Form **8879-EO**

IRS *e-file* Signature Authorization for an Exempt Organization

For calendar year 2011, or fiscal year beginning 07/01 , 2011, and ending 06/30 , 20 12

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

▶ See instructions on back.

OMB No. 1545-1878

2011

Department of the Treasury
Internal Revenue Service

Name of exempt organization

WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number

52-0591531

Name and title of officer

KIMBERLY S. REPAC, VP CFO

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

Check the box for the return for which you are using this Form 8879-E0 and enter the applicable amount, if any, from the return. If you check the box on line **1a**, **2a**, **3a**, **4a**, or **5a**, below, and the amount on that line for the return being filed with this form was blank, then leave line **1b**, **2b**, **3b**, **4b**, or **5b**, whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than 1 line in Part I.

1a	Form 990 check here ▶ [X]	b	Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b 378659850.
2a	Form 990-EZ check here ▶ [ ]	b	Total revenue, if any (Form 990-EZ, line 9)	2b
3a	Form 1120-POL check here ▶ [ ]	b	Total tax (Form 1120-POL, line 22)	3b
4a	Form 990-PF check here ▶ [ ]	b	Tax based on investment income (Form 990-PF, Part VI, line 5)	4b
5a	Form 8868 check here ▶ [ ]	b	Balance Due (Form 8868, Part I, line 3c or Part II, line 8c)	5b

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2011 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize GRANT THORNTON LLP (ERO firm name) to enter my PIN 1 4 2 1 9 as my signature

Enter five numbers, but do not enter all zeros

on the organization's tax year 2011 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2011 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ Kimberly S Repac Date ▶ 4/30/13

Part III Certification and Authentication

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

2 3 6 9 5 3 3 6 6 0 5

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2011 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ Date ▶ 4/30/2013

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

For Paperwork Reduction Act Notice, see back of form.

Form **8879-EO** (2011)

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Cumulative E-File History 2011

FED

Locator:	0120ET
Tax Payer Name:	WESTERN MD HEALTH SYSTEM CORP. INC.
Return Type:	990, 990

Submitted Date	5/1/2013 11:15:29 AM
Acknowledgement Date	5/1/2013 11:15:29 AM
Status	Rejected
Submission ID	NONE
Submitted Date	5/1/2013 12:07:08 PM
Acknowledgement Date	5/1/2013 12:26:41 PM
Status	Accepted
Submission ID	23695320131215000000

Print Close

Form **990**

Department of the Treasury
Internal Revenue Service

eturn of Organization Exempt From Income T

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

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

OMB No. 1545-0047

2011

Open to Public Inspection

A For the 2011 calendar year, or tax year beginning 07/01, **2011, and ending** 06/30, **20**12

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

C Name of organization
WESTERN MD HEALTH SYSTEM CORP. INC.

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) — Room/suite
P.O. BOX 539

City or town, state or country, and ZIP + 4
CUMBERLAND, MD 21501-0539

D Employer identification number
52-0591531

E Telephone number
(240) 964-8003

G Gross receipts $ 411,804,188.

F Name and address of principal officer: KIMBERLY S. REPAC
P.O. BOX 539 CUMBERLAND, MD 21501

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

H(b) Are all affiliates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

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

J Website: ▶ WWW.WMHS.COM

K Form of organization: ☐ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1905 **M** State of legal domicile: MD

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:
THE MISSION OF WESTERN MD HEALTH SYSTEM IS TO IMPROVE THE HEALTH STATUS AND QUALITY OF LIFE OF THE INDIVIDUALS AND THE COMMUNITIES SERVED, ESPECIALLY THOSE IN NEED - SUPERIOR CARE FOR ALL WE SERVE

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

3	Number of voting members of the governing body (Part VI, line 1a)	3	15.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	10.
5	Total number of individuals employed in calendar year 2011 (Part V, line 2a)	5	2,545.
6	Total number of volunteers (estimate if necessary)	6	0
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	820,867.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	96,894.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	553,674.	1,902,139.
9	Program service revenue (Part VIII, line 2g)	357,244,346.	366,612,044.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	6,892,177.	8,163,641.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,578,838.	1,982,026.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	370,269,035.	378,659,850.

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)	135,322,094.	143,447,254.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	223,956,359.	237,601,648.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	359,278,453.	381,048,902.
19	Revenue less expenses. Subtract line 18 from line 12	10,990,582.	-2,389,052.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	558,711,707.	556,652,526.
21	Total liabilities (Part X, line 26)	411,234,728.	450,740,686.
22	Net assets or fund balances. Subtract line 21 from line 20	147,476,979.	105,911,840.

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

▶ Kimberly S Repac — Signature of officer — Date 5/1/13

▶ Kimberly S Repac SR Vice President / CFO — Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name: FRANK GIARDINI	Preparer's signature:	Date: 4/30/13	Check ☐ if self-employed	PTIN: P00532355
Firm's name ▶ GRANT THORNTON LLP			Firm's EIN ▶	36-6055558
Firm's address ▶ 2001 MARKET STREET, SUITE 3100 PHILADELPHIA, PA 19103			Phone no.	215-561-4200

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

For Paperwork Reduction Act Notice, see the separate instructions.

Form **990** (2011)

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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:

THE MISSION OF WESTERN MD HEALTH SYSTEM IS TO IMPROVE THE HEALTH STATUS AND QUALITY OF LIFE OF THE INDIVIDUALS AND THE COMMUNITIES SERVED, ESPECIALLY THOSE IN NEED - SUPERIOR CARE FOR ALL WE SERVE

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

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

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

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations 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 $ 224,694,756. including grants of $) (Revenue $ 242,187,919.)

ANCILLARY CARE

WESTERN MARYLAND HEALTH SYSTEM (WMHS) OFFERS A COMPREHENSIVE RANGE OF GENERAL AND SPECIALTY SERVICES FOR PATIENTS. SURGICAL, LABORATORY, RADIOLOGY, CARDIOLOGY, CANCER, RESPIRATORY AND PULMONARY ARE THE LARGER SERVICES PROVIDED AT THE HOSPITAL. A SMALLER SCALE OF ANCILLARY SERVICES ARE PROVIDED AT THE NURSING HOME.

4b (Code:) (Expenses $ 79,423,826. including grants of $) (Revenue $ 85,729,796.)

INPATIENT ROUTINE CARE

WESTERN MARYLAND HEALTH SYSTEM (WMHS) IS A FULL SERVICE COMMUNITY HOSPITAL LICENSED FOR 283 BEDS INCLUDING MEDICAL-SURGICAL, INTENSIVE CARE, HIGH LEVEL CARE, OBSTETRIC, PEDIATRIC, PSYCHIATRIC REHABILITATION, NURSERY, AND 88 NURSING HOME BEDS. FOR THE YEAR, 14,807 PATIENTS WERE ADMITTED TO THE HOSPITAL AND FOR THE NURSING HOME, THE AVERAGE DAILY CENSUS WAS 81 PATIENTS. THE HEALTH SYSTEM ACCEPTS PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. THOSE PATIENTS WHO MEET CERTAIN CRITERIA UNDER WMHS'S CHARITY CARE POLICIES RECEIVE SERVICES AT NO CHARGE OR AT AN AMOUNT LESS THAN FULL CHARGES.

4c (Code:) (Expenses $ 24,098,682. including grants of $) (Revenue $ 25,922,143.)

PHYSICIAN PRACTICES, CLINICS, AND HOME CARE

WESTERN MARYLAND HEALTH SYSTEM (WMHS) OPERATES 18 PHYSICIAN PRACTICES, 2 URGENT CARE CLINICS, AND A HOME CARE PRACTICE. THE PHYSICIAN PRACTICES HAD 77,830 ENCOUNTERS; THE CLINICS HAD 16,627 ENCOUNTERS AND HOME CARE HAD 26,819 VISITS FOR THE YEAR.

4d Other program services (Describe in Schedule O.) ATTACHMENT 1

(Expenses $ 11,200,796. including grants of $) (Revenue $ 11,959,527.)

4e Total program service expenses ▶ 339,418,060.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

			Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a 123		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b 0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return .	2a 2,545		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)			
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a	X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*	3b	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a	X	
b	If "Yes," enter the name of the foreign country: ▶ CAYMAN ISLANDS See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.			
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible?	6a		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b		
7	**Organizations that may receive deductible contributions under section 170(c).**			
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c		X
d	If "Yes," indicate the number of Forms 8282 filed during the year 7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? . . .	7e		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . .	7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h		
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8		
9	**Sponsoring organizations maintaining donor advised funds.**			
a	Did the organization make any taxable distributions under section 4966?	9a		
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b		
10	**Section 501(c)(7) organizations.** Enter:			
a	Initiation fees and capital contributions included on Part VIII, line 12 . . . . . 10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities 10b			
11	**Section 501(c)(12) organizations.** Enter:			
a	Gross income from members or shareholders 11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) 11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year 12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**			
a	Is the organization licensed to issue qualified health plans in more than one state?	13a		
	Note. See the instructions for additional information the organization must report on Schedule O.			
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans 13b			
c	Enter the amount of reserves on hand 13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a		X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b		

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

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

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year. If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.	1a 15		
b	Enter the number of voting members included in line 1a, above, who are independent	1b 10		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6		X
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		X
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		X
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9		X

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

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

Section C. Disclosure

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

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

☐ Own website ☐ Another's website ☒ Upon request

19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶ WESTERN MARYLAND HEALTH SYSTEM PO BOX 539 CUMBERLAND, MD 21502 240-964-8002

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 . . . . . ☐

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 (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) BRIAN HASSLINGER BOARD MEMBER	1.00	X						0	0	0
(2) JOYCE K LAPP, CFP BOARD MEMBER	1.00	X						0	0	0
(3) ELIZABETH HURWITZ-SCHWAB BOARD MEMBER	1.00	X						0	0	0
(4) FREDERICK THAYER BOARD MEMBER	1.00	X						0	0	0
(5) M KATHRYN BURKEY BOARD MEMBER	1.00	X						0	0	0
(6) MARY PIROLOZZI BOARD MEMBER	1.00	X						0	0	0
(7) ROLF HAARSTAD BOARD MEMBER	1.00	X						0	0	0
(8) SCOTT WATKINS MD BOARD MEMBER	1.00	X						0	0	0
(9) SHARON NICOL BOARD MEMBER	1.00	X						0	0	0
(10) RICHARD J WATRO BOARD MEMBER	1.00	X						0	0	0
(11) BARRY P RONAN PRESIDENT/CEO	40.00			X				694,160.	0	159,101.
(12) DONALD ALEXANDER CHAIRMAN	1.00			X				0	0	0
(13) GREGG WOLFF MD SECRETARY	1.00			X				0	0	0
(14) JOHN DAVIS VICE CHAIRMAN	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 (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
15) KIM LEONARD TREASURER	1.00			X				0	0	0
16) KIMBERLY S REPAC VP CFO	40.00			X				310,801.	0	42,476.
17) THOMAS C DOWDELL VP OPERATIONS COO	40.00			X				322,573.	0	48,654.
18) JO M WILSON VP SUPPORT OPERATIONS	40.00				X			171,371.	0	29,279.
19) KEVIN R TURLEY VP SUPPORT OPERATIONS	40.00				X			163,875.	0	34,762.
20) MARK J SULLIVAN VP HUMAN RESOURCES	40.00				X			205,636.	0	35,443.
21) MICHELE R MARTZ VP FINANCIAL SERVICES	40.00				X			146,797.	0	32,016.
22) NANCY D ADAMS VP CNO	40.00				X			232,672.	0	38,810.
23) WILLIAM BYERS VP CIO	40.00				X			136,977.	0	30,871.
24) GARY SCHMIDT, MD PHYSICIAN	40.00					X		814,278.	0	77,367.
25) CHRISTOPHER B HAAS, MD PHYSICIAN	40.00					X		579,140.	0	54,085.
1b Sub-total ▶								694,160.	0	159,101.
c Total from continuation sheets to Part VII, Section A ▶								5,070,069.	0	619,659.
d Total (add lines 1b and 1c) ▶								5,764,229.	0	778,760.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 84

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 2		

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 ▶ 25

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 (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
26) MARK G NELSON, MD PHYSICIAN	40.00					X		621,027.	0	62,463.
27) ROBERT CHOU, MD PHYSICIAN	40.00					X		503,031.	0	55,375.
28) SUBRATO J DEB, MD PHYSICIAN	40.00					X		590,181.	0	60,491.
29) JAMES M RAVER, MD PHYSICIAN	40.00						X	271,710.	0	17,567.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 84

