SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047
2010
Open to Public Inspection

Name of the organization: Western MD Health System Corp. Inc.
Employer identification number: 52-0591531

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. [X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities [ ] Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing free care to low income individuals? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: [ ] 100% [ ] 150% [X] 200% [ ] Other ______ %	3a	X	
b	Did the organization use FPG to determine eligibility for providing discounted care to low income individuals? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: [ ] 200% [ ] 250% [X] 300% [ ] 350% [ ] 400% [ ] Other ______ %	3b	X	
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"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheets 1 and 2)		13,895	11,211,255		11,211,255	
b Unreimbursed Medicaid (from Worksheet 3, column a)			2,199,298	1,624,150	575,148	
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		13,895	13,410,553	1,624,150	11,786,403	
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		16,334	726,201	19,983	706,218	
f Health professions education (from Worksheet 5)		113,912	896,420	300	896,120	
g Subsidized health services (from Worksheet 6)		89,574	30,069,306	12,607,768	17,461,538	
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)		17,646	488,267	72,394	415,873	
j **Total.** Other Benefits		237,466	32,180,194	12,700,445	19,479,749	
k **Total.** Add lines 7d and 7j		251,361	45,590,747	14,324,595	31,266,152	

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			403,995		403,995	
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building			133,894		133,894	
7	Community health improvement advocacy						
8	Workforce development			1,141,836		1,141,836	
9	Other						
10	Total			1,679,725		1,679,725	

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Line	Amount	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	7,064,701		
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	1,232,734		

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 as community benefit.

Section B. Medicare

		Line	Amount
5	Enter total revenue received from Medicare (including DSH and IME)	5	134,159,397
6	Enter Medicare allowable costs of care relating to payments on line 5	6	109,555,564
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	24,603,833

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:

☐ Cost accounting system ☒ Cost to charge ratio ☐ Other

Section C. Collection Practices

		Line	Yes	No
9a	Did the organization have a written debt collection policy during the tax year?	9a	X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	X	

Part IV Management Companies and Joint Ventures

	(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	Cumberland Propertie	Rental	100.000		
2	Willowbrook Health S	Health Care	100.000		
3	Johnson Heights Med	Rental	83.950		16.050
4	Memorial Med Ctr Ser	Building Maintenance	100.000		
5	Haystack Imaging	Health Care	50.000		50.000
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 1

Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1 Western MD Reg Medical Center 12500 Willowbrook Road Cumberland, MD	X	X					X		
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									

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: Western MD Reg Medical 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	1	X	
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j	[X] Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 2010			
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	3	X	
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	4		X
5	Did the hospital facility make its Needs Assessment widely available to the public?	5	X	
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a	[ ] Hospital facility's website			
b	[X] Available upon request from the hospital facility			
c	[X] 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	[X] Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b	[X] Execution of the implementation strategy			
c	[X] Participation in the development of a community-wide community benefit plan			
d	[X] Participation in the execution of a community-wide community benefit plan			
e	[X] Inclusion of a community benefit section in operational plans			
f	[X] Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[X] 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	7	X	
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?	8	X	
9	Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 200.0000 %			

Part V Facility Information (continued) Western MD Reg Medical Center

			Yes	No
10	Used FPG to determine eligibility for providing discounted care to low income individuals?	10	X	
	If "Yes," indicate the FPG family income limit for eligiblity for discounted care: 300.0000 %			
11	Explained the basis for calculating amounts charged to patients?	11	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[X] Asset level			
c	[X] Medical indigency			
d	[X] Insurance status			
e	[X] Uninsured discount			
f	[X] Medicaid/Medicare			
g	[X] State regulation			
h	[X] Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12	X	
13	Included measures to publicize the policy within the community served by the hospital facility?	13	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The policy was posted on the hospital facility's website			
b	[X] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[X] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[X] 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	X	
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	[X] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[X] 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?	16	X	
	If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):			
a	[X] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[X] 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	[X] Notified patients of the financial assistance policy on admission			
b	[ ] Notified patients of the financial assistance policy prior to discharge			
c	[X] Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	[X] Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e	[X] Other (describe in Part VI)			

Part V Facility Information (continued) Western MD Reg Medical 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?	18	X	

If "No," indicate the reasons why (check all that apply):

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility did not have a policy relating to emergency medical care
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)
- d ☐ Other (describe in Part VI)

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 ☐ The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility
- b ☐ The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility
- c ☐ The hospital facility used the Medicare rate for those services
- d ☒ Other (describe in Part VI)

			Yes	No
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.	20		X
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.	21	X	

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? 1

Name and address	Type of Facility (describe)
1 Frostburg Nursing and Rehab Ct 48 Tarn Terrace Frostburg MD 21532	Nursing Home
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 hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

01. Related organization annual community benefit report (Part I, line 6a)

In response to the growing interest in the types and scope of community benefit services provided by Maryland Hospitals, the Maryland General Assembly passed House Bill 15 during the 2001 Legislative Session, which created a new responsibility under the Health Services Cost Review Commission (HSCRC). Under the law, HSCRC is responsible for collecting hospital community benefit information from individual hospitals to compile into a publicly available statewide Community Benefit Report. This larger statewide document contains summary information.

