance	8,576,809.	8,218,935.	357,874.	0.
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24f. If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O.)				
a <u>DRUGS/PHARMACY</u>	28,551,740.	28,510,921.	40,819.	
b <u>MEDICAL/SURGICAL SUPPLIES</u>	26,205,287.	26,182,462.	22,825.	
c <u>BAD DEBTS</u>	18,153,399.	18,153,399.		
d <u>IMPLANTS/PROST.</u>	9,414,279.	9,414,220.	59.	
e <u>FOOD SERVICE</u>	5,816,531.	5,515,608.	300,923.	
f All other expenses	17,714,493.	14,769,121.	2,945,372.	
25 Total functional expenses. Add lines 1 through 24f	434,830,357.	379,260,317.	55,570,040.	0.
26 Joint Costs. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720). Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X Balance Sheet

		(A) Beginning of year		(B) End of year	
Assets	1	Cash - non-interest-bearing	6,378.	1	6,428.
	2	Savings and temporary cash investments	774,224.	2	194,039.
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	46,884,632.	4	61,540,128.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions)		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use	5,840,785.	8	6,680,009.
	9	Prepaid expenses and deferred charges	715,281.	9	931,948.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 447,810,781.		
	10b	Less: accumulated depreciation	10b 209,221,892.		
	10c		221,848,133.	10c	238,588,889.
	11	Investments - publicly traded securities		11	
	12	Investments - other securities. See Part IV, line 11	1,026,012.	12	485,215.
	13	Investments - program-related. See Part IV, line 11		13	
	14	Intangible assets		14	
15	Other assets. See Part IV, line 11	2,420,581.	15	1,734,362.	
16	Total assets. Add lines 1 through 15 (must equal line 34)	279,516,026.	16	310,161,018.	
Liabilities	17	Accounts payable and accrued expenses	42,259,717.	17	40,284,965.
	18	Grants payable		18	
	19	Deferred revenue	329,983.	19	323,611.
	20	Tax-exempt bond liabilities		20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities. Complete Part X of Schedule D	30,078,218.	25	32,624,191.
	26	Total liabilities. Add lines 17 through 25	72,667,918.	26	73,232,767.
Net Assets or Fund Balances	Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27	Unrestricted net assets	206,422,096.	27	236,443,036.
	28	Temporarily restricted net assets	426,012.	28	485,215.
	29	Permanently restricted net assets		29	
	Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
33	Total net assets or fund balances	206,848,108.	33	236,928,251.	
34	Total liabilities and net assets/fund balances.	279,516,026.	34	310,161,018.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	452,919,866.
2	Total expenses (must equal Part IX, column (A), line 25)	2	434,830,357.
3	Revenue less expenses. Subtract line 2 from line 1	3	18,089,509.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	206,848,108.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	11,990,634.
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	236,928,251.

Part XII Financial Statements and Reporting

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

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

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047

2010

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

Name of the organization FRANKLIN SQUARE HOSPITAL CENTER INC.	Employer identification number 52-0608007
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Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

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

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

	Yes	No
(i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	11g(i)	
(ii) A family member of a person described in (i) above?	11g(ii)	
(iii) A 35% controlled entity of a person described in (i) or (ii) above?	11g(iii)	

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

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule A (Form 990 or 990-EZ) 2010

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

Section A. Public Support

Table with 7 columns: (a) 2006, (b) 2007, (c) 2008, (d) 2009, (e) 2010, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f); 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2006, (b) 2007, (c) 2008, (d) 2009, (e) 2010, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities, whether or not the business is regularly carried on; 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.); 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2010 (line 6, column (f) divided by line 11, column (f)); 15 Public support percentage from 2009 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2010; 16b 33 1/3% support test - 2009; 17a 10%-facts-and-circumstances test - 2010; 17b 10%-facts-and-circumstances test - 2009; 18 Private foundation.

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
9 Amounts from line 6.						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2010 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2009 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2010 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2009 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2010. 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 - 2009. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization ►

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

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

**SCHEDULE D
(Form 990)**

Supplemental Financial Statements

OMB No. 1545-0047

2010

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

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

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

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate contributions to (during year)		
3 Aggregate grants from (during year)		
4 Aggregate value at end of year		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

- 1 Purpose(s) of conservation easements held by the organization (check all that apply).
- | | |
|--|--|
| <input type="checkbox"/> Preservation of land for public use (e.g., recreation or education) | <input type="checkbox"/> Preservation of an historically important land area |
| <input type="checkbox"/> Protection of natural habitat | <input type="checkbox"/> Preservation of a certified historic structure |
| <input type="checkbox"/> Preservation of open space | |

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

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

- 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____
- 4 Number of states where property subject to conservation easement is located ▶ _____
- 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? Yes No
- 6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____
- 7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ \$ _____
- 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and 170(h)(4)(B)(ii)? Yes No
- 9 In Part XIV, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 Provide the estimated percentage of the year end balance held as:

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

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

- (i) unrelated organizations
- (ii) related organizations

	Yes	No
3a(i)		
3a(ii)		
3b		

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

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

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

Description of Investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		386,702.		386,702.
b Buildings		156,835,402.	70,480,986.	86,354,416.
c Leasehold improvements		2,211,560.	1,353,414.	858,146.
d Equipment		259,153,527.	131,780,461.	127,373,066.
e Other		29,223,590.	5,607,031.	23,616,559.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) ▶				238,588,889.

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

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

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

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

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

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

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

1. (a) Description of liability	(b) Amount
(1) Federal income taxes	
(2) ADVANCED FROM 3RD PARTY PAYORS	12,628,533.
(3) WORKERS COMPENSATION	5,322,757.
(4) STOCK OPTION PLAN	440,785.
(5) ASBESTOS ABATEMENT LIABILITY	243,225.
(6) OTHER LIABILITY	13,988,891.
(7)	
(8)	
(9)	
(10)	
(11)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	32,624,191.

2. FIN 48 (ASC 740) Footnote. In Part XIV, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740).

Part XIV Supplemental Information (continued)

FIN 48 FOOTNOTE

SCHEDULE D, PART X

INCOME TAXES ARE ACCOUNTED FOR UNDER THE ASSET AND LIABILITY METHOD. DEFERRED TAX ASSETS AND LIABILITIES ARE RECOGNIZED FOR THE FUTURE TAX CONSEQUENCES ATTRIBUTABLE TO DIFFERENCES BETWEEN THE FINANCIAL STATEMENT CARRYING AMOUNTS OF EXISTING ASSETS AND LIABILITIES AND THEIR RESPECTIVE TAX BASES AND OPERATING LOSS AND TAX CREDIT CARRYFORWARDS. DEFERRED TAX ASSETS AND LIABILITIES ARE MEASURED USING ENACTED TAX RATES EXPECTED TO APPLY TO TAXABLE INCOME IN THE YEARS IN WHICH THOSE TEMPORARY DIFFERENCES ARE EXPECTED TO BE RECOVERED OR SETTLED. THE EFFECT ON DEFERRED TAX ASSETS AND LIABILITIES OF A CHANGE IN TAX RATES IS RECOGNIZED IN THE PERIOD THAT INCLUDES THE ENACTMENT DATE. ANY CHANGES TO THE VALUATION ALLOWANCE ON THE DEFERRED TAX ASSET ARE REFLECTED IN TH YEAR OF CHANGE. THE CORPORATION ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH THE FASB ACCOUNTING STANDARDS CODIFICATION (ASC) TOPIC 740, INCOME TAXES. THERE WAS NO LIABILITY RECORDED FOR UNCERTAIN TAX POSITIONS AS OF JUNE 30, 2011.