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

Section B. Independent Contractors

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

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

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

Part VIII Statement of Revenue

			(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				
	d Related organizations	1d	2,469.			
	e Government grants (contributions)	1e	817,197.			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	1,082,473.			
	g Noncash contributions included in lines 1a-1f: $					
	h Total. Add lines 1a-1f		1,902,139.			
Program Service Revenue		Business Code				
	2a ANCILLARY CARE	621990	243,000,578.	242,187,919.	812,659.	
	b INPATIENT ROUTINE CARE	621990	85,729,796.	85,729,796.		
	c PHYSICIAN PRACTICES, CLINICS & HOME CARE	621990	25,922,143.	25,922,143.		
	d EMERGENCY CARE	621990	11,959,527.	11,959,527.		
	e					
	f All other program service revenue					
	g Total. Add lines 2a-2f		366,612,044.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		7,882,147.		8,208.	7,873,939.
	4 Income from investment of tax-exempt bond proceeds		0			
	5 Royalties		0			
		(i) Real	(ii) Personal			
	6a Gross rents	884,468.	15,180.			
	b Less: rental expenses	671,887.				
	c Rental income or (loss)	212,581.	15,180.			
	d Net rental income or (loss)		227,761.			227,761.
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory	30,782,615.	1,971,330.			
	b Less: cost or other basis and sales expenses	30,501,129.	1,971,322.			
	c Gain or (loss)	281,486.	8.			
	d Net gain or (loss)		281,494.			281,494.
	8a Gross income from fundraising events (not including $ ____ of contributions reported on line 1c). See Part IV, line 18 a					
	b Less: direct expenses b					
	c Net income or (loss) from fundraising events		0			
	9a Gross income from gaming activities. See Part IV, line 19 a					
	b Less: direct expenses b					
	c Net income or (loss) from gaming activities		0			
	10a Gross sales of inventory, less returns and allowances a					
	b Less: cost of goods sold b					
	c Net income or (loss) from sales of inventory		0			
	Miscellaneous Revenue	Business Code				
	11a CAFETERIA	621500	155,709.	155,709.		
	b REIMBURSEMENT OF EXPENSES	621500	1,179,196.	1,179,196.		
	c MISCELLANEOUS	621500	419,360.	419,360.		
	d All other revenue					
	e Total. Add lines 11a-11d		1,754,265.			
	12 Total revenue. See instructions		378,659,850.	367,553,650.	820,867.	8,383,194.

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).

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21	0			
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	0			
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	2,929,690.	2,724,612.	205,078.	
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	107,221,255.	99,715,767.	7,505,488.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	8,566,357.	7,966,712.	599,645.	
9 Other employee benefits	17,282,067.	16,072,322.	1,209,745.	
10 Payroll taxes	7,447,885.	6,926,533.	521,352.	
11 Fees for services (non-employees):				
a Management	0			
b Legal	244,286.		244,286.	
c Accounting	0			
d Lobbying	0			
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	0			
g Other	0			
12 Advertising and promotion	298,934.	278,009.	20,925.	
13 Office expenses	70,185,780.	65,272,775.	4,913,005.	
14 Information technology	3,573,615.	3,323,462.	250,153.	
15 Royalties	0			
16 Occupancy	4,368,361.	4,015,544.	352,817.	
17 Travel	658,368.	612,282.	46,086.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	0			
20 Interest	15,788,388.		15,788,388.	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	28,773,261.	26,759,133.	2,014,128.	
23 Insurance	4,758,341.	4,425,257.	333,084.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a CONTRACTUAL/CHARITY	76,832,956.	71,454,649.	5,378,307.	
b BAD DEBTS	5,817,391.	5,410,174.	407,217.	
c MEDICAL PROFESSIONAL FEES	6,474,489.	6,021,275.	453,214.	
d MINORITY INTEREST	4,627,795.	4,303,849.	323,946.	
e All other expenses	15,199,683.	14,135,705.	1,063,978.	
25 Total functional expenses. Add lines 1 through 24e	381,048,902.	339,418,060.	41,630,842.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	40,422,879.	1	40,319,518.
	2	Savings and temporary cash investments	17,627,379.	2	28,189,638.
	3	Pledges and grants receivable, net	0	3	0
	4	Accounts receivable, net	44,624,768.	4	41,515,157.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	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)	0	6	0
	7	Notes and loans receivable, net	0	7	0
	8	Inventories for sale or use	6,995,412.	8	5,690,768.
	9	Prepaid expenses and deferred charges	5,037,911.	9	4,018,510.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 588,061,789.			
	b	Less: accumulated depreciation — 10b: 233,610,084.	373,141,092.	10c	354,451,705.
	11	Investments - publicly traded securities	0	11	0
	12	Investments - other securities. See Part IV, line 11	0	12	0
	13	Investments - program-related. See Part IV, line 11	0	13	0
	14	Intangible assets	0	14	0
	15	Other assets. See Part IV, line 11	70,862,266.	15	82,467,230.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	558,711,707.	16	556,652,526.
Liabilities	17	Accounts payable and accrued expenses	28,343,570.	17	30,486,432.
	18	Grants payable	0	18	0
	19	Deferred revenue	0	19	0
	20	Tax-exempt bond liabilities	332,874,301.	20	325,778,295.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties	0	23	0
	24	Unsecured notes and loans payable to unrelated third parties	0	24	0
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	50,016,857.	25	94,475,959.
	26	**Total liabilities.** Add lines 17 through 25	411,234,728.	26	450,740,686.
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	145,897,920.	27	105,146,654.
	28	Temporarily restricted net assets	1,333,477.	28	524,327.
	29	Permanently restricted net assets	245,582.	29	240,859.
		Organizations that do not follow SFAS 117, check here ▶ [ ] and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	147,476,979.	33	105,911,840.
	34	Total liabilities and net assets/fund balances	558,711,707.	34	556,652,526.

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	378,659,850.
2	Total expenses (must equal Part IX, column (A), line 25)	2	381,048,902.
3	Revenue less expenses. Subtract line 2 from line 1	3	-2,389,052.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	147,476,979.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-39,176,087.
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	105,911,840.

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		X
b	Were the organization's financial statements audited by an independent accountant?	2b	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.	2c	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: ☐ Separate basis ☐ Consolidated basis ☒ 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?	3a	X	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b	X	

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number
52-0591531

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 [X] 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?

(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)

	Yes	No
11g(i)		
11g(ii)		
11g(iii)		

h Provide the following information about the supported organization(s).

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2011 (line 6, column (f) divided by line 11, column (f)) . . . . . 14 %

15 Public support percentage from 2010 Schedule A, Part II, line 14 . . . . . 15 %

16a **33 1/3% support test - 2011.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support test - 2010.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test - 2011.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2010.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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 2011 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2010 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2011 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2010 Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2011.** 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 - 2010.** 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; and Part III, line 12. Also complete this part for any additional information. (See instructions).

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

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.

OMB No. 1545-0047

2011

Name of the organization
WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number
52-0591531

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

[ ] For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

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

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of $5,000 or more during the year . . . . . ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on Part I, line 2, of its Form 990-PF, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number 52-0591531

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	STATE OF MD DEPT HEALTH & MENTAL HYGIENE 301 W PRESTON STREET BALTIMORE, MD 21201	$ 761,974.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
2	ALLEGANY COUNTY HEALTH DEPT BOX 1745, WILLOWBROOK ROAD CUMBERLAND, MD 21502	$ 36,899.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
3	WESTERN MD INSURANCE COMPANY PO BOX 10233, 171 ELGIN AVE KY1-1002 GEORGE TOWN GRAND CAYMAN CAYMAN ISLANDS	$ 11,136.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number 52-0591531

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

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

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

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

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

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

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

Name of organization WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number 52-0591531

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

For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once. See instructions.) ▶ $

Use duplicate copies of Part III if additional space is needed.

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization

WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number

52-0591531

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? ☐ Yes ☐ No

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

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

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

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

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

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

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

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

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

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ 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 the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	1,567,441.	2,281,205.	2,244,200.	185,778.	
b Contributions	30,000.	94,675.	353,302.	2,058,879.	
c Net investment earnings, gains, and losses	-4,723.	-755.	12,294.	9,552.	
d Grants or scholarships					
e Other expenditures for facilities and programs	-871,859.	-807,684.	-328,591.	-10,009.	
f Administrative expenses					
g End of year balance	2,464,577.	3,182,809.	2,938,387.	2,264,218.	

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

- a Board designated or quasi-endowment ▶ 33.4100 %
- b Permanent endowment ▶ 66.5900 %
- c Temporarily restricted endowment ▶ _____ %

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

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

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

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 property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		6,391,699.		6,391,699.
b Buildings		400,563,339.	108,179,358.	292,383,981.
c Leasehold improvements				
d Equipment		171,197,908.	121,923,846.	49,274,062.
e Other		9,908,843.	3,506,880.	6,401,963.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				354,451,705.

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) FUNDS ON DEPOSIT WITH TRUSTEE	15,303,034.
(2) OTHER ACCOUNTS RECEIVABLE	5,168,971.
(3) A/R FROM AFFILIATES	1,647,358.
(4) IMPREST FUND - W/C	1,037,166.
(5) INVESTMENT-BOARD DESIGNATED	944,709.
(6) RESTRICTED BY DONOR	732,477.
(7) INVESTMENT IN AFFILIATES	16,752,365.
(8) OTHER LONG TERM INVESTMENTS	36,623,391.
(9) UNDER BOND INDENTURE	4,257,759.
(10)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	82,467,230.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) FEDERAL INCOME TAXES	1,268.
(3) PAYABLES TO THIRD PARTY PROGRAMS	8,049,643.
(4) UNAMORTIZED BOND PREMIUM	10,189,547.
(5) EQUIPMENT LOAN PAYABLE	558,844.
(6) DEFERRED COMP	658,481.
(7) PROFESSIONAL INSURANCE	12,376,949.
(8) PENSION LIABILITY	60,202,223.
(9) MINORITY INTEREST PAYABLE	2,094,229.
(10) ASBESTOS ABATEMENT	344,775.
(11)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	94,475,959.

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 XI Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	378,659,850.
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	381,048,902.
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	-2,389,052.
4	Net unrealized gains (losses) on investments	4	660,637.
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	-39,836,724.
9	Total adjustments (net). Add lines 4 through 8	9	-39,176,087.
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	-41,565,139.

Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements			1	303,164,141.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a	665,360.		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV.)	2d			
e	Add lines **2a** through **2d**			2e	665,360.
3	Subtract line **2e** from line **1**			3	302,498,781.
4	Amounts included on Form 990, Part VIII, line 12, but not on line **1**:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIV.)	4b	76,161,069.		
c	Add lines **4a** and **4b**			4c	76,161,069.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	378,659,850.

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements			1	300,260,038.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIV.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	300,260,038.
4	Amounts included on Form 990, Part IX, line 25, but not on line **1**:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIV.)	4b	80,788,864.		
c	Add lines **4a** and **4b**			4c	80,788,864.
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	381,048,902.

Part XIV Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

SEE PAGE 5

Part XIV Supplemental Information *(continued)*

ENDOWMENT FUNDS

PART V LINE 4

INTENDED USES OF THE INCOME FROM THE PUGH ENDOWMENT FUND ARE TO PROVIDE FREE BEDS AND FREE SERVICE TO THOSE WHO MAY BECOME PATIENTS AND WHO THROUGH FINANCIAL INABILITY MAY BE UNABLE TO MAKE PROVISIONS FOR THEIR OWN MEDICAL AND/OR SURGICAL RELIEF.

ANDERSON FAMILY FOUNDATION ENDOWMENT FUND IS RESTRICTED FOR USE TO ADDRESS HOSPITAL ACQUIRED INFECTIONS.

