

PWC US TAX LLP  
2001 MARKET ST, SUITE 1800  
PHILADELPHIA PA 19103

UNION HOSPITAL OF CECIL COUNTY, INC.  
INSTRUCTIONS FOR FILING  
FORM 8879-TE  
IRS E-FILE SIGNATURE AUTHORIZATION FOR FORM 990  
FOR THE YEAR ENDED JUNE 30, 2024

THE ORIGINAL IRS E-FILE SIGNATURE AUTHORIZATION FORM SHOULD BE  
SIGNED (USE FULL NAME) AND DATED BY AN AUTHORIZED OFFICER OF THE  
ORGANIZATION.

RETURN YOUR SIGNED IRS E-FILE SIGNATURE AUTHORIZATION FORM  
8879-TE TO:

PWC US TAX LLP  
2001 MARKET ST, SUITE 1800  
PHILADELPHIA PA 19103

THERE IS NO TAX DUE WITH THE FILING OF THIS RETURN.

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 OR BEFORE MAY 15, 2025.  
WE WOULD APPRECIATE YOU 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.

Form **8879-TE****IRS E-file Signature Authorization  
for a Tax Exempt Entity**

OMB No. 1545-0047

For calendar year 2023, or fiscal year beginning 07/01/2023 and ending 06/30/2024**2023**Department of the Treasury  
Internal Revenue Service**Do not send to the IRS. Keep for your records.**  
Go to **www.irs.gov/Form8879TE** for the latest information.

Name of filer

EIN or SSN

UNION HOSPITAL OF CECIL COUNTY, INC.52-0607945

Name and title of officer or person subject to tax

ROBERT MCMURRAY, CFO**Part I Type of Return and Return Information**

Check the box for the return for which you are using this Form 8879-TE and enter the applicable amount, if any, from the return. Form 8038-CP and Form 5330 filers may enter dollars and cents. For all other forms, enter whole dollars only. If you check the box on line 1a, 2a, 3a, 4a, 5a, 6a, 7a, 8a, 9a, or 10a below, and the amount on that line for the return being filed with this form was blank, then leave line 1b, 2b, 3b, 4b, 5b, 6b, 7b, 8b, 9b, or 10b, 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 one line in Part I.

<b>1a</b> Form 990 check here . . . . .	<input checked="" type="checkbox"/>	<b>b</b> Total revenue, if any (Form 990, Part VIII, column (A), line 12) . . . .	<b>1b</b>	<u>194522015.</u>
<b>2a</b> Form 990-EZ check here . . . . .	<input type="checkbox"/>	<b>b</b> Total revenue, if any (Form 990-EZ, line 9) . . . . .	<b>2b</b>	
<b>3a</b> Form 1120-POL check here . . . . .	<input type="checkbox"/>	<b>b</b> Total tax (Form 1120-POL, line 22) . . . . .	<b>3b</b>	
<b>4a</b> Form 990-PF check here . . . . .	<input type="checkbox"/>	<b>b</b> Tax based on investment income (Form 990-PF, Part V, line 5) . . . .	<b>4b</b>	
<b>5a</b> Form 8868 check here . . . . .	<input type="checkbox"/>	<b>b</b> Balance due (Form 8868, line 3c) . . . . .	<b>5b</b>	
<b>6a</b> Form 990-T check here . . . . .	<input type="checkbox"/>	<b>b</b> Total tax (Form 990-T, Part III, line 4) . . . . .	<b>6b</b>	
<b>7a</b> Form 4720 check here . . . . .	<input type="checkbox"/>	<b>b</b> Total tax (Form 4720, Part III, line 1) . . . . .	<b>7b</b>	
<b>8a</b> Form 5227 check here . . . . .	<input type="checkbox"/>	<b>b</b> FMV of assets at end of tax year (Form 5227, Item D) . . . . .	<b>8b</b>	
<b>9a</b> Form 5330 check here . . . . .	<input type="checkbox"/>	<b>b</b> Tax due (Form 5330, Part II, line 19) . . . . .	<b>9b</b>	
<b>10a</b> Form 8038-CP check here . . . . .	<input type="checkbox"/>	<b>b</b> Amount of credit payment requested (Form 8038-CP, Part III, line 22) . . . .	<b>10b</b>	

**Part II Declaration and Signature Authorization of Officer or Person Subject to Tax**

Under penalties of perjury, I declare that ☒ I am an officer of the above entity or ☐ I am a person subject to tax with respect to (name of entity) \_\_\_\_\_, (EIN) \_\_\_\_\_ and that I have examined a copy of the 2023 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 electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the 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 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 electronic return and, if applicable, the consent to electronic funds withdrawal.