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

	(a) Event #1		(b) Event #2	(c) Other Events	(d) Total events (add col. (a) through col. (c))
	GOLF TOURNAMENT		NONE	0	
	(event type)		(event type)	(total number)	
Revenue					
1 Gross receipts	121,633.				121,633.
2 Less: Charitable contributions	95,451.				95,451.
3 Gross income (line 1 minus line 2)	26,182.				26,182.
Direct Expenses					
4 Cash prizes					
5 Noncash prizes					
6 Rent/facility costs					
7 Food and beverages					
8 Entertainment					
9 Other direct expenses	33,314.				33,314.
10 Direct expense summary. Add lines 4 through 9 in column (d)					(33,314.)
11 Net income summary. Combine line 3, column (d), and line 10					-7,132.

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

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

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

11 Does the organization operate gaming activities with nonmembers? Yes No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? Yes No

13 Indicate the percentage of gaming activity operated in:
a The organization's facility 13a %
b An outside facility 13b %

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

Name ▶ -----

Address ▶ -----

15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? Yes No

b If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ ----- and the amount of gaming revenue retained by the third party ▶ \$ -----

c If "Yes," enter name and address of the third party:

Name ▶ -----

Address ▶ -----

16 Gaming manager information:

Name ▶ -----

Gaming manager compensation ▶ \$ -----

Description of services provided ▶ -----

Director/officer Employee Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? Yes No

b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ -----

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

SCHEDULE H
(Form 990)

Hospitals

OMB No. 1545-0047

2010

Open to Public Inspection

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

Department of the Treasury
Internal Revenue Service

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

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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 Worksheets 1 and 2)			8,367,249.	0.	8,367,249.	2.01
b Unreimbursed Medicaid (from Worksheet 3, column a)			0.	0.	0.	0.00
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)			0.	0.	0.	0.00
d Total Financial Assistance and Means-Tested Government Programs			8,367,249.	0.	8,367,249.	2.01
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			2,125,443.	46,931.	2,078,512.	.50
f Health professions education (from Worksheet 5)			15,143,864.	0.	15,143,864.	3.63
g Subsidized health services (from Worksheet 6)			17,499,067.	12,997,752.	4,501,315.	1.08
h Research (from Worksheet 7)			1,434.	0.	1,434.	0.00
i Cash and in-kind contributions to community groups (from Worksheet 8)			261,638.	0.	261,638.	.06
j Total. Other Benefits			35,031,446.	13,044,683.	21,986,763.	5.27
k Total. Add lines 7d and 7j			43,398,695.	13,044,683.	30,354,012.	7.28

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule H (Form 990) 2010

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support			114,216.	0.	114,216.	.03
4 Environmental improvements						
5 Leadership development and training for community members			2,221.	0.	2,221.	
6 Coalition building						
7 Community health improvement advocacy			47,834.	0.	47,834.	.01
8 Workforce development						
9 Other						
10 Total			164,271.	0.	164,271.	.04

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Does 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 (at cost)	2		11,791,844.
3 Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy	3		0.
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts in community benefit.			

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5		0.
6 Enter Medicare allowable costs of care relating to payments on line 5	6		0.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7		0.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other			

Section C. Collection Practices

9a Does 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

(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 (continued)

Section B. Facility Policies and Practices

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

Name of Hospital Facility: FRANKLIN SQUARE HOSPITAL CENTER

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8 If "Yes," indicate what the Needs Assessment describes (check all that apply):		
a	<input type="checkbox"/> A definition of the community served by the hospital facility		
b	<input type="checkbox"/> Demographics of the community		
c	<input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input type="checkbox"/> How data was obtained		
e	<input type="checkbox"/> The health needs of the community		
f	<input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs		
j	<input type="checkbox"/> Other (describe in Part VI)		
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20__ __		
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted		
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI		
5	Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):		
a	<input type="checkbox"/> Hospital facility's website		
b	<input type="checkbox"/> Available upon request from the hospital facility		
c	<input type="checkbox"/> Other (describe in Part VI)		
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):		
a	<input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b	<input type="checkbox"/> Execution of the implementation strategy		
c	<input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d	<input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e	<input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f	<input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g	<input type="checkbox"/> Prioritization of health needs in its community		
h	<input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i	<input type="checkbox"/> Other (describe in Part VI)		
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs		
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?		
9	Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for free care: __ __ __ %		

Part V Facility Information (continued) FRANKLIN SQUARE HOSPITAL CENTER

		Yes	No
10	Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for discounted care: _ _ _ %	10	
11	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply):	11	
a	<input type="checkbox"/> Income level		
b	<input type="checkbox"/> Asset level		
c	<input type="checkbox"/> Medical indigency		
d	<input type="checkbox"/> Insurance status		
e	<input type="checkbox"/> Uninsured discount		
f	<input type="checkbox"/> Medicaid/Medicare		
g	<input type="checkbox"/> State regulation		
h	<input type="checkbox"/> Other (describe in Part VI)		
12	Explained the method for applying for financial assistance?	12	
13	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	13	
a	<input type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input type="checkbox"/> The policy was attached to billing invoices		
c	<input type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Part VI)		

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14	
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:		
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other actions (describe in Part VI)		
16	Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year? If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):	16	
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other actions (describe in Part VI)		
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply):		
a	<input type="checkbox"/> Notified patients of the financial assistance policy on admission		
b	<input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c	<input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d	<input type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance		
e	<input type="checkbox"/> Other (describe in Part VI)		

Part V Facility Information (continued) FRANKLIN SQUARE HOSPITAL CENTER

Policy Relating to Emergency Medical Care

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

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):		
a	<input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility		
b	<input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility		
c	<input type="checkbox"/> The hospital facility used the Medicare rate for those services		
d	<input type="checkbox"/> Other (describe in Part VI)		
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI.		
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient? If "Yes," explain in Part VI.		