OTHER CHANGES IN NET ASSETS

PART XI LINE 8

MINIMUM PENSION LIABILITY ADJUSTMENT	$ (39,795,000)
TRANSFER TO OPERATIONS	(1,576,716)
INCOME RELEASED FROM RESTRICTED	807,146
RESTRICTED DONATIONS	734,857
CARING FUND 6/30/2011	(39,720)
CARING FUND 6/30/2012	32,709
TOTAL	$ (39,836,724)

OTHER REVENUES INCLUDED ON FORM 990

PART XII LINE 4B

DEDUCTIONS FROM REVENUE:	
CONTRACTUAL ALLOWANCES:	$ 60,884,103
CHARITY:	15,948,853
RENTAL EXPENSES INCLUDED IN REVENUE:	(671,887)
TOTAL	$ 76,161,069

OTHER EXPENSES INCLUDED ON FORM 990

PART XIII LINE 4B

DEDUCTIONS FROM REVENUE:	
CONTRACTUAL ALLOWANCES:	$ 60,884,103
CHARITY:	15,948,853
RENTAL EXPENSES INCLUDED IN REVENUE:	(671,887)
DISTRIBUTIONS TO NON-CONTROLLING INTERESTS:	4,627,795
TOTAL:	$ 80,788,864

LIABILITY FOR UNCERTAIN TAX POSITIONS (FIN 48 FOOTNOTE)

SCHEDULE D PART X

THE HEALTH SYSTEM AND SUBSTANTIALLY ALL OF ITS AFFILIATES ARE EXEMPT FROM FEDERAL INCOME TAX, EXCEPT FOR UNRELATED BUSINESS INCOME, WHICH IS NONEXISTENT, UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE. ACCORDINGLY, NO PROVISION FOR INCOME TAXES IS MADE IN THE CONSOLIDATED FINANCIAL STATEMENTS FOR THESE ENTITIES.

SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization

WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number

52-0591531

Part I General Information on Activities Outside the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 14b.

1 **For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☐ Yes ☐ No

2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.

3 Activities per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e.g., fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
(1) CENTRAL AMERICA/CARIBBEAN	1.		PROGRAM SERVICES	INSURANCE	2,048,884.
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Sub-total	1.				2,048,884.
b Total from continuation sheets to Part I					
c **Totals** (add lines 3a and 3b)	1.				2,048,884.

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 15, for any recipient who received more than $5,000. Check this box if no one recipient received more than $5,000 . . . . . ▶ ☐

1	(a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
(11)									
(12)									
(13)									
(14)									
(15)									
(16)									

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter . . . . . ▶

3 Enter total number of other organizations or entities . . . . . ▶

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 16. Part III can be duplicated if additional space is needed.

	(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								
(13)								
(14)								
(15)								
(16)								
(17)								
(18)								

Part IV Foreign Forms

1	Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	[X] Yes	[ ] No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A)*	[ ] Yes	[X] No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations. (see Instructions for Form 5471)*	[X] Yes	[ ] No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund. (see Instructions for Form 8621)*	[ ] Yes	[X] No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons With Respect To Certain Foreign Partnerships. (see Instructions for Form 8865)*	[ ] Yes	[X] No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to file Form 5713, International Boycott Report (see Instructions for Form 5713)*	[ ] Yes	[X] No

Part V **Supplemental Information**

Complete this part to provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE H (Form 990)

Hospitals

▶ 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

OMB No. 1545-0047

2011

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	X	
b	If "Yes," was it a written policy?	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. [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? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: [ ] 100% [ ] 150% [X] 200% [ ] Other _____ %	X	
b	Did the organization use FPG to determine eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: [ ] 200% [ ] 250% [X] 300% [ ] 350% [ ] 400% [ ] Other _____ %	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"?	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a	Did the organization prepare a community benefit report during the tax year?	X	
b	If "Yes," did the organization make it available to the public?	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		27970	14,375,312.		14,375,312.	3.77
b Medicaid (from Worksheet 3, column a)			7,886,184.	6,743,673.	1,142,511.	.30
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		27970	22,261,496.	6,743,673.	15,517,823.	4.07
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		23454	673,618.	12,264.	661,354.	.17
f Health professions education (from Worksheet 5)		105609	731,686.		731,686.	.19
g Subsidized health services (from Worksheet 6)		89794	35,230,927.	15,363,113.	19,867,814.	5.20
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)		12901	470,326.	65,506.	404,820.	.11
j **Total.** Other Benefits		231758	37,106,557.	15,440,883.	21,665,674.	5.67
k **Total.** Add lines 7d and 7j		259728	59,368,053.	22,184,556.	37,183,497.	9.74

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			138,138.		138,138.	.04
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			130,586.		130,586.	.03
7 Community health improvement advocacy						
8 Workforce development			865,771.		865,771.	.23
9 Other						
10 Total			1,134,495.		1,134,495.	.30

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

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2	Enter the amount of the organization's bad debt expense 2 7,390,933.			
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy 3 1,573,541.			
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

5	Enter total revenue received from Medicare (including DSH and IME)	5	136,383,559.	
6	Enter Medicare allowable costs of care relating to payments on line 5	6	110,693,459.	
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	25,690,100.	
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other			

Section C. Collection Practices

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

Part IV **Management Companies and Joint Ventures** (see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1	CUMBERLAND PROPERT	RENTAL	100.00000		
2	WILLOWBROOK HEALTH S	HEALTHCARE	100.00000		
3	JOHNSON HEIGHTS MED	RENTAL	83.95000		16.05000
4	MEMORIAL MED CTR SER	BUILDING MAINTENANCE	100.00000		
5	HAYSTACK IMAGING	HEALTHCARE	50.00000		50.00000
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

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

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 21502	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 tax year 2011)				
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 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: 20 1 2			
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	[X] 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?	9	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 2 0 0 %			
	If "No," explain in Part VI the criteria the hospital facility used.			

Part V **Facility Information** *(continued)* WESTERN MD REG MEDICAL CENTER

		Yes	No
10	Used FPG to determine eligibility for providing *discounted* care?	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 300 %		
	If "No," explain in Part VI the criteria the hospital facility used.		
11	Explained the basis for calculating amounts charged to patients?	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	[ ] Other (describe in Part VI)		
12	Explained the method for applying for financial assistance?	X	
13	Included measures to publicize the policy within the community served by the hospital facility?	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	[ ] 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 (FAP) that explained actions the hospital facility may take upon non-payment?	X	
15	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:		
a	[X] Reporting to credit agency		
b	[ ] Lawsuits		
c	[ ] Liens on residences		
d	[ ] Body attachments		
e	[ ] Other similar actions (describe in Part VI)		
16	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	X	
	If "Yes," check all actions in which the hospital facility or a third party engaged:		
a	[X] Reporting to credit agency		
b	[ ] Lawsuits		
c	[ ] Liens on residences		
d	[ ] Body attachments		
e	[ ] Other similar actions (describe in Part VI)		
17	Indicate which efforts the hospital facility made before initiating any of the 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 patients were eligible for financial assistance under the hospital facility's financial assistance policy		
e	[ ] 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?	X	
	If "No," indicate why:		
a	☐ The hospital facility did not provide care for any emergency medical conditions		
b	☐ The hospital facility's policy was not in writing		
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	☐ Other (describe in Part VI)		

Individuals Eligible for Financial Assistance

19	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	☒ Other (describe in 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?		X
	If "Yes," explain in Part VI.		
21	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient?	X	
	If "Yes," explain in Part VI.		

Part V Facility Information *(continued)*

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 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, 9, 10, 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.

SCHEDULE H, PART II COMMUNITY BUILDING ACTIVITIES

COMMUNITY SUPPORT - WMHS HAS IN PLACE A DISASTER READINESS PROGRAM. AS THE LARGEST HOSPITAL IN THE AREA AND THE LARGEST EMPLOYER, WMHS HAS INCURRED COSTS TO BE ABLE TO DEAL WITH A DISASTER IF THE NEED ARISES.

COALITION BUILDING - WMHS WORKS WITH COMMUNITY PARTNERS TO IMPROVE THE HEALTH IN THE COMMUNITY. EDUCATION PROGRAMS, SCREENINGS, AND VARIOUS OTHER EVENTS ARE CONDUCTED BY WMHS.

WORKFORCE DEVELOPMENT - WMHS IS ACTIVELY INVOLVED IN THE RECRUITMENT OF PHYSICIANS AND OTHER HEALTH PROFESSIONALS FOR THE FEDERALLY MEDICAL UNDERSERVED AREA THROUGH A COLLABORATION WITH REGIONAL PARTNERS.

SCHEDULE H, PART III BAD DEBT EXPENSE, 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.

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, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

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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 WAS AVAILABLE TO MAKE A DETERMINATION OF THEIR ELIGIBILITY, IS BASED UPON A REVIEW OF RECORDS OF PATIENTS WHO HAD ACCOUNTS WRITTEN OFF.

WMHS HAS AN AUDIT OF ITS FINANCIAL STATEMENTS PREPARED. THE COMMUNITY BENEFITS AMOUNT SHOWN IN SCHEDULE H - PART I DO NOT INCLUDE BAD DEBT EXPENSE.

SCHEDULE H, PART III SECTION B MEDICARE, LINE 8

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

Part VI Supplemental Information

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HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

SCHEDULE H, PART III SECTION B MEDICARE

LINE 8, COSTING METHODOLOGY

COST TO CHARGE RATIO.

SCHEDULE H, PART III SECTION C COLLECTION PRACTICES, LINE 9B

- THE WESTERN MARYLAND HEALTH SYSTEM PROVIDES CARE TO ALL PATIENTS SEEKING CARE, REGARDLESS OF THEIR ABILITY TO PAY. A PATIENT'S ABILITY TO PAY IS BASED ON A REVIEW WHICH IS DONE BY A MEMBER OF THE HEALTH SYSTEM'S BUSINESS OFFICE. THIS REVIEW ASSURES THAT ALL PATIENTS WHO SEEK EMERGENCY OR URGENT CARE RECEIVE THOSE SERVICES REGARDLESS OF THE PATIENT'S ABILITY TO PAY.

-IN ACCORDANCE WITH MARYLAND LAW, THE WESTERN MARYLAND HEALTH SYSTEM HAS A FINANCIAL ASSISTANCE POLICY AND PATIENTS MAY BE ENTITLED TO RECEIVE FINANCIAL ASSISTANCE WITH THE COST OF MEDICALLY NECESSARY HOSPITAL

Part VI Supplemental Information

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SERVICES IF THEY HAVE A LOW INCOME, DO NOT HAVE INSURANCE, OR THEIR INSURANCE DOES NOT COVER MEDICALLY-NECESSARY HOSPITAL CARE.

-THE WESTERN MARYLAND HEALTH SYSTEM MEETS OR EXCEEDS THE STATE'S LEGAL REQUIREMENT BY PROVIDING FINANCIAL ASSISTANCE BASED ON INCOME ESTABLISHED BY AND PUBLISHED BY THE FEDERAL GOVERNMENT EACH YEAR.

-THOSE PATIENTS THAT MEET THE FINANCIAL ASSISTANCE POLICY CRITERIA DESCRIBED ABOVE MAY RECEIVE ASSISTANCE FROM THE HEALTH SYSTEM IN PAYING THEIR BILL. IF A PATIENT BELIEVES HE HAS WRONGLY BEEN REFERRED TO A COLLECTION AGENCY, HE HAS THE RIGHT TO CONTACT THE HOSPITAL TO REQUEST ASSISTANCE.

SCHEDULE H, PART V FACILITY INFORMATION

COMMUNITY HEALTH NEEDS ASSESSMENT

LINE 1, DESCRIPTION

LINE 3, PERSONS CONSULTED

LINE 5C, AVAILABLE TO PUBLIC

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UTILIZING THE ASSOCIATION OF COMMUNITY HEALTH IMPROVEMENT TOOLKIT, WMHS COMPILED A LIST OF DESIRED DATA AND POTENTIAL SOURCES. RAW DATA FROM THE OVER 40 SOURCES WAS COMPILED AND PUT ON A DASHBOARD, ALONG WITH ADDITIONAL NARRATIVE FOR ANALYSIS. A COMPLETE LIST OF THE SOURCE LIST CAN BE FOUND AT:

HTTP://WWW.ALLEGANYHEALTHPLANNINGCOALITION.COM/PDF/ALLEGANYCODATASOURCELIST07_2011.PDF

MANAGEMENT TEAMS FROM BOTH THE WMHS AND THE ALLEGANY COUNTY HEALTH DEPARTMENT REVIEWED THE RAW DATA, NARRATIVE, AND SOURCE LIST, TO IDENTIFY MISSING ELEMENTS, RAISE QUESTIONS, AND BEGIN ANALYSIS. CRITERIA TO IDENTIFY THE MOST SIGNIFICANT HEALTH ISSUES INCLUDED MAGNITUDE, SEVERITY COMPARED TO TARGET AND LEVEL OF NEED FOR VULNERABLE POPULATIONS. THE NEED FOR TRANSPORTATION WAS UNCLEAR BASED ON THE SECONDARY DATA, SO A SURVEY WAS CREATED AND DISTRIBUTED TO PATIENTS IN THE EMERGENCY DEPARTMENT, HEALTH DEPARTMENT CLINICS, AND TRI-STATE COMMUNITY HEALTH CENTER (FQHC). THE RESULTS OF THE SURVEY WERE ADDED TO THE DATA.