02. Bad debt description footnote (Part III, line 4)

Bad debt expenses are for those services rendered to patients who have been determined to have the financial capacity, but are unwilling to pay. The total expense is write-offs, made after following the provisions of the hospital's collection and write-off policy, less bad debt recoveries. An estimate of the amount of charity care attributable to patients who likely would qualify for financial assistance under the hospital's charity care policy, if sufficient information had been available to make a determination of their eligibility, was based upon a review of records of patients who had accounts written off. WMHS has an audit prepared at the system level and the financial statements do not contain a footnote describing bad debt expense. The accounting for bad debts is explained above.

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 hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

03. Allowable Medicare costing methodology (Part III, line 8)

Maryland's regulatory system creates a unique process for hospital payment that differs from the rest of the nation. The 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.

04. Subsidized health services costs (Part I, line 7(g))

Included as subsidized health services were costs attributable to physician clinics. This amounted to $2,374,140.

05. Debt expense included (Part I, line 7, col, (f))

Bad debt expense included on Part IX, line 25 column (A),line 25 column (A), subtracted for the purpose of calculating the percentage in this column totaled $5,831,966.

06. Costing methodology explanation (Part I, line 7)

Amounts reported in the table were calculated based upon the community benefit expenses entered in a community benefit cost accounting system by the appropriate individuals involved with the service provided. All patient segments (inpatient,

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.

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

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

outpatient, emergency room, etc) were included. Where appropriate, indirect costs were determined by a ratio calculation of overhead and capital costs in relation to direct costs from the HSCRC Annual Cost Report.

07. Collection practices (Part III, line 9b)

Please refer to charity care policy in the attached community benefits report narratives.

08. Needs assessment (Part VI, question 2)

Please refer to the community health needs assessment in the attached community benefits report narratives.

09. Patient education (Part VI, question 3)

Please refer to the charity care and financial assistance policies in the attached community benefits report narratives.

10. Community information (Part VI, question 4)

Please refer to the general hospital demographics and characteristics in the attached community benefits report narratives.

11. Community building activities (Part II)

Community building activities relate to WMHS actions regarding community disaster readiness support, coalition building, and workforce development.

12. Promoting community health (Part VI, question 5)

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

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

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

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

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

Please refer to the hospital community benefit program and initiatives in the attached community benefits report narratives.

13. Affiliated health care system (Part VI, question 6)

All members of the WMHS pursue the specifically identified needs of the communities through the programs and initiatives listed in the community benefit report.

14. State filings (Part VI, question 7)

WMHS files a copy of the community benefits report with the State of Maryland.

15. Other Needs Assessment information (Part V, question 1j)

Please refer to the community health needs assessment in the attached community benefits report narratives.

16. Community representative input (Part V, question 3)

Please refer to the community health needs assessment in the attached community benefits report narratives.

17. Other included hospital facilities (Part V, question 4)

No other hospital facilities were involved with the creation of the WMHS community needs assessment.

18. Other means widely available (Part V, question 5c)

Please refer to the community health needs assessment in the attached community benefits report narratives.

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 hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

19. Other means of meeting Needs Assessment (Part V, question 6i)

Please refer to the community health needs assessment in the attached community benefits report narratives.

20. Needs not addressed 9partV, question 7)

WMHS addressed all needs identified in the latest community needs assessment.

21. Other basis factors (Part V, question 11h)

Please refer to the sliding scale adjustments aand medical hardship financial grid in the attached community benefits report narratives.

22. Other publication methods (Part V, question 13g)

Please refer to the charity care and financial assistance policies in the attached community benefits report narratives.

23. Other collection actions permitted (Part V, question 15e)

WMHS pursues collection actions by referring patients to a credit agency.

24. Other collection actions engaged (Part V, question 16e)

WMHS authorizes third party agencies to pursue collection actions against patients.

25. Pre-collection actions (Part V, question 17e)

Please refer to the financial assistance policy in the attached community benefits report narratives.