Part V Facility Information (continued)

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

(list in order of size, measured by total revenue per facility, from largest to smallest)

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

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

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CHARITY CARE AT COST**PART I, LINE 7A**

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL

PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES

COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A RATE-SETTING

PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME

AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S

UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED

CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO

BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

UNREIMBURSED MEDICAID**PART I, LINE 7B**

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL

PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES

COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A RATE-SETTING

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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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 AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME

AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S

UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED

CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO

BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. COMMUNITY

BENEFIT EXPENSES ARE EQUAL TO MEDICAID REVENUES IN MARYLAND, AS SUCH, THE

NET EFFECT IS ZERO. THE EXCEPTION TO THIS IS THE IMPACT ON THE HOSPITAL

OF ITS SHARE OF THE MEDICAID ASSESSMENT. IN RECENT YEARS, THE STATE OF

MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING

HOSPITALS THROUGH THE RATE-SETTING SYSTEM.

HEALTH PROFESSIONS EDUCATION

PART I, LINE 7F

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL

PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES

COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A RATE-SETTING

PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME

Part VI Supplemental Information

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AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S

UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED

CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO

BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

PERCENT OF TOTAL EXPENSE

PART I, LINE 7, COLUMN (F)

BAD DEBT EXPENSE OF \$18,153,399 HAS BEEN REMOVED FROM TOTAL EXPENSE TO

CALCULATE THE PERCENTAGES IN COLUMN (F).

BAD DEBT

PART III, LINE 4

MEDSTAR HEALTH AND ITS AFFILIATED ORGANIZATIONS REPORT BAD DEBT

EXPENSE IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES

(GAAP) AND HFMA 15. AMOUNTS THAT ARE NOT EXPECTED TO BE COLLECTED,

FOR PATIENTS QUALIFYING UNDER MEDSTAR HEALTH'S FINANCIAL ASSISTANCE

Part VI Supplemental Information

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POLICY, ARE WRITTEN OFF TO CHARITY CARE AND REPORTED AS A REDUCTION

TO REVENUE. BAD DEBT EXPENSE RESULTS FROM MANAGEMENT'S INABILITY TO

COLLECT REVENUES THAT MEET THE GAAP CRITERIA FOR REVENUE RECOGNITION.

BAD DEBT REPRESENTS AN OPERATING EXPENSE AND IS REFLECTED AS A

SEPARATE LINE ITEM ON THE ORGANIZATION'S STATEMENT OF OPERATIONS.

HOWEVER, MEDSTAR AND ITS AFFILIATED ENTITIES DO NOT MAKE A

DETERMINATION AS TO WHETHER SELF PAY AMOUNTS ARE COLLECTIBLE IN

DETERMINING REVENUE RECOGNITION. RESERVE MODELS, WHICH HAVE BEEN

DEVELOPED BASED ON HISTORICAL COLLECTION RESULTS AND WHICH ARE

ADJUSTED PERIODICALLY BASED ON ACTUAL COLLECTIONS EXPERIENCE, ARE

USED TO ESTIMATE UNCOLLECTIBLE AMOUNTS ACROSS ALL PAYORS INCLUDING

SELF PAY. BAD DEBT DETERMINATIONS ARE MADE ONLY AFTER SUFFICIENT

EVIDENCE IS OBTAINED TO SUPPORT THAT AN AMOUNT IS NOT COLLECTIBLE.

MEDICARE

Part VI Supplemental Information

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PART III, LINE 8

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

NEEDS ASSESSMENT

PART VI, LINE 2

AS A COMMUNITY PARTNER, MEDSTAR FRANKLIN SQUARE MEDICAL CENTER (MFSMC)
 WORKS COLLABORATIVELY WITH LOCAL PARTNERS TO IDENTIFY KEY HEALTH NEEDS.

Part VI Supplemental Information

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PARTNERS INCLUDE, BUT ARE NOT LIMITED TO: THE BALTIMORE COUNTY DEPARTMENT

OF HEALTH, NOT-FOR-PROFIT AND SOCIAL SERVICE AGENCIES, SCHOOLS AND

UNIVERSITIES, FAITH BASED ORGANIZATIONS AND COMMUNITY BASED COALITIONS.

LOCAL, STATE AND NATIONAL HEALTH GOALS ARE ALSO USED TO ASSESS THE NEEDS

OF THE COMMUNITY. IN ADDITION, HOSPITAL SERVICE UTILIZATION PATTERNS,

SUCH AS THE CAUSES OF EMERGENCY ROOM VISITS AND INPATIENT ADMISSIONS HELP

DETERMINE THE HEALTH NEEDS OF THE COMMUNITY.

THE HOSPITAL'S MOST RECENT COMMUNITY HEALTH ASSESSMENT WAS CONDUCTED IN

2007-2008. MFSMC LED AND FINANCIALLY SUPPORTED THE ASSESSMENT, WHICH

FOCUSED ON THE SOUTHEASTERN PORTION OF BALTIMORE COUNTY. THE PURPOSE OF

THE PROJECT WAS THREEFOLD: (1) TO ASSESS THE CURRENT HEALTH AND

WELL-BEING OF SOUTHEAST BALTIMORE RESIDENTS; (2) TO IDENTIFY

DISCREPANCIES IN SERVICE NEEDS AND OUTCOMES AMONG AREA RESIDENTS; AND (3)

TO DEVISE A STRATEGIC PLAN FOR CORRECTING IDENTIFIED DISCREPANCIES. IN

APRIL 2008, MFSMC PUBLISHED AN ACTION PLAN FOR DEVELOPING COORDINATED AND

COLLABORATIVE EFFORTS AND INVESTING IN ECONOMIC AND SOCIAL RESOURCES IN

WAYS THAT IMPROVE THE HEALTH AND WELL-BEING FOR ALL OF SOUTHEASTERN

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BALTIMORE COUNTY'S RESIDENTS. RESOURCES WHICH ARE CURRENTLY AVAILABLE TO

MEET THE ACTION PLAN WERE IDENTIFIED IN FY2009 THROUGH A COLLABORATIVE

EFFORT AMONG PROFESSIONAL NETWORKS, COUNTY AGENCIES AND COMMUNITY

ORGANIZATIONS. IN FY2010, BEST PRACTICES AND FUNDING SOURCES FOR ACTION

ITEMS WERE ASSESSED. IN FY2011 THE HOSPITAL AND ITS NETWORK PARTNERS

COMPLETED SOME INITIATIVES AND CONTINUE TO DEVELOP OTHER PROGRAMS.

AS A PROUD MEMBER OF MEDSTAR HEALTH, REPRESENTATIVES FROM MFSMC ALSO

PARTICIPATE IN THE MEDSTAR HEALTH COMMUNITY BENEFIT WORKGROUP. THE

WORKGROUP IS COMPRISED OF COMMUNITY HEALTH PROFESSIONALS WHO REPRESENT

ALL NINE MEDSTAR HOSPITALS. THE TEAM ANALYZES LOCAL AND REGIONAL

COMMUNITY HEALTH DATA, ESTABLISHES SYSTEM-WIDE COMMUNITY HEALTH

PROGRAMMING PERFORMANCE AND EVALUATION MEASURES AND SHARES BEST

PRACTICES.