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WMHS WORKED COLLABORATIVELY WITH THE HEALTH DEPARTMENT TO CREATE A PRESENTATION UTILIZING THE FOLLOWING FRAMEWORK:

- DEMOGRAPHICS- CHARACTERISTICS OF COMMUNITY AND PATIENTS
- LIFESTYLE CHOICES AND ENVIRONMENT
- HEALTH NEEDS & DISEASE STATUS
- ACCESS TO CARE (PAYORS & PROVIDERS, BARRIERS)

THE WMHS COMMUNITY ADVISORY BOARD HELPED CREATE A LIST OF COMMUNITY ORGANIZATIONS AND FOCUS GROUPS TO PARTICIPATE IN THE PROCESS. BETWEEN JULY AND OCTOBER 2011, THE WMHS DIRECTOR OF COMMUNITY HEALTH & WELLNESS AND A REPRESENTATIVE FROM THE ALLEGANY COUNTY HEALTH DEPARTMENT, SHARED THE PROCESS AND RESULTS OF COMMUNITY HEALTH NEEDS ASSESSMENT IN A PUBLIC FORUM AND IN SESSIONS WITH OVER 20 GROUPS INCLUDING:

- WMHS BOARD OF DIRECTORS & COMMUNITY ADVISORY BOARD
- WORKGROUP ON ACCESS TO CARE
- LOCAL DRUG AND ALCOHOL ABUSE COUNCIL

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- LOCAL MANAGEMENT BOARD

- COMMUNITY WELLNESS COALITION

- WESTERN MARYLAND AHEC BOARD

- SCHOOL HEALTH COUNCIL

- MENTAL HEALTH ADVISORY BOARD

- BOARD OF HEALTH

- CUMBERLAND MINISTERIAL ASSN.

- COUNTY UNITED WAY

- CUMBERLAND HOUSING RENTAL ADVISORY BOARD

- NEIGHBORHOOD ADVISORY COMMISSION

- COMMUNITY TRUST FOUNDATION

- ALLIED HEALTH STUDENTS AT ALLEGANY COLLEGE OF MARYLAND

AFTER PRESENTING THE DATA, PARTICIPANTS WERE ASKED TO IDENTIFY THE TOP 5 PRIORITIES IN RANK ORDER BASED ON A LIST OF 13 IDENTIFIED COMMUNITY HEALTH NEEDS, TAKING INTO CONSIDERATION:

- COMMUNITY CAPACITY TO ACT ON ISSUE (MONEY, POLITICS, CULTURE)

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- FEASIBILITY OF HAVING MEASURABLE IMPACT ON ISSUE

- COMMUNITY RESOURCES ALREADY FOCUSED ON ISSUE

- ISSUE IS ROOT CAUSE OF OTHER PROBLEMS

THE OPTION TO IDENTIFY ADDITIONAL NEEDS WAS MADE AVAILABLE, BUT NONE WERE SUGGESTED. PARTICIPANTS WERE ALSO ASKED TO IDENTIFY POTENTIAL PARTNERS FOR ADDRESSING THESE NEEDS AND ANY KNOWN BARRIERS.

TO EXAMINE THE CONNECTION BETWEEN COMMUNITY HEALTH NEEDS, SOCIAL DETERMINANTS AND ECONOMIC DEVELOPMENT, MEETINGS WERE HELD WITH CITY AND COUNTY GOVERNMENT OFFICIALS AND REPRESENTATIVES IDENTIFIED BY COUNTY ADMINISTRATOR--FROM TRANSPORTATION, HOUSING, ECONOMIC DEVELOPMENT, PUBLIC SAFETY, AND GIS AS WELL AS WITH THE ALLEGANY COUNTY CHAMBER OF COMMERCE ECONOMIC DEVELOPMENT COMMITTEE.

A NOMINAL PROCESS WAS USED TO COMBINE THE VARIOUS RANKINGS FROM THE GROUPS INTO A FINAL DRAFT LIST OF PRIORITIES. TOBACCO USE, OBESITY, ACCESS TO CARE, EMOTIONAL & MENTAL HEALTH, AND SUBSTANCE ABUSE, TOP THE

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LIST OF PRIORITIES IDENTIFIED BY THE COMMUNITY.

IN AUGUST 2011, WMHS AND ACHD MET TO IDENTIFY THE PROPOSED MEMBERSHIP OF THE ALLEGANY COUNTY HEALTH PLANNING COALITION. BY OCTOBER, THE COALITION WAS CONFIRMED; MEMBERS MET WITH REPRESENTATIVES FROM SHIP, ESTABLISHED A VISION AND MISSION, AND APPROVED THE ORGANIZATIONAL STRUCTURE AND PRIORITY LIST. RATHER THAN CREATE DUPLICATIVE COMMITTEES, THE ALLEGANY COUNTY HEALTH PLANNING COALITION UTILIZES ESTABLISHED WORKGROUPS AND COMMITTEES ALREADY FUNCTIONING SUCCESSFULLY IN THE COMMUNITY. COMMUNICATION IS MAINTAINED BETWEEN THESE ENTITIES AND THE COALITION EITHER BY COALITION MEMBERS WHO SERVE ON THE COMMITTEES OR DESIGNATED STAFF FROM WMHS OR ACHD. THE OPERATIONAL STRUCTURE OF THE COALITION IS PROVIDED BY TARGETED STAFF AT THE ALLEGANY COUNTY HEALTH DEPARTMENT AND THE WESTERN MARYLAND HEALTH SYSTEM.

ONCE THE PRIORITY NEEDS WERE FINALIZED, REPRESENTATIVES FROM WMHS AND ACHD RESEARCHED AND COMPILED EVIDENCE BASE PRACTICES, CURRENT PROGRAMS/SERVICES, AND POTENTIAL PARTNERSHIPS TO ADDRESS EACH PRIORITY.

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SERVICE LINE LEADERS AT WMHS WERE ASKED TO REVIEW THIS INFORMATION AND RECOMMEND STRATEGIES TO ADDRESS THE NEEDS. MEMBERS OF THE ALLEGANY COUNTY HEALTH PLANNING COALITION DID THE SAME. BASED ON THESE RECOMMENDATIONS, THE WMHS DIRECTOR OF COMMUNITY HEALTH AND WELLNESS AND THE ACHD HEALTH PLANNER, COMPILED A DRAFT ACTION PLAN FOR EACH PRIORITY NEED. THE DRAFT ACTION PLAN WAS REVIEWED AND EDITED BY WMHS SERVICE LINE LEADERS AND SYSTEM MANAGEMENT. IN ADDITION TO THE STRATEGIES IN THE LOCAL HEALTH ACTION PLAN, WMHS IDENTIFIED SEVERAL STRATEGIES TO INDEPENDENTLY ADDRESS THE NEEDS OF THE COMMUNITY.

BY DECEMBER 31, 2011, THE DATA SOURCES, ANALYSIS, IDENTIFIED COMMUNITY PRIORITIES AND IMPLEMENTATION PLAN WERE POSTED FOR THE PUBLIC AT: HTTP://WWW.ALLEGANYHEALTHPLANNINGCOALITION.COM/AND THE WMHS WEBSITE HAS A LINK TO THE SITE. FOR EACH OF THE PRIORITIES, THERE ARE OVERALL STRATEGIES, ACTIONS, IDENTIFIED PARTNERS, PROGRESS MEASURES AND A TIMEFRAME. THE WMHS BOARD OF DIRECTORS APPROVED THE PLAN OF ACTION ON JANUARY 26, 2012.

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FROM JANUARY - APRIL 2012, COMMITMENTS TO THE ACTION PLAN AND SUGGESTED IMPROVEMENTS WERE OBTAINED FROM THE IDENTIFIED COMMUNITY ORGANIZATIONS AND WORKGROUPS. EITHER WMHS OR ACHD WAS IDENTIFIED AS THE LEAD AGENCY FOR ALL ACTIONS IN THE PLAN, AND LEAD AND SUPPORT SOURCES FOR ALL OF THE MEASURES WERE IDENTIFIED. PROGRESS ON THE STRATEGIC ACTIONS ARE ASSESSED AND REPORTED EVERY SIX MONTHS. THE LEAD AGENCIES REPORT TO THE COALITION, AND THEN THE MEMBERS RANK THE LEVEL OF PROGRESS MADE. THE AVERAGE RANKING IS USED AND DEMONSTRATED WITH SIGNAL STRENGTH SYMBOLS RANGING FROM 1 FOR NO PROGRESS TO 5 FOR EXCELLENT. JUSTIFICATION FOR THE PROGRESS ASSESSMENT CAN BE FOUND IN THE COALITION MINUTES.

THE LOCAL HEALTH ACTION PLAN HAS A BASELINE MEASURE AND 2014 GOAL FOR EACH OF THE 13 PRIORITIES. WHEN APPROPRIATE, THESE MEASURES WERE LINKED TO A SHIP MEASURE. A DASHBOARD THAT SHOWS THE STATUS BASED ON THE PERCENTAGE VARIANCE BETWEEN THE COUNTY BASELINE AND STATE BASELINE FOR EACH GOAL IS POSTED AT:

HTTP:/WWW.ALLEGANYHEALTHPLANNINGCOALITION.COM/ , UNDER LOCAL HEALTH ACTION PLAN. THIS DASHBOARD WILL BE UPDATED ANNUALLY.

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INFORMATION ABOUT COMMUNITY HEALTH NEEDS WAS SOUGHT FROM THE ALLEGANY COUNTY HEALTH OFFICER AND VARIOUS PUBLIC HEALTH EXPERTS AT BOTH THE LOCAL HEALTH DEPARTMENT AND STATE HEALTH DEPARTMENT. AS NOTED IN THE PRIOR SECTION, THERE WERE NUMEROUS COMMUNITY ORGANIZATIONS CONSULTED IN THE PROCESS INCLUDING: LOCAL DRUG AND ALCOHOL ABUSE COUNCIL, COMMUNITY WELLNESS COALITION, MENTAL HEALTH ADVISORY BOARD, CUMBERLAND MINISTERIAL ASSOCIATION, CUMBERLAND HOUSING RENTAL ADVISORY BOARD, NEIGHBORHOOD ADVISORY COMMISSION, COMMUNITY TRUST FOUNDATION, AND ALLIED HEALTH STUDENTS AT ALLEGANY COLLEGE OF MARYLAND. MANY OF THESE ENTITIES ARE ACTUALLY GROUPS OF ORGANIZATIONS INVOLVING REPRESENTATIVES FROM DIVERSE SUB POPULATIONS WITHIN THE SERVICE AREA. FOR EXAMPLE, THE LOCAL DRUG AND ALCOHOL ABUSE COUNCIL INVOLVES REPRESENTATIVES FROM DEPARTMENT OF SOCIAL SERVICES, DEPARTMENT OF JUVENILE SERVICES, REGIONAL PAROLE & PROBATION, STATE'S ATTORNEY, DISTRICT PUBLIC DEFENDER-ALLEGANY AND GARRETT COUNTIES, COUNTY SHERIFF, ADMINISTRATIVE JUDGE OF THE CIRCUIT COURT, SUBSTANCE ABUSE PROVIDER, CONSUMER - ADDICTIONS TREATMENT, ACHD, MD STATE POLICE, BOARD OF EDUCATION, FROSTBURG STATE UNIVERSITY, ALLEGANY COLLEGE OF MD,

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ALLEGANY RADIO CORPORATION, SALVATION ARMY, CHESSIE FEDERAL CREDIT UNION, COMMUNITY UNITY IN ACTION, AFFECTED NEWBORN PROGRAM, YOUTH REPRESENTATIVE. INDIVIDUALS RANGING FROM ELECTED OFFICIALS TO RESIDENTS OF PUBLIC HOUSING HAVE BEEN ENGAGED IN THE PROCESS.