**PIN: check one box only**

☒ I authorize PWC US TAX LLP to enter my PIN 14232 as my signature  
ERO firm name Enter five numbers, but do not enter all zeros

on the tax year 2023 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 or person subject to tax with respect to the entity, I will enter my PIN as my signature on the tax year 2023 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.

Signature of officer or person subject to tax

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.

23522313400

Do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2023 electronically filed return 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

Antonio C Runo

Date

05/14/2025

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

For Privacy Act and Paperwork Reduction Act Notice, see back of form.

Form **8879-TE** (2023)

JSA

3X3008 3.000

6830QG 472W

V23-7.16 0000024737

Form **990**

Department of the Treasury  
Internal Revenue Service

# Return of Organization Exempt From Income Tax

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

Do not enter social security numbers on this form as it may be made public.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

**Open to Public Inspection**

<b>A</b> For the 2023 calendar year, or tax year beginning 07/01/2023 and ending 06/30/2024	
<b>B</b> Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C</b> Name of organization UNION HOSPITAL OF CECIL COUNTY, INC. Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite 4000 NEXUS DRIVE, NW3-100 City or town, state or province, country, and ZIP or foreign postal code WILMINGTON, DE 19803 <b>F</b> Name and address of principal officer: AMY MARSTON 106 BOW STREET, ELKTON, MD 21921-5596 <b>H(a)</b> Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>H(b)</b> Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. See instructions. <b>H(c)</b> Group exemption number
<b>D</b> Employer identification number 52-0607945 <b>E</b> Telephone number (410) 398-4000 <b>G</b> Gross receipts \$ 210,202,168.	<b>I</b> Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527 <b>J</b> Website: WWW.UHCC.COM <b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other <b>L</b> Year of formation: 1903 <b>M</b> State of legal domicile: MD

<b>Part I Summary</b>		
<b>Activities &amp; Governance</b>	<b>1</b> Briefly describe the organization's mission or most significant activities: TO PROVIDE CHARITABLE HEALTHCARE SERVICES TO THE RESIDENTS OF CECIL COUNTY, MD AND THE SURROUNDING AREA.	
	<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)	3 12
	<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	4 9
	<b>5</b> Total number of individuals employed in calendar year 2023 (Part V, line 2a)	5 1,394
	<b>6</b> Total number of volunteers (estimate if necessary)	6 183
	<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	7a 1,640,335.
<b>7b</b> Net unrelated business taxable income from Form 990-T, Part I, line 11	7b NONE	
<b>Revenue</b>	<b>8</b> Contributions and grants (Part VIII, line 1h)	Prior Year 902,376. Current Year 173,336.
	<b>9</b> Program service revenue (Part VIII, line 2g)	172,643,201. 186,412,171.
	<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,580,560. 5,543,871.
	<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,719,965. 2,392,637.
	<b>12</b> Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	177,846,102. 194,522,015.
	<b>Expenses</b>	<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)		NONE NONE
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)		122,030,806. 124,692,604.
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)		NONE NONE
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25)		NONE
<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)		70,389,001. 68,606,520.
<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)		192,419,807. 193,299,124.
<b>Net Assets or Fund Balances</b>	<b>19</b> Revenue less expenses. Subtract line 18 from line 12	-14,573,705. 1,222,891.
	<b>20</b> Total assets (Part X, line 16)	Beginning of Current Year 186,066,867. End of Year 209,167,049.
	<b>21</b> Total liabilities (Part X, line 26)	156,038,586. 167,642,633.
	<b>22</b> Net assets or fund balances. Subtract line 21 from line 20.	30,028,281. 41,524,416.