Part VI Supplemental Information

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PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

AS ONE OF THE REGION'S LEADING NOT-FOR-PROFIT HEALTHCARE SYSTEMS, MEDSTAR

HEALTH IS COMMITTED TO ENSURING THAT UNINSURED PATIENTS WITHIN THE

COMMUNITIES WE SERVE WHO LACK FINANCIAL RESOURCES HAVE ACCESS TO

NECESSARY HOSPITAL SERVICES. MEDSTAR HEALTH AND ITS HEALTHCARE

FACILITIES WILL:

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

COMPASSION.

" SERVE THE EMERGENCY HEALTH CARE NEEDS OF EVERYONE WHO PRESENTS AT

OUR FACILITIES REGARDLESS OF A PATIENT'S ABILITY TO PAY FOR CARE.

" ASSIST THOSE PATIENTS WHO ARE ADMITTED THROUGH OUR ADMISSIONS

PROCESS FOR NON-URGENT, MEDICALLY NECESSARY CARE WHO CANNOT PAY FOR PART

OR ALL OF THE CARE THEY RECEIVE.

" BALANCE NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH BROADER

FISCAL RESPONSIBILITIES IN ORDER TO KEEP ITS HOSPITALS' DOORS OPEN FOR

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ALL WHO MAY NEED CARE IN THE COMMUNITY.

IN MEETING ITS COMMITMENTS, MEDSTAR HEALTH'S FACILITIES WILL WORK WITH
 THEIR UNINSURED PATIENTS TO GAIN AN UNDERSTANDING OF EACH PATIENT'S
 FINANCIAL RESOURCES PRIOR TO ADMISSION (FOR SCHEDULED SERVICES) OR PRIOR
 TO BILLING (FOR EMERGENCY SERVICES). BASED ON THIS INFORMATION AND
 PATIENT ELIGIBILITY, MEDSTAR HEALTH'S FACILITIES WILL ASSIST UNINSURED
 PATIENTS WHO RESIDE WITHIN THE COMMUNITIES WE SERVE IN ONE OR MORE OF THE
 FOLLOWING WAYS:

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

" ASSIST WITH ENROLLMENT IN PUBLICLY-FUNDED PROGRAMS FOR THE
 UNINSURED (E.G., D.C. HEALTHCARE ALLIANCE).

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

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

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

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

EACH MEDSTAR HEALTH FACILITY (IN COOPERATION AND CONSULTATION WITH THE
FINANCE DIVISION OF MEDSTAR HEALTH) WILL SPECIFY THE COMMUNITIES IT
SERVES BASED ON THE GEOGRAPHIC AREAS IT HAS SERVED HISTORICALLY FOR THE
PURPOSE OF IMPLEMENTING THIS POLICY. EACH FACILITY WILL POST THE POLICY,
INCLUDING A DESCRIPTION OF THE APPLICABLE COMMUNITIES IT SERVES, IN EACH
MAJOR PATIENT REGISTRATION AREA AND IN ANY OTHER AREAS REQUIRED BY
APPLICABLE REGULATIONS, WILL COMMUNICATE THE INFORMATION TO PATIENTS AS
REQUIRED BY THIS POLICY AND APPLICABLE REGULATIONS AND WILL MAKE A COPY
OF THE POLICY AVAILABLE TO ALL PATIENTS.

MEDSTAR HEALTH BELIEVES THAT ITS PATIENTS HAVE PERSONAL RESPONSIBILITIES
RELATED TO THE FINANCIAL ASPECTS OF THEIR HEALTHCARE NEEDS. THE CHARITY
CARE, FINANCIAL ASSISTANCE, AND PERIODIC PAYMENT PLANS AVAILABLE UNDER

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THIS POLICY WILL NOT BE AVAILABLE TO THOSE PATIENTS WHO FAIL TO FULFILL

THEIR RESPONSIBILITIES. FOR PURPOSES OF THIS POLICY, PATIENT

RESPONSIBILITIES INCLUDE:

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

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

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

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

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SCHEDULES .

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

COMMUNITY INFORMATION

PART VI, LINE 4

GEOGRAPHIC: LOCATED IN THE ROSEDALE SECTION OF EASTERN BALTIMORE COUNTY,
MARYLAND, MEDSTAR FRANKLIN SQUARE MEDICAL CENTER'S SERVICE AREA INCLUDES
NEIGHBORHOODS IN EASTERN BALTIMORE CITY, SOUTHEASTERN BALTIMORE COUNTY
AND EXTENDING UP TO SOUTHERN HARFORD COUNTY, ADJACENT TO THE CHESAPEAKE
BAY.

SIGNIFICANT DEMOGRAPHIC CHARACTERISTICS RELEVANT TO THE NEEDS THE
HOSPITAL SEEKS TO MEET:

THIS AREA HAS A LARGE BASE POPULATION OF APPROXIMATELY 503,072, AND IS
PROJECTED TO GROW BY 3.7% IN THE NEXT FIVE YEARS, TO ABOUT 521,728. THE
SERVICE AREA HAS BECOME A MUCH MORE DIVERSE COMMUNITY OVER THE PAST FEW

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DECADES. THE AREA, PARTICULARLY EASTERN BALTIMORE CITY AND EASTERN
BALTIMORE COUNTY, CAN BE DESCRIBED AS BLUE-COLLAR, HIGH SCHOOL EDUCATED,
AND ECONOMICALLY DEPRESSED, WITH A DIVERSE POPULATION CONSISTING OF
CAUCASIANS (71.2%), AFRICAN-AMERICANS (20.5%), ASIAN/PACIFIC ISLANDERS
(2.6%), HISPANICS/LATINOS (3.2%), AND OTHERS (2.4%). FORTY-TWO PERCENT
OF THE POPULATION IS EITHER VERY YOUNG OR ELDERLY, WITH 24% OF RESIDENTS
UNDER THE AGE OF EIGHTEEN AND 18% OVER 65 YEARS OF AGE. POVERTY IS A
SIGNIFICANT PROBLEM IN EASTERN BALTIMORE COUNTY. STATISTICS SHOW THAT
46% OF THE RESIDENTS ABOVE 24 YEARS OF AGE HAVE A HIGH SCHOOL OR LOWER
LEVEL OF EDUCATION. STATISTICS ALSO SHOW THAT THE MEDIAN HOUSEHOLD INCOME
IN THE ESSEX/MIDDLE RIVER/DUNDALK AREA OF APPROXIMATELY \$49,200 IS MUCH
LOWER THAN THE OVERALL COUNTY MEDIAN OF \$74,750. BASED ON HOSPITAL
UTILIZATION DATA, THE NUMBER OF INDIVIDUALS WHO ARE UNINSURED OR
UNDERINSURED IN THE HOSPITAL'S CATCHMENT AREA IS ESTIMATED TO BE 38% AND
GROWING. THIS IS A DIRECT RESULT OF THE DECLINE IN MANUFACTURING
INDUSTRIES IN THE REGION, WHICH ARE BEING REDUCED OR DECLARING BANKRUPTCY
(E.G., GENERAL MOTORS OLDSMOBILE ASSEMBLY PLANT AND BETHLEHEM STEEL
CORPORATION, BOTH OF WHOM WERE PREVIOUSLY MAJOR EMPLOYERS IN THE AREA).

