

COHEN RUTHERFORD + KNIGHT, PC  
CERTIFIED PUBLIC ACCOUNTANTS  
6903 ROCKLEDGE DRIVE, SUITE 500  
BETHESDA, MD 20817  
301-828-1008

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INSTRUCTIONS FOR FILING  
ATLANTIC GENERAL HOSPITAL  
FORM 8879-EO - IRS E-FILE SIGNATURE AUTHORIZATION  
FOR THE PERIOD ENDED JUNE 30, 2013

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SIGNATURE...

THE ORIGINAL IRS E-FILE SIGNATURE AUTHORIZATION FORM SHOULD BE  
SIGNED (USE FULL NAME) AND DATED BY THE TAXPAYER.

FILING...

RETURN YOUR SIGNED FORM 8879-EO TO:

COHEN, RUTHERFORD + KNIGHT, PC  
6903 ROCKLEDGE DRIVE, SUITE 500  
BETHESDA MD 20817-1800

PAYMENT OF TAX...

NO PAYMENT OF TAX IS REQUIRED.

FORM 8879-EO SERVES AS A REPLACEMENT FOR YOUR SIGNATURE THAT WOULD BE  
AFFIXED TO FORM 990 IF YOU PAPER FILED YOUR RETURN.  
PLEASE DO NOT SEPARATELY FILE FORM 990 WITH THE INTERNAL REVENUE  
SERVICE. DOING SO WILL DELAY THE PROCESSING OF YOUR RETURN.

WE MUST RECEIVE YOUR SIGNED FORM BEFORE WE CAN ELECTRONICALLY  
TRANSMIT YOUR RETURN WHICH IS DUE ON MAY 15, 2014. WE  
WOULD APPRECIATE YOUR RETURNING THIS FORM AS SOON AS POSSIBLE  
AS THIS WILL EXPEDITE THE PROCESSING OF YOUR RETURN. THE INTERNAL  
REVENUE SERVICE WILL NOTIFY US WHEN YOUR RETURN IS ACCEPTED.  
YOUR RETURN IS NOT CONSIDERED FILED UNTIL THE INTERNAL REVENUE  
SERVICE CONFIRMS THEIR ACCEPTANCE, WHICH MAY OCCUR AFTER THE DUE  
DATE OF YOUR RETURN.

IF POSSIBLE, PLEASE EMAIL THE SIGNED FORM TO TECKLOFF@CRKCPA.COM OR  
FAX IT TO ME AT 301-530-3625.

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

For calendar year 2012, or fiscal year beginning 07/01, 2012, and ending 06/30, 2013

Department of the Treasury  
Internal Revenue Service

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

**2012**

Name of exempt organization

**ATLANTIC GENERAL HOSPITAL**

Employer identification number

**52-1656507**

Name and title of officer

**CHERYL NOTTINGHAM, VP FINANCE**

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

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

<b>1a</b> Form 990 check here ▶ <input checked="" type="checkbox"/>	<b>b Total revenue</b> , if any (Form 990, Part VIII, column (A), line 12) . . .	<b>1b</b> <u>96530148.</u>
<b>2a</b> Form 990-EZ check here ▶ <input type="checkbox"/>	<b>b Total revenue</b> , if any (Form 990-EZ, line 9) . . . . .	<b>2b</b> _____
<b>3a</b> Form 1120-POL check here ▶ <input type="checkbox"/>	<b>b Total tax</b> (Form 1120-POL, line 22) . . . . .	<b>3b</b> _____
<b>4a</b> Form 990-PF check here ▶ <input type="checkbox"/>	<b>b Tax based on investment income</b> (Form 990-PF, Part VI, line 5). . . . .	<b>4b</b> _____
<b>5a</b> Form 8868 check here ▶ <input type="checkbox"/>	<b>b Balance Due</b> (Form 8868, Part I, line 3c or Part II, line 8c) . . . . .	<b>5b</b> _____

**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 2012 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

**Officer's PIN: check one box only**

I authorize COHEN, RUTHERFORD + KNIGH to enter my PIN 

1	4	2	3	1
---	---	---	---	---

 as my signature  
ERO firm name Enter five numbers, but do not enter all zeros

on the organization's tax year 2012 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 2012 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 ▶ \_\_\_\_\_

Date ▶ \_\_\_\_\_

**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.

5	2	0	5	1	5	2	0	8	1	7
---	---	---	---	---	---	---	---	---	---	---

  
do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2012 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 ▶ 05/09/2014

**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.**

**Return of Organization Exempt From Income Tax**  
 Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

Department of the Treasury  
Internal Revenue Service

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

**A For the 2012 calendar year, or tax year beginning** 07/01, 2012, and ending 06/30, 2013

<b>B</b> Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C Name of organization</b> ATLANTIC GENERAL HOSPITAL Doing Business As			<b>D Employer identification number</b> 52-1656507	
	Number and street (or P.O. box if mail is not delivered to street address)		Room/suite	<b>E Telephone number</b> (410) 641-1100	
	City, town or post office, state, and ZIP code BERLIN, MD 21811			<b>G Gross receipts \$</b> 96,917,583.	
	<b>F Name and address of principal officer:</b> MICHAEL FRANKLIN 9733 HEALTHWAY DR BERLIN, MD 21811			<b>H(a) Is this a group return for affiliates?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>H(b) Are all affiliates included?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)	
<b>I Tax-exempt status:</b> <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527					
<b>J Website:</b> ▶ WWW.ATLANTICGENERAL.ORG				<b>H(c) Group exemption number</b> ▶	
<b>K Form of organization:</b> <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶				<b>L Year of formation:</b> 1989 <b>M State of legal domicile:</b> MD	

**Part I Summary**

<b>Activities &amp; Governance</b>	<b>1</b> Briefly describe the organization's mission or most significant activities: TO PROVIDE QUALITY CARE, PERSONALIZED SERVICE AND EDUCATION TO IMPROVE INDIVIDUAL AND COMMUNITY HEALTH.			
	<b>2</b> Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.			
	<b>3</b>	Number of voting members of the governing body (Part VI, line 1a)	20.	
	<b>4</b>	Number of independent voting members of the governing body (Part VI, line 1b)	18.	
	<b>5</b>	Total number of individuals employed in calendar year 2012 (Part V, line 2a)	909.	
	<b>6</b>	Total number of volunteers (estimate if necessary)	326.	
	<b>7a</b>	Total unrelated business revenue from Part VIII, column (C), line 12	142,138.	
	<b>7b</b>	Net unrelated business taxable income from Form 990-T, line 34	0	
<b>Revenue</b>			<b>Prior Year</b>	<b>Current Year</b>
	<b>8</b>	Contributions and grants (Part VIII, line 1h)	826,119.	995,710.
	<b>9</b>	Program service revenue (Part VIII, line 2g)	87,199,389.	94,743,283.
	<b>10</b>	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	456,832.	461,313.
	<b>11</b>	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	540,145.	329,842.
	<b>12</b>	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	89,022,485.	96,530,148.
<b>Expenses</b>	<b>13</b>	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0	0
	<b>14</b>	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	<b>15</b>	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	47,328,084.	50,312,433.
	<b>16a</b>	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	<b>b</b>	Total fundraising expenses (Part IX, column (D), line 25) ▶ 222,101.		
	<b>17</b>	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	39,755,820.	43,658,891.
	<b>18</b>	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	87,083,904.	93,971,324.
	<b>19</b>	Revenue less expenses. Subtract line 18 from line 12	1,938,581.	2,558,824.
<b>Net Assets or Fund Balances</b>			<b>Beginning of Current Year</b>	<b>End of Year</b>
	<b>20</b>	Total assets (Part X, line 16)	85,601,952.	84,185,231.
	<b>21</b>	Total liabilities (Part X, line 26)	46,739,002.	42,254,899.
	<b>22</b>	Net assets or fund balances. Subtract line 21 from line 20	38,862,950.	41,930,332.

**Part II Signature Block**

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

<b>Sign Here</b>	Signature of officer _____ Date _____	
	Type or print name and title _____	

<b>Paid Preparer Use Only</b>	Print/Type preparer's name TINA C ECKLOFF	Preparer's signature _____	Date 05/09/2014	Check <input type="checkbox"/> if self-employed	PTIN P01074058
	Firm's name ▶ COHEN, RUTHERFORD + KNIGHT, PC			Firm's EIN ▶ 52-1202280	
	Firm's address ▶ 6903 ROCKLEDGE DRIVE, SUITE 500 BETHESDA, MD 20817-1800			Phone no. 301-828-1008	

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

**For Paperwork Reduction Act Notice, see the separate instructions.**

**Part III Statement of Program Service Accomplishments**

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

1 Briefly describe the organization's mission:

TO PROVIDE QUALITY CARE, PERSONALIZED SERVICE AND EDUCATION TO IMPROVE INDIVIDUAL AND COMMUNITY HEALTH.

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

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

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

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code: ) (Expenses \$ 75,891,244. including grants of \$ ) (Revenue \$ 94,743,283. )

ATLANTIC GENERAL HOSPITAL IS A NON PROFIT HEALTHCARE PROVIDER FOCUSING ON INPATIENT AND OUTPATIENT SERVICES FOR OUR LOCAL COMMUNITY. WE ALSO OPERATE MULTIPLE PHYSICIAN OFFICES THROUGHOUT THE REGION THAT PROVIDES FAMILY, INTERNAL AND SPECIALTY MEDICINE TO OUR LOCAL RESIDENTS. WE HAD THE FOLLOWING KEY STATISTICS DURING THE 2012 TAX YEAR: ADMISSIONS: 3,086, PATIENT DAYS: 11,710, ED VISITS: 37,664, SURGERIES: 7,322, OTHER OUTPATIENT VISITS: 73,794, TOTAL VISITS TO OUR PHYSICIAN PRACITICES WERE 70,523.

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

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

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

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

4e Total program service expenses ▶ 75,891,244.

**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)? <i>If "Yes," complete Schedule A</i> . . . . .	X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (see instructions)? . . . . .	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i> . . . . .		X
4 <b>Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i> . . . . .		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? <i>If "Yes," complete Schedule C, Part III</i> . . . . .		
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? <i>If "Yes," complete Schedule D, Part I</i> . . . . .		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i> . . . . .		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i> . . . . .		X
9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i> . . . . .		X
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i> . . . . .	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? <i>If "Yes," complete Schedule D, Part VI</i> . . . . .	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? <i>If "Yes," complete Schedule D, Part VII</i> . . . . .		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? <i>If "Yes," complete Schedule D, Part VIII</i> . . . . .		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? <i>If "Yes," complete Schedule D, Part IX</i> . . . . .		X
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i> . . . . .	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)? <i>If "Yes," complete Schedule D, Part X</i> . . . . .		X
12 a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i> . . . . .		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i> . . . . .	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i> . . . . .		X
14 a Did the organization maintain an office, employees, or agents outside of the United States? . . . . .		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i> . . . . .		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? <i>If "Yes," complete Schedule F, Parts II and IV</i> . . . . .		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? <i>If "Yes," complete Schedule F, Parts III and IV</i> . . . . .		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? <i>If "Yes," complete Schedule G, Part I (see instructions)</i> . . . . .		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? <i>If "Yes," complete Schedule G, Part II</i> . . . . .	X	
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i> . . . . .		X
20 a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> . . . . .	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? . . . . .	X	

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

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 1a through 14b regarding Form 1096, Form W-2G, Form W-3, and various tax compliance issues.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include 1a (20), 1b (18), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

Table with 3 columns: Question, Yes, No. Rows include 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD,
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: CHERYL NOTTINGHAM 9733 HEALTHWAY DRIVE BERLIN, MD 21811 410-641-9095

**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 (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) MICHAEL FRANKLIN PRESIDENT & CEO	40.00 0	X		X			431,266.	0	6,250.	
(2) J RUSSELL BARRETT DIRECTOR	2.00 0	X					0	0	0	
(3) JEFFREY GREENWOOD DIRECTOR	2.00 0	X					0	0	0	
(4) DEBBIE GOELLER EX OFFICIO	2.00 0	X					0	0	0	
(5) ROBERT DURKIN DIRECTOR	2.00 0	X					106,670.	0	0	
(6) MICHAEL JAMES DIRECTOR	2.00 0	X					0	0	0	
(7) WILLIAM HUDSON SECRETARY	2.00 0	X		X			0	0	0	
(8) MICHAEL GUERRIERI DIRECTOR	2.00 0	X					0	0	0	
(9) WINN BOOTH DIRECTOR	3.00 0	X					0	0	0	
(10) JAMES BERGEY JR TREASURER	2.00 0	X		X			0	0	0	
(11) ERIC BONTEMPO EX OFFICIO	2.00 0	X					0	0	0	
(12) LOUIS TAYLOR VICE CHAIR	3.00 0	X		X			0	0	0	
(13) JOHN BURBAGE JR CHAIR	3.00 0	X		X			0	0	0	
(14) HUGH CROPPER IV DIRECTOR	2.00 0	X					0	0	0	

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
( 15) ELIZABETH GREGORY ----- DIRECTOR	2.00 ----- 0	X						0	0	0
( 16) GARRY MUMFORD ----- DIRECTOR	2.00 ----- 0	X						0	0	0
( 17) HEATHER STANSBURY ----- DIRECTOR	2.00 ----- 0	X						0	0	0
( 18) THOMAS D BECK ----- EX OFFICIO	2.00 ----- 0	X						0	0	0
( 19) HARRIET L JOHNSON ----- DIRECTOR	2.00 ----- 0	X						0	0	0
( 20) EDWIN CASTANEDA ----- DIRECTOR	2.00 ----- 0	X						0	0	0
( 21) LAURA BREN ----- EX OFFICIO	2.00 ----- 0	X						0	0	0
( 22) CHERYL NOTTINGHAM ----- CFO	40.00 ----- 0			X				196,440.	0	4,668.
( 23) COLLEEN WAREING ----- VP PATIENT CARE	40.00 ----- 0				X			148,494.	0	3,572.
( 24) JAMES BRANNON ----- VP PROFESSIONAL SERVICES	40.00 ----- 0				X			158,725.	0	3,730.
( 25) CHARLES KIM ----- PHYSICIAN	40.00 ----- 0					X		393,421.	0	6,250.
<b>1b Sub-total</b> .....								537,936.	0	6,250.
<b>c Total from continuation sheets to Part VII, Section A</b> .....								2,432,017.	0	43,220.
<b>d Total (add lines 1b and 1c)</b> .....								2,969,953.	0	49,470.