IN ADDITION TO THE OVER 25 GROUPS WITH WHICH WE DISCUSSED THE COMMUNITY HEALTH NEEDS ASSESSMENT AND LOCAL HEALTH ACTION PLAN, WE ENGAGED THE MEMBERS OF THE ALLEGANY COUNTY HEALTH PLANNING COALITION. IN ADDITION TO WMHS AND ACHD, COALITION MEMBERS ARE FROM:

- ALLEGANY COUNTY PUBLIC SCHOOLS
- WESTERN MARYLAND AREA HEALTH EDUCATION CENTER
- COUNTY UNITED WAY
- TRI-STATE COMMUNITY HEALTH CENTER (FQHC)
- ALLEGANY COUNTY HUMAN RESOURCES DEVELOPMENT COMMISSION

IT IS THE ROLE OF THE ALLEGANY COUNTY HEALTH PLANNING COALITION TO COORDINATE THE STRATEGIC ACTIONS AMONG COMMUNITY GROUPS. COORDINATION

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, 9, 10, 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.

INCLUDES MONITORING PROGRESS AND PROMOTING PUBLIC EDUCATION REGARDING

COMMUNITY HEALTH STATUS. WMHS IS THE CO-LEADER OF THE COALITION.

SCHEDULE H, PART V FACILITY INFORMATION

FINANCIAL ASSISTANCE POLICY, LINE 19

WMHS DETERMINES THE MAXIMUM AMOUNTS THAT CAN BE CHARGED TO THE FINANCIAL

ASSISTANCE POLICY ("FAP") ELIGIBLE INDIVIDUALS BY USING SLIDING SCALE

TABLES BASED UPON PERCENTAGES OF FEDERAL POVERTY LEVELS ("FPL").

SCHEDULE H, PART V FACILITY INFORMATION

COMMUNITY HEALTH NEEDS ASSESSMENT, LINE 6I

WMHS AND THE ALLEGANY COUNTY HEALTH DEPARTMENT CONDUCTED A COMMUNITY

HEALTH ASSESSMENT IN THE SUMMER OF 2011. A LOCAL HEALTH ACTION PLAN WAS

DEVELOPED TO ADDRESS THE TOP 13 PRIORITIES IDENTIFIED BY THE ASSESSMENT.

RISING TO THE TOP OF THE LIST OF PRIORITIES WERE TOBACCO USE, OBESITY,

ACCESS TO CARE, AND EMOTIONAL AND MENTAL HEALTH. THE WMHS BOARD APPROVED

THE NEEDS ASSESSMENT AND ACTION PLAN ON JANUARY 26, 2012.

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, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

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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.

SCHEDULE H, PART V FACILITY INFORMATION

INDIVIDUALS ELIGIBLE FOR FINANCIAL ASSISTANCE, LINE 21

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 GOVERNMENT PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. IN ACCORDANCE WITH MARYLAND LAW, THE WESTERN MARYLAND HEALTH SYSTEM HAS A FINANCIAL ASSISTANCE POLICY AND PATIENTS MAY BE ENTITLED TO RECEIVE FINANCIAL ASSISTANCE WITH THE COST OF MEDICALLY NECESSARY HOSPITAL SERVICES IF THEY HAVE A LOW INCOME, DO NOT HAVE INSURANCE, OR THEIR INSURANCE DOES NOT COVER MEDICALLY-NECESSARY HOSPITAL CARE.

SCHEDULE H, PART VI SUPPLEMENTAL INFORMATION

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE, LINE 3

WESTERN MARYLAND HEALTH SYSTEM IS COMMITTED TO PROVIDING FINANCIAL ASSISTANCE TO PERSONS WHO HAVE HEALTH CARE NEEDS AND ARE UNINSURED, UNDERINSURED, INELIGIBLE FOR A GOVERNMENT PROGRAM, OR OTHERWISE UNABLE TO

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, 9, 10, 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.

PAY, FOR MEDICALLY NECESSARY CARE BASED ON THEIR INDIVIDUAL SITUATION. A PATIENT CAN QUALIFY FOR FINANCIAL ASSISTANCE EITHER THROUGH LACK OF SUFFICIENT INSURANCE OR FINANCIAL HARDSHIP DUE TO EXCESSIVE MEDICAL DEBT.

IT IS THE POLICY OF WMHS TO PROVIDE FINANCIAL ASSISTANCE BASED ON INDIGENCE OR EXCESSIVE MEDICAL DEBT FOR PATIENTS WHO MEET SPECIFIED FINANCIAL CRITERIA AND REQUEST SUCH ASSISTANCE.

WMHS WILL POST NOTICES OF AVAILABILITY AT PATIENT REGISTRATION SITES, ADMISSIONS, BUSINESS OFFICE AND AT THE EMERGENCY DEPARTMENT. NOTICE OF AVAILABILITY WILL ALSO BE SENT TO PATIENTS ON PATIENT BILL STATEMENTS. A PATIENT BILLING AND FINANCIAL ASSISTANCE INFORMATION SHEET WILL BE PROVIDED TO INPATIENTS VIA THE ADMISSION HANDBOOK GIVEN TO EVERY ADMITTED PATIENT. THIS IS PROVIDED TO PATIENTS PRIOR TO DISCHARGE AND IS ALSO AVAILABLE TO ALL PATIENTS UPON REQUEST.

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, 9, 10, 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.

SCHEDULE H, PART VI SUPPLEMENTAL INFORMATION

COMMUNITY INFORMATION, LINE 4

WMHS PROVIDES PRIMARY AND SECONDARY ACUTE CARE SERVICES FOR A SIX COUNTY REGION COVERING THE UPPER POTOMAC REGION OF MARYLAND, EASTERN WEST VIRGINIA AND SOUTHWESTERN PENNSYLVANIA. WITH ALMOST 87% OF THE PATIENTS RESIDING IN EITHER ALLEGANY COUNTY, MARYLAND (72.5%) OR MINERAL COUNTY, WEST VIRGINIA (13.94%), WMHS CONSIDERS THESE COMMUNITIES ITS COMMUNITY BENEFIT SERVICE AREA.

SCHEDULE H, PART VI SUPPLEMENTAL INFORMATION

PROMOTION OF COMMUNITY HEALTH, LINE 5

SEE COMMUNITY BENEFIT SUMMARY IN SCHEDULE O.

SCHEDULE H, PART VI SUPPLEMENTAL INFORMATION

AFFILIATED HEALTH CARE SYSTEM, LINE 6

- WESTERN MD HEALTH SYSTEM (EIN: 52-1971675), TAX EXEMPT UNDER 501(C)(3), PUBLIC CHARTY STATUS 3, HEALTH CARE FACILITY

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, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

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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.

-SETON REGIONAL HEALTH SYSTEM (EIN: 52-1333566), TAX EXEMPT UNDER 501(C)(3), PUBLIC CHARITY STATUS 11 TYPE I, CHARITABLE

-WMHS FOUNDATION (EIN: 35-2289841), TAX EXEMPT UNDER 501(C)(3), PUBLIC CHARITY STATUS 11 TYPE I, FUNDRAISING

-MEMORIAL MEDICAL CENTER SERVICES (EIN: 52-1317704), C CORPORATION, BUILDING MAINTENANCE

-WILLOWBROOK HC CONDO (37-1538510), C CORPORATION, CONDO MANAGEMENT

-HAYSTACK CONSOLIDATED (52-1335895), C CORPORATION, MEDICAL SERVICES

-WESTERN MD MEDICAL SUPPLY (26-0119241), C CORPORATION, MEDICAL SUPPLY SALES

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, 9, 10, 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.

SCHEDULE H, PART VI SUPPLEMENTAL INFORMATION

STATE FILING OF COMMUNITY BENEFIT REPORT, LINE 7

WMHS FILES A COMMUNITY BENEFIT REPORT WITH THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION (HSCRC).

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

2011

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		
	[X] 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	X	
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	X	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director. Explain in Part III.			
	[X] Compensation committee	[X] Written employment contract		
	[X] Independent compensation consultant	[X] Compensation survey or study		
	[X] Form 990 of other organizations	[X] 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?	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 Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

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

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

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 BARRY P RONAN	(i)	501,031.	100,000.	93,129.	139,431.	20,426.	854,017.	77,564.
	(ii)	0	0	0	0	0	0	
2 KIMBERLY S REPAC	(i)	269,351.	40,500.	950.	25,364.	17,691.	353,856.	
	(ii)	0	0	0	0	0	0	
3 THOMAS C DOWDELL	(i)	277,946.	41,808.	2,819.	28,166.	21,097.	371,836.	
	(ii)	0	0	0	0	0	0	
4 JO M WILSON	(i)	155,004.	15,500.	867.	15,493.	14,108.	200,972.	
	(ii)	0	0	0	0	0	0	
5 KEVIN R TURLEY	(i)	148,301.	15,080.	494.	15,351.	19,741.	198,967.	
	(ii)	0	0	0	0	0	0	
6 MARK J SULLIVAN	(i)	185,278.	18,600.	1,758.	18,986.	16,862.	241,484.	
	(ii)	0	0	0	0	0	0	
7 MICHELE R MARTZ	(i)	133,302.	13,208.	287.	13,646.	18,660.	179,103.	
	(ii)	0	0	0	0	0	0	
8 NANCY D ADAMS	(i)	200,958.	30,450.	1,264.	21,314.	17,934.	271,920.	
	(ii)	0	0	0	0	0	0	
9 GARY SCHMIDT, MD	(i)	810,367.	0	3,911.	59,566.	18,431.	892,275.	
	(ii)	0	0	0	0	0	0	
10 CHRISTOPHER B HAAS, MD	(i)	510,930.	60,000.	8,210.	44,520.	10,321.	633,981.	
	(ii)	0	0	0	0	0	0	
11 MARK G NELSON, MD	(i)	579,179.	30,000.	11,848.	47,040.	16,179.	684,246.	
	(ii)	0	0	0	0	0	0	
12 ROBERT CHOU, MD	(i)	467,190.	35,000.	841.	39,665.	16,466.	559,162.	
	(ii)	0	0	0	0	0	0	
13 SUBRATO J DEB, MD	(i)	508,695.	75,000.	6,486.	45,069.	16,179.	651,429.	
	(ii)	0	0	0	0	0	0	
14 JAMES M RAVER, MD	(i)	161,846.	0	109,864.	17,291.	435.	289,436.	
	(ii)	0	0	0	0	0	0	
15 WILLIAM BYERS	(i)	129,827.	6,907.	243.	12,933.	18,228.	168,138.	
	(ii)	0	0	0	0	0	0	
16	(i)							
	(ii)							

Part III Supplemental Information

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

SEVERENCE PAYMENTS

SCHEDULE J, LINE 4A AND LINE 7

JAMES M. RAVER, MD RECEIVED A SEVERENCE PAYMENT IN THE AMOUNT OF $108,435.

SUPPLEMENTAL NON-QUALIFIED RETIRMENT PLAN

SCHEDULE J, LINE 4B AND LINE 7

BARRY P. RONAN RECEIVED A SERP PAYOUT IN THE AMOUNT OF $77,564.

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 VI.

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2011

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		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	MHHEFA	52-0936091	574217ZYA	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		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	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		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	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)* MHHEFA

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X						
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X						
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
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		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	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						
3a 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?								
4a Were gross proceeds invested in a guaranteed investment contract (GIC)?	X							
b Name of provider	WACHOVIA SECURITIES							
c Term of GIC	30.000							
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 Procedures To Undertake Corrective Action

Check the box if the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations . . . . . ☐ Yes ☒ No

Part VI **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

2011

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	(e) Sharing of organization's revenues? No
(1)	KIMBERLY S. REPAC	SR. VP CFO	25,208,694.	MD PHYSICIAN CARE		X
(2)	BARRY P. RONAN	PRESIDENT & CEO	25,208,694.	MD PHYSICIAN CARE		X
(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 WITH INTERESTED PERSONS

SCHEDULE L PART IV

THESE TRANSACTIONS REPRESENT THE MONETARY VALUE OF BUSINESS TRANSACTIONS

BETWEEN MD PHYSICIANS CARE AND WESTERN MARYLAND HEALTH SYSTEM.