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CURRENTLY, THE LARGEST EMPLOYER IN THE AREA IS THE HOSPITAL. THE
 INCREASING NUMBER OF FAMILIES AND INDIVIDUALS WITH EITHER NO HEALTH
 INSURANCE OR SEVERELY CURBED HEALTH INSURANCE REPRESENTS A SERIOUS
 CONCERN FOR THE HEALTHCARE COMMUNITY AND GOVERNMENT AGENCIES.

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

AS A COMMUNITY PARTNER, THE HOSPITAL ENGAGES IN A NUMBER OF COMMUNITY
 BENEFIT ACTIVITIES TO IMPROVE AND PROMOTE THE HEALTH AND WELLBEING OF THE
 COMMUNITY. FOR EXAMPLE, IN PARTNERSHIP WITH BALTIMORE COUNTY AND
 HEALTHCARE FOR THE HOMELESS IN BALTIMORE CITY, MFSMC ESTABLISHED A NEW
 PRIMARY CARE ACCESS POINT FOR HOMELESS PERSONS IN BALTIMORE COUNTY. THE
 HOSPITAL PROVIDES THE PRIMARY HEALTHCARE STAFF, IN-KIND SUPPORT IN
 TECHNICAL ASSISTANCE, INFORMATION TECHNOLOGY, FINANCE/BUDGET/BILLING, AND
 PUBLIC RELATIONS AND MARKETING. MFSMC ALSO PROVIDES WRITE OFFS FOR LABS
 AND SPECIALTY SERVICES.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

ADDITIONALLY, MFSCM EVALUATES OVER 300 CHILDREN EACH YEAR WHO ARE
 SUSPECTED OF BEING ABUSED. CHILDREN IN EASTERN BALTIMORE COUNTY ARE
 ALMOST 50% MORE LIKELY AS CHILDREN IN THE REST OF THE COUNTY TO BE ABUSE
 VICTIMS. IN RESPONSE TO THE HIGH INCIDENCE OF ABUSE, THE DEPARTMENT OF
 PEDIATRICS DEVELOPED A COMPREHENSIVE APPROACH TO DIAGNOSE AND PREVENT
 CHILD ABUSE. THE FRANKLIN SQUARE HOSPITAL CHILD PROTECTION TEAM (CPT)
 BEGAN TO FUNCTION IN NOVEMBER, 2000. THE LEADERS OF THE CPT ARE A SOCIAL
 WORKER COORDINATOR, THE MEDICAL DIRECTOR, AND ON-CALL SOCIAL WORK AND
 MEDICAL STAFF. THE TEAM PROVIDES 24/7 COVERAGE TO THE HOSPITAL AND
 EVALUATES ANY CHILD WHO IS SUSPECTED OF BEING PHYSICALLY OR SEXUALLY
 ABUSED. THIS SERVICE HAS PROVEN TO BE A SIGNIFICANT CONTRIBUTION TO THE
 COMMUNITY - IMPACTING THOUSANDS OF PARENTS AND CHILDREN.

AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR FRANKLIN SQUARE MEDICAL
 CENTER IS ABLE TO EXPAND ITS CAPACITY TO MEET THE NEEDS OF THE COMMUNITY

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

BY PARTNERING WITH OTHER MEDSTAR HOSPITALS AND ASSOCIATED ENTITIES.

MEDSTAR HEALTH RESOURCES ASSIST THE HOSPITAL IN COMMUNITY HEALTH PLANNING

TO MEET THE NEEDS OF THE UNINSURED AND OTHER VULNERABLE POPULATIONS.

THROUGH ITS COMMUNITY HEALTH FUNCTION, MEDSTAR HEALTH PROVIDES MFSMC WITH

TECHNICAL SUPPORT TO ENHANCE COMMUNITY HEALTH PROGRAMMING AND EVALUATION.

MEDSTAR'S CORPORATE PHILANTHROPY DIVISION IDENTIFIES PUBLIC AND PRIVATE

FUNDING SOURCES TO ENSURE THE AVAILABILITY OF HIGH QUALITY HEALTH

SERVICES, REGARDLESS OF ABILITY TO PAY.

STATE FILING OF COMMUNITY BENEFIT REPORT

PART VI, LINE 7

THE COMMUNITY BENEFIT REPORT FOR MEDSTAR FRANKLIN SQUARE MEDICAL CENTER

IS FILED IN THE STATE OF MARYLAND.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number

52-0608007

Part I Questions Regarding Compensation

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

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

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

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

3 Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director. Check all that apply.

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

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

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

Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.

5 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
- b** Any related organization?
- If "Yes" to line 5a or 5b, describe in Part III.

6 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization?
- b** Any related organization?
- If "Yes" to line 6a or 6b, describe in Part III.

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

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

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

	Yes	No
1a		
1b		
2		
3		
4a		X
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7		X
8		X
9		

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

Schedule J (Form 990) 2010

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

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

Note. The sum of columns (B)(i)-(iii) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a.

(A) Name	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 KENNETH A SAMET	(i) 0. (ii) 1,180,163. (iii) 273,473.	0. 1,354,791. 81,704.	0. 590,140. 0.	0. 112,797. 0.	0. 19,468. 4,882.	0. 3,257,359. 360,059.	0. 0. 0.
2 ADRIENNE KIRBY	(i) 351,176. (ii) 0. (iii) 427,276.	53,252. 0. 51,823.	0. 0. 0.	4,054. 0. 5,754.	13,932. 0. 2,241.	422,414. 0. 487,094.	0. 0. 0.
3 YVONNE OTTAVIANO	(i) 365,540. (ii) 0. (iii) 362,714.	30,002. 0. 33,063.	0. 0. 0.	4,989. 0. 7,612.	12,483. 0. 15,332.	413,014. 0. 418,721.	0. 0. 0.
4 WILLIAM MCGUIRE	(i) 394,999. (ii) 0. (iii) 333,583.	50,000. 0. 153,691.	0. 0. 0.	1,208. 0. 3,516.	15,509. 0. 14,430.	461,716. 0. 505,220.	0. 0. 0.
5 WILLIAM WATERFIELD	(i) 235,183. (ii) 0. (iii) 181,528.	109,898. 0. 39,691.	0. 0. 0.	16,873. 0. 2,660.	19,171. 0. 7,637.	381,125. 0. 231,516.	0. 0. 0.
6 LAWRENCE STRASSNER	(i) 223,310. (ii) 0. (iii) 577,942.	83,480. 0. 482,393.	0. 0. 0.	0. 0. 19,315.	15,706. 0. 19,063.	322,496. 0. 1,098,713.	0. 0. 0.
11 GLENN VISBEEN	(i) 0. (ii) 0. (iii) 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.
12 CARL SCHINDELAR	(i) 0. (ii) 0. (iii) 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.
13	(i) 0. (ii) 0. (iii) 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.
14	(i) 0. (ii) 0. (iii) 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.
15	(i) 0. (ii) 0. (iii) 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.
16	(i) 0. (ii) 0. (iii) 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.