**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 ► 54

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
<b>ATTACHMENT 1</b>		

**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 ► 13



**Part VIII Statement of Revenue**

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>					
	<b>b</b> Membership dues . . . . .	<b>1b</b>					
	<b>c</b> Fundraising events . . . . .	<b>1c</b>	265,010.				
	<b>d</b> Related organizations . . . . .	<b>1d</b>					
	<b>e</b> Government grants (contributions) . . . . .	<b>1e</b>	50,000.				
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above . . . . .	<b>1f</b>	680,700.				
	<b>g</b> Noncash contributions included in lines 1a-1f: \$ . . . . .		7,312.				
	<b>h Total.</b> Add lines 1a-1f . . . . .		995,710.				
<b>Program Service Revenue</b>	<b>Business Code</b>						
	<b>2a</b> NET PATIENT REVENUE . . . . .		92,207,315.	92,207,315.			
	<b>b</b> OTHER OPERATING . . . . .	621110	671,303.	529,165.	142,138.		
	<b>c</b> MEANINGFUL USE FUNDS . . . . .		1,864,665.	1,864,665.			
	<b>d</b> . . . . .						
	<b>e</b> . . . . .						
	<b>f</b> All other program service revenue . . . . .						
<b>g Total.</b> Add lines 2a-2f . . . . .		94,743,283.					
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .	ATTACHMENT 2		272,314.		272,314.	
	<b>4</b> Income from investment of tax-exempt bond proceeds . . . . .			0			
	<b>5</b> Royalties . . . . .			0			
	<b>6a</b> Gross rents . . . . .	(i) Real	(ii) Personal				
		111,144.					
		<b>b</b> Less: rental expenses . . . . .			240,698.		
		<b>c</b> Rental income or (loss) . . . . .			-129,554.		
	<b>d</b> Net rental income or (loss) . . . . .			-129,554.		-129,554.	
	<b>7a</b> Gross amount from sales of assets other than inventory . . . . .	(i) Securities	(ii) Other				
		116,800.	72,199.				
		<b>b</b> Less: cost or other basis and sales expenses . . . . .					
		<b>c</b> Gain or (loss) . . . . .			116,800.	72,199.	
	<b>d</b> Net gain or (loss) . . . . .			188,999.		188,999.	
	<b>8a</b> Gross income from fundraising events (not including \$ 265,010. of contributions reported on line 1c). See Part IV, line 18 . . . . .	ATCH 3					
	<b>a</b> . . . . .			45,673.			
<b>b</b> Less: direct expenses . . . . .			63,438.				
<b>c</b> Net income or (loss) from fundraising events . . . . .	ATCH 4		-17,765.		-17,765.		
<b>9a</b> Gross income from gaming activities. See Part IV, line 19 . . . . .							
<b>a</b> . . . . .							
<b>b</b> Less: direct expenses . . . . .							
<b>c</b> Net income or (loss) from gaming activities . . . . .			0				
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .							
	<b>a</b> . . . . .			241,784.			
	<b>b</b> Less: cost of goods sold . . . . .	ATCH 5		83,299.			
<b>c</b> Net income or (loss) from sales of inventory . . . . .			158,485.		158,485.		
<b>Miscellaneous Revenue</b>		<b>Business Code</b>					
<b>11a</b> CAFETERIA . . . . .			177,279.	177,279.			
<b>b</b> MISCELLANEOUS . . . . .			141,397.	141,397.			
<b>c</b> . . . . .							
<b>d</b> All other revenue . . . . .							
<b>e Total.</b> Add lines 11a-11d . . . . .			318,676.				
<b>12 Total revenue.</b> See instructions . . . . .			96,530,148.	94,919,821.	142,138.	472,479.	

**Part IX Statement of Functional Expenses**

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

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

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21 . . . . .	0			
2 Grants and other assistance to individuals in the United States. See Part IV, line 22 . . . . .	0			
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16 . . . . .	0			
4 Benefits paid to or for members . . . . .	0			
5 Compensation of current officers, directors, trustees, and key employees . . . . .	977,031.		977,031.	
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 . . . . .	40,137,831.	34,659,830.	5,354,656.	123,345.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) . . . . .	515,956.	434,951.	79,457.	1,548.
9 Other employee benefits . . . . .	5,842,664.	4,925,366.	899,770.	17,528.
10 Payroll taxes . . . . .	2,838,951.	2,393,236.	437,198.	8,517.
11 Fees for services (non-employees):	0			
a Management . . . . .	0			
b Legal . . . . .	102,539.	655.	101,884.	
c Accounting . . . . .	172,922.		172,922.	
d Lobbying . . . . .	0			
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees . . . . .	0			
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.) . . . . .	4,149,240.	3,480,057.	669,183.	
12 Advertising and promotion . . . . .	777,832.	177,765.	598,607.	1,460.
13 Office expenses . . . . .	16,648,610.	14,987,283.	1,648,983.	12,344.
14 Information technology . . . . .	1,559,115.		1,559,115.	
15 Royalties . . . . .	0			
16 Occupancy . . . . .	1,851,989.	1,682,343.	169,646.	
17 Travel . . . . .	203,959.	113,623.	88,400.	1,936.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .	0			
19 Conferences, conventions, and meetings . . . . .	44,093.	10,138.	33,955.	
20 Interest . . . . .	663,743.	539,940.	123,803.	
21 Payments to affiliates . . . . .	0			
22 Depreciation, depletion, and amortization . . . . .	5,653,390.	4,547,101.	1,106,289.	
23 Insurance . . . . .	1,485,714.	1,474,314.	11,400.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <u>OUTSIDE LAB SERVICES</u> . . . . .	877,923.	877,923.		
b <u>REPAIRS &amp; MAINTENANCE</u> . . . . .	3,290,954.	3,106,155.	184,799.	
c <u>LAUNDRY AND LINENS</u> . . . . .	479,083.	479,083.		
d <u>DATA PROCESSING</u> . . . . .	12,965.	12,965.		
e All other expenses . . . . .	5,684,820.	1,988,516.	3,640,881.	55,423.
25 <b>Total functional expenses.</b> Add lines 1 through 24e	93,971,324.	75,891,244.	17,857,979.	222,101.
26 <b>Joint costs.</b> Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) . . . . .	0			

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year	
<b>Assets</b>	1	Cash - non-interest-bearing	0	1	0
	2	Savings and temporary cash investments	17,259,762.	2	16,281,525.
	3	Pledges and grants receivable, net	11,667.	3	56,517.
	4	Accounts receivable, net	9,207,236.	4	8,758,180.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0	6	0
	7	Notes and loans receivable, net	0	7	0
	8	Inventories for sale or use	1,955,288.	8	1,963,267.
	9	Prepaid expenses and deferred charges	1,609,728.	9	2,098,294.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 85,348,606.		
	b	Less: accumulated depreciation	10b 39,074,355.	10c	46,274,251.
	11	Investments - publicly traded securities	4,513,706.	11	4,932,278.
	12	Investments - other securities. See Part IV, line 11	2,441,167.	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	3,455,191.	15	3,820,919.
16	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34)	85,601,952.	16	84,185,231.	
<b>Liabilities</b>	17	Accounts payable and accrued expenses	12,143,449.	17	12,016,230.
	18	Grants payable	0	18	0
	19	Deferred revenue	0	19	0
	20	Tax-exempt bond liabilities	20,999,672.	20	19,295,111.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties	4,724,056.	23	4,245,687.
	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	8,871,825.	25	6,697,871.	
26	<b>Total liabilities.</b> Add lines 17 through 25	46,739,002.	26	42,254,899.	
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>				
	27	Unrestricted net assets	38,622,485.	27	41,615,824.
	28	Temporarily restricted net assets	240,465.	28	314,508.
	29	Permanently restricted net assets	0	29	0
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>				
	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	<b>Total net assets or fund balances</b>	38,862,950.	33	41,930,332.	
34	<b>Total liabilities and net assets/fund balances.</b>	85,601,952.	34	84,185,231.	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	96,530,148.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	93,971,324.
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	2,558,824.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	38,862,950.
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	227,731.
<b>6</b>	Donated services and use of facilities	<b>6</b>	21,000.
<b>7</b>	Investment expenses	<b>7</b>	0
<b>8</b>	Prior period adjustments	<b>8</b>	0
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	259,827.
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	41,930,332.

**Part XII Financial Statements and Reporting**

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

		Yes	No
<b>1</b>	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
<b>2a</b>	Were the organization's financial statements compiled or reviewed by an independent accountant? . . . . . If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		X
<b>b</b>	Were the organization's financial statements audited by an independent accountant? . . . . . If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	X	
<b>c</b>	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? . . . . . If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	X	
<b>3a</b>	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? . . . . .		X
<b>b</b>	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits		

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

**Public Charity Status and Public Support**

OMB No. 1545-0047

**2012**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

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

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

<b>Name of the organization</b> ATLANTIC GENERAL HOSPITAL	<b>Employer identification number</b> 52-1656507
--	---

**Part I Reason for Public Charity Status** (All organizations must complete this part.) See instructions.

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

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

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

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

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

Schedule A (Form 990 or 990-EZ) 2012

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

Section A. Public Support

Table with 7 columns: (a) 2008, (b) 2009, (c) 2010, (d) 2011, (e) 2012, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f); 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2008, (b) 2009, (c) 2010, (d) 2011, (e) 2012, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities, whether or not the business is regularly carried on; 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.); 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2012 (line 6, column (f) divided by line 11, column (f)); 15 Public support percentage from 2011 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2012; b 33 1/3% support test - 2011; 17a 10%-facts-and-circumstances test - 2012; b 10%-facts-and-circumstances test - 2011; 18 Private foundation.

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

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

Section A. Public Support

Table with 7 columns: (a) 2008, (b) 2009, (c) 2010, (d) 2011, (e) 2012, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Gross receipts from admissions, merchandise sold or services performed; 3 Gross receipts from activities that are not an unrelated trade or business under section 513; 4 Tax revenues levied for the organization's benefit; 5 The value of services or facilities furnished by a governmental unit; 6 Total. Add lines 1 through 5; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 7c Add lines 7a and 7b; 8 Public support (Subtract line 7c from line 6).

Section B. Total Support

Table with 7 columns: (a) 2008, (b) 2009, (c) 2010, (d) 2011, (e) 2012, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 10b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975; 10c Add lines 10a and 10b; 11 Net income from unrelated business activities not included in line 10b, 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

Table with 3 columns: Description, Line Number, Percentage. Row 15: Public support percentage for 2012 (line 8, column (f) divided by line 13, column (f)) - 15 - %; Row 16: Public support percentage from 2011 Schedule A, Part III, line 15 - 16 - %

Section D. Computation of Investment Income Percentage

Table with 3 columns: Description, Line Number, Percentage. Row 17: Investment income percentage for 2012 (line 10c, column (f) divided by line 13, column (f)) - 17 - %; Row 18: Investment income percentage from 2011 Schedule A, Part III, line 17 - 18 - %

19a 33 1/3% support tests - 2012. 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 - 2011. 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

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**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).

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**Schedule of Contributors**

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

**2012**

<b>Name of the organization</b> ATLANTIC GENERAL HOSPITAL	<b>Employer identification number</b>  52-1656507
--	---

**Organization type** (check one):

**Filers of:**

**Section:**

- Form 990 or 990-EZ       501(c)(<sup>3</sup> ) (enter number) organization
- 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
- 527 political organization
- Form 990-PF              501(c)(3) exempt private foundation
- 4947(a)(1) nonexempt charitable trust treated as a private foundation
- 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

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

**General Rule**

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

**Special Rules**

- For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of (1) \$5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.
- For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.
- For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of \$5,000 or more during the year . . . . . ▶ \$ \_\_\_\_\_

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

Employer identification number  
52-1656507**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	BULL ON THE BEACH RESTAURANTS ----- 12507 SUNSET AVENUE #8 ----- OCEAN CITY, MD 21842 -----	\$ 22,675.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/>  (Complete Part II if there is a noncash contribution.)
2	CALVIN B TAYLOR BANKING CO ----- PO BOX 5 ----- BERLIN, MD 21811 -----	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/>  (Complete Part II if there is a noncash contribution.)
3	CAROUSEL RESORT HOTEL AND CONDOMINIUMS ----- 11700 COASTAL HIGHWAY ----- OCEAN CITY, MD 21811 -----	\$ 11,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/>  (Complete Part II if there is a noncash contribution.)
4	C VINCENT HOLLAND ENDOWMENT ----- 1324 BELMONT AVENUE STE 401 ----- SALISBURY, MD 21804 -----	\$ 86,529.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/>  (Complete Part II if there is a noncash contribution.)
5	COMMUNITY FOUNDATION EASTERN SHORE ----- 1324 BELMONT AVE STE 401 ----- SALISBURY, MD 21804 -----	\$ 80,491.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/>  (Complete Part II if there is a noncash contribution.)
6	DOUGH ROLLER RESTAURANTS ----- PO BOX 419 ----- OCEAN CITY, MD 21842 -----	\$ 6,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/>  (Complete Part II if there is a noncash contribution.)

Name of organization ATLANTIC GENERAL HOSPITAL

Employer identification number  
52-1656507**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	EMERGENCY SERVICE ASSOCIATES PA 100 E CARROLL ST SALISBURY, MD 21801	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
8	ESTATE OF ALICE M EASTBURN 11021 NICHOLAS LANE STE E5 OCEAN PINES, MD 21811	\$ 28,923.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
9	ESTATE OF EUGENE J PICASSO 13 EASTON AVENUE OCEAN PINES, MD 21811	\$ 125,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
10	HAL GLICK SERVICE AWARD GALA 11036 WORCHESTER HIGHWAY BERLIN, MD 21811	\$ 12,209.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
11	HOMER AND MARTHA GUDELSKY FAMILY FOUND 11900 TECH ROAD SILVER SPRING, MD 21904	\$ 75,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
12	HORACE AND JO ANNE QUILLIN 102 QUILLIN DR BERLIN, MD 21811	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization ATLANTIC GENERAL HOSPITAL

Employer identification number  
52-1656507**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
13	JACK BURBAGE FOUNDATION INC ----- 9428 STEPHEN DECATUR HIGHWAY ----- BERLIN, MD 21811 -----	\$ 14,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/>  (Complete Part II if there is a noncash contribution.)
14	KELLY FOODS CORPORATION ----- 33337 MEDINA RD ----- MEDINA, OH 44256 -----	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/>  (Complete Part II if there is a noncash contribution.)
15	THE M&T CHARITABLE FOUNDATION ----- 25 S CHARLES ST ----- BALTIMORE, MD 21201 -----	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/>  (Complete Part II if there is a noncash contribution.)
16	WALTER M STANSELL JR ----- 11708 GUM POINT RD ----- BERLIN, MD 21811 -----	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/>  (Complete Part II if there is a noncash contribution.)
17	MICHELLE AND JOHN FAGER ----- 11831 BACK CREEK ROAD ----- BISHOPVILLE, MD 21813 -----	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/>  (Complete Part II if there is a noncash contribution.)
18	PENINSULA IMAGING LLC ----- 1655 WOODBROOKE DR STE 101 ----- SALISBURY, MD 21804 -----	\$ 5,600.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/>  (Complete Part II if there is a noncash contribution.)

Name of organization **ATLANTIC GENERAL HOSPITAL**

Employer identification number  
52-1656507

**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
19	SCHWAB CHARITABLE FUND ----- 211 MAIN STREET FLOOR 10 ----- SAN FRANCISCO, CA 94105 -----	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
20	SILBERSTEIN INSURANCE GROUP ----- 2330 W JOPPA RD STE 311 ----- LUTHERVILLE, MD 21093 -----	\$ 5,650.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
21	SYSCO EASTERN MARYLAND LLC ----- PO BOX 477 ----- POCOMOKE CITY, MD 21851 -----	\$ 56,800.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
22	THE ARTHUR PERDUE FOUNDATION ----- 501 SILVERSIDE RD ----- WILMINGTON, DE 19809-1377 -----	\$ 40,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
23	WORCHESTER COUNTY COMMISSIONERS ----- PO BOX 248 ----- SNOW HILL, MD 21863 -----	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
---	----- ----- -----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

**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
17	BEVERAGES ----- ----- -----	\$ 5,000.	-----
(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 ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

**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	
----- ----- -----		----- ----- -----	
-----	----- ----- -----	----- ----- -----	----- ----- -----
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
----- ----- -----		----- ----- -----	
-----	----- ----- -----	----- ----- -----	----- ----- -----
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
----- ----- -----		----- ----- -----	
-----	----- ----- -----	----- ----- -----	----- ----- -----
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
----- ----- -----		----- ----- -----	

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2012

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990. See separate instructions.