<b>Part II Signature Block</b>					
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 ROBERT MCMURRAY		Date		
	ROBERT MCMURRAY		CFO		
	Type or print name and title				
<b>Paid Preparer Use Only</b>	Print/Type preparer's name ANTONIO C RUSSO		Preparer's signature Antonio C Russo		Date 05/14/2025
	Firm's name PWC US TAX LLP		Check <input type="checkbox"/> if self-employed		PTIN P00858539
	Firm's address 2001 MARKET ST, SUITE 1800 PHILADELPHIA, PA 19103		Firm's EIN 92-0460586		Phone no. 267-330-3000

May the IRS discuss this return with the preparer shown above? See instructions. ☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Form **990** (2023)

**Part III** **Statement of Program Service Accomplishments**

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

**1** Briefly describe the organization's mission:

UNION HOSPITAL OF CECIL COUNTY, INC.'S MISSION IS TO PROVIDE  
CHARITABLE HEALTHCARE SERVICES TO THE RESIDENTS OF CECIL COUNTY,  
MARYLAND; WESTERN NEW CASTLE COUNTY, DELAWARE; AND SOUTHERN CHESTER  
COUNTY, PENNSYLVANIA.

**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 \$ 167,294,867. including grants of \$ NONE ) (Revenue \$ 186,924,195. )  
SEE SCHEDULE O

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

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

**4d** Other program services (Describe on Schedule O.)  
(Expenses \$ including grants of \$ ) (Revenue \$ )

**4e** Total program service expenses 167,294,867.

**Part IV Checklist of Required Schedules**

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

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

	Yes	No
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III . . . . .</i>		X
<b>23</b> 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	
<b>24a</b> 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 25a . . . . .</i>	X	
<b>24b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .		X
<b>24c</b> 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
<b>24d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .		X
<b>25a</b> <b>Section 501(c)(3), 501(c)(4), and 501(c)(29) 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>25b</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
<b>26</b> Did the organization report any amount on Part X, line 5 or 22, for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part II . . . . .</i>		X
<b>27</b> Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III . . . . .</i>		X
<b>28</b> Was the organization a party to a business transaction with one of the following parties? (See the Schedule L, Part IV, instructions for applicable filing thresholds, conditions, and exceptions).		
<b>28a</b> A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? <i>If "Yes," complete Schedule L, Part IV . . . . .</i>		X
<b>28b</b> A family member of any individual described in line 28a? <i>If "Yes," complete Schedule L, Part IV . . . . .</i>		X
<b>28c</b> A 35% controlled entity of one or more individuals and/or organizations described in line 28a or 28b? <i>If "Yes," complete Schedule L, Part IV . . . . .</i>		X
<b>29</b> Did the organization receive more than \$25,000 in noncash contributions? <i>If "Yes," complete Schedule M . . . . .</i>		X
<b>30</b> 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
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I . . . . .</i>		X
<b>32</b> 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
<b>33</b> 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
<b>34</b> 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	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)? . . . . .		X
<b>35b</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>		
<b>36</b> <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
<b>37</b> 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
<b>38</b> Did the organization complete Schedule O and provide explanations on 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 or note to any line in this Part V ☒

	Yes	No
<b>1a</b> Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable . . . . .		
<b>1b</b> Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable. . . . .		
<b>1c</b> Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	X	