Schedule J (Form 990) 2010

Part III Supplemental Information

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

RETIREMENT PLAN

SCHEDULE J, PART I, LINE 4B

KENNETH SAMET

KENNETH SAMET'S OTHER REPORTABLE COMPENSATION IN PART II, COLUMN (B) (III) INCLUDES \$568,506 REPRESENTING MR. SAMET'S ACCRUED BENEFIT IN A SUPPLEMENTAL RETIREMENT PLAN, WHICH WAS EARNED DURING THE PAST 22 YEARS OF SERVICE. THIS AMOUNT WAS NOT ACTUALLY PAID TO MR. SAMET, BUT WAS REPORTED AS COMPENSATION UNDER FICA TAX-REPORTING RULES.

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

OMB No. 1545-0047

2010

Open To Public
Inspection

Name of the organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number

52-0608007

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

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

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

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

Part II Loans to and/or From Interested Persons.

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

1	(a) Name of interested person and purpose	(b) Loan to or from the organization?		(c) Original principal amount	(d) Balance due	(e) In default?		(f) Approved by board or committee?		(g) Written agreement?	
		To	From			Yes	No	Yes	No	Yes	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.

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

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

Schedule L (Form 990 or 990-EZ) 2010

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) ORTHOPEDIC & HAND SURGERY ASSOCIATES, PA	SEE PART V	300,000.	ORTHOPEDIC SERVICES		x
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

DR. IRA GUBERNICK, A BOARD MEMBER AT FRANKLIN SQUARE HOSPITAL, OWNS MORE THAN 5% OF ORTHOPEDIC & HAND SURGERY ASSOCIATES, P.A. (OHSA), WHICH PROVIDES MANAGEMENT AND SUPPORT SERVICES TO FRANKLIN SQUARE HOSPITAL'S ORTHODEPIC, SPORTS MEDICINE, AND EMERGENCY DEPARTMENTS. OHSA'S GROSS REVENUES RECEIVED FROM THE HOSPITAL FOR THE YEAR WERE \$0.3 MILLION.

SCHEDULE O
(Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

OMB No. 1545-0047

2010

Open to Public
Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization

Employer identification number

FRANKLIN SQUARE HOSPITAL CENTER INC.

52-0608007

DESCRIPTION OF EXEMPT PURPOSE ACHIEVEMENTS

PART III, LINE 4A

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

ORGANIZATION MEMBERS

PART VI, LINE 6

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

DESCRIPTION OF MEMBERS

PART VI, LINE 7A

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT MARYLAND NON-STOCK CORPORATION, THE ORGANIZATION MAY RECOMMEND PERSON(S) FOR MEMBERSHIP ON THE ORGANIZATION'S GOVERNING BODY. ANY SUCH

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

RECOMMENDATION BY THE ORGANIZATION IS SUBJECT TO APPROVAL BY THE GOVERNANCE COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR HEALTH, INC. THE BOARD OF MEDSTAR HEALTH, INC. HAS DELEGATED CERTAIN APPROVAL AUTHORITY TO THE GOVERNANCE COMMITTEE AND THE PRESIDENT & CEO OF MEDSTAR HEALTH, INC.

DECISIONS OF GOVERNING BODY

PART VI, LINE 7B

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

PROCESS FOR REVIEWING FORM 990

PART VI, LINE 11A

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

Name of the organization

Employer identification number

FRANKLIN SQUARE HOSPITAL CENTER INC.

52-0608007

GIVEN AN OPPORTUNITY TO PROVIDE ANY INPUT OR COMMENTS RELATING TO THE FORM 990 PRIOR TO ITS FILING.

CONFLICT OF INTEREST POLICY

PART VI, LINE 12C

APPOINTMENT OF BOARDS OF DIRECTORS

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

ANNUAL DISCLOSURES - ALL OFFICERS, DIRECTORS, AND SENIOR MANAGERS

ALL OFFICERS, DIRECTORS AND SENIOR MANAGERS ARE REQUIRED, NOT LESS THAN ANNUALLY, TO COMPLETE A SURVEY OF QUESTIONS CONCERNING ANY TRANSACTIONS OR RELATIONSHIPS WHICH WOULD OR COULD REPRESENT A CONFLICT OF INTEREST. SUCH DISCLOSURES (IF ANY) ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE RESOLVED. IN ADDITION, OFFICERS AND DIRECTORS OF MARYLAND HOSPITALS AND NURSING CENTERS ARE REQUIRED TO ANNUALLY DISCLOSE ADDITIONAL INFORMATION RELATING TO POTENTIAL CONFLICTS OF INTEREST AND SUCH DISCLOSURES ARE REPORTED TO THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION (HSCRC).

DESCRIPTION OF EXECUTIVE COMPENSATION

Name of the organization

Employer identification number

FRANKLIN SQUARE HOSPITAL CENTER INC.

52-0608007

PART VI, LINE 15

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

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

THE COMMITTEE HAS ENGAGED ERNST & YOUNG LLP ("E&Y") TO SERVE AS AN ADVISOR ON THE REASONABLENESS AND COMPETITIVENESS OF THE PROGRAM. IN DETERMINING REASONABLENESS AND COMPETITIVENESS, E&Y REVIEWS MARKET PRACTICES AND TRENDS, AND MAKES RECOMMENDATIONS RELATED TO THE PROGRAM. E&Y UTILIZES INFORMATION FROM CUSTOM SURVEYS, NATIONAL COMPENSATION

Name of the organization FRANKLIN SQUARE HOSPITAL CENTER INC.	Employer identification number 52-0608007
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SURVEYS, PROPRIETARY DATABASES, AND CLIENT EXPERIENCES TO DETERMINE ITS FINAL RECOMMENDATIONS. E&Y PRESENTS THEIR FINDINGS AND RECOMMENDATIONS TO THE COMMITTEE. THE COMMITTEE MAKES THE FINAL DECISIONS ON ALL OF THE COMPENSATION DETERMINATIONS OF THE PROGRAM. ALL DECISIONS MADE BY THE COMMITTEE ARE CONTEMPORANEOUSLY DOCUMENTED.