Name of the organization

ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

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

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate contributions to (during year), 3 Aggregate grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors 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?, 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?

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

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year, 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?, 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)?, 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

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

Schedule D (Form 990) 2012

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

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

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

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

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

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

Table with columns for Amount and rows for 1c Beginning balance, 1d Additions during the year, 1e Distributions during the year, 1f Ending balance.

2a Did the organization include an amount on Form 990, Part X, line 21?

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

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

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

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

- a Board designated or quasi-endowment 64.0000%
b Permanent endowment 36.0000%
c Temporarily restricted endowment %

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

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

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

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

Table with columns (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value and rows for 1a Land, 1b Buildings, 1c Leasehold improvements, 1d Equipment, 1e Other.

Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c)).

**Part VII Investments - Other Securities.** 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) _____		
<b>Total.</b> (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)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 13.) ▶		

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

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

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) SWAP	
(3) INTEREST PAYABLE	57,480.
(4) ADVANCES FROM THIRD PARTIES	707,263.
(5) CAPITAL LEASE	612,359.
(6) SOFTWARE LEASE	2,084,326.
(7) INSURANCE UNPAID LOSS	3,236,443.
(8)	
(9)	
(10)	
(11)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	6,697,871.

2. FIN 48 (ASC 740) Footnote. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII.

**Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return**

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

**Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return**

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

**Part XIII 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, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

ENDOWMENT FUND HELD BY UNRELATED ENTITY

SCHEDULE D, PART V, LINE 3

THE COMMUNITY FOUNDATION OF THE EASTERN SHORE HOLDS, AND ACCOUNTS FOR IN

ITS FINANCIAL STATEMENTS, A PERMANENT ENDOWMENT FUND (THE "FUND")

ESTABLISHED IN THE HOSPITAL'S NAME. THE HOSPITAL IS THE SOLE BENEFICIARY

OF THE FUND AND IS ENTITLED TO INVESTMENT INCOME EARNED BY THE FUND. THE

2012 TAX YEAR ENDING BALANCE FOR THE FUND WAS \$1,821,146.

**Part XIII** Supplemental Information *(continued)*

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

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events	
		GOLF TOURNAMENT <small>(event type)</small>	PENGUIN SWIM <small>(event type)</small>	1. <small>(total number)</small>	(add col. (a) through col. (c))	
Revenue	1	Gross receipts . . . . .	109,349.	79,934.	121,400.	310,683.
	2	Less: Contributions . . . . .	93,366.	61,349.	110,295.	265,010.
	3	Gross income (line 1 minus line 2). . . . .	15,983.	18,585.	11,105.	45,673.
Direct Expenses	4	Cash prizes . . . . .				
	5	Noncash prizes . . . . .	6,145.	14,044.		20,189.
	6	Rent/facility costs . . . . .	6,809.	215.	3,956.	10,980.
	7	Food and beverages . . . . .	4,129.	51.	20,150.	24,330.
	8	Entertainment . . . . .			800.	800.
	9	Other direct expenses . . . . .	1,119.	1,990.	4,030.	7,139.
	10	Direct expense summary. Add lines 4 through 9 in column (d) . . . . . ▶				( 63,438.)
11	Net income summary. Combine line 3, column (d), and line 10 . . . . . ▶				-17,765.	

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

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

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

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

b If "No," explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

b If "Yes," explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 11 Does the organization operate gaming activities with nonmembers?  Yes  No
- 12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming?  Yes  No
- 13 Indicate the percentage of gaming activity operated in:
 

a The organization's facility	<b>13a</b>	%
b An outside facility	<b>13b</b>	%
- 14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ -----

Address ▶ -----

- 15 a Does the organization have a contract with a third party from whom the organization receives gaming revenue?  Yes  No
- b If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ \_\_\_\_\_ and the amount of gaming revenue retained by the third party ▶ \$ \_\_\_\_\_.
- c If "Yes," enter name and address of the third party:

Name ▶ -----

Address ▶ -----

16 Gaming manager information:

Name ▶ -----

Gaming manager compensation ▶ \$ -----

Description of services provided ▶ -----

Director/officer       Employee       Independent contractor

17 Mandatory distributions:

- a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license?  Yes  No
- b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ \_\_\_\_\_

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

**SCHEDULE H**  
**(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2012**

**Open to Public Inspection**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

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

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

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			2,610,907.		2,610,907.	2.78
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .						
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
<b>d</b> <b>Total</b> Financial Assistance and Means-Tested Government Programs . . . . .			2,610,907.		2,610,907.	2.78
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) . . . . .			889,244.	3,175.	886,069.	.94
<b>f</b> Health professions education (from Worksheet 5) . . . . .			553,219.		553,219.	.59
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .			12,744,378.	8,247,087.	4,497,291.	4.79
<b>h</b> Research (from Worksheet 7) . . . . .			499.		499.	
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			177,103.		177,103.	.19
<b>j</b> <b>Total</b> Other Benefits . . . . .			14,364,443.	8,250,262.	6,114,181.	6.51
<b>k</b> <b>Total</b> . Add lines 7d and 7j. . . . .			16,975,350.	8,250,262.	8,725,088.	9.29

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

Schedule H (Form 990) 2012

**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		20	421.		421.	
2 Economic development		397	14,761.		14,761.	.02
3 Community support		1983	54,197.		54,197.	.06
4 Environmental improvements		27	30,480.		30,480.	.03
5 Leadership development and training for community members						
6 Coalition building		7875	67,866.	17.	67,849.	.07
7 Community health improvement advocacy		1696	26,540.		26,540.	.03
8 Workforce development		69	5,615.		5,615.	.01
9 Other						
10 Total		12067	199,880.	17.	199,863.	.22

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

**Section A. Bad Debt Expense**

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

**Section B. Medicare**

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

**Section C. Collection Practices**

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

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

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

**Part V Facility Information**

**Section A. Hospital Facilities**

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

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

Name, address, and primary website address

**1** ATLANTIC GENERAL HOSPITAL

9733 HEALTHWAY DRIVE

BERLIN

MD 21811

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
<b>1</b>	X	X					X			
<b>2</b>										
<b>3</b>										
<b>4</b>										
<b>5</b>										
<b>6</b>										
<b>7</b>										
<b>8</b>										
<b>9</b>										
<b>10</b>										
<b>11</b>										
<b>12</b>										

**Part V Facility Information (continued)**

**Section B. Facility Policies and Practices**

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

Name of hospital facility or facility reporting group ATLANTIC GENERAL HOSPITAL

For single facility filers only: line number of hospital facility (from Schedule H, Part V, Section A) 1

		Yes	No
<b>Community Health Needs Assessment</b> (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)			
<b>1</b>	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9 . . . . .	X	
If "Yes," indicate what the CHNA report describes (check all that apply):			
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
<b>j</b>	<input type="checkbox"/> Other (describe in Part VI)		
<b>2</b>	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>1 2</u>		
<b>3</b>	In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? 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. . . . .	X	
<b>4</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI . . . . .		X
<b>5</b>	Did the hospital facility make its CHNA report widely available to the public? . . . . .	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website		
<b>b</b>	<input checked="" type="checkbox"/> Available upon request from the hospital facility		
<b>c</b>	<input type="checkbox"/> Other (describe in Part VI)		
<b>6</b>	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):		
<b>a</b>	<input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA		
<b>b</b>	<input checked="" type="checkbox"/> Execution of the implementation strategy		
<b>c</b>	<input checked="" type="checkbox"/> Participation in the development of a community-wide plan		
<b>d</b>	<input checked="" type="checkbox"/> Participation in the execution of a community-wide plan		
<b>e</b>	<input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans		
<b>f</b>	<input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA		
<b>g</b>	<input checked="" type="checkbox"/> Prioritization of health needs in its community		
<b>h</b>	<input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
<b>i</b>	<input type="checkbox"/> Other (describe in Part VI)		
<b>7</b>	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs . . .		X
<b>8a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .		X
<b>8b</b>	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

**Part V Facility Information (continued)**

Financial Assistance Policy ATLANTIC GENERAL HOSPITAL		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? . . . . .	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care? . . . . . If "Yes," indicate the FPG family income limit for eligibility for free care: <u>2</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	X	
11	Used FPG to determine eligibility for providing <i>discounted</i> care? . . . . . If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>3</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	X	
12	Explained the basis for calculating amounts charged to patients? . . . . . If "Yes," indicate the factors used in determining such amounts (check all that apply):	X	
a	<input checked="" type="checkbox"/> Income level		
b	<input checked="" type="checkbox"/> Asset level		
c	<input checked="" type="checkbox"/> Medical indigency		
d	<input type="checkbox"/> Insurance status		
e	<input type="checkbox"/> Uninsured discount		
f	<input type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input type="checkbox"/> Other (describe in Part VI)		
13	Explained the method for applying for financial assistance? . . . . .	X	
14	Included measures to publicize the policy within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input type="checkbox"/> The policy was attached to billing invoices		
c	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Part VI)		
<b>Billing and Collections</b>			
15	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	
16	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	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		
17	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? . . . . . If "Yes," check all actions in which the hospital facility or a third party engaged:		X
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		

**Part V Facility Information (continued)** ATLANTIC GENERAL HOSPITAL

**18** Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a  Notified individuals of the financial assistance policy on admission
- b  Notified individuals of the financial assistance policy prior to discharge
- c  Notified individuals of the financial assistance policy in communications with the patients regarding the patients' bills
- d  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)

**Policy Relating to Emergency Medical Care**

**19** 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? . . . . .

	Yes	No
<b>19</b>	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)

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

**20** 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)


**21** During the tax year, did the hospital facility charge any of its FAP-eligible individuals, 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? . . . . .

<b>20</b>		X

If "Yes," explain in Part VI.

**22** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

<b>21</b>		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? 14

Name and address	Type of Facility (describe)
<b>1</b> ATLANTIC HEALTH CENTER 9714 HEALTHWAY DR BERLIN MD 21811	MEDICAL OFFICE
<b>2</b> TOWNSEND MEDICAL CENTER 1001 PHILADELPHIA AVE OCEAN CITY MD 21842	MEDICAL OFFICE
<b>3</b> OCEAN PINES MEDICAL OFFICE 11107 RACETRACK RD BERLIN MD 21811	MEDICAL OFFICE
<b>4</b> CARDIO/PULMONARY CLINIC ROUTES 346 & 50 BERLIN MD 21811	MEDICAL OFFICE
<b>5</b> ATLANTIC ENDOSCOPY CENTER 10231 OLD OCEAN CITY BLVD #205 BERLIN MD 21811	MEDICAL OFFICE
<b>6</b> DR MCWHITE'S OFFICE 10231 OLD OCEAN CITY BLVD #210 BERLIN MD 21811	MEDICAL OFFICE
<b>7</b> THE WOUND CARE CENTER 10231 OLD OCEAN CITY BLVD #104 BERLIN MD 21811	MEDICAL OFFICE
<b>8</b> MEDICAL OFFICE KIRBY 10231 OLD OCEAN CITY BLVD #208 BERLIN MD 21811	MEDICAL OFFICE
<b>9</b> POCOMOKE MEDICAL OFFICE 101-A MARKET STREET POCOMOKE MD 21851	MEDICAL OFFICE
<b>10</b> IMMEDICARE CLINIC 101 EAST DUPONT HIGHWAY MILLSBORO DE 11192	MEDICAL OFFICE

Schedule H (Form 990) 2012

**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? \_\_\_\_\_

Name and address	Type of Facility (describe)
<b>1</b> IMMEDICARE CLINIC 11011 MANKLIN CREEK RD BERLIN MD 21811	MEDICAL OFFICE
<b>2</b> SELBYVILLE MEDICAL OFFICE 38394 DUPONT HIGHWAY SELBYVILLE DE 19944	MEDICAL OFFICE
<b>3</b> MEDICAL OFFICE 10311 OLD OCEAN CITY STE 2 BERLIN MD 21801	MEDICAL OFFICE
<b>4</b> MEDICAL OFFICE 314 FRANKLIN AVE STE 103 BERLIN MD 21811	MEDICAL OFFICE
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

PART I, LINE 3C

IN ADDITION TO QUALIFYING FOR FINANCIAL ASSISTANCE BECAUSE THE PATIENT'S FAMILY INCOME FALLS BELOW THE FEDERAL POVERTY GUIDELINES THRESHOLDS (FREE CARE FOR FAMILY INCOME LESS THAN 200% OF THE FEDERAL POVERTY GUIDELINES, AND DISCOUNTED CARE FOR FAMILY INCOME LESS THAN 300% OF THE FEDERAL POVERTY GUIDELINES), A PATIENT MAY QUALIFY FOR FINANCIAL ASSISTANCE IF THAT PATIENT INCURS A FINANCIAL HARDSHIP AND HAS FAMILY INCOME UNDER 500% OF THE FEDERAL POVERTY GUIDELINES. A FINANCIAL HARDSHIP MEANS MEDICAL DEBT INCURRED BY A FAMILY OVER A TWELVE MONTH PERIOD THAT EXCEEDS 25% OF THE FAMILY'S INCOME. ONLY INCOME AND FAMILY SIZE WILL BE CONSIDERED IN APPROVING APPLICATIONS FOR FINANCIAL ASSISTANCE, UNLESS THE AMOUNT OWED IS GREATER THAN \$20,000, THE PATIENT'S TAX RETURN SHOWS A SIGNIFICANT AMOUNT OF INTEREST INCOME, OR THE PATIENT INDICATES THAT THE PATIENT HAS BEEN LIVING OFF OF THEIR SAVINGS ACCOUNT. IF ONE OF THE SCENARIOS LISTED ABOVE IS APPLICABLE, THEN THE ORGANIZATION MAY CONSIDER THE PATIENT'S LIQUID ASSETS, INCLUDING THE PATIENT'S CHECKING AND SAVINGS ACCOUNTS, STOCKS, BONDS, CD'S, MONEY MARKET OR ANY OTHER ACCOUNTS FOR THE PAST

**Part VI Supplemental Information**

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
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THREE MONTHS. HOWEVER, THE FOLLOWING ASSETS ARE ALWAYS EXCLUDED: THE FIRST \$10,000 OF MONETARY ASSETS, UP TO \$150,000 IN A PRIMARY RESIDENCE, AND CERTAIN RETIREMENT BENEFITS, SUCH AS 401K PLANS WHERE THE IRS HAS GRANTED PREFERENTIAL TAX TREATMENT. IF THE PATIENT IS ALREADY ENROLLED IN A MEANS-TESTED PROGRAM, THE PATIENT IS DEEMED ELIGIBLE FOR FREE CARE ON A PRESUMPTIVE BASIS, WITHOUT REQUIRING ANY OF THE FINANCIAL DOCUMENTS REQUIRED ON A FULL APPLICATION.