**Part V Statements Regarding Other IRS Filings and Tax Compliance** (continued)

	Yes	No
<b>2a</b> Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	<b>2a</b>	1,394
<b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	<b>2b</b>	X
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year?	<b>3a</b>	X
<b>b</b> If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation on Schedule O	<b>3b</b>	X
<b>4a</b> At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	<b>4a</b>	X
<b>b</b> If "Yes," enter the name of the foreign country See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	<b>5a</b>	X
<b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	<b>5b</b>	X
<b>c</b> If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	<b>5c</b>	
<b>6a</b> Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	<b>6a</b>	X
<b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	<b>6b</b>	
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>		
<b>a</b> Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	<b>7a</b>	X
<b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided?	<b>7b</b>	
<b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	<b>7c</b>	X
<b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year	<b>7d</b>	
<b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	<b>7e</b>	X
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	<b>7f</b>	X
<b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	<b>7g</b>	
<b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	<b>7h</b>	
<b>8 Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	<b>8</b>	
<b>9 Sponsoring organizations maintaining donor advised funds.</b>		
<b>a</b> Did the sponsoring organization make any taxable distributions under section 4966?	<b>9a</b>	
<b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	<b>9b</b>	
<b>10 Section 501(c)(7) organizations.</b> Enter:		
<b>a</b> Initiation fees and capital contributions included on Part VIII, line 12	<b>10a</b>	
<b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	<b>10b</b>	
<b>11 Section 501(c)(12) organizations.</b> Enter:		
<b>a</b> Gross income from members or shareholders	<b>11a</b>	
<b>b</b> Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.)	<b>11b</b>	
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?	<b>12a</b>	
<b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year	<b>12b</b>	
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>a</b> Is the organization licensed to issue qualified health plans in more than one state? <b>Note:</b> See the instructions for additional information the organization must report on Schedule O.	<b>13a</b>	
<b>b</b> Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	<b>13b</b>	
<b>c</b> Enter the amount of reserves on hand	<b>13c</b>	
<b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year?	<b>14a</b>	X
<b>b</b> If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation on Schedule O	<b>14b</b>	
<b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see the instructions and file Form 4720, Schedule N.	<b>15</b>	X
<b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.	<b>16</b>	X
<b>17 Section 501(c)(21) organizations.</b> Did the trust, or any disqualified or other person engage in any activities that would result in the imposition of an excise tax under section 4951, 4952, or 4953? If "Yes," complete Form 6069.	<b>17</b>	

**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 on Schedule O. See instructions.Check if Schedule O contains a response or note to any line in this Part VI ☒ **X****Section A. Governing Body and Management**

	Yes	No
<b>1a</b> Enter the number of voting members of the governing body at the end of the tax year . . . . . If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain on Schedule O.	<b>1a</b> 12	
<b>b</b> Enter the number of voting members included on line 1a, above, who are independent. . . . .	<b>1b</b> 9	
<b>2</b> Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? . . . . .	<b>2</b>	<input checked="" type="checkbox"/> X
<b>3</b> Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person? . . . .	<b>3</b>	<input checked="" type="checkbox"/> X
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? . . . . .	<b>4</b>	<input checked="" type="checkbox"/> X
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets? . . . .	<b>5</b>	<input checked="" type="checkbox"/> X
<b>6</b> Did the organization have members or stockholders? . . . . .	<b>6</b>	<input checked="" type="checkbox"/> X
<b>7a</b> Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? . . . . .	<b>7a</b>	<input checked="" type="checkbox"/> X
<b>b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? . . . . .	<b>7b</b>	<input checked="" type="checkbox"/> X
<b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
<b>a</b> The governing body? . . . . .	<b>8a</b>	<input checked="" type="checkbox"/> X
<b>b</b> Each committee with authority to act on behalf of the governing body? . . . . .	<b>8b</b>	<input checked="" type="checkbox"/> X
<b>9</b> Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses on Schedule O. . . . .	<b>9</b>	<input checked="" type="checkbox"/> X

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

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

**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 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain on Schedule O)

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

**20** State the name, address, and telephone number of the person who possesses the organization's books and records.  
 SR. VP'S OFFICE 4000 NEXUS DRIVE, NW3-100 WILMINGTON, DE 19803

302-428-2441



**Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**Check if Schedule O contains a response or note to any line in this Part VII ☒ X**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees****1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See the 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, box 6 of Form 1099-MISC, and/or box 1 of Form 1099-NEC) 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.

See the instructions for the order in which to list the persons above.