FINANCIAL STATEMENT AVAILABILITY

PART VI, LINE 19

MEDSTAR HEALTH POSTS ITS ANNUAL FINANCIAL AUDIT AND QUARTERLY FINANCIAL REPORTS TO THE ELECTRONIC MUNICIPAL MARKET ACCESS (EMMA) SYSTEM. THE ORGANIZATION ALSO E-MAILS ITS ANNUAL AND QUARTERLY DISCLOSURES TO HOLDERS OF THE COMPANY'S PUBLICLY TRADED DEBT. THE COMPANY'S GOVERNANCE DOCUMENTS AND CONFLICTS OF INTEREST POLICIES ARE AVAILABLE UPON REQUEST THROUGH ITS CORPORATE (OR AS APPLICABLE ENTITY) PUBLIC INFORMATION OFFICES.

OTHER CHANGES IN NET ASSETS

PART XI, LINE 5

EQUITY TRANSFERS	\$ 11,927,152
UNREALIZED GAIN ON INVESTMENTS.....	63,482
	=====
TOTAL:	\$ 11,990,634

Name of the organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number

52-0608007

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

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR FRANKLIN SQUARE MEDICAL CENTER'S MISSION IS TO PROVIDE SAFE, HIGH QUALITY CARE, EXCELLENT SERVICE, AND EDUCATION TO IMPROVE THE HEALTH OF THE COMMUNITY.

MEDSTAR FRANKLIN SQUARE MEDICAL CENTER (MFSMC) IS AN ACUTE-CARE TEACHING HOSPITAL LOCATED IN EASTERN BALTIMORE COUNTY, MARYLAND. A NEW SEVEN-STORY PATIENT TOWER WAS OPENED IN FISCAL 2011 AND INCLUDES A NEW EMERGENCY DEPARTMENT AND 291 PRIVATE PATIENT ROOMS. THE HOSPITAL'S CANCER INSTITUTE IS A 64,000 SQUARE FOOT FACILITY PROVIDING CANCER PATIENTS AND THEIR FAMILIES WITH A BROAD RANGE OF ONCOLOGY SERVICES, INCLUDING SCREENING, DIAGNOSIS AND TREATMENT. IN FISCAL YEAR 2011, MFSMC HAD 24,283 INPATIENT ADMISSIONS, 204,026 OUTPATIENT VISITS AND 105,989 EMERGENCY VISITS.

ATTACHMENT 2PART VII - CONTINUATION OF OFFICERS, DIRECTORS, TRUSTEES,
KEY EMPLOYEES AND HIGHEST COMPENSATED EMPLOYEES

(1)=IND.TRUSTEE/DIR. (2)=INS.TRUSTEE (3)=OFFICER (4)=KEY EMP. (5)=HIGHEST COMP. (6)=FORMER

(A) NAME AND TITLE	(B) HOURS	(C) POSITION					COMPENSATION FROM			
		(1)	(2)	(3)	(4)	(5)	(6)	(D) ORG.	(E) REL. ORG.	(F) OTHER
29 CARL SCHINDELAR FORMER OFFICER	1.00				X			0. 1,060,335.		38,378.

ATTACHMENT 3FORM 990, PART VII, COLUMN B - ESTIMATED AVERAGE PER WEEK

NAME AND TITLE	HOURS DEVOTED FOR RELATED ORGANIZATION
KENNETH A SAMET DIRECTOR	40.00
CARL SCHINDELAR FORMER OFFICER	40.00

Name of the organization FRANKLIN SQUARE HOSPITAL CENTER INC.	Employer identification number 52-0608007
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ATTACHMENT 4990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
BOVIS LEND LEASE ONE PRESERVE PARKWAY, SUITE 700 ROCKVILLE, MD 20852	CONSTRUCTION MGMT	34,934,639.
CHESAPEAKE PERIOPERATIVE SERVICES PO BOX 17568 BALTIMORE, MD 21297	MEDICAL SERVICES	9,646,824.
MORRISON MANAGEMENT SPECIALIST 4721 MORRISON DRIVE MOBILE, AL 36609	FOOD SRVC PROVIDER	4,001,002.
GKV CASCADE BUILDING, 1030 HULL STREET BALTIMORE, MD 21230	MARKETING SERVICES	940,462.
SLEEP SERVICES OF AMERICA PO BOX 198320 ATLANTA, GA 30384	MEDICAL SERVICES	928,923.
TOTAL COMPENSATION		<u>50,451,850.</u>

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

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

OMB No. 1545-0047

2010

Open to Public Inspection

Employer identification number
52-0608007

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

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) MEDSTAR HEALTH ANESTHESIA SERVICES B LLC 20-5909703 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237	HEALTH SVCS	MD	8,736,444.	926,231.	N/A
(2) -----					
(3) -----					
(4) -----					
(5) -----					
(6) -----					

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

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

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Schedule R (Form 990) 2010

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number
52-0608007

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

	(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity	
						Yes	No
(1)	-----	-----	-----	-----	-----		
(2)	-----	-----	-----	-----	-----		
(3)	-----	-----	-----	-----	-----		
(4)	-----	-----	-----	-----	-----		
(5)	-----	-----	-----	-----	-----		
(6)	-----	-----	-----	-----	-----		

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

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

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

Schedule R (Form 990) 2010

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047
2010
Open to Public Inspection

Name of the organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number
52-0608007

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

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

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	FOUNDATION FOR GEORGETOWN UNIVERSITY HOS HOSPITAL ADMIN, 1 MAIN BLDG WASHINGTON, DC 20007 52-2339873	FOUNDATION	DC	501(C)(3)	11A I	N/A	X	
(2)	GOOD SAMARITAN HOSPITAL FOUNDATION, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-2307122	FOUNDATION	MD	501(C)(3)	11A I	N/A	X	
(3)	GOOD SAMARITAN NURSING CENTER, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-1672866	MEDICAL SVCS	MD	501(C)(3)	9	N/A	X	
(4)	GS HOUSING, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-1481656	ELDER HOUSING	MD	501(C)(3)	9	N/A	X	
(5)	GS PROPERTIES, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-1429853	ADMIN SVCS	MD	501(C)(3)	11A I	N/A	X	
(6)	HARBOR HOSPITAL FOUNDATION, INC. 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225 52-1284532	FOUNDATION	MD	501(C)(3)	11A I	N/A	X	
(7)	MEDSTAR HEALTH INFUSION, INC. 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1980510	MEDICAL SVCS	MD	501(C)(3)	9	N/A	X	