PART I, LINE 5

IT IS THE ORGANIZATION'S POLICY TO PROVIDE FINANCIAL ASSISTANCE TO ANY INDIVIDUAL THAT QUALIFIES UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY, REGARDLESS OF THE AMOUNT OF CHARITY CARE BUDGETED FOR BY THE ORGANIZATION DURING THE YEAR.

PART I, LINE 6

THE ORGANIZATION FILES A COMMUNITY BENEFIT REPORT WITH THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION ANNUALLY. THE COMMUNITY BENEFIT

**Part VI Supplemental Information**

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REPORT IS AVAILABLE TO THE PUBLIC.

PART I LINES 7A, 7B AND 7F

MARYLAND HOSPITAL ASSOCIATION UNIFIED MARYLAND HOSPITAL RESPONSES

SCHEDULE H PART I LINE 7A, 7B AND 7F 7A. CHARITY CARE AT COST AND 7F.

HEALTH PROFESSIONS EDUCATION ARE EXPLAINED IN THE FOLLOWING: MARYLAND'S

REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT

DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW

COMMISSION, (HSCRC) DETERMINES PAYMENT THROUGH A RATE SETTING PROCESS AND

ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE

SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL PAYOR

SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH

PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY

OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. 7B. UNREIMBURSED

MEDICAID IS EXPLAINED IN THE FOLLOWING: 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)

**Part VI Supplemental Information**

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 INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES  
 DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL PAYOR SYSTEM  
 INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS'  
 RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY DIRECTED  
 OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. COMMUNITY BENEFIT  
 EXPENSES ARE EQUAL TO MEDICAID REVENUES IN MARYLAND, AS SUCH, THE NET  
 EFFECT IS ZERO. THE EXCEPTION TO THIS IS THE IMPACT ON THE HOSPITAL OF  
 ITS SHARE OF THE MEDICAID ASSESSMENT. IN RECENT YEARS, THE STATE OF  
 MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING  
 HOSPITALS THROUGH THE RATE SETTING SYSTEM. DURING THE 2012 TAX YEAR, THE  
 MEDICAID PROVIDER ASSESSMENT WAS \$364,384.

PART I, LINE 7G

ATLANTIC GENERAL HOSPITAL INCURRED \$4,497,291 OF NET COMMUNITY BENEFIT  
 EXPENSE FROM UNDERTAKING SUBSIDIZED HEALTH SERVICES DURING ITS 2012 TAX  
 YEAR. OF THIS AMOUNT, \$4,151,359 WAS RELATED TO LOSSES ASSOCIATED WITH

**Part VI Supplemental Information**

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OPERATING PHYSICIAN PRACTICES RUN DIRECTLY BY ATLANTIC GENERAL HOSPITAL.

ATLANTIC GENERAL HOSPITAL HAS PUT TOGETHER THIS PHYSICIAN NETWORK,  
 DESPITE THE FINANCIAL LOSS IT CREATES FOR THE ORGANIZATION, IN ORDER TO  
 MEET AN IDENTIFIED COMMUNITY NEED. IN PARTICULAR, THERE IS A SHORTAGE OF  
 PRIMARY CARE AND SPECIALIST PHYSICIANS IN THE COMMUNITY, AND IN ORDER TO  
 HELP PROVIDE ADEQUATE PHYSICIAN COVERAGE TO ITS COMMUNITY, ATLANTIC  
 GENERAL HAS RECRUITED AND EMPLOYED PHYSICIANS TO REDUCE THE GAP. THIS  
 SHORTAGE OF PHYSICIANS IS PARTICULARLY ACUTE IN THE RURAL AREAS  
 SURROUNDING THE HOSPITAL, WHICH ATLANTIC GENERAL HOSPITAL HAS ATTEMPTED  
 TO ALLEVIATE BY LOCATING ITS PHYSICIAN OFFICES THROUGHOUT THE COMMUNITY  
 (INCLUDING IN RURAL AREAS).

PART III, LINE 4

TEXT FROM THE ORGANIZATION'S FOOTNOTE:

NET PATIENT SERVICE REVENUE AND PATIENT ACCOUNTS RECEIVABLE

**Part VI Supplemental Information**

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NET PATIENT SERVICE REVENUE IS REPORTED AT ESTIMATED NET REALIZABLE AMOUNTS FROM PATIENTS, THIRD PARTY PAYERS, AND OTHERS FOR SERVICES RENDERED. PATIENT ACCOUNTS RECEIVABLE INCLUDE HOSPITAL AND PHYSICIAN CHARGES FOR ACCOUNTS DUE FROM MEDICARE, MARYLAND MEDICAL ASSISTANCE (MEDICAID), CAREFIRST, COMMERCIAL AND MANAGED CARE INSURERS, AND SELF-PAYING PATIENTS. DEDUCTED FROM PATIENT ACCOUNTS RECEIVABLE ARE ESTIMATES OF ALLOWANCES FOR THE EXCESS OF CHARGES OVER THE PAYMENTS ON PATIENT ACCOUNTS TO BE RECEIVED FROM THIRD PARTY PAYERS AND UNCOLLECTIBLE AMOUNTS RELATED TO SELF-PAYING PATIENTS. THESE ESTIMATES ARE CALCULATED BY MANAGEMENT BASED ON HISTORICAL COLLECTION EXPERIENCE AND ANALYSIS OF FINANCIAL CLASS AND AGE OF GROUPS OF ACCOUNTS RECEIVABLE. THESE ESTIMATES OF ALLOWANCES ARE INCLUDED IN NET PATIENT SERVICE REVENUE, WHEREAS THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS IS REPORTED AS AN OPERATING EXPENSE.

THE BAD DEBT EXPENSE REPORTED ON LINE 2 WAS THE AMOUNT OF GROSS PATIENT CHARGES UNCOLLECTED FROM PATIENTS THAT DID NOT QUALIFY FOR FINANCIAL

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ASSISTANCE.

WE BELIEVE THAT A MATERIALLY SIGNIFICANT PERCENTAGE OF OUR BAD DEBT EXPENSE WOULD BE CLASSIFIED AS "CHARITY CARE" HAD THE PATIENT CREATING THE BAD DEBT EXPENSE FILED FOR FINANCIAL ASSISTANCE. HOWEVER, WE DO NOT CURRENTLY POSSESS THE CAPACITY FOR DETERMINING HOW MANY OF OUR PATIENTS WOULD HAVE BEEN ELIGIBLE FOR CHARITY CARE HAD THEY COMPLETED THE FINANCIAL ASSISTANCE APPLICATION. ANY ESTIMATE ON OUR PART WOULD BE PURELY "SPECULATIVE" AND WE COULD NOT SUPPORT IT THROUGH EMPIRICAL DATA, THEREFORE, WE HAVE CHOSEN TO LEAVE THIS NUMBER BLANK. WE HAVE NOT NOTED THE NUMBER AS BEING ZERO, SINCE WE KNOW SOME OF THE BAD DEBT EXPENSE WOULD QUALIFY AS CHARITY CARE, BUT WE HAVE LEFT THIS ANSWER BLANK BECAUSE WE FEEL AN ACCURATE ESTIMATE IS UNOBTAINABLE.

PART III, LINE 8

WE USED THE MEDICARE COST REPORT TO DETERMINE MEDICARE ALLOWABLE COSTS COMPARED TO MEDICARE TOTAL REVENUE.

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PART III, LINE 9B

THE CURRENT FINANCIAL ASSISTANCE APPLICATION PROCESS ALLOWS FOR PATIENTS TO APPLY FOR, AND RECEIVE, FINANCIAL ASSISTANCE, AT ANY POINT, POST DISCHARGE. WHEN A PATIENT IS SUBSEQUENTLY FOUND ELIGIBLE FOR FINANCIAL ASSISTANCE POST DISCHARGE, THE ORGANIZATION WILL APPLY THE APPLICABLE FINANCIAL ASSISTANCE DISCOUNT TO ALL OUTSTANDING BALANCES ON THE PATIENT'S ACCOUNT AND IMMEDIATELY CEASE TO ATTEMPT TO COLLECT ANY AMOUNTS IN EXCESS OF ANY FINANCIAL ASSISTANCE DISCOUNTED AMOUNT STILL DUE. THE HOSPITAL WILL PROVIDE A REFUND FOR AMOUNTS PAID BY A PATIENT THAT WAS SUBSEQUENTLY FOUND TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE ON THE DATE OF SERVICE, WHICH AMOUNTS WERE IN EXCESS OF THE AMOUNT DUE AFTER THE APPLICATION OF THE APPLICABLE FINANCIAL ASSISTANCE DISCOUNT, SO LONG AS THE APPLICATION FOR FINANCIAL ASSISTANCE WAS SUBMITTED BY THE PATIENT WITHIN TWO YEARS OF THE DATE OF SERVICE.

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PART V, SECTION B, LINE 3

THE HOSPITAL FACILITY TOOK INTO ACCOUNT INPUT FROM REPRESENTATIVES OF THE COMMUNITY SERVED BY THE HOSPITAL FACILITY, INCLUDING THOSE WITH SPECIAL EXPERTISE IN PUBLIC HEALTH AND REPRESENTATIVES FROM UNDERSERVED, UNINSURED OR MINORITY GROUPS. IN PARTICULAR, INFORMATION WAS GATHERED FROM PARTICIPANTS IN OUR FREE CLINICS AND SCREENINGS, CHURCH GROUPS (VARIOUS CONGREGATIONS TO WHOM WE PROVIDE SERVICES AND THROUGH THOSE REPRESENTED IN OUR FAITH BASED PARTNERSHIP), LOCAL BUSINESSES AND THROUGH OUR COMMUNITY HEALTH FAIRS. THIS PRIMARY DATA WAS COLLECTED THROUGH THE USE OF PAPER QUESTIONNAIRES PROVIDED DIRECTLY TO THE PARTICIPANTS, AS WELL AS QUESTIONNAIRES THAT COULD BE ACCESSED ON THE HOSPITAL FACILITY'S WEBSITE.

WE ALSO CONSULTED WITH NUMEROUS AGENCIES IN THE COMMUNITY WHO ARE KNOWLEDGEABLE ABOUT HEALTH NEEDS OF THE COMMUNITY, INCLUDING:

WORCESTER COUNTY HEALTH DEPARTMENT

**Part VI Supplemental Information**

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WORCESTER COUNTY PREVENTION OFFICE

WORCESTER COUNTY MENTAL/BEHAVIOR HEALTH SERVICES

MAC, INC. (MAINTAINING ACTIVE CITIZENS-YOUR AREA AGENCY OF AGING)

CAREGIVERS RESOURCE CENTER

LOCAL PARKS AND RECREATION DEPARTMENTS

TRI-COUNTY DIABETES ALLIANCE

TRI-COUNTY COMMUNITY HEALTH BOARD

COASTAL HOSPICE

WORCESTER COUNTY BOARD OF EDUCATION

WORCESTER YOUTH AND FAMILY SERVICES

PART V, SECTION B, LINE 4

PART OF THE DATA USED IN OUR COMMUNITY HEALTH NEEDS ASSESSMENT STEMS FROM THE TRI-COUNTY NEEDS ASSESSMENT UNDERTAKEN IN CONJUNCTION WITH PENINSULA REGIONAL MEDICAL CENTER IN SALISBURY AND MCCREADY HOSPITAL IN CRISFIELD.

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PART V, SECTION B, LINE 6

DURING THE HOSPITAL FACILITY'S 2012 TAX YEAR, IT BEGAN TO ADDRESS CERTAIN COMMUNITY HEALTH NEEDS IDENTIFIED IN ITS MOST RECENTLY CONDUCTED CHNA PURSUANT TO THE IMPLEMENTATION STRATEGY. BELOW IS A BRIEF DESCRIPTION OF SOME OF THE ACTIVITIES UNDERTAKEN TO MEET IDENTIFIED COMMUNITY HEALTH NEEDS:

1- TO COMBAT OBESITY IN THE COMMUNITY TO ALL AGES, THE FOLLOWING ACTIVITIES WERE UNDERTAKEN:

\* AGH IN COLLABORATION WITH THE WORCESTER COUNTY BOARD OF EDUCATION AND UNIVERSITY OF MD HEALTH LITERACY CENTER IMPLEMENTED A STRATEGY TO INTEGRATE HEALTH LITERACY STANDARDS IN THE GENERAL CURRICULUM STANDARDS AS A NEW MODEL THROUGHOUT THE COUNTY AND TO BE PRESENTED FOR ADOPTION AT THE STATE/NATIONAL LEVEL;

\* PARTICIPATION IN THE JUST WALK PROGRAM WITH WCHD THROUGH OUR

**Part VI Supplemental Information**

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ASSOCIATE WELLNESS PROGRAM;

\* PROVIDE AN ON-SITE FARMER'S MARKET THAT IS OPEN TO THE COMMUNITY

AS WELL AS ASSOCIATES;

\* THROUGH THE TCHIP HEALTH DEPARTMENT PROGRAM WE DEVELOPED A TRI-

COUNTY FARMERS MARKET BROCHURE FOR DISTRIBUTION;

\* PROVIDE HYPERTENSION AND BMI SCREENING CLINICS;

\* PROVIDE A WORKSITE WELLNESS PROGRAM FOR OUR ASSOCIATES AND HELP

OTHER LOCAL BUSINESSES BY PROVIDING SERVICES FOR THEIR PROGRAMS;

\* PROVIDE FREE NUTRITION SPEAKERS THROUGH OUR SPEAKER'S BUREAU TO AREA

BUSINESSES AND CIVIC GROUPS; AND

\* PARTNER WITH THE TRI-COUNTY DIABETES ALLIANCE TO PROVIDE DIABETES

**Part VI Supplemental Information**

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SERVICES.

2- TO PROVIDE GREATER ACCESS TO CARE IN THE COMMUNITY, THE FOLLOWING  
ACTIVITIES WERE UNDERTAKEN:

A. TO PROVIDE FREE SCREENINGS THROUGHOUT THE SERVICE AREA (DE, UPPER  
AND LOWER WORCESTER COUNTY):

\* WE PROVIDE 8 HYPERTENSION CLINICS EACH MONTH THROUGHOUT OUR  
SERVICE AREA;

\* WE PLACED TWO NEW PHYSICIANS IN THE LOWER DE AREA;

\* WE PROVIDE SCREENINGS AND EDUCATION TO THE WORKERS AT THE  
POULTRY PLANTS;

\* WE PROVIDE FREE SCREENINGS IN THE IMMEDICARE CENTERS IN LOCAL

**Part VI Supplemental Information**

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RITE AID PHARMACIES; AND

\* WE HOLD HEALTH FAIRS IN VARIOUS AREAS THROUGHOUT OUR SERVICE AREA.

B. TO ASSIST IN WORKPLACE DEVELOPMENT OF HEALTHCARE CAREERS ADDRESSING THE SHORTAGE OF PROVIDERS IN OUR SERVICE AREA:

\* WE PROVIDE MENTORING PROGRAMS TO NURSES, DIETICIANS, PHARMACY STUDENTS, RADIOLOGY STUDENTS, PHYSICIAN ASSISTANT, COMMUNITY HEALTH STUDENTS, NURSE PRACTITIONER STUDENTS, SOCIAL WORK STUDENTS. 10,000 STAFF HOURS WERE USED TO CONDUCT SUCH ACTIVITIES.