☐ 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/ 1099-NEC)	(E) Reportable compensation from related organizations (W-2/ 1099-MISC/ 1099-NEC)	(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) SHARON T. KURFUERST FORMER PRESIDENT	NONE NONE						X	NONE	1,311,367.	NONE
(2) ROBERT MCMURRAY TREASURER (EX-OFFICIO)	1.00 44.00			X				NONE	1,040,419.	88,327.
(3) JENNIFER L. SCHWARTZ, ESQ SECRETARY (EX-OFFICIO)	1.00 44.00			X				NONE	926,687.	80,121.
(4) JUSTIN SAUSVILLE, MD DIRECTOR	44.00 1.00	X						766,042.	NONE	20,878.
(5) FAHD RAHMAN, MD PHYSICIAN	45.00 NONE					X		751,159.	NONE	20,878.
(6) ROGER D. WU, MD PHYSICIAN	45.00 NONE					X		623,067.	NONE	21,255.
(7) RYAN GERACIMOS, MD CHIEF MEDICAL OFF. - THRU 3/24	44.00 1.00				X			620,269.	NONE	15,122.
(8) CLAIRE YI ZHANG PHYSICIAN	45.00 NONE					X		516,129.	NONE	NONE
(9) GEORGE GIANNOUKOS PHYSICIAN	45.00 NONE					X		511,568.	NONE	NONE
(10) JAMES MICHEAL JARVIS PHYSICIAN	45.00 NONE					X		495,424.	NONE	NONE
(11) AMY MARSTON DIRECTOR/CAMPUS OPS OFCR	44.00 1.00	X						NONE	331,745.	20,878.
(12) DONNA MALONEY DIRECTOR OF FINANCE	1.00 44.00				X			NONE	246,261.	20,878.
(13) JOSE MA, MD DIRECTOR - THRU 8/23	44.00 1.00	X						252,761.	NONE	12,506.
(14) JOAN PIRRUNG, MSN, APRN, ACNS CHIEF NURSING OFFICER	44.00 1.00				X			238,411.	NONE	20,878.

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 ) MICHELLE TWUM-DANSO DIRECTOR HR - CECIL THRU 1/24	44.00 1.00				X			NONE	238,170.	13,910.
( 16 ) ROBERT ASANTE DIRECTOR	1.00 44.00	X						NONE	226,928.	20,878.
( 17 ) DERON G. BROWN FORMER FINANCE DIRECTOR	NONE 44.00						X	NONE	199,146.	NONE
( 18 ) CHRISTY DRYER, DNP DIRECTOR	1.00 1.00	X						NONE	NONE	NONE
( 19 ) DAVID TROLIO VICE CHAIR - AS OF 01/24	1.00 1.00	X		X				NONE	NONE	NONE
( 20 ) DWIGHT D. THOMEY, ESQ. DIRECTOR, CHAIR - THRU 12/23	1.00 3.00	X		X				NONE	NONE	NONE
( 21 ) JACQUES RENE DIRECTOR	1.00 1.00	X						NONE	NONE	NONE
( 22 ) LEO NAJERA, MD DIRECTOR	1.00 2.00	X						NONE	NONE	NONE
( 23 ) MORGAN MILLER, MLIS CHAIR - AS OF 01/24	1.00 1.00	X		X				NONE	NONE	NONE
( 24 ) ROBERT PALSGROVE DIRECTOR	1.00 1.00	X						NONE	NONE	NONE
( 25 ) JOHN NESS DIRECTOR	1.00 1.00	X						NONE	NONE	NONE
1b Sub-total								4,774,830.	4,520,723.	356,509.
c Total from continuation sheets to Part VII, Section A								NONE	NONE	NONE
d Total (add lines 1b and 1c)								4,774,830.	4,520,723.	356,509.

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 215

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

Section B. Independent Contractors

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

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

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

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

[illegible]

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 ►

		Yes	No
3	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> . . . . .		
	<b>3</b>	X	
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i> . . . . .		
	<b>4</b>	X	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i> . . . . .		
	<b>5</b>		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)	(B)	(C)
SEE SCHEDULE O Name and business address	Description of services	Compensation