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

Schedule R (Form 990) 2010

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2010

Open to Public
Inspection

Employer identification number
52-0608007

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) MEDSTAR HEALTH VISITING NURSES ASSOCIATI 4061 POWDERMILL ROAD CALVERTON, MD 20705 53-0196597	MEDICAL SVCS	MD	501 (C) (3)	9	N/A		X
(2) MEDSTAR LONG TERM CARE CORPORATION 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1489097	HOSPITAL	MD	501 (C) (3)	3	N/A		X
(3) MEDSTAR VNA HEALTHCARE 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1458516	MEDICAL SVCS	MD	501 (C) (3)	9	N/A		X
(4) MGH COMMUNITY HEALTH, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1372467	MEDICAL SVCS	MD	501 (C) (3)	9	N/A		X
(5) MGH HEALTH FOUNDATION, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1129959	FOUNDATION	MD	501 (C) (3)	7	N/A		X
(6) MGH HEALTH SERVICES, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1366812	FOUNDATION	MD	501 (C) (3)	11A I	N/A		X
(7) MGH WOMEN'S BOARD 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-6039600	FOUNDATION	MD	501 (C) (3)	11A I	N/A		X

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Schedule R (Form 990) 2010

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PAGE 66

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number

52-0608007

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2010

Open to Public Inspection

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

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

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

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	NATIONAL REHABILITATION HOSPITAL 102 IRVING STREET NW WASHINGTON, DC 20010 52-1369749	HOSPITAL	DC	501 (C) (3)	3	N/A		X
(2)	REGIONAL REHAB AT OLNEY, INC. 16101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-2310902	MEDICAL SVCS	MD	501 (C) (3)	3	N/A		X
(3)	SUBURBAN / MRH MEDICAL REHABILITATION, I 102 IRVING STREET NW WASHINGTON, DC 20010 52-1931151	MEDICAL SVCS	DC	501 (C) (3)	3	N/A		X
(4)	THE THOMAS O'NEIL CATHOLIC HEALTH CARE F 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-1104382	FOUNDATION	MD	501 (C) (3)	11A I	N/A		X
(5)	UNION MEMORIAL HOSPITAL FOUNDATION, INC. 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218 52-1446828	FOUNDATION	MD	501 (C) (3)	11A I	N/A		X
(6)	VNA, INC. 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1332411	ADMIN SVCS	MD	501 (C) (3)	11A I	N/A		X
(7)	MHC FOUNDATION, INC. 110 IRVING STREET NW WASHINGTON, DC 20010 52-1791670	FOUNDATION	DC	501 (C) (3)	11A I	N/A		X

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

Schedule R (Form 990) 2010

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PAGE 67

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047
2010

Open to Public Inspection

Name of the organization

FRANKLIN SQUARE HOSPITAL CENTER INC.

Employer identification number
52-0608007

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) WOODBOURNE WOODS, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 52-2299070	ELDER HOUSING	MD	501(C)(3)	9	N/A		X
(2) HOSPICE OF ST. MARY'S, INC. PO BOX 527 LEONARDTOWN, MD 20650 52-2153926	SUPPORT ORG	MD	501(C)(3)	11B II	N/A		X
(3) ST. MARY'S HOSPITAL OF ST. MARY'S COUNTY 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650 52-0619006	HOSPITAL	MD	501(C)(3)	3	N/A		X
(4) ST. MARY'S HOSPITAL FOUNDATION, INC. PO BOX 527 LEONARDTOWN, MD 20650 52-1051368	SUPPORT ORG	MD	501(C)(3)	11D III	N/A		X
(5) FRANKLIN SQUARE HOSPITAL CENTER FDN 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237 52-2329546	FOUNDATION	MD	501(C)(3)	11A I	N/A		X
(6) -----							
(7) -----							

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

Schedule R (Form 990) 2010

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

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

Part IV Identification of Related Organizations Taxable as a Corporation or Trust (Complete if the organization answered "Yes" 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
(1) MEDSTAR PHARMACIES, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 52-1513056	DRUG SALES	MD	N/A	C CORP			
(2) EXTENCARE, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 52-1556228	MEDICAL SERVI	MD	N/A	C CORP			
(3) HELIX RESOURCES MANAGEMENT, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 52-1913070	ADMIN SERVICE	MD	N/A	C CORP			
(4) HELIXCARE MEDICAL GROUP, LLC 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 52-1955580	MEDICAL SERVI	MD	N/A	C CORP			
(5) HELIXCARE PROPERTIES, LLC 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 52-1966695	MEDICAL SERVI	MD	N/A	C CORP			
(6) PARKWAY VENTURES, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 52-1893569	HOLDING COMPA	MD	N/A	C CORP			
(7) PHYSICIANS ADMINISTRATIVE SERVICES, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 23-7042074	BILLING SERVI	MD	N/A	C CORP			

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) _____												
(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
(1) MEDSTAR FAMILY CHOICE, INC. 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 52-1995521	MANAGED CARE	MD	N/A	C CORP			
(2) MEDSTAR ENTERPRISES, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 52-2139841	ADMIN SERVICE	MD	N/A	C CORP			
(3) NASCOTT, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 52-1693808	MEDICAL SERVI	MD	N/A	C CORP			
(4) STAR BILLING, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 52-1850113	BILLING SERVI	MD	N/A	C CORP			
(5) WASHINGTON RISK NETWORK MANAGEMENT, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 52-2132677	MEDICAL SERVI	MD	N/A	C CORP			
(6) WASHINGTON HOSPITAL CENTER PHYSICIAN HOS 100 IRVING STREET NW WASHINGTON, DC 20010 52-1931000	MEDICAL SERVI	MD	N/A	C CORP			
(7) MEDSTAR PHYSICIAN PARTNERS, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705 52-2030809	MEDICAL SERVI	MD	N/A	C CORP			

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) -----												
(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
(1) NRH AMBULATORY SERVICES, INC. 102 IRVING STREET NW WASHINGTON, DC 20010 52-1930165	REHAB SERVICE	MD	N/A	C CORP			
(2) FRANKLIN SQUARE DRIVE LAND CONDO ASSOCIA 5565 STERRETT PLACE, 5TH FLOOR COLUMBIA, MD 21044 76-0756352	CONDO OWNER A	MD	N/A	C CORP			
(3) MGH DIVERSIFIED SERVICES, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1943602	MEDICAL SERVI	MD	N/A	C CORP			
(4) ST. MARY'S HEALTH ALLIANCE, INC. 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650 52-1930331	MEDICAL SERVI	MD	N/A	C CORP			
(5) GREENSPRING FINANCIAL INSURANCE LIMITED 23 LIME TREE BAY AVENUE PO BOX 1051 KY1-1102 GRAND CAYMAN 98-0188617	INSURANCE	CJ	N/A	C CORP			
(6) -----							
(7) -----							

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

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

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

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

(a) Name of other organization	(b) Transaction type (e-f)	(c) Amount involved	(d) Method of determining amount involved
(1) CHURCH HOME AND HOSPITAL OF THE CITY OF BALTI	O	500,000.	FMV
(2) HH MEDSTAR HEALTH INC	P	285,309.	FMV
(3) THE GOOD SAMARITAN HOSPITAL OF MARYLAND	P	202,719.	FMV
(4) HARBOR HOSPITAL INC	P	65,419.	FMV
(5)			
(6)			

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

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

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

Part VII Supplemental Information

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