C. TARGET THE UNDERSERVED OF THE NEED FOR MAMMOGRAMS AND COLON SCREENINGS:

\* WE PROVIDE TARGETED EDUCATION AND SCREENINGS THROUGH OUR HEALTH

**Part VI Supplemental Information**

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FAIRS AND OTHER SERVICES TO THE UNDERSERVED THROUGH OUR LOCAL CHURCHES, PLACES OF BUSINESSES AND COMMUNITY EVENTS (NATIONAL NIGHT OUT, HOMELESS RESOURCE DAYS, AFFORDABLE HOUSING ASSOC., GO RED EVENT, KOMEN SYMPOSIUM, FOOD BANK DISTRIBUTION LOCATIONS, ASC EVENTS). 8,000 STAFF HOURS WERE UTILIZED TO CONDUCT SUCH ACTIVITIES.

3- TO PROVIDE EDUCATION AND AWARENESS OF MENTAL HEALTH SERVICES IN THE SERVICE AREA, THE FOLLOWING ACTIVITIES WERE UNDERTAKEN:

- \* MENTAL HEALTH SERVICES PROVIDED AT OUR ATLANTIC HEALTH SERVICES IN COLLABORATION WITH WORCESTER COUNTY HEALTH DEPARTMENT.
- \* PARTNERSHIP WITH SHEPARD PRATT TO EXTEND OUR MENTAL HEALTH SERVICES THROUGH HEALTH FAIRS AND OTHER COMMUNITY EVENTS (MENTAL HEALTH GROUP WERE AT 10 EVENTS)

**Part VI Supplemental Information**

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4- TO REDUCE PREVENTABLE HOSPITALIZATIONS UTILIZING THE PATIENT CENTERED MEDICAL HOME MODEL FOR CHRONIC DISEASES MANAGEMENT AND PREVENTION SUCH AS COPD, CHF AND DIABETES, THE FOLLOWING ACTIVITIES WERE UNDERTAKEN:

\* EDUCATION PROVIDED THROUGH THE FAITH BASED PARTNERSHIPS TO AREA CHURCHES;

\* INCREASE IN EVIDENCE BASED PROGRAMMING, INCLUDING LIVING WELL CHRONIC DISEASE SELF-MANAGEMENT, PAIN MANAGEMENT, AND STEPPING ON FALLS PREVENTION; AND

\* PROVIDING PATIENTS WITH AN IMPROVED PATIENT CENTERED MEDICAL HOME MODEL OF CARE

WITH RESPECT TO THE COMMUNITY HEALTH NEEDS IDENTIFIED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA), WE PLAN TO TRACK CERTAIN DEMOGRAPHIC AND

**Part VI Supplemental Information**

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OUTCOME DATA AND TO PROVIDE UPDATES REGARDING THE IMPACT OF OUR  
ACTIVIITES AS WE MOVE FORWARD.

PART V, SECTION B, LINE 7

THE HOSPITAL FACILITY WILL NOT ATTEMPT TO ADDRESS ALL OF THE IDENTIFIED  
NEEDS IN ITS COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). WHEN UNDERTAKING  
THE CHNA AND IMPLEMENTATION STRATEGY, THE HOSPITAL FACILITY WENT THROUGH  
A PRIORITIZATION PROCESS TO DETERMINE THOSE COMMUNITY HEALTH NEEDS THAT  
THE HOSPITAL FACILITY WOULD ATTEMPT TO ADDRESS. SOME OF THE FACTORS  
CONSIDERED WHEN PRIORITIZING THE NEEDS WERE THE SIZE AND SEVERITY OF THE  
NEED, THE HOSPITAL FACILITY'S ABILITY TO IMPACT THE NEED, THE  
AVAILABILITY OF OTHER RESOURCES AND STAKEHOLDERS IN THE COMMUNITY THAT  
ARE ALREADY ATTEMPTING TO MEET THE NEED, AND THE ABILITY FOR THE HOSPITAL  
TO EFFICIENTLY UTILIZE FINANCIAL RESOURCES TO EFFECT EACH NEED.

PURSUANT TO THE PRIORITIZATION PROCESS, THE HOSPITAL FACIITY DETERMINED

**Part VI Supplemental Information**

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THAT CERTAIN IDENTIFIED NEEDS WOULD NOT BE ADDRESSED BY THE HOSPITAL FACILITY, INCLUDING TRANSPORTATION AND DENTAL HEALTH SERVICES. WHILE TRANSPORTATION, PUBLIC OR PRIVATE, REMAINS A BARRIER IN THE RURAL COMMUNITY TO BETTER ACCESS TO HEALTH CARE, THERE ARE OTHER COMMUNITY ORGANIZATIONS BETTER ALIGNED TO ADDRESS THIS PRIORITY. FOR EXAMPLE, THERE IS THE SHORE TRANSIT SYSTEM, SHORE UP AND MEDICAL TRANSIT THROUGH AMERICAN CANCER SOCIETY AND OTHER ORGANIZATIONS THAT ADDRESS THIS NEED. IN ADDITION, DENTAL HEALTH SERVICES IS CURRENTLY ADDRESSED IN THE COMMUNITY BY THE PROGRAM AT THE COUNTY HEALTH DEPARTMENT, AS WELL AS THE FEDERAL PROGRAM THREE LOWER COUNTIES (TLC) AND BY LA RED IN SUSSEX COUNTY, DE.

PART V, LINE 18

THE HOSPITAL FACILITY OR AN AUTHORIZED THIRD PARTY DID NOT UNDERTAKE ANY OF THE COLLECTION ACTIONS NOTED IN PART V, SECTION B, LINE 16 BEFORE MAKING REASONABLE EFFORTS TO DETERMINE ANY PATIENT'S ELIGIBILITY UNDER

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THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY. IN ORDER TO HELP DETERMINE PATIENTS' ELIGIBILITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL UNDERTAKES A NUMBER OF ACTIONS, INCLUDING NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY ON ADMISSION, NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY PRIOR TO DISCHARGE, NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY IN COMMUNICATIONS WITH THE PATIENTS' BILLS, AND DOCUMENTING ITS DETERMINATION OF WHETHER PATIENTS WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY.

PART V, LINE 20

THE HOSPITAL FACILITY PROVIDES A DISCOUNT OF AT LEAST 50% OFF OF GROSS CHARGES FOR THE PROVISION OF EMERGENCY AND OTHER MEDICALLY NECESSARY CARE TO ANY INDIVIDUAL THAT IS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY. PURSUANT TO THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) ALL-PAYOR SYSTEM FOR HOSPITALS IN THE STATE OF MARYLAND, THE GREATEST DISCOUNT OFF OF GROSS CHARGES FOR THE

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PROVISION OF EMERGENCY AND OTHER MEDICALLY NECESSARY CARE PERMITTED TO ANY COMMERCIAL INSURER OR MEDICARE IS ONLY 6%. AS A RESULT, THE HOSPITAL FACILITY WAS ABLE TO DETERMINE THAT THE MAXIMUM AMOUNT CHARGED TO INDIVIDUALS THAT WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY WAS NOT GREATER THAN THE AMOUNT GENERALLY BILLED TO INDIVIDUALS WHO HAVE INSURANCE COVERING SUCH CARE.

PART V, LINE 21

THE HOSPITAL FACILITY DOES NOT CHARGE ANY INDIVIDUALS THAT IT KNOWS ARE ELIGIBLE FOR FINANCIAL ASSISTANCE AN AMOUNT EQUAL TO THE GROSS CHARGE FOR ANY SERVICE. THE HOSPITAL USES THE CHARGE MASTER RATES FOR A SERVICE AS A STARTING POINT AGAINST WHICH THE DISCOUNTS MANDATED IN THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY ARE APPLIED TO DETERMINE THE AMOUNT ACTUALLY BILLED TO PATIENTS ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY. THE HOSPITAL FACILITY WILL NOT COLLECT PAYMENT FROM ANY PATIENT ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY IN EXCESS OF

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THE REDUCED AMOUNT THAT IS ACTUALLY BILLED TO SUCH FINANCIAL ASSISTANCE  
PATIENT.

PART VI, LINE 2 NEEDS ASSESSMENT

THE ORGANIZATION ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITY IT  
SERVES THROUGH MANY DIFFERENT ACTIVITIES, STUDIES AND COLLABORATIONS WITH  
LOCAL GOVERNMENT AND NON-GOVERNMENT ORGANIZATIONS. THE HOSPITAL IS  
CURRENTLY WORKING UNDER THE STRATEGIC INITIATIVES WHICH WERE DEVELOPED  
FOR PLANNING THROUGH 2015. EACH YEAR, WITHIN THIS FRAMEWORK THE HOSPITAL  
MAKES PLANS FOR THE UPCOMING YEAR USING THE SWOT/GAP ANALYSIS MODEL.  
USING THIS MODEL THE LEADERSHIP TEAM MEETS WITH THE MEDICAL STAFF TO LOOK  
AT STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS TO PLAN FOR THE  
COMING FISCAL YEAR. THIS INFORMATION THEN GOES TO THE BOARD TO, ALONG  
WITH SENIOR LEADERSHIP, FINALIZE THE STRATEGIC INITIATIVES FOR THE COMING  
YEAR. USING THIS INFORMATION THE COMMUNITY BENEFITS COMMITTEE AND THE  
VISIONS FOR TOTAL HEALTH ADVISORY BOARD DETERMINE THE GOALS FOR THE  
COMING YEAR. THE DOCUMENTS USED BY THE HOSPITAL TO DETERMINE COMMUNITY

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NEEDS ARE: THE HEALTH ASSESSMENT PUBLICATION FROM THE HEALTH DEPARTMENT,  
 LOCAL AGENCIES AND 3 HOSPITALS, WORCESTER COUNTY LOCAL HEALTH PLAN,  
 FY2008 TRI-COUNTY ADOLESCENTS ASSOCIATION STATE OF MARYLAND CANER  
 REGISTRY LATEST CENSUS UPDATE FEEDBACK FROM AREA PHYSICIANS AND COMMUNITY  
 MEMBERS QUESTIONNAIRES AND EVALUATIONS FROM OUR COMMUNITY EVENTS NCR  
 PICKER PATIENT EVALUATIONS AND FEEDBACK HOSPITAL PERCEPTION SURVEY 2010  
 IN ADDITION, INFORMATION REGARDING COMMUNITY HEALTH NEEDS IS OBTAINED AS  
 A RESULT OF THE ORGANIZATION'S LEADERSHIP MEMBERS SITTING ON THE BOARDS  
 OF MANY COMMUNITY ORGANIZATIONS, INCLUDING: PUBLIC SAFETY NET COUNCIL  
 CHILD ADVOCACY BOARD WORCESTER COUNTY SCHOOL BOARD YMCA TRI COUNTY  
 DIABETES CHAMBERS OF COMMERCE OF TOWNS THROUGHOUT THE REGION MANY HEALTH  
 DEPARTMENT COUNCILS MHA COMMITTEES STATE HEALTH DEPARTMENT BOARDS WE  
 ALSO HAVE A "VISIONS FOR TOTAL HEALTH ADVISORY BOARD" COMPRISED OF  
 COMMUNITY PROVIDERS OF HEALTH RELATED SERVICES INCLUDING TRADITIONAL AS  
 WELL AS INTEGRATIVE HEALTH SERVICES. THROUGH THIS COMMITTEE WE CAN KEEP  
 OUR FINGER ON THE PULSE OF THE AREA IN WHICH WE SERVE. THIS COMMITTEE  
 GIVES US GREAT FEEDBACK ON SERVICES AND PROGRAMS THAT ARE NEEDED THOSE

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THAT ARE WORKING AND THOSE THAT AREN'T. IT IS THROUGH THIS COMMITTEE THAT PUTS ON A MAJOR HEALTH CONFERENCE EACH YEAR, WHICH PROVIDES HEALTH EDUCATION AS WELL AS SCREENINGS. IN THE 2010 TAX YEAR, THE COMMITTEE DECIDED TO TAKE HEALTH CONFERENCE "ON THE ROAD" AND TO HOLD IT IN DIFFERENT TOWNS IN OUR SERVICE AREA EACH YEAR. HAVING HELD IT IN THE NORTHERN END OF THE COUNTY SINCE ITS INCEPTION, IT WAS HELD IN THE SOUTHERNMOST TOWN IN THE COUNTY IN NOVEMBER 2010. WE MET WITH GREAT SUCCESS, AND ACCORDING TO THE EVALUATIONS, WERE ABLE TO PROVIDE SERVICES TO PEOPLE WHO OTHERWISE WOULD NOT HAVE GOTTEN THEM. THE ORGANIZATION'S AUXILIARY VOLUNTEERS ARE ANOTHER GREAT RESOURCE FOR DETERMINING COMMUNITY HEALTH NEEDS. THE ORGANIZATION HAS OVER 400 AUXILIANS. THEY ARE ACTIVE ON MANY COMMITTEES WITHIN THE HOSPITAL AND ALSO REPRESENT THE HOSPITAL ON DIFFERENT COMMUNITY BOARDS. IN ADDITION, THE ORGANIZATION WORKS VERY CLOSELY WITH ITS LOCAL HEALTH DEPARTMENT TO PLAN SERVICES TO MEET COMMUNITY NEEDS AND DECREASE THE DUPLICATION OF SERVICES IN THE COMMUNITY. MEMBERS OF THE HOSPITAL STAFF SIT ON MANY COMMITTEES AND BOARDS OF THE LOCAL HEALTH DEPARTMENT.

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PART VI, LINE 3 PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

WE INFORM INDIVIDUALS IN THE COMMUNITY ABOUT THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY IN A NUMBER OF WAYS. FIRST, THERE IS SIGNAGE THROUGHOUT THE HOSPITAL, AS WELL AS BROCHURES IN ALL WAITING AREAS, EXPLAINING THAT THE ORGANIZATION PROVIDES FINANCIAL ASSISTANCE. IN ADDITION, ARTICLES ARE PUBLISHED IN NEWSLETTERS THAT ARE DISTRIBUTED TO THE HOMES OF ALL RESIDENTS IN THE COMMUNITY NOTING THE EXISTENCE OF THE ORGANIZATION'S FINANCIAL ASSISTANCE PROGRAM. HOSPITAL STAFF IS EDUCATED TO ANSWER QUESTIONS RELATED TO APPLYING FOR FINANCIAL ASSISTANCE, AND HOSPITAL SUPPORT SERVICES HELPS PATIENTS APPLY FOR MEDICAL ASSISTANCE (SUCH AS MEDICAID). FURTHERMORE, HOSPITAL FINANCIAL COUNSELORS HELP GUIDE PATIENTS TO FINANCIAL AID SERVICES THEY MAY QUALIFY FOR. ALL INPATIENTS ARE PROVIDED WITH A FINANCIAL ASSISTANCE APPLICATION IN THEIR DISCHARGE PACKAGE. IN ADDITION, DURING THE REGISTRATION PROCESS, IF THE PATIENT DOES NOT HAVE INSURANCE THE REGISTRAR OR FINANCIAL COUNSELOR WILL ASK IF THEY ARE INTERESTED IN APPLYING FOR FINANCIAL ASSISTANCE AND HELP WITH FILLING OUT THE APPLICATION. ANY PATIENT WHO SEEKS FINANCIAL OR MEDICAL

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ASSISTANCE WILL READILY FIND INFORMATION AND HOSPITAL STAFF TO HELP WITH THE PROCESS.