**Part VIII Statement of Revenue**

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
<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>				
	<b>d</b>	Related organizations . . . . .	<b>1d</b>	173,336.			
	<b>e</b>	Government grants (contributions) . .	<b>1e</b>				
	<b>f</b>	All other contributions, gifts, grants, and similar amounts not included above .	<b>1f</b>	NONE			
	<b>g</b>	Noncash contributions included in lines 1a-1f . . . . .	<b>1g</b>	\$			
	<b>h</b>	<b>Total.</b> Add lines 1a-1f . . . . .		173,336.			
	<b>Program Service Revenue</b>				Business Code		
<b>2a</b>		NET PATIENT SERVICE REVENUE	621990	186,092,763.	186,092,763.		
<b>b</b>		OTHER OPERATING REVENUE	621990	224,008.	188,008.	36,000.	
<b>c</b>		MANAGEMENT FEE REVENUE	623990	95,400.	95,400.		
<b>d</b>							
<b>e</b>							
<b>f</b>		All other program service revenue . . . . .					
<b>g</b>		<b>Total.</b> Add lines 2a-2f . . . . .		186,412,171.			
<b>Other Revenue</b>	<b>3</b>	Investment income (including dividends, interest, and other similar amounts) . . . . .		2,163,316.		-2,093.	2,165,409.
	<b>4</b>	Income from investment of tax-exempt bond proceeds . . .		NONE			
	<b>5</b>	Royalties . . . . .		NONE			
			(i) Real	(ii) Personal			
	<b>6a</b>	Gross rents . . . . .	<b>6a</b>	66,382.			
	<b>b</b>	Less: rental expenses	<b>6b</b>	6,509.			
	<b>c</b>	Rental income or (loss)	<b>6c</b>	59,873.	NONE		
	<b>d</b>	Net rental income or (loss) . . . . .		59,873.			59,873.
	<b>7a</b>	Gross amount from sales of assets other than inventory		(i) Securities	(ii) Other		
	<b>7a</b>		19,054,199.	NONE			
	<b>b</b>	Less: cost or other basis and sales expenses . .	<b>7b</b>	15,640,589.	33,055.		
	<b>c</b>	Gain or (loss) . . . . .	<b>7c</b>	3,413,610.	-33,055.		
	<b>d</b>	Net gain or (loss) . . . . .		3,380,555.		118,262.	3,262,293.
	<b>8a</b>	Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18 . . . . .	<b>8a</b>	NONE			
	<b>b</b>	Less: direct expenses . . . . .	<b>8b</b>	NONE			
	<b>c</b>	Net income or (loss) from fundraising events . . . . .		NONE			
	<b>9a</b>	Gross income from gaming activities. See Part IV, line 19 . . . . .	<b>9a</b>	NONE			
<b>b</b>	Less: direct expenses . . . . .	<b>9b</b>	NONE				
<b>c</b>	Net income or (loss) from gaming activities . . . . .		NONE				
<b>10a</b>	Gross sales of inventory, less returns and allowances . . . . .	<b>10a</b>	NONE				
<b>b</b>	Less: cost of goods sold . . . . .	<b>10b</b>	NONE				
<b>c</b>	Net income or (loss) from sales of inventory . . . . .		NONE				
<b>Miscellaneous Revenue</b>				Business Code			
	<b>11a</b>	LABORATORY REVENUE	621500	2,000,190.	512,024.	1,488,166.	
	<b>b</b>	CAFETERIA/FOOD SERVICE REVENUE	722210	332,021.			332,021.
	<b>c</b>	OTHER REVENUE	900009	553.			553.
	<b>d</b>	All other revenue . . . . .					
	<b>e</b>	<b>Total.</b> Add lines 11a-11d . . . . .		2,332,764.			
<b>12</b>	<b>Total revenue.</b> See instructions . . . . .			194,522,015.	186,888,195.	1,640,335.	5,820,149.

**Part IX Statement of Functional Expenses***Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).*Check if Schedule O contains a response or note to any line in this Part IX ☐**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 . . . . .	NONE			
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 . . . . .	NONE			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 . . . . .	NONE			
<b>4</b> Benefits paid to or for members . . . . .	NONE			
<b>5</b> Compensation of current officers, directors, trustees, and key employees . . . . .	2,078,331.	1,830,953.	247,378.	NONE
<b>6</b> Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .	NONE			
<b>7</b> Other salaries and wages . . . . .	94,002,791.	82,813,912.	11,188,879.	NONE
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) . . . . .	4,611,034.	3,919,379.	691,655.	NONE
<b>9</b> Other employee benefits . . . . .	16,823,979.	15,001,833.	1,822,146.	NONE
<b>10</b> Payroll taxes . . . . .	7,176,469.	5,565,374.	1,611,095.	NONE
<b>11</b> Fees for services (nonemployees):				
<b>a</b> Management . . . . .	NONE			