OTHER PROGRAM SERVICES

PART III LINE 4D

EMERGENCY CARE

WESTERN MARYLAND HEALTH SYSTEM (WMHS) OPERATES A 24-HOUR/7-DAY-A-WEEK EMERGENCY ROOM WHICH SERVES AS THE DESIGNATED AREA-WIDE TRAUMA CENTER. 57,146 VISITS WERE REGISTERED IN THE EMERGENCY ROOM FOR THE YEAR ENDING JUNE 30, 2012.

OFFICERS AND TRUSTEES BUSINESS RELATIONSHIPS

PART VI, LINE 2

MICHELE R. MARTZ (KEY EMPLOYEE) SERVES ON THE BOARD OF THE UNITED WAY OF THE POTOMAC HIGHLANDS OF WHICH MARY BETH PIROLOZZI (TRUSTEE) IS THE EXECUTIVE DIRECTOR. M. KATHRYN BURKEY (TRUSTEE) SERVES ON THE BOARD OF FIRST UNITED CORPORATION AND FIRST UNITED BANK AND TRUST, OF WHICH FREDERICK THAYER (TRUSTEE) IS A SENIOR VICE PRESIDENT.

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 CHIEF FINANCIAL OFFICER (CFO) 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 FILING OF THE FORM. SUBSEQUENT TO ITS REVIEW, THE EXECUTIVE COMMITTEE REPORTS

BACK TO THE BOARD REGARDING ITS OVERSIGHT OF THE FORM 990. THE BOARD IS INFORMED THAT A COMPLETE COPY OF THE FORM 990 IS AVAILABLE ON THE BOARD'S SECURE PASSWORD PROTECTED WEB SITE.

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 QUESTIONNAIRE 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 QUESTIONNAIRES 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 THE POTENTIAL RESOLUTIONS OF THE CONFLICT.

PROCESS FOR DETERMINING COMPENSATION

PART VI, LINE 15A & 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

Name of the organization
WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number
52-0591531

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.

AVAILABILITY OF GOVERNING DOCUMENTS TO PUBLIC

PART VI LINE 19

WHILE THE FEDERAL TAX LAWS DO NOT MANDATE THAT THE ORGANIZATION'S 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 ORGANIZATION'S FINANCIAL STATEMENTS ARE ALSO SUBMITTED TO THE HEALTH SERVICES COST REVIEW COMMISSION WHICH IS AVAILABLE FOR PUBLIC INSPECTION AS WELL.

OTHER CHANGES IN NET ASSETS OR FUND BALANCES

PART XI LINE 5

MINIMUM PENSION LIABILITY ADJUSTMENT	$ (39,795,000)
TRANSFER TO OPERATIONS	(1,576,716)
INCOME RELEASED FROM RESTRICTED	807,146
RESTRICTED DONATIONS	734,857
CARING FUND 6/30/2011	(39,720)
CARING FUND 6/30/2012	32,709

Name of the organization
WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number
52-0591531

UNREALIZED LOSS ON INVESTMENTS	660,637
TOTAL	$ (39,176,087)

SCHEDULE H - COMMUNITY BENEFIT SUMMARY

MISSION STATEMENT: SUPERIOR CARE FOR ALL WE SERVE

VISION STATEMENT: DEMONSTRATED LEADER IN THE DELIVERY OF EXCEPTIONAL HEALTHCARE SERVICES THROUGHOUT THE TRI-STATE REGION

CORE VALUES - I2CARE:

- INTEGRITY: DEMONSTRATE HONESTY AND STRAIGHTFORWARDNESS IN ALL RELATIONSHIPS
- INNOVATION: PURSUE CONTINUOUS IMPROVEMENT THROUGH CREATIVE NEW IDEAS, METHODS, AND PRACTICES
- COMPASSION: SHOW CARE AND KINDNESS TO ALL WE SERVE AND WITH WHOM WE WORK
- ACCOUNTABILITY: ENSURE EFFECTIVE STEWARDSHIP OF THE COMMUNITY'S TRUST
- RESPECT: DEMONSTRATE A HIGH REGARD FOR THE DIGNITY AND WORTH OF EACH PERSON
- EXCELLENCE: STRIVE FOR SUPERIOR PERFORMANCE IN ALL THAT WE DO

COMMUNITY BENEFIT SUMMARY (CONTINUED)

WMHS OVERVIEW:

Name of the organization: WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number: 52-0591531

WESTERN MARYLAND HEALTH SYSTEM (WMHS) STRIVES TO ENHANCE PATIENT CARE WHILE REDUCING HEALTHCARE COSTS. IMPROVING THE OVERALL HEALTH OF THE COMMUNITY IS ANOTHER IMPORTANT GOAL OF WMHS.

THE WESTERN MARYLAND HEALTH SYSTEM OFFERS A COMPREHENSIVE RANGE OF GENERAL AND SPECIALTY SERVICES FOR MEDICAL, SURGICAL, PEDIATRIC, AND OBSTETRICAL PATIENTS. SOPHISTICATED DIAGNOSTIC TESTING SERVICES ARE PROVIDED AT THE HOSPITAL, AS WELL AS AT OFF-SITE, OUTPATIENT DIAGNOSTIC CENTERS. AN EXTENSIVE RANGE OF PHYSICIAN SPECIALTIES IS AVAILABLE, WITH OVER 200 PHYSICIANS PRACTICING IN THE COMMUNITY.

IN AN EFFORT TO FURTHER ENHANCE HEALTH CARE SERVICES, WMHS DEVELOPED 8 SPECIALTY CENTERS - BEHAVIORAL HEALTH, CARDIAC SERVICES, CHILDREN'S AND ADOLESCENTS' HEALTH, ONCOLOGY SERVICES, OUTPATIENT SERVICES, ORTHOPEDICS AND JOINT RECONSTRUCTION, TRAUMA SERVICES AND WOMEN'S HEALTH.

EMERGENCY SERVICES ARE PROVIDED AT THE WESTERN MARYLAND REGIONAL MEDICAL CENTER, WHICH SERVES AS THE DESIGNATED AREA WIDE TRAUMA CENTER IN THE MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEMS (MIEMSS). CRITICAL CARE SERVICES, AS WELL AS SURGICAL SERVICES, A TRAUMA PROGRAM AND COMPREHENSIVE INPATIENT REHABILITATION UNIT.

THE HEART INSTITUTE AT WMHS PROVIDES A COMPREHENSIVE RANGE OF CARDIAC DIAGNOSTIC AND TREATMENT SERVICES, INCLUDING OPEN-HEART SURGERY AND

INTERVENTIONAL CARDIOLOGY (ANGIOPLASTY).

A FULL RANGE OF CANCER SERVICES IS AVAILABLE THROUGH THE SCHWAB FAMILY REGIONAL CANCER CENTER, WHICH IS ACCREDITED BY THE AMERICAN COLLEGE OF SURGEONS. INCLUDED IN THE WMHS PROGRAM ARE DIAGNOSTIC TESTING; A WIDE ARRAY OF TREATMENT SERVICES, INCLUDING RADIATION ONCOLOGY; HOSPICE SERVICES, AND MANY PATIENT SUPPORT SERVICES.

LONG-TERM CARE SERVICES ARE PROVIDED THROUGH THE FROSTBURG NURSING AND REHABILITATION CENTER, AN 88-BED NURSING HOME.

IMPROVING THE COMMUNITY'S OVERALL HEALTH IS AN IMPORTANT ASPECT OF WMHS. HEALTH PROMOTION ACTIVITIES INCLUDE HEALTH SCREENINGS, CLASSES ON ADOPTING HEALTHY LIFESTYLES, AND EXERCISE PROGRAMS. SPECIAL ACTIVITIES FOR CHILDREN AND SENIOR CITIZENS, AS WELL AS OTHER AT-RISK POPULATIONS, ARE OFFERED THROUGHOUT THE YEAR.

WMHS STRATEGIC GOALS FY2012 - FY2014
INCREASE PHYSICIAN COLLABORATION:
- SELECT AND ON-BOARD CHIEF MEDICAL OFFICER
- DEVELOP PHYSICIAN INTEGRATION WORKING GROUP
- DEVELOP FINANCIAL ALIGNMENT PILOT PROGRAM
- IMPLEMENT COMPUTERIZED PHYSICIAN ORDER ENTRY/ELECTRONIC HEALTH RECORDS (CPOE/HER)

REDESIGN CARE DELIVERY:

- INCREASE PRIMARY CARE PHYSICIAN (PCP) NETWORK AND REACH
- DEVELOP ACUTE CARE PATHWAYS AND PROTOCOLS
- EXPAND CASE MANAGEMENT TO COMPREHENSIVE DISEASE MANAGEMENT
- ENHANCE CARE TRANSITION PROCESS TO POST-ACUTE CARE PROVIDERS

ENGAGE PATIENTS AND IMPROVE ACCESS TO CARE:

- IDENTIFY AND ACT UPON MISSION-CRITICAL ASPECTS OF COMMUNITY HEALTH AND WELLNESS THAT WMHS CAN BEST INFLUENCE
- EXPAND EMPLOYEE WELLNESS TO IMPROVE THE HEALTH STATUS OF WMHS WORKFORCE AND ESTABLISH WMHS AS A ROLE MODEL FOR HEALTHY LIVING IN THE COMMUNITY
- LAUNCH A COMPREHENSIVE MISSION-FOCUSED CAMPAIGN TO COMMUNICATE HEALTH AND WELLNESS INFORMATION AND ACTIVELY ENGAGE AT-RISK POPULATIONS IN-HEALTHY LIVING

FOCUS ON BUSINESS MODEL DISCIPLINE:

- DEFINE GEOGRAPHIC AND PRODUCT/SERVICE MIX
- DEVELOP AND IMPLEMENT IT INFRASTRUCTURE TO ALIGN WITH STRATEGIC INITIATIVES
- IMPROVE THE WMHS VALUE PROPOSITION - REDUCE COST STRUCTURE
- IMPROVE THE WMHS VALUE PROPOSITION - INCREASE CLINICAL QUALITY
- DEVELOP WORKFORCE LEADERSHIP TO IMPROVE PATIENT EXPERIENCE

COMMUNITY HEALTH ASSESSMENT

THE WESTERN MARYLAND HEALTH SYSTEM IS COMMITTED TO IMPROVING THE HEALTH OF THE CITIZENS WE SERVE AND IS A FOUNDING MEMBER OF THE ALLEGANY COUNTY HEALTH PLANNING COALITION. THIS IS A GROUP OF COMMUNITY PARTNERS WORKING

Name of the organization
WESTERN MD HEALTH SYSTEM CORP. INC.
Employer identification number
52-0591531

TOGETHER FOR A HEALTHIER COMMUNITY.

WMHS AND THE ALLEGANY COUNTY HEALTH DEPARTMENT CONDUCTED A COMMUNITY HEALTH ASSESSMENT IN THE SUMMER OF 2011. A LOCAL HEALTH ACTION PLAN WAS DEVELOPED TO ADDRESS THE TOP 13 PRIORITIES IDENTIFIED BY THE ASSESSMENT. RISING TO THE TOP OF THE LIST OF PRIORITIES WERE TOBACCO USE, OBESITY, ACCESS TO CARE, AND EMOTIONAL AND MENTAL HEALTH.

THE STATISTICAL INFORMATION COMPILED ABOUT THE HEALTH STATUS OF THE COUNTY AND A SUMMARY OF COMMUNITY HEALTH NEEDS ARE AVAILABLE AT WWW.ALLEGANYHEALTHPLANNINGCOALITION.COM. ACTIONS TO ADDRESS EACH OF THE TOP 13 PRIORITIES ARE ON THE SITE AS WELL.

"THESE ACTION PLANS ARE DESIGNED TO ENGAGE EVERYONE IN THE COMMUNITY, INCLUDING BUSINESSES, CHURCHES, CIVIC ORGANIZATIONS, AND INDIVIDUALS," EXPLAINS NANCY FORLIFER, DIRECTOR OF COMMUNITY HEALTH AND WELLNESS AT WMHS. "THE STRATEGIES RANGE FROM EDUCATION ABOUT MAKING HEALTHIER CHOICES ON A PERSONAL LEVEL TO IMPLEMENTATION OF PUBLIC POLICY CHANGES THAT PROMOTE BETTER HEALTH."

THE COALITION MEETS MONTHLY AND THE PUBLIC IS WELCOME TO ATTEND THE MEETINGS, WHICH ARE HELD AT THE ALLEGANY COUNTY HEALTH DEPARTMENT ON WILLOWBROOK ROAD. THE MEETING SCHEDULE AND THE MINUTES FROM THE MEETINGS ARE AVAILABLE ON THE WEBSITE.