PART VI, LINE 4 COMMUNITY INFORMATION

ATLANTIC GENERAL IS LOCATED IN WORCESTER COUNTY, WHICH IS THE EASTERNMOST COUNTY LOCATED IN THE U.S. STATE OF MARYLAND. WORCESTER COUNTY COMPRISES ATLANTIC GENERAL'S PRIMARY SERVICE AREA. WORCESTER COUNTY CONTAINS THE ENTIRE LENGTH OF THE STATE'S ATLANTIC COAST LINE. IT IS HOME TO THE POPULAR VACATION RESORT AREA OF OCEAN CITY. THE COUNTY IS APPROXIMATELY 60 MILES LONG. ACCORDING TO THE U.S. CENSUS BUREAU, THE COUNTY HAS A TOTAL AREA OF 695 SQUARE MILES OF WHICH, 473 SQUARE MILES OF IT IS LAND AND 221 SQUARE MILES OF IT IS WATER. ATLANTIC GENERAL IS LOCATED IN A NON-URBAN AREA OF WORCESTER COUNTY, 10 MILES FROM THE ATLANTIC OCEAN. THE 2010 CENSUS SHOWED A POPULATION OF THE COUNTY OF 51,454. THE LARGEST CONCENTRATION OF THE POPULATION IS IN THE NORTHERN PART OF THE COUNTY, WHICH IS WHERE THE OCEAN CITY RESORT AREA IS LOCATED, AS WELL AS THE BERLIN/OCEAN PINES AREA. THE AREA IS A MECCA FOR RETIREES WHO LIVE HERE

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FULL TIME OR DIVIDE THEIR TIME BETWEEN MARYLAND AND FLORIDA. MEDIAN HOUSEHOLD INCOME OF RESIDENTS OF WORCESTER COUNTY IN 2008 WAS \$50,347 (BELOW THE STATEWIDE AVERAGE OF \$70,482). THE PERCENTAGE OF RESIDENTS BELOW THE POVERTY LEVEL IS 10.5% COMPARED TO A 8.2% STATEWIDE. THE AVERAGE AGE OF THE RESIDENTS IS BROKEN DOWN AS FOLLOWS: 5 > 5%, 18 > 18.8%, 65 < 23%. 51.6% OF THE POPULATION IS FEMALE, 14.8% OF THE POPULATION IS BLACK AND 83% OF THE POPULATION IS WHITE. 51% OF THE PATIENTS CARED FOR AT THE HOSPITAL ARE MEDICARE PATIENTS. THE REMAINING PAYOR MIX IS THE FOLLOWING: MEDICAID 6%, COMMERCIAL AND HMO'S 23%, CARE FIRST 13%, AND SELF PAY AND OTHERS 7%. IN THE WORCESTER COUNTY HEALTH DEPARTMENT REPORT FROM 2005, THE AGE-ADJUSTED MORTALITY RATE IS 800/100,000 AND FOR THE OVER 64 YEARS OF AGE POPULATION IT WAS 4,000/100,000. INFORMATION FROM THE SAME REPORT SHOWED THE TOP THREE LEADING CAUSES OF DEATH IN THE COUNTY WERE: #1 CANCER, #2 CARDIOVASCULAR DISEASES, #3 ACCIDENTS. DURING THE SUMMER MONTHS, THE ORGANIZATION PROVIDES A SIGNIFICANT AMOUNT OF HEALTH CARE SERVICES (PREDOMINANTLY EMERGENCY CARE) TO TOURISTS VISITING THE OCEAN RESORT OF OCEAN CITY, MD. THIS IS RELATED TO THE FACT THAT THE

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POPULATION OF OCEAN CITY INCREASES BY ABOUT 100,000 EACH YEAR DURING THE  
TOURIST SEASON.

PART VI, LINE 5 PROMOTION OF COMMUNITY HEALTH

THE ORGANIZATION'S GOVERNING BODY IS COMPOSED PRIMARILY OF INDEPENDENT MEMBERS FROM THE ORGANIZATION'S COMMUNITY. IN ADDITION, THE ORGANIZATION'S MEDICAL STAFF IS OPEN TO ALL QUALIFIED PHYSICIANS IN THE COMMUNITY. ALL FINANCIAL SURPLUSES EARNED BY THE ORGANIZATION ARE USED TO ENHANCE THE ORGANIZATION'S PATIENT SERVICES, INCLUDING THROUGH THE UNDERTAKING OF VARIOUS COMMUNITY BENEFIT ACTIVITIES. THE ORGANIZATION UNDERTAKES NUMEROUS ACTIVITIES TO PROMOTE THE HEALTH OF ITS COMMUNITY. IN PARTICULAR, THE ORGANIZATION HAS IDENTIFIED A COMMUNITY NEED FOR ACCESS TO ADDITIONAL PHYSICIANS LOCATED IN THE COMMUNITY. IN ORDER TO MEET THIS IDENTIFIED COMMUNITY NEED, THE ORGANIZATION HAS DIRECTLY EMPLOYED NUMEROUS PHYSICIANS AT A SUBSTANTIAL COST TO THE ORGANIZATION.

IN ADDITION, THE ORGANIZATION UNDERTAKES COMMUNITY BUILDING ACTIVITIES TO

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PROMOTE THE PROGRAMS THE ORGANIZATION OFFERS AND ASSURE THEY ARE REACHING THE TARGETED AUDIENCE. EXAMPLES OF THESE SPECIFIC ACTIVITIES WOULD BE THE SMALL NEIGHBORHOOD-TYPE HEALTH FAIRS IN WHICH WE ARE INVOLVED, AT WHICH EVENTS YOUNG PEOPLE ARE TARGETED AND NEEDS THAT ARE FILLED THROUGH OUR SPEAKERS BUREAU.

OTHER INVOLVEMENT IN COMMUNITY BUILDING ACTIVITIES INCLUDE: OUR PARTICIPATION IN THE LOCAL HABITAT FOR HUMANITY. THROUGH THIS GROUP OUR STAFF HAS LOGGED MANY HOURS OF SERVICE TO BUILD HOUSES FOR 3 LOCAL FAMILIES. SCHOOL MENTORING PROGRAMS IS ANOTHER COMMUNITY BUILDING ACTIVITY IN WHICH OUR STAFF IS VERY ACTIVE. WE HAVE STUDENTS FROM OUR LOCAL HIGH SCHOOL WHO DO A SHADOWING PROGRAM THROUGHOUT ALL DEPARTMENTS OF OUR HOSPITAL. THIS HELPS THEM IN MAKING A CAREER CHOICE THROUGH EXPOSURE TO DIFFERENT JOBS IN THE HEALTH CARE ARENA.

WE HAVE STAFF WHO REPRESENT THE HOSPITAL ON MANY CIVIC BOARDS SUCH AS ALL THE LOCAL AREA CHAMBERS, VARIOUS CIVIC GROUPS SUCH AS LIONS CLUB AND

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ROTARY, YMCA AND THE LOCAL COUNTY SCHOOL BOARD. WE ALSO PARTICIPATE IN  
THE ACS RELAY FOR LIFE, MARCH OF DIMES WALK FOR BABIES.

WE PROVIDE EMS TRAINING FOR THE LOCAL FIRE COMPANIES, MOST OF WHOM ARE  
VOLUNTEER STAFFED. WE OFFER AN EXCHANGE PROGRAM OF EQUIPMENT WHICH HELPS  
THEM WITH TRANSPORTS TO THE EMERGENCY DEPARTMENT.

AGH WORKS WITH THE LOCAL FAITH BASED COMMUNITIES BY PROVIDING EDUCATION  
AND SERVICES TO THEIR CONGREGATIONS. WE HAVE A FAITH BASED MEDICAL HOME  
GROUP WHICH MEETS WITH CLERGY AND LAY HEALTH AMBASSADORS FROM THEIR  
HOUSES OF WORSHIP TO FUNNEL THE MESSAGE OF HEALTH AND WELLNESS TO THEIR  
PEOPLE.

ONE OF OUR BUILDINGS ON CAMPUS HOUSES OUR COUNTY CHILD ADVOCACY CENTER.  
THROUGH THIS STATE OF THE ART FACILITY THE VICTIM HAS TO TELL THEIR STORY  
ONLY ONCE TO ONE PERSON WHILE ALL THE OTHERS WHO NEED TO SEE AND HEAR THE  
TESTIMONY CAN WATCH THROUGH A CLOSED CIRCUIT SYSTEM.

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ALSO PART OF OUR COMMUNITY BUILDING PROGRAM INCLUDES OUR PARTICIPATION IN DISASTER PREPAREDNESS. BECAUSE WE ARE GEOGRAPHICALLY LOCATED IN AN AREA OF EXTREME POTENTIAL DISASTER, ONLY 6 MILES FROM THE ATLANTIC OCEAN, WE WOULD BE THE SOURCE OF CARE AND PROTECTION FOR MANY IN THE AREA SHOULD A MAJOR HURRICANE HIT OUR AREA OF COASTLINE. PART OF THE HOSPITAL'S PROVISION FOR THE COMMUNITY IN SUCH A DISASTER WOULD BE TO PROVIDE CLEAN DRINKING WATER FOR THEM; THROUGH THE NEW WATER PURIFICATION SYSTEM WHICH WE RECENTLY PURCHASED AND INSTALLED WE HAVE THE ABILITY TO PROVIDE CLEAN WATER FOR NOT JUST OUR PATIENTS AND STAFF BUT FOR THE COMMUNITY AT LARGE.

WE ALSO WORK CLOSELY WITH OUR LOCAL PUBLIC AND PRIVATE SCHOOLS TO OFFER EDUCATION PROGRAMMING. EACH YEAR WE HOST OVER 500 KINDERGARTEN STUDENTS FOR OUR HOSPITAL TOURS. THIS SERVES TO INTRODUCE THEM TO THE SERVICES OF THE HOSPITAL IN HOPES THAT THEIR TRIP FOR SERVICES WILL NOT BE A FRIGHTENING. FOR THE PAST SEVERAL YEARS WE HAVE SPONSORED A MAJOR ASSEMBLY PROGRAM WHICH FIGHTS CHILDHOOD OBESITY INTO THE ELEMENTARY

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SCHOOLS. MANY OF OUR ASSOCIATES SERVE ON VARIOUS BOARDS OF THE SCHOOL SYSTEM OFFERING OUR EXPERTISE. THROUGH OUR SPEAKER'S BUREAU WE SEND SPEAKERS INTO MANY CLASSROOMS FOR INSTRUCTION.

SOME ADDITIONAL SERVICES WHICH THE HOSPITAL PROVIDES FOR FREE TO THE COMMUNITY, WHICH PROMOTE HEALTH INCLUDE:

1. LIVING WELL PROGRAM - THIS CHRONIC DISEASE SELF MANAGEMENT PROGRAM FROM STANFORD UNIVERSITY TEACHES PEOPLE HOW TO LIVE A BETTER LIFE IN THE MIDST OF THE LIMITATIONS CAUSED BY THEIR CHRONIC CONDITIONS.
2. HYPERTENSION CLINICS - BLOOD PRESSURE SCREENINGS IN LOCAL PHARMACIES MONTHLY AS WELL AS AT MANY OTHER MEETINGS AND CONVENTIONS IN THE AREA. THESE HELP RESIDENTS MONITOR THEIR BLOOD PRESSURE AND RELIEVE SOME OVERCROWDING IN PHYSICIAN OFFICES. THIS ALLOWS US THE OPPORTUNITY TO PROVIDE ONE-ON-ONE TEACHING TO INDIVIDUALS.

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- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

3. HEALTHFAIRS - THE HOSPITAL IS INVOLVED IN SEVERAL LARGE AND SMALL HEALTHFAIR EVENTS IN VARIOUS LOCATIONS THROUGHOUT THE YEAR. ONE SUCH EVENT IS A PARTNERSHIP WITH AARP TO OFFER A FAIR WITH MANY SCREENINGS AND HEALTH INFORMATION. WE ALSO SPONSOR AN EDUCATIONAL AND SCREENING CONFERENCE ONCE A YEAR CALLED OUR VISIONS FOR TOTAL HEALTH CONFERENCE. THIS IS HELD IN VARIOUS LOCATIONS WITHIN OUR SERVICE AREA WHICH ALLOWS US TO PROVIDE FREE SERVICES TO THOSE WHO MIGHT NOT OTHERWISE BE ABLE TO ACCESS HEALTH CARE. WE ALSO PARTNER WITH MANY CHURCHES AND COMMUNITY GROUPS TO OFFER SMALL HEALTH FAIRS.

4. WE PROVIDE EDUCATION IN WRITTEN FORM THROUGH LOCAL PUBLICATIONS (NEWSPAPERS AND MAGAZINES) AND OUR OWN ON CALL QUARTERLY PUBLICATION. MANY OF OUR PHYSICIANS PROVIDE ARTICLES FOR THESE.

5. WE ALSO HAVE A SPEAKER'S BUREAU WHICH PROVIDES EDUCATIONAL PRESENTATIONS FOR AREA CIVIC GROUPS, BUSINESSES, CHURCHES, SCHOOLS AND CONVENTIONS WHICH ARE HELD IN OUR RESORT AREA.

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

6. WE PROVIDE EDUCATION FOR THE LOCAL SCHOOLS THROUGH OUR HOSPITAL TOUR PROGRAM AND SPONSORSHIP OF FOOD PLAY PRODUCTIONS. THESE PROGRAMS ALLOW US TO SPREAD THE HEALTH MESSAGE AGAINST CHILDHOOD OBESITY TO THE YOUNGER GENERATION.

7. BEING IN A BEACH RESORT COMMUNITY THERE ARE MANY SPORTING EVENTS WHICH OCCUR LOCALLY. WE PARTICIPATE IN MANY OF THESE BY PROVIDING FIRST AID ON SITE FOR THOSE IN ATTENDANCE AND THOSE PARTICIPATING IN THE ACTIVITY.

PART VI, LINE 6 AFFILIATED HEALTH CARE SYSTEM  
 IN ADDITION TO OPERATING AN ACUTE CARE HOSPITAL THAT PROVIDES A 24 HOUR ER. ATLANTIC GENERAL HOSPITAL EMPLOYS A NETWORK OF PRIMARY CARE AND SPECIALIST PHYSICIANS THAT PROVIDE NEEDED HEALTH CARE SERVICES THROUGHOUT ATLANTIC GENERAL'S COMMUNITY, INCLUDING SERVING SOME OF THE HOSPITAL'S MORE RURAL AREAS. BECAUSE OF THE RURAL NATURE OF THE COMMUNITIES THE HOSPITAL SERVES, TRANSPORTATION FOR HEALTHCARE CAN BE

**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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
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- 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

CHALLENGING. BY LOCATING THESE EMPLOYED PHYSICIANS' OFFICES THROUGHOUT THE HOSPITAL'S SERVICE REGION, THE HOSPITAL IS ABLE TO HELP IMPROVE ACCESS TO PHYSICIANS' SERVICES FOR MEMBERS OF THE COMMUNITY. AGH'S EMPLOYED PHYSICIANS PROVIDED \$ OF CHARITY CARE AT GROSS CHARGES DURING THE 2012 TAX YEAR.