26. No written emergency medical care policy (Part V, question 18d)

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 hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

A written policy is currently in practice at WMHS regarding emergency medical care.

27. Other methods for determining amounts billed (Part V, question 19d)

Please refer to the financial assistance policy in the attached community benefits report narratives.

28. Eligible patients billed (Part V, question 20)

No patients eligible for the WMHS financial assistance policy were charged more than the amount generally billed to other patients.

29. Amount Charged Equal to Gross Amount (Part V, question 21)

All WMHS patients were charged gross amounts similar to other patients for similar procedures.

30. Limited eligible individuals (Part V, question 18c)

A written policy is currently in practice at WMHS regarding emergency medical care.

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: Western MD Health System Corp. Inc.

Employer identification number: 52-0591531

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. ☐ First-class or charter travel ☐ Housing allowance or residence for personal use ☐ Travel for companions ☐ Payments for business use of personal residence ☐ Tax indemnification and gross-up payments ☐ Health or social club dues or initiation fees ☐ Discretionary spending account ☐ Personal services (e.g., maid, chauffeur, chef)			
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
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?	2		
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. ☒ Compensation committee ☒ Written employment contract ☒ Independent compensation consultant ☒ Compensation survey or study ☐ Form 990 of other organizations ☒ 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 related organization?	4a	X	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) 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?	5a		X
b	Any related organization?	5b		X
	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?	6a		X
b	Any related organization?	6b		X
	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	7	X	
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 Regs. section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

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

For each individual whose compensation must be reported 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 Barry P Ronan	(i)	482,508	0	313,587	180,908	13,284	990,287	710,123
	(ii)	0	0	0	0	0	0	0
2 James M Raver MD	(i)	181,108	0	181,609	35,276	682	398,675	407,757
	(ii)	0	0	0	0	0	0	0
3 Thomas C Dowdell	(i)	273,239	0	2,115	31,268	15,392	322,014	374,318
	(ii)	0	0	0	0	0	0	0
4 Kimberly S Repac	(i)	260,010	0	919	27,349	13,107	301,385	353,341
	(ii)	0	0	0	0	0	0	0
5 Nancy D Adams	(i)	195,926	0	1,079	22,634	12,965	232,604	268,159
	(ii)	0	0	0	0	0	0	0
6 Mark J Sullivan	(i)	182,385	0	1,727	21,028	12,933	218,073	247,523
	(ii)	0	0	0	0	0	0	0
7 Jo M Wilson	(i)	143,822	0	836	15,285	12,849	172,792	211,139
	(ii)	0	0	0	0	0	0	0
8 Kevin R Turley	(i)	147,898	60,000	464	21,973	15,114	245,449	216,373
	(ii)	0	0	0	0	0	0	0
9 Michele R Martz	(i)	129,719	0	256	14,836	15,074	159,885	185,509
	(ii)	0	0	0	0	0	0	0
10 Mark G Nelson MD	(i)	575,088	0	14,131	50,454	15,540	655,213	660,260
	(ii)	0	0	0	0	0	0	0
11 Subrato J Deb MD	(i)	497,115	50,000	6,719	47,685	15,540	617,059	570,721
	(ii)	0	0	0	0	0	0	0
12 Robert Chou MD	(i)	452,783	35,000	810	41,821	13,284	543,698	540,811
	(ii)	0	0	0	0	0	0	0
13 Alida Podrumar MD	(i)	339,997	80,000	2,391	36,206	7,308	465,902	389,568
	(ii)	0	0	0	0	0	0	0
14 Blanche Mavromatis MD	(i)	351,805	66,000	3,759	36,019	15,533	473,116	0
	(ii)	0	0	0	0	0	0	0
15 To Balance Report	(i)	1,000,001	0	0	0	0	1,000,001	0
	(ii)	0	0	0	0	0	0	0
16	(i)							
	(ii)							

Part III Supplemental Information

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

01. Other non-fixed payments (Part I, line 7)

James Raver - 145,402 - Severance payments

Barry Ronan - 311,265 - SERP payout

SCHEDULE K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part V.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization: Western MD Health System Corp. Inc.