Name of the organization: WESTERN MD HEALTH SYSTEM CORP. INC.

Employer identification number: 52-0591531

MEMBERS OF THE ALLEGANY COUNTY HEALTH PLANNING COALITION INCLUDE THE ALLEGANY COUNTY HEALTH DEPARTMENT, WMHS, ALLEGANY COUNTY BOARD OF EDUCATION, COUNTY UNITED WAY, TRI-STATE COMMUNITY HEALTH CENTER, AND THE WESTERN MARYLAND AREA HEALTH EDUCATION CENTER.

ATTACHMENT 1

FORM 990, PART III, LINE 4D - OTHER PROGRAM SERVICES

DESCRIPTION	GRANTS	EXPENSES	REVENUE
EMERGENCY CARE		11,200,796.	11,959,527.
TOTALS		11,200,796.	11,959,527.

ATTACHMENT 2

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
HAYSTACK IMAGING PO BOX 539 CUMBERLAND, MD 21502	DIAGNOSTIC	12,417,991.
PHARMACARE 3 COMMERCE DRIVE CUMBERLAND, MD 21502	PHARMACY	3,949,919.
ARAMARK HEALTHCARE 25271 NETWORK PLACE CHICAGO, IL 60673-1252	DIETARY	2,161,535.
CUMBERLAND ANESTHESIA & PAIN PO BOX 1571 CUMBERLAND, MD 21501-1571	ANESTHESIA	2,104,226.
CROTHALL HEALTHCARE 13028 COLLECTIONS CENTER DRIVE CHICAGO, IL 60693	HOUSEKEEPING	1,177,613.
TOTAL COMPENSATION		21,811,284.

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

2011

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" to 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" to Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) WESTERN MD HEALTH SYSTEM PO BOX 539 CUMBERLAND, MD 21501 52-1971675	HLTH CARE	MD	501(C)(3)	3	N/A		X
(2) SETON REGIONAL HEALTH SYSTEM 900 SETON DRIVE CUMBERLAND, MD 21502 52-1333566	CHARITABLE	MD	501(C)(3)	I-O	N/A		X
(3) CUMBERLAND PROPERTIES, INC PO BOX 539 CUMBERLAND, MD 21501 52-1522252	RENTAL	MD	501(C)(3)	3	N/A		X
(4) WMHS FOUNDATION PO BOX 539 CUMBERLAND, MD 21501 35-2289841	FUNDRAISING	MD	501(C)(3)	I-O	N/A		X
(5) WILLOWBROOK HEALTH SERVICES PO BOX 539 CUMBERLAND, MD 21501 52-2005140	HLTH CARE	MD	501(C)(3)	3	N/A		X
(6)							
(7)							

Part III **Identification of Related Organizations Taxable as a Partnership** (Complete if the organization answered "Yes" to 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 52-1775175 625 KENT AVENUE	RENTAL	MD	N/A	RELATED	-68,753.	1,560,202.		X	0	X		83.9500
(2) HAYSTACK IMAGING 04-3783141 900 SETON DRIVE	HLTH CARE	MD	N/A	RELATED	4,646,917.	2,772,055.		X	0		X	50.0000
(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) MEMORIAL MED CTR SVCS 52-1317704 PO BOX 539 CUMBERLAND, MD 21501	BLDG MAINT	MD	N/A	C CORP	-1,604.	611,462.	100.0000
(2) WILLOWBROOK HC CONDO 37-1538510 PO BOX 539 CUMBERLAND, MD 21501	CONDO MGMT	MD	N/A	C CORP	112.	72,030.	53.3000
(3) HAYSTACK CONSOLIDATED 52-1335895 900 SETON DRIVE CUMBERLAND, MD 21504	MED SVCS	MD	N/A	C CORP	0	0	
(4) WESTERN MD MED SUPPLY 26-0119241 11110 MEDICAL CAMPUS RD HAGERSTOWN, MD 21742	MED SALES	MD	N/A	LLC	-22,464.	437,578.	33.3300
(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.

			Yes	No
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II–IV?			
a	Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity	1a		X
b	Gift, grant, or capital contribution to related organization(s)	1b		X
c	Gift, grant, or capital contribution from related organization(s)	1c	X	
d	Loans or loan guarantees to or for related organization(s)	1d	X	
e	Loans or loan guarantees by related organization(s)	1e		X
f	Sale of assets to related organization(s)	1f		X
g	Purchase of assets from related organization(s)	1g		X
h	Exchange of assets with related organization(s)	1h		X
i	Lease of facilities, equipment, or other assets to related organization(s)	1i	X	
j	Lease of facilities, equipment, or other assets from related organization(s)	1j	X	
k	Performance of services or membership or fundraising solicitations for related organization(s)	1k	X	
l	Performance of services or membership or fundraising solicitations by related organization(s)	1l		X
m	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1m	X	
n	Sharing of paid employees with related organization(s)	1n	X	
o	Reimbursement paid to related organization(s) for expenses	1o		X
p	Reimbursement paid by related organization(s) for expenses	1p	X	
q	Other transfer of cash or property to related organization(s)	1q	X	
r	Other transfer of cash or property from related 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)	JOHNSON SEIGHTS MEDICAL BLDG PARTNERSHIP	J P Q	273,879.	MARKET
(2)	HAYSTACK IMAGING SERVICES, LLC	LKMNPQR	13,820,590.	MARKET
(3)	MEMORIAL MEDICAL CENTER SERVICES	P	50,466.	MARKET
(4)	WILLOWBROOK HEALTH CENTER CONDOMINIUM	K P	318,903.	MARKET
(5)	WMHS FOUNDATION INC.	C N P R	1,277,184.	MAREKT
(6)	WESTERN MARYLAND MEDICAL SUPPLY	P	826,356.	MARKET

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

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

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

Part VII **Supplemental Information**

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

Form **5471**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Information Return of U.S. Persons With Respect To Certain Foreign Corporations

▶ **See separate instructions.**

Information furnished for the foreign corporation's annual accounting period (tax year required by section 898) (see instructions) beginning 7/1/2011 , and ending 6/30/2012

OMB No. 1545-0704

Attachment Sequence No. **121**

Name of person filing this return
Western Maryland Health System

Number, street, and room or suite no. (or P.O. box number if mail is not delivered to street address)
12400 Willowbrook Road, P.O. Box 539

City or town, state, and ZIP code
Cumberland MD 21502

A Identifying number
52-1971675

B Category of filer (See instructions. Check applicable box(es)):
1 (repealed) 2 [ ] 3 [ ] 4 [X] 5 [X]

C Enter the total percentage of the foreign corporation's voting stock you owned at the end of its annual accounting period 100.00%

Filer's tax year beginning 7/1/2011 , and ending 6/30/2012

D Person(s) on whose behalf this information return is filed:

(1) Name	(2) Address	(3) Identifying number	(4) Check applicable box(es)		
			Shareholder	Officer	Director

Important: *Fill in all applicable lines and schedules. All information* ***must*** *be in English. All amounts* ***must*** *be stated in U.S. dollars unless otherwise indicated.*

1a Name and address of foreign corporation
Name Western Maryland Insurance Company, Ltd.
Address P.O. Box 10233 City Grand Cayman
State Zip KY1-1002 Country Cayman Islands

b(1) Employer identification number, if any
98-0446260

b(2) Reference ID number (see instructions)

c Country under whose laws incorporated
Cayman Islands

d Date of incorporation	e Principal place of business	f Principal business activity code number	g Principal business activity	h Functional currency
12/14/2004	Cayman Islands	525190	Other Insurance Funds	US Dollar

2 Provide the following information for the foreign corporation's accounting period stated above.

a Name, address, and identifying number of branch office or agent (if any) in the United States
Name **N/A** ID Num
Address
City ST Zip

b If a U.S. income tax return was filed, enter:

(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)
N/A	**N/A**

c Name and address of foreign corporation's statutory or resident agent in country of incorporation
Name Kane (Cayman) Limited
Address P.O. Box 10233
City Grand Cayman ST Zip KY1-1002
Country Cayman Islands

d Name and address (including corporate department, if applicable) of person (or persons) with custody of the books and records of the foreign corporation, and the location of such books and records, if different
Name **Same as 2c**
Address City
State Zip Country
Location of Books/Records if different

Schedule A Stock of the Foreign Corporation

(a) Description of each class of stock	(b) Number of shares issued and outstanding	
	(i) Beginning of annual accounting period	(ii) End of annual accounting period
COMMON	50,000	50,000

For Paperwork Reduction Act Notice, see instructions.
(HTA)

Schedule B U.S. Shareholders of Foreign Corporation (see instructions)

(a) Name, address, and identifying number of shareholder	(b) Description of each class of stock held by shareholder. **Note:** *This description should match the corresponding description entered in Schedule A, column (a).*	(c) Number of shares held at beginning of annual accounting period	(d) Number of shares held at end of annual accounting period	(e) Pro rata share of subpart F income (enter as a percentage)
Name Western Maryland Health System Str 12400 Willowbrook Road, P.O. Box 539 City Cumberland ST MD Zip 21502 ID Num 52-1971675	Common	50,000	50,000	100.00%
Name Str City ST Zip ID Num				
Name Str City ST Zip ID Num				
Name Str City ST Zip ID Num				
Name Str City ST Zip ID Num				

Schedule C Income Statement (see instructions)

Important: *Report all information in functional currency in accordance with U.S. GAAP. Also, report each amount in U.S. dollars translated from functional currency (using GAAP translation rules). However, if the functional currency is the U.S. dollar, complete only the U.S. Dollars column. See instructions for special rules for DASTM corporations.*

			Functional Currency	U.S. Dollars
Income	1 a Gross receipts or sales	1a		2,368,475
	b Returns and allowances	1b		
	c Subtract line 1b from line 1a	1c		2,368,475
	2 Cost of goods sold	2		
	3 Gross profit (subtract line 2 from line 1c)	3		2,368,475
	4 Dividends	4		
	5 Interest	5		167,160
	6 a Gross rents	6a		
	b Gross royalties and license fees	6b		
	7 Net gain or (loss) on sale of capital assets	7		266,219
	8 Other income (attach schedule)	8		
	9 Total income (add lines 3 through 8)	9		2,801,854
Deductions	10 Compensation not deducted elsewhere	10		
	11 a Rents	11a		
	b Royalties and license fees	11b		
	12 Interest	12		
	13 Depreciation not deducted elsewhere	13		
	14 Depletion	14		
	15 Taxes (exclude provision for income, war profits, and excess profits taxes)	15		
	16 Other deductions (attach schedule—exclude provision for income, war profits, and excess profits taxes) **See Statement**	16		2,091,124
	17 Total deductions (add lines 10 through 16)	17		2,091,124
Net Income	18 Net income or (loss) before extraordinary items, prior period adjustments, and the provision for income, war profits, and excess profits taxes (subtract line 17 from line 9)	18		710,730
	19 Extraordinary items and prior period adjustments (see instructions)	19		
	20 Provision for income, war profits, and excess profits taxes (see instructions)	20		
	21 Current year net income or (loss) per books (combine lines 18 through 20)	21		710,730

Schedule E Income, War Profits, and Excess Profits Taxes Paid or Accrued (see instructions)

	(a) Name of country or U.S. possession	Amount of tax (b) In foreign currency	(c) Conversion rate	(d) In U.S. dollars
1	U.S.			
2				
3				
4				
5				
6				
7				
8	Total ▶			0

Schedule F Balance Sheet

Important: *Report all amounts in U.S. dollars prepared and translated in accordance with U.S. GAAP. See instructions for an exception for DASTM corporations.*