IN ADDITION, THE HOSPITAL RUNS ATLANTIC HEALTH CLINIC, WHICH IS A FACILITY THAT OFFERS CARE ON A SLIDING FEE COST BASIS.

**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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 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.
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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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

STATE FILING OF COMMUNITY BENEFIT REPORT

MD,

**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

**2012**

**Open to Public Inspection**

Name of the organization

ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

**Part I Questions Regarding Compensation**

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

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

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

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

**3** Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

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

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

- a** Receive a severance payment or change-of-control payment? **4a**  Yes  No
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b**  Yes  No
- c** Participate in, or receive payment from, an equity-based compensation arrangement? **4c**  Yes  No
- 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**  Yes  No
- b** Any related organization? **5b**  Yes  No
- 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**  Yes  No
- b** Any related organization? **6b**  Yes  No
- 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**  Yes  No

**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**  Yes  No

**9** If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? **9**  Yes  No

	Yes	No
<b>1b</b>		
<b>2</b>		
<b>4a</b>		<input checked="" type="checkbox"/>
<b>4b</b>		<input checked="" type="checkbox"/>
<b>4c</b>		<input checked="" type="checkbox"/>
<b>5a</b>		<input checked="" type="checkbox"/>
<b>5b</b>		<input checked="" type="checkbox"/>
<b>6a</b>		<input checked="" type="checkbox"/>
<b>6b</b>		<input checked="" type="checkbox"/>
<b>7</b>		<input checked="" type="checkbox"/>
<b>8</b>		<input checked="" type="checkbox"/>
<b>9</b>		<input checked="" type="checkbox"/>

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

Schedule J (Form 990) 2012

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 MICHAEL FRANKLIN PRESIDENT & CEO	(i)	348,934.	64,189.	18,143.	6,250.	0	437,516.	0
	(ii)	0	0	0	0	0	0	0
2 CHERYL NOTTINGHAM CFO	(i)	180,454.	15,848.	138.	4,668.	0	201,108.	0
	(ii)	0	0	0	0	0	0	0
3 CHARLES KIM PHYSICIAN	(i)	372,227.	4,104.	17,090.	6,250.	0	399,671.	0
	(ii)	0	0	0	0	0	0	0
4 JEFFREY FERNLEY PHYSICIAN	(i)	344,620.	8,342.	17,090.	6,250.	0	376,302.	0
	(ii)	0	0	0	0	0	0	0
5 JAMES SKOLKA PHYSICIAN	(i)	359,087.	2,337.	22,638.	6,250.	0	390,312.	0
	(ii)	0	0	0	0	0	0	0
6 SCOTT KNOWLTON PHYSICIAN	(i)	393,410.	4,746.	54.	6,250.	0	404,460.	0
	(ii)	0	0	0	0	0	0	0
7 COLLEEN WAREING VP PATIENT CARE	(i)	142,710.	5,526.	258.	3,572.	0	152,066.	0
	(ii)	0	0	0	0	0	0	0
8 JAMES BRANNON VP PROFESSIONAL SERVICES	(i)	146,666.	11,999.	60.	3,730.	0	162,455.	0
	(ii)	0	0	0	0	0	0	0
9 MICHAEL STIVELMAN PHYSICIAN	(i)	378,265.	4,090.	258.	6,250.	0	388,863.	0
	(ii)	0	0	0	0	0	0	0
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

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**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.

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**SCHEDULE K  
(Form 990)**

**Supplemental Information on Tax-Exempt Bonds**

OMB No. 1545-0047

**2012**

**Open to Public  
Inspection**

▶ **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.**

Department of the Treasury  
Internal Revenue Service

Name of the organization

ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

**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
<b>A</b> MAYOR AND COUNCIL OF BERLIN, MD			06/29/2010	2,200,000.	2010 A REVENUE BOND CANCER CENTER,		X		X		X
<b>B</b> MAYOR AND COUNCIL OF BERLIN, MD			12/13/2010	10,000,000.	2010 SERIES B&C REV BOND CANCER CT		X		X		X
<b>C</b>											
<b>D</b>											

**Part II Proceeds**

	A		B		C		D	
<b>1</b> Amount of bonds retired . . . . .	427,778.		1,551,546.					
<b>2</b> Amount of bonds legally defeased . . . . .								
<b>3</b> Total proceeds of issue . . . . .	2,200,000.		10,000,867.					
<b>4</b> Gross proceeds in reserve funds . . . . .								
<b>5</b> Capitalized interest from proceeds . . . . .								
<b>6</b> Proceeds in refunding escrows . . . . .								
<b>7</b> Issuance costs from proceeds . . . . .	44,000.		59,584.					
<b>8</b> Credit enhancement from proceeds . . . . .								
<b>9</b> Working capital expenditures from proceeds . . . . .								
<b>10</b> Capital expenditures from proceeds . . . . .	2,156,000.		9,518,440.					
<b>11</b> Other spent proceeds . . . . .			422,843.					
<b>12</b> Other unspent proceeds . . . . .								
<b>13</b> Year of substantial completion . . . . .	2012		2012					
	Yes	No	Yes	No	Yes	No	Yes	No
<b>14</b> Were the bonds issued as part of a current refunding issue? . . . . .		X		X				
<b>15</b> Were the bonds issued as part of an advance refunding issue? . . . . .		X		X				
<b>16</b> Has the final allocation of proceeds been made? . . . . .	X		X					
<b>17</b> Does the organization maintain adequate books and records to support the final allocation of proceeds? . . . . .	X		X					

**Part III Private Business Use**

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

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

Schedule K (Form 990) 2012

**Part III Private Business Use (Continued)**

TAX EXEMPT BONDS

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .		X		X				
<b>b</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? . . . . .								
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? . . . . .		X		X				
<b>d</b> 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? . . . . .								
<b>4</b> 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 . . . . . ▶		%		%		%		%
<b>5</b> 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 . . . . . ▶		%		%		%		%
<b>6</b> Total of lines 4 and 5 . . . . .		%		%		%		%
<b>7</b> Does the bond issue meet the private security or payment test? . . . . .		X		X				
<b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? . . . . .		X		X				
<b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . . . . .		%		%		%		%
<b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? . . . . .								
<b>9</b> Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? . . . . .	X		X					

**Part IV Arbitrage**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b> Has the issuer filed Form 8038-T? . . . . .		X		X				
<b>2</b> If "No" to line 1, did the following apply? . . . . .								
<b>a</b> Rebate not due yet? . . . . .	X		X					
<b>b</b> Exception to rebate? . . . . .		X		X				
<b>c</b> No rebate due? . . . . .		X		X				
If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed . . . . .								
<b>3</b> Is the bond issue a variable rate issue? . . . . .		X	X					
<b>4a</b> Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? . . . . .		X		X				
<b>b</b> Name of provider . . . . .								
<b>c</b> Term of hedge . . . . .								
<b>d</b> Was the hedge superintegrated? . . . . .								
<b>e</b> Was the hedge terminated? . . . . .								



**Part VI** **Supplemental Information.** Complete this part to provide additional information for responses to questions on Schedule K (see instructions) *(Continued)*

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

Department of the Treasury  
Internal Revenue Service

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

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

OMB No. 1545-0047

**2012**

**Open to Public  
Inspection**

Name of the organization

ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

PROCESS OF REVIEWING RETURN

PART VI LINE 11B

THE DIRECTOR OF FINANCE COMPILES THE NECESSARY INFORMATION FROM THE ORGANIZATION'S ACCOUNTING RECORDS, INFORMATION RECEIVED FROM THE FOUNDATION, AND INFORMATION RECEIVED FROM THE PATIENT BILLING OFFICE. THE COMPILED INFORMATION IS THEN SENT TO THE ORGANIZATION'S OUTSIDE TAX ACCOUNTANTS TO HELP PREPARE THE FORM 990. A DRAFT OF THE FORM 990 IS THEN REVIEWED BY THE DIRECTOR OF FINANCE, THE CFO, AND THE CEO OF THE ORGANIZATION AND ANY COMMENTS ARE REFLECTED IN A FURTHER REVISED DRAFT. PRIOR TO FILING THE FORM 990, THE LATEST VERSION OF THE FORM 990 IS MADE AVAILABLE TO ALL MEMBERS OF THE BOARD FOR THEIR REVIEW AND COMMENTS.

MONITORING AND ENFORCING CONFLICTS OF INTEREST

PART VI, LINE 12C

IT IS THE POLICY OF ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM THAT MEMBERS OF THE BOARD OF DIRECTORS, THE HOSPITAL PRESIDENT, AND THE SENIOR LEADERSHIP STAFF WILL BE REQUIRED TO SIGN AN ANNUAL CONFLICT OF INTEREST STATEMENT AND TO ADHERE TO THE CONFLICT OF INTEREST POLICY. THIS WILL BE SIGNED ANNUALLY IN OCTOBER. ALL CANDIDATES FOR BOARD MEMBERSHIP MUST BE ADVISED OF THIS POLICY PRIOR TO THEIR ELECTION TO THE BOARD.

DETERMINATION OF COMPENSATION

PART VI, LINE 15

THE ORGANIZATION UTILIZES A COMPENSATION COMMITTEE, A WRITTEN EMPLOYMENT

Name of the organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
---	--

CONTRACT, A COMPENSTION SURVEY OR STUDY AND AN APPROVAL BY THE BOARD OR  
COMPENSATION COMMITTEE.

## DOCUMENT AVAILABILITY

PART VI, LINE 19

THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST  
POLICY AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.

## RECONCILIATION OF NET ASSETS

PART XI, LINE 5

CHANGE IN SWAP FAIR VALUE                      \$259,827

ATTACHMENT 1990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
WAVELENGTH INFORMATION SYSTEMS PO BOX 739 BERLIN, MD 21811	IT SERVICES	1,553,365.
GENESIS ELDERCARE REHABILITATION SERVICE PO BOX 7247-6524 PHILADELPHIA, PA 13170-6524	PT, OT & ST SERVICES	459,649.
GGI BUILDERS INC PO BOX 282 SALISBURY, MD 21803	CONSTRUCTION	833,928.
HORIZON CSA LLC 265 PIT ROAD MOORESVILLE, NC 28115	MEDICAL SERVICES	589,154.
ATS, INC. 2040 SHIPLEY DRIVE SALISBURY, MD 21801	IT AND COMMUNICATION	455,364.

Name of the organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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ATTACHMENT 2FORM 990, PART VIII - INVESTMENT INCOME

<u>DESCRIPTION</u>	(A) <u>TOTAL REVENUE</u>	(B) <u>RELATED OR EXEMPT REVENUE</u>	(C) <u>UNRELATED BUSINESS REV.</u>	(D) <u>EXCLUDED REVENUE</u>
INTEREST INCOME	272,314.			272,314.
TOTALS	<u>272,314.</u>			<u>272,314.</u>

ATTACHMENT 3FORM 990, PART VIII - EXCLUDED CONTRIBUTIONS

<u>DESCRIPTION</u>	<u>AMOUNT</u>
GOLF TOURNAMENT	93,366.
PENGUIN SWIM	61,349.
HOSPITAL ANNIVERSARY CELEBRATE	110,295.
TOTAL	<u>265,010.</u>

ATTACHMENT 4FORM 990, PART VIII - FUNDRAISING EVENTS

<u>DESCRIPTION</u>	<u>GROSS INCOME</u>	<u>DIRECT EXPENSES</u>	<u>NET INCOME</u>
GOLF TOURNAMENT	15,983.	18,202.	-2,219.
PENGUIN SWIM	18,585.	16,300.	2,285.
HOSPITAL ANNIVERSARY CELEBRATE	11,105.	28,936.	-17,831.
TOTALS	<u>45,673.</u>	<u>63,438.</u>	<u>-17,765.</u>

Name of the organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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ATTACHMENT 5FORM 990, PART VIII - GROSS SALES AND COST OF GOODS SOLD

GROSS SALES LESS RETURNS AND ALLOWANCES .....	241,784.
INVENTORY AT BEGINNING OF YEAR .....	
PURCHASES .....	83,299.
SALARIES AND WAGES .....	
OTHER COSTS .....	
SUBTOTAL .....	<u>83,299.</u>
MINUS ENDING INVENTORY .....	
COST OF GOODS SOLD .....	<u>83,299.</u>

ATTACHMENT 6FORM 990, PART X - PREPAID EXPENSES AND DEFERRED CHARGES

<u>DESCRIPTION</u>	<u>ENDING BOOK VALUE</u>
PREPAID EXPENSES	2,098,294.
TOTALS	<u>2,098,294.</u>

ATTACHMENT 7FORM 990, PART X - INVESTMENTS - PUBLICLY TRADED SECURITIES

<u>DESCRIPTION</u>	<u>ENDING BOOK VALUE</u>	<u>COST OR FMV</u>
EQUITY SECURITIES	4,902,501.	FMV
TREASURY SECURITIES	29,777.	FMV
TOTALS	<u>4,932,278.</u>	



Name of the organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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ATTACHMENT 8 (CONT'D)

LENDER: M&T BANK  
 ORIGINAL AMOUNT: 5,172,000.  
 MATURITY DATE: 04/09/2013

BEGINNING BALANCE DUE .....	4,310,000.
ENDING BALANCE DUE .....	<u>4,137,528.</u>

LENDER: GMAC  
 ORIGINAL AMOUNT: 32,325.  
 INTEREST RATE:  
 MATURITY DATE: 11/13/2012  
 REPAYMENT TERMS: 36 MONTHLY INSTALLMENTS AND ONE FINAL PYMT

BEGINNING BALANCE DUE .....	4,490.
ENDING BALANCE DUE .....	_____

TOTAL BEGINNING MORTGAGES AND OTHER NOTES PAYABLE	<u>4,724,056.</u>
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TOTAL ENDING MORTGAGES AND OTHER NOTES PAYABLE	<u>4,245,687.</u>
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**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2012**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

▶ **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.**

Name of the organization

ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) ATLANTIC IMMEDICARE LLC 20-5095845 9733 HEALTHWAY DRIVE BERLIN, MD 21811	HEALTHCARE	MD	449,815.	488,423.	AGH
(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	No
(1) -----							
(2) -----							
(3) -----							
(4) -----							
(5) -----							
(6) -----							
(7) -----							

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

Schedule R (Form 990) 2012

**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?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) -----												
(2) -----												
(3) -----												
(4) -----												
(5) -----												
(6) -----												
(7) -----												

**Part IV Identification of Related Organizations Taxable as a Corporation or Trust** (Complete if the organization answered "Yes" 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	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) -----									
(2) -----									
(3) -----									
(4) -----									
(5) -----									
(6) -----									
(7) -----									

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

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

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

**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-s)	(c) Amount involved	(d) Method of determining amount involved
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

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

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

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

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**Part VII** **Supplemental Information**

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

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SUPPLEMENT TO RENT AND ROYALTY SCHEDULE

OTHER DEDUCTIONS

MORTGAGE INTEREST PAID TO FINANCIAL INSTITUTIONS

210,212.

DEPRECIATION

30,486.

240,698.