Employer identification number: 52-0591531

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased Yes	(g) Defeased No	(h) On behalf of issuer Yes	(h) On behalf of issuer No	(i) Pooled financing Yes	(i) Pooled financing No
A	MHHEFA	52-0936091	574217ZY4	11-14-2006	348,650,000	Replace hospital facility		X		X		X
B												
C												
D												

Part II Proceeds

	A	B	C	D
1 Amount of bonds retired	16,170,000			
2 Amount of bonds legally defeased				
3 Total proceeds of issue	360,637,993			
4 Gross proceeds in reserve funds	25,500,000			
5 Capitalized interest from proceeds	31,542,000			
6 Proceeds in refunding escrows	8,371,923			
7 Issuance costs from proceeds	2,823,891			
8 Credit enhancement from proceeds				
9 Working capital expenditures from proceeds				
10 Capital expenditures from proceeds	292,400,179			
11 Other spent proceeds				
12 Other unspent proceeds				
13 Year of substantial completion	2009			

	A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
14 Were the bonds issued as part of a current refunding issue?		X						
15 Were the bonds issued as part of an advance refunding issue?	X							
16 Has the final allocation of proceeds been made?	X							
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use

	A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X						
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X						

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

Part III Private Business Use (Continued)

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
3 a	Are there any management or service contracts that may result in private business use of bond-financed property?		X						
b	Are there any research agreements that may result in private business use of bond-financed property?		X						
c	Does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts or research agreements relating to the financed property?	X							
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶		%		%		%		%
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶		%		%		%		%
6	Total of lines 4 and 5		%		%		%		%
7	Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?	X							

Part IV Arbitrage

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
1	Has a Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate, been filed with respect to the bond issue?		X						
2	Is the bond issue a variable rate issue?		X						
3 a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X						
b	Name of provider								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								
4 a	Were gross proceeds invested in a GIC?	X							
b	Name of provider	Wachovia							
c	Term of GIC		30						
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?	X							
5	Were any gross proceeds invested beyond an available temporary period?		X						
6	Did the bond issue qualify for an exception to rebate?		X						

Part V Supplemental Information.

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

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: Western MD Health System Corp. Inc.

Employer identification number: 52-0591531

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.

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

	(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)			

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) Kheder Ashker MD	Board Member	365,003	Neurosurgeon		X
(2) Rolf K Haarstad	Board Member	277,000	Prof Svcs		X
(3) Kimberly S Repac	SR VP, CFO	17,730,007	MD Physician Care		X
(4) Barry P Ronan	President, CEO	17,730,007	MD Physician Care		X
(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).

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization	Employer identification number
Western MD Health System Corp. Inc.	52-0591531

01. Officer, directors, etc. family relationship (Part VI, line 2)

Thomas C Dowdell and Michele R Martz serve on the Board of the United Way of the Potomac Highlands of which Mary Beth Pirolozzi is the Executive Director M Kathryn Burkey also serves on the Board of First United Corporation and First United Bank and Trust.

02. Form 990 governing body review (Part VI, line 11)

On an annual basis, the Executive Committee of the Board of Directors meets to review IRS Form 990 and 990T before it is filed with the Internal Revenue Service. The Vice President of Financial Services for the hospital presents an executive summary and then provides a detailed review and explanation of each form. Any open items or questions are resolved prior to the timely filing of the form on November 15th. Subsequent to its review, the Executive Committee reports back to the Board regarding its oversight of the Form 990.

03. Conflict of interest policy compliance (Part VI, line 12c)

The WMHS Board of Directors monitors proposed or ongoing transactions for conflicts of interest and addresses any potential or actual conflicts. Pursuant to the Conflicts of Interest Policy, an annual conflict questionaire is distributed to all interested persons. Interested persons are required to disclose real or potential conflicts at the time when such conflicts arise. When one becomes an interested person and annually thereafter, they are required to sign a statement affirming that they have received, read, understand, and agree to comply with the policy. The completed questionaires are reviewed by the Board. The procedures for addressing any conflict include the conflict being fully disclosed and discussed with the interested person along with potential resolutions of the conflict.

04. CEO, executive director, top management comp (Part VI, line 15a)

The Board appoints a Compensation Committee of independent directors without a conflict of

Name of the organization: Western MD Health System Corp. Inc.

Employer identification number: 52-0591531

interest with respect to the compensation arrangement, responsible for setting reasonable compensation packages for each officer or key employee, including the CEO. The Committee develops, consistent with organizational philosophy and principle, the annual performance goals and criteria to be used in determining merit increases and variable compensation. The Committee also hires an independent compensation and benefits specialist to review, analyze and provide benchmarking data for the total compensation and benefits packages. Comparability data is obtained for similar job responsibilities. Written records of all analyses are maintained to support decisions related to key employees and officers.