	Assets		(a) Beginning of annual accounting period	(b) End of annual accounting period
1	Cash	1	9,326,172	961,818
2a	Trade notes and accounts receivable	2a		
b	Less allowance for bad debts	2b		
3	Inventories	3		
4	Other current assets (attach schedule) See Statement	4	4,185,512	4,698,412
5	Loans to shareholders and other related persons	5		
6	Investment in subsidiaries (attach schedule)	6		
7	Other investments (attach schedule) See Statement	7	0	9,997,686
8a	Buildings and other depreciable assets	8a		
b	Less accumulated depreciation	8b		
9a	Depletable assets	9a		
b	Less accumulated depletion	9b		
10	Land (net of any amortization)	10		
11	Intangible assets:			
a	Goodwill	11a		
b	Organization costs	11b		
c	Patents, trademarks, and other intangible assets	11c		
d	Less accumulated amortization for lines 11a, b, and c	11d		
12	Other assets (attach schedule) See Statement	12	348,194	365,000
13	Total assets	13	13,859,878	16,022,916
	Liabilities and Shareholders' Equity			
14	Accounts payable	14	42,604	50,602
15	Other current liabilities (attach schedule) See Statement	15	51,852	31,687
16	Loans from shareholders and other related persons	16		
17	Other liabilities (attach schedule) See Statement	17	9,919,699	11,384,174
18	Capital stock:			
a	Preferred stock	18a		
b	Common stock	18b	50,000	50,000
19	Paid-in or capital surplus (attach reconciliation) See Statement	19	70,000	70,000
20	Retained earnings	20	3,725,723	4,436,453
21	Less cost of treasury stock	21		
22	Total liabilities and shareholders' equity	22	13,859,878	16,022,916

Schedule G Other Information

		Yes	No
1	During the tax year, did the foreign corporation own at least a 10% interest, directly or indirectly, in any foreign partnership? If "Yes," see the instructions for required attachment.	☐	☒
2	During the tax year, did the foreign corporation own an interest in any trust?	☐	☒
3	During the tax year, did the foreign corporation own any foreign entities that were disregarded as entities separate from their owners under Regulations sections 301.7701-2 and 301.7701-3 (see instructions)? If "Yes," you are generally required to attach Form 8858 for each entity (see instructions).	☐	☒
4	During the tax year, was the foreign corporation a participant in any cost sharing arrangement?	☐	☒
5	During the course of the tax year, did the foreign corporation become a participant in any cost sharing arrangement?	☐	☒

Schedule H Current Earnings and Profits (see instructions)

Important: *Enter the amounts on lines 1 through 5c in* ***functional*** *currency.*

		Net Additions	Net Subtractions		
1	Current year net income or (loss) per foreign books of account			1	710,730
2	Net adjustments made to line 1 to determine current earnings and profits according to U.S. financial and tax accounting standards (see instructions):				
a	Capital gains or losses		252,350		
b	Depreciation and amortization				
c	Depletion				
d	Investment or incentive allowance				
e	Charges to statutory reserves				
f	Inventory adjustments				
g	Taxes				
h	Other (attach schedule) See Statement	1,519,085	2,368,475		
3	Total net additions	1,519,085			
4	Total net subtractions		2,620,825		
5 a	Current earnings and profits (line 1 plus line 3 minus line 4)			5a	-391,010
b	DASTM gain or (loss) for foreign corporations that use DASTM (see instructions)			5b	
c	Combine lines 5a and 5b			5c	-391,010
d	Current earnings and profits in U.S. dollars (line 5c translated at the appropriate exchange rate as defined in section 989(b) and the related regulations (see instructions)) Enter exchange rate used for line 5d ▶			5d	-391,010

1.

Schedule I Summary of Shareholder's Income From Foreign Corporation (see instructions)

1	Subpart F income (line 38b, Worksheet A in the instructions)	1	0
2	Earnings invested in U.S. property (line 17, Worksheet B in the instructions)	2	
3	Previously excluded subpart F income withdrawn from qualified investments (line 6b, Worksheet C in the instructions)	3	
4	Previously excluded export trade income withdrawn from investment in export trade assets (line 7b, Worksheet D in the instructions)	4	
5	Factoring income	5	
6	Total of lines 1 through 5. Enter here and on your income tax return. See instructions	6	0
7	Dividends received (translated at spot rate on payment date under section 989(b)(1))	7	
8	Exchange gain or (loss) on a distribution of previously taxed income	8	

	Yes	No
• Was any income of the foreign corporation blocked?	☐	☒
• Did any such income become unblocked during the tax year (see section 964(b))?	☐	☒

If the answer to either question is "Yes," attach an explanation.

SCHEDULE J (Form 5471)
(Rev. December 2005)
Department of the Treasury
Internal Revenue Service

Accumulated Earnings and Profits (E&P) of Controlled Foreign Corporation

▶ **Attach to Form 5471. See Instructions for Form 5471.**

OMB No. 1545-0704

Name of person filing Form 5471
Western Maryland Health System

Identifying number
52-1971675

Name of foreign corporation
Western Maryland Insurance Company, Ltd.

Important: Enter amounts in functional currency.	(a) Post-1986 Undistributed Earnings (post-86 section 959(c)(3) balance)	(b) Pre-1987 E&P Not Previously Taxed (pre-87 section 959(c)(3) balance)	(c) Previously Taxed E&P (see instructions) (sections 959(c)(1) and (2) balances)			(d) Total Section 964(a) E&P (combine columns (a), (b), and (c))
			(i) Earnings Invested in U.S. Property	*(ii)* Earnings Invested in Excess Passive Assets	*(iii)* Subpart F Income	
1 Balance at beginning of year	-882,613					-882,613
2 a Current year E&P						
b Current year deficit in E&P	391,010					
3 Total current and accumulated E&P not previously taxed (line 1 plus line 2a **or** line 1 minus line 2b)	-1,273,623					
4 Amounts included under section 951(a) or reclassified under section 959(c) in current year						
5 a Actual distributions or reclassifications of previously taxed E&P						
b Actual distributions of nonpreviously taxed E&P						
6 a Balance of previously taxed E&P at end of year (line 1 plus line 4, minus line 5a)						
b Balance of E&P not previously taxed at end of year (line 3 minus line 4, minus line 5b)	-1,273,623					
7 Balance at end of year. (Enter amount from line 6a or line 6b, whichever is applicable.)	-1,273,623					-1,273,623

SCHEDULE M (Form 5471)
(Rev. December 2010)
Department of the Treasury
Internal Revenue Service

Transactions Between Controlled Foreign Corporation and Shareholders or Other Related Persons

▶ Attach to Form 5471. See Instructions for Form 5471.

OMB No. 1545-0704

Name of person filing Form 5471
Western Maryland Health System

Identifying number
52-1971675

Name of foreign corporation
Western Maryland Insurance Company, Ltd.

Important: *Complete a* ***separate*** *Schedule M for each controlled foreign corporation. Enter the totals for each type of transaction that occurred during the annual accounting period between the foreign corporation and the persons listed in columns (b) through (f). All amounts must be stated in U.S. dollars translated from functional currency at the average exchange rate for the foreign corporation's tax year. See instructions.*

Enter the relevant functional currency and the exchange rate used throughout this schedule ▶ US Dollar

1.

(a) Transactions of foreign corporation	(b) U.S. person filing this return	(c) Any domestic corporation or partnership controlled by U.S. person filing this return	(d) Any other foreign corporation or partnership controlled by U.S. person filing this return	(e) 10% or more U.S. shareholder of controlled foreign corporation (other than the U.S. person filing this return)	(f) 10% or more U.S. shareholder of any corporation controlling the foreign corporation
1 Sales of stock in trade (inventory)					
2 Sales of tangible property other than stock in trade					
3 Sales of property rights (patents, trademarks, etc.)					
4 Platform contribution transaction payments received					
5 Cost sharing transaction payments received					
6 Compensation received for technical, managerial, engineering, construction, or like services					
7 Commissions received					
8 Rents, royalties, and license fees received					
9 Dividends received (exclude deemed distributions under subpart F and distributions of previously taxed income)					
10 Interest received					
11 Premiums received for insurance or reinsurance	1,095,000				
12 Add lines 1 through 11	1,095,000				
13 Purchases of stock in trade (inventory)					
14 Purchases of tangible property other than stock in trade					
15 Purchases of property rights (patents, trademarks, etc.)					
16 Platform contribution transaction payments paid					
17 Cost sharing transaction payments paid					
18 Compensation paid for technical, managerial, engineering, construction, or like services					
19 Commissions paid					
20 Rents, royalties, and license fees paid					
21 Dividends paid					
22 Interest paid					
23 Premiums paid for insurance or reinsurance					
24 Add lines 13 through 23					
25 Amounts borrowed (enter the maximum loan balance during the year) — see instructions					
26 Amounts loaned (enter the maximum loan balance during the year) — see instructions					

Line 16, Sch C (5471) - Other Deductions

U.S Dollars

1	Underwriting Expenses	1	1,821,723
2	Professional Fees	2	103,208
3	Risk Management Grants	3	52,019
4	Investment Fees	4	42,238
5	Management Fees	5	37,500
6	Travel and Meeting Expenses	6	20,204
7	Government Fees	7	11,649
8	Miscellaneous Expenses	8	2,583
9		9	
10	Total other deductions	10	2,091,124

Line 4, Sch F (5471) - Other Current Assets

			Beginning	End
1	Claims Escrow Fund	1	96,295	168,474
2	Prepaid Expenses	2	20,596	14,363
3	Outstanding Losses Recoverable	3	3,353,911	3,853,911
4	Premiums Receivable	4	714,710	584,554
5	Interest Receivable	5	0	77,110
6		6		
7		7		
8		8		
9		9		
10		10		
11	Total other current assets	11	4,185,512	4,698,412

Line 7, Sch F (5471) - Other Investments

			Beginning	End
1	U.S. Corporate Bonds	1	0	4,768,919
2	U.S. Government Bonds	2	0	2,218,403
3	U.S. Corporate Mortgage/Asset Backed Securities	3	0	928,907
4	U.S. Collateralised Mortgage Obligations	4	0	893,039
5	U.S. Municipal Bonds	5	0	29,169
6	Non-U.S. Corporate Bonds	6	0	141,361
7	Non-Exchange Traded Funds	7	0	1,017,888
8		8		
9		9		
10		10		
11	Total other investments	11	0	9,997,686

Line 12, Sch F (5471) - Other Assets

			Beginning	End
1	Deferred Reinsurance Premium Ceded	1	348,194	365,000
2		2		
3		3		
4		4		
5		5		
6		6		
7		7		
8		8		
9		9		
10		10		
11	Total other assets	11	348,194	365,000

Line 15, Sch F (5471) - Other Current Liabilities

		Beginning	End
1 Due to Parent - Grants	1	51,852	23,300
2 Due to Parent - Losses Payable	2	0	8,387
3	3		
4	4		
5	5		
6	6		
7	7		
8	8		
9	9		
10	10		
11 Total other current liabilities	11	51,852	31,687

Line 17, Sch F (5471) - Other Liabilities

		Beginning	End
1 Unearned Premium Reserve	1	1,203,911	1,190,461
2 Provision for Outstanding Losses	2	8,715,788	10,193,713
3	3		
4	4		
5	5		
6	6		
7	7		
8	8		
9	9		
10	10		
11 Total other liabilities	11	9,919,699	11,384,174

Line 19, Sch F (5471) - Paid-In or Capital Surplus

		Beginning	End
1 Additional Paid-In Capital	1	70,000	70,000
2	2		
3	3		
4	4		
5	5		
6	6		
7	7		
8	8		
9	9		
10	10		
11 Total Paid-In or Capital Surplus	11	70,000	70,000

Line 2h, Sch H (5471) - Other

		Additions	Subtractions
1 Related Party Premiums	1		2,368,475
2 Related Party Claims Paid and Movement in Loss Reserves	2	1,519,085	
3	3		
4	4		
5	5		
6	6		
7	7		
8	8		
9	9		
10	10		
11 Total Other	11	1,519,085	2,368,475

Disclosure Statement Related to Form 5471 Filed on Behalf of the Taxpayer

Under the constructive ownership rules of the Internal Revenue Code Sections 318(a) and 958(b), the taxpayer is required to file Form 5471, *Information Return of U.S. Persons With Respect to Certain Foreign Corporations,* as a Category 4 and/or Category 5 filer with respect to Western Maryland Insurance Company, Ltd. (the "foreign corporation"). This filing requirement is or will be satisfied through the filing of Form 5471 with respect to the foreign corporation on the taxpayer's behalf by the U.S. taxpayer identified below.

Name: Western Maryland Health System
Address: 12400 Willowbrook Road, P.O. Box 539, Cumberland, MD 21502
Identifying Number of U.S. Tax Return With Which Form 5471 Was Filed: 52-1971675
IRS Service Center Where U.S. Tax Return Was or Will Be Filed: **(To be completed by U.S. taxpayer)**