RENT AND ROYALTY SUMMARY

<u>PROPERTY</u>	<u>TOTAL INCOME</u>	<u>DEPLETION/ DEPRECIATION</u>	<u>OTHER EXPENSES</u>	<u>ALLOWABLE NET INCOME</u>
RENTAL PROPERTY-MOB	111,144.		240,698.	-129,554.
TOTALS	<u>111,144.</u>		<u>240,698.</u>	<u>-129,554.</u>

**SCHEDULE D  
(Form 1041)**

Department of the Treasury  
Internal Revenue Service

**Capital Gains and Losses**

▶ Attach to Form 1041, Form 5227, or Form 990-T.  
▶ Information about Schedule D (Form 1041) and its separate instructions is at  
[www.irs.gov/form1041](http://www.irs.gov/form1041).

OMB No. 1545-0092

**2012**

Name of estate or trust <b>ATLANTIC GENERAL HOSPITAL</b>	Employer identification number <b>52-1656507</b>
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**Note:** Form 5227 filers need to complete *only* Parts I and II.

**Part I Short-Term Capital Gains and Losses - Assets Held One Year or Less**

(a) Description of property (Example: 100 shares 7% preferred of "Z" Co.)	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Sales price	(e) Cost or other basis (see instructions)	(f) Gain or (loss) for the entire year Subtract (e) from (d)
<b>1a</b>					

<b>b</b> Enter the short-term gain or (loss), if any, from Schedule D-1, line 1b . . . . .	<b>1b</b>	
<b>2</b> Short-term capital gain or (loss) from Forms 4684, 6252, 6781, and 8824 . . . . .	<b>2</b>	
<b>3</b> Net short-term gain or (loss) from partnerships, S corporations, and other estates or trusts . . . . .	<b>3</b>	
<b>4</b> Short-term capital loss carryover. Enter the amount, if any, from line 9 of the 2011 Capital Loss Carryover Worksheet . . . . .	<b>4</b>	( )
<b>5</b> <b>Net short-term gain or (loss).</b> Combine lines 1a through 4 in column (f). Enter here and on line 13, column (3) on the back . . . . . ▶	<b>5</b>	

**Part II Long-Term Capital Gains and Losses - Assets Held More Than One Year**

(a) Description of property (Example: 100 shares 7% preferred of "Z" Co.)	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Sales price	(e) Cost or other basis (see instructions)	(f) Gain or (loss) for the entire year Subtract (e) from (d)
<b>6a</b>					

<b>b</b> Enter the long-term gain or (loss), if any, from Schedule D-1, line 6b . . . . .	<b>6b</b>	116,800.
<b>7</b> Long-term capital gain or (loss) from Forms 2439, 4684, 6252, 6781, and 8824 . . . . .	<b>7</b>	
<b>8</b> Net long-term gain or (loss) from partnerships, S corporations, and other estates or trusts . . . . .	<b>8</b>	
<b>9</b> Capital gain distributions . . . . .	<b>9</b>	
<b>10</b> Gain from Form 4797, Part I . . . . .	<b>10</b>	72,199.
<b>11</b> Long-term capital loss carryover. Enter the amount, if any, from line 14 of the 2011 Capital Loss Carryover Worksheet . . . . .	<b>11</b>	( )
<b>12</b> <b>Net long-term gain or (loss).</b> Combine lines 6a through 11 in column (f). Enter here and on line 14a, column (3) on the back . . . . . ▶	<b>12</b>	188,999.

For Paperwork Reduction Act Notice, see the Instructions for Form 1041.

Schedule D (Form 1041) 2012

<b>Part III Summary of Parts I and II</b>		(1) Beneficiaries' (see instr.)	(2) Estate's or trust's	(3) Total
<b>Caution: Read the instructions before completing this part.</b>				
<b>13</b>	<b>Net short-term gain or (loss)</b> . . . . .	<b>13</b>		
<b>14</b>	<b>Net long-term gain or (loss):</b>			
<b>a</b>	Total for year . . . . .	<b>14a</b>		188,999.
<b>b</b>	Unrecaptured section 1250 gain (see line 18 of the wrksht.) . . . . .	<b>14b</b>		
<b>c</b>	28% rate gain . . . . .	<b>14c</b>		
<b>15</b>	<b>Total net gain or (loss).</b> Combine lines 13 and 14 . . . . . ▶	<b>15</b>		188,999.

**Note:** If line 15, column (3), is a net gain, enter the gain on Form 1041, line 4 (or Form 990-T, Part I, line 4a). If lines 14a and 15, column (2), are net gains, go to Part V, and **do not** complete Part IV. If line 15, column (3), is a net loss, complete Part IV and the **Capital Loss Carryover Worksheet**, as necessary.

**Part IV Capital Loss Limitation**

<b>16</b>	Enter here and enter as a (loss) on Form 1041, line 4 (or Form 990-T, Part I, line 4c, if a trust), the <b>smaller</b> of: <b>a</b> The loss on line 15, column (3) or <b>b</b> \$3,000 . . . . .	<b>16</b>	( )
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**Note:** If the loss on line 15, column (3), is more than \$3,000, or if Form 1041, page 1, line 22 (or Form 990-T, line 34), is a loss, complete the **Capital Loss Carryover Worksheet** in the instructions to figure your capital loss carryover.

**Part V Tax Computation Using Maximum Capital Gains Rates**

**Form 1041 filers.** Complete this part **only** if both lines 14a and 15 in column (2) are gains, or an amount is entered in Part I or Part II and there is an entry on Form 1041, line 2b(2), and Form 1041, line 22, is more than zero.

**Caution:** Skip this part and complete the **Schedule D Tax Worksheet** in the instructions if:

- Either line 14b, col. (2) or line 14c, col. (2) is more than zero, or
- Both Form 1041, line 2b(1), and Form 4952, line 4g are more than zero.

**Form 990-T trusts.** Complete this part **only** if both lines 14a and 15 are gains, or qualified dividends are included in income in Part I of Form 990-T, and Form 990-T, line 34, is more than zero. Skip this part and complete the **Schedule D Tax Worksheet** in the instructions if either line 14b, col. (2) or line 14c, col. (2) is more than zero.

<b>17</b>	Enter taxable income from Form 1041, line 22 (or Form 990-T, line 34) . . . . .	<b>17</b>	
<b>18</b>	Enter the <b>smaller</b> of line 14a or 15 in column (2) but not less than zero . . . . .	<b>18</b>	
<b>19</b>	Enter the estate's or trust's qualified dividends from Form 1041, line 2b(2) (or enter the qualified dividends included in income in Part I of Form 990-T) . . . . .	<b>19</b>	
<b>20</b>	Add lines 18 and 19 . . . . .	<b>20</b>	
<b>21</b>	If the estate or trust is filing Form 4952, enter the amount from line 4g; otherwise, enter -0- . . . . . ▶	<b>21</b>	
<b>22</b>	Subtract line 21 from line 20. If zero or less, enter -0- . . . . .	<b>22</b>	
<b>23</b>	Subtract line 22 from line 17. If zero or less, enter -0- . . . . .	<b>23</b>	
<b>24</b>	Enter the <b>smaller</b> of the amount on line 17 or \$2,400 . . . . .	<b>24</b>	
<b>25</b>	Is the amount on line 23 equal to or more than the amount on line 24? <input type="checkbox"/> <b>Yes.</b> Skip lines 25 and 26; go to line 27 and check the "No" box. <input type="checkbox"/> <b>No.</b> Enter the amount from line 23 . . . . .	<b>25</b>	
<b>26</b>	Subtract line 25 from line 24 . . . . .	<b>26</b>	
<b>27</b>	Are the amounts on lines 22 and 26 the same? <input type="checkbox"/> <b>Yes.</b> Skip lines 27 thru 30; go to line 31. <input type="checkbox"/> <b>No.</b> Enter the smaller of line 17 or line 22 . . . . .	<b>27</b>	
<b>28</b>	Enter the amount from line 26 (If line 26 is blank, enter -0-) . . . . .	<b>28</b>	
<b>29</b>	Subtract line 28 from line 27 . . . . .	<b>29</b>	
<b>30</b>	Multiply line 29 by 15% (.15) . . . . .	<b>30</b>	
<b>31</b>	Figure the tax on the amount on line 23. Use the 2012 Tax Rate Schedule for Estates and Trusts (see the Schedule G instructions in the instructions for Form 1041) . . . . .	<b>31</b>	
<b>32</b>	Add lines 30 and 31 . . . . .	<b>32</b>	
<b>33</b>	Figure the tax on the amount on line 17. Use the 2012 Tax Rate Schedule for Estates and Trusts (see the Schedule G instructions in the instructions for Form 1041) . . . . .	<b>33</b>	
<b>34</b>	<b>Tax on all taxable income.</b> Enter the <b>smaller</b> of line 32 or line 33 here and on Form 1041, Schedule G, line 1a (or Form 990-T, line 36) . . . . .	<b>34</b>	



Sales of Business Property
(Also Involuntary Conversions and Recapture Amounts
Under Sections 179 and 280F(b)(2))

Department of the Treasury
Internal Revenue Service

Attach to your tax return.
Information about Form 4797 and its separate instructions is at www.irs.gov/form4797.

Attachment Sequence No. 27

Name(s) shown on return ATLANTIC GENERAL HOSPITAL
Identifying number 52-1656507

1 Enter the gross proceeds from sales or exchanges reported to you for 2012 on Form(s) 1099-B or 1099-S (or substitute statement) that you are including on line 2, 10, or 20 (see instructions).

Part I Sales or Exchanges of Property Used in a Trade or Business and Involuntary Conversions From Other Than Casualty or Theft - Most Property Held More Than 1 Year (see instructions)

Table with 7 columns: (a) Description of property, (b) Date acquired, (c) Date sold, (d) Gross sales price, (e) Depreciation allowed or allowable since acquisition, (f) Cost or other basis, plus improvements and expense of sale, (g) Gain or (loss). Row 1: ATTACHMENT 1, 72,199.

3 Gain, if any, from Form 4684, line 39
4 Section 1231 gain from installment sales from Form 6252, line 26 or 37
5 Section 1231 gain or (loss) from like-kind exchanges from Form 8824
6 Gain, if any, from line 32, from other than casualty or theft
7 Combine lines 2 through 6. Enter the gain or (loss) here and on the appropriate line as follows: 72,199.
Partnerships (except electing large partnerships) and S corporations. Report the gain or (loss) following the instructions for Form 1065, Schedule K, line 10, or Form 1120S, Schedule K, line 9. Skip lines 8, 9, 11, and 12 below.
Individuals, partners, S corporation shareholders, and all others. If line 7 is zero or a loss, enter the amount from line 7 on line 11 below and skip lines 8 and 9. If line 7 is a gain and you did not have any prior year section 1231 losses, or they were recaptured in an earlier year, enter the gain from line 7 as a long-term capital gain on the Schedule D filed with your return and skip lines 8, 9, 11, and 12 below.
8 Nonrecaptured net section 1231 losses from prior years (see instructions)
9 Subtract line 8 from line 7. If zero or less, enter -0-. If line 9 is zero, enter the gain from line 7 on line 12 below. If line 9 is more than zero, enter the amount from line 8 on line 12 below and enter the gain from line 9 as a long-term capital gain on the Schedule D filed with your return (see instructions)

Part II Ordinary Gains and Losses (see instructions)

10 Ordinary gains and losses not included on lines 11 through 16 (include property held 1 year or less):

11 Loss, if any, from line 7
12 Gain, if any, from line 7 or amount from line 8, if applicable
13 Gain, if any, from line 31
14 Net gain or (loss) from Form 4684, lines 31 and 38a
15 Ordinary gain from installment sales from Form 6252, line 25 or 36
16 Ordinary gain or (loss) from like-kind exchanges from Form 8824
17 Combine lines 10 through 16
18 For all except individual returns, enter the amount from line 17 on the appropriate line of your return and skip lines a and b below. For individual returns, complete lines a and b below:
a If the loss on line 11 includes a loss from Form 4684, line 35, column (b)(ii), enter that part of the loss here. Enter the part of the loss from income-producing property on Schedule A (Form 1040), line 28, and the part of the loss from property used as an employee on Schedule A (Form 1040), line 23. Identify as from "Form 4797, line 18a." See instructions
b Redetermine the gain or (loss) on line 17 excluding the loss, if any, on line 18a. Enter here and on Form 1040, line 14

For Paperwork Reduction Act Notice, see separate instructions. Form 4797 (2012)

**Part III Gain From Disposition of Property Under Sections 1245, 1250, 1252, 1254, and 1255**  
(see instructions)

19 (a) Description of section 1245, 1250, 1252, 1254, or 1255 property:		(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)
A			
B			
C			
D			
These columns relate to the properties on lines 19A through 19D. ▶		Property A	Property B
		Property C	Property D
20	Gross sales price (Note: See line 1 before completing.)	20	
21	Cost or other basis plus expense of sale	21	
22	Depreciation (or depletion) allowed or allowable	22	
23	Adjusted basis. Subtract line 22 from line 21	23	
24	Total gain. Subtract line 23 from line 20	24	
<b>25 If section 1245 property:</b>			
a	Depreciation allowed or allowable from line 22	25a	
b	Enter the smaller of line 24 or 25a	25b	
<b>26 If section 1250 property:</b> If straight line depreciation was used, enter -0- on line 26g, except for a corporation subject to section 291.			
a	Additional depreciation after 1975 (see instructions)	26a	
b	Applicable percentage multiplied by the smaller of line 24 or line 26a (see instructions)	26b	
c	Subtract line 26a from line 24. If residential rental property or line 24 is not more than line 26a, skip lines 26d and 26e	26c	
d	Additional depreciation after 1969 and before 1976	26d	
e	Enter the smaller of line 26c or 26d	26e	
f	Section 291 amount (corporations only)	26f	
g	Add lines 26b, 26e, and 26f	26g	
<b>27 If section 1252 property:</b> Skip this section if you did not dispose of farmland or if this form is being completed for a partnership (other than an electing large partnership).			
a	Soil, water, and land clearing expenses	27a	
b	Line 27a multiplied by applicable percentage (see instructions)	27b	
c	Enter the smaller of line 24 or 27b	27c	
<b>28 If section 1254 property:</b>			
a	Intangible drilling and development costs, expenditures for development of mines and other natural deposits, mining exploration costs, and depletion (see instructions)	28a	
b	Enter the smaller of line 24 or 28a	28b	
<b>29 If section 1255 property:</b>			
a	Applicable percentage of payments excluded from income under section 126 (see instructions)	29a	
b	Enter the smaller of line 24 or 29a (see instructions)	29b	

**Summary of Part III Gains.** Complete property columns A through D through line 29b before going to line 30.

30	Total gains for all properties. Add property columns A through D, line 24	30	
31	Add property columns A through D, lines 25b, 26g, 27c, 28b, and 29b. Enter here and on line 13	31	
32	Subtract line 31 from line 30. Enter the portion from casualty or theft on Form 4684, line 33. Enter the portion from other than casualty or theft on Form 4797, line 6	32	

**Part IV Recapture Amounts Under Sections 179 and 280F(b)(2) When Business Use Drops to 50% or Less**  
(see instructions)

		(a) Section 179	(b) Section 280F(b)(2)
33	Section 179 expense deduction or depreciation allowable in prior years	33	
34	Recomputed depreciation (see instructions)	34	
35	Recapture amount. Subtract line 34 from line 33. See the instructions for where to report	35	