05. Other officer or key employee compensation (Part VI, line 15b

The Board appoints a Compensation Committee of independent directors without a conflict of interest with respect to the compensation arrangement, responsible for setting reasonable compensation packages for each officer or key employee, including the CEO. The Committee develops, consistent with organizational philosophy and principle, the annual performance goals and criteria to be used in determining merit increases and variable compensation. The Committee also hires an independent compensation and benefits specialist to review, analyze and provide benchmarking data for the total compensation and benefits packages. Comparability data is obtained for similar job responsibilities. Written records of all analyses are maintained to support decisions related to key employees and officers.

06. Governing documents, etc, available to public (Part VI, line 19)

While the federal tax laws do not mandate that the organizations governing documents, conflict of interest policy and financial statements be made available for public inspection, the organization makes its financial statements available upon request. In Maryland, the organizations financial statements are also submitted to the Health Services Cost Review Commission which is available for public inspection as well.

Name of the organization: Western MD Health System Corp. Inc.

Employer identification number: 52-0591531

07. Explanation of other changes in net assets or fund balances (Part XI, line 5)

Income Released from Restricted - $2,797,897

Pension Liability Adjustment - $14,018,000

Restricted Donations - $1,023,717

Transfer to Operations - ($1,736,726)

Unrealized Loss on Investments - ($754)

Employee Caring Fund - $39,720

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: Western MD Health System Corp. Inc.

Employer identification number: 52-0591531

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)	Western MD Health System, 52-1971675 PO Box 539, 21502-0539	Health Care	MD	501c3	III-O	no		X
(2)	Seton Regional Health System, 52-1333566 PO Box 539, 21502-0539	Charitable	MD	501c3	III-O	no		X
(3)	Cumberland Properties Inc., 52-1522252 PO Box 539, 21502-0539	Rental	MD	501c7	III-O	no		X
(4)	Willowbrook Health Services, 52-2005140 PO Box 539, 21502-0539	Health Care	MD	501c3	III-O	no		X
(5)	WMHS Foundation Inc., 35-2289841 PO Box 539, 21502-0539	Charitable	MD	501c3	III-O	no		X
(6)								
(7)								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) Johnson Heights Medi 625 Kent Avenue	Rental	MD	no	1 - Related	(74,274)	1,886,480		X		X		83.95
(2) Haystack Imaging Ser PO Box 539	Health Care	MD	no	1 - Related	3,694,703	2,939,862		X			X	50.00
(3)												
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) Haystack Consolidated Services, 52-1335895 PO Box 539, 21502-0539	Medical Services	MD	no	C Corp			100.00
(2) Western MD Medical Supply, 26-0119241 11110 Medical Campus Road, 21742	Medical Sales	MD	no	C Corp			33.33
(3) Memorial Medical Ctr Services, 52-1317704 PO Box 539, 21502-0539	Bldg Maint	MD	no	C Corp	316	611,955	100.00
(4) Willowbrook Health Ctr Condo, 37-1538510 PO Box 539, 21502-0539	Condo Management	MD	no	C Corp	188	74,845	53.30
(5)							
(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.

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?

		Line	Yes	No
a	Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	1a		X
b	Gift, grant, or capital contribution to other organization(s)	1b		X
c	Gift, grant, or capital contribution from other organization(s)	1c	X	
d	Loans or loan guarantees to or for other organization(s)	1d		X
e	Loans or loan guarantees by other organization(s)	1e		X
f	Sale of assets to other organization(s)	1f		X
g	Purchase of assets from other organization(s)	1g		X
h	Exchange of assets	1h		X
i	Lease of facilities, equipment, or other assets to other organization(s)	1i	X	
j	Lease of facilities, equipment, or other assets from other organization(s)	1j	X	
k	Performance of services or membership or fundraising solicitations for other organization(s)	1k	X	
l	Performance of services or membership or fundraising solicitations by other organization(s)	1l		X
m	Sharing of facilities, equipment, mailing lists, or other assets	1m	X	
n	Sharing of paid employees	1n	X	
o	Reimbursement paid to other organization for expenses	1o		X
p	Reimbursement paid by other organization for expenses	1p	X	
q	Other transfer of cash or property to other organization(s)	1q	X	
r	Other transfer of cash or property from other organization(s)	1r	X	

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

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

Part VI Unrelated Organizations Taxable as a Partnership (Complete if the organization answered "Yes" to 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)											

Statement of Program Service Accomplishments	2010 01
Name(s) as shown on return Western MD Health System Corp. Inc.	Your Social Security Number 52-0591531

Form 990, Part III(d)

Program Service Code	
Program Service Expenses	$8890756
Grants and allocations included in above expense	$0
Program Services Revenue	$9947124

Explanation

Emergency Medical Care - Emergency Room Visits - 55,183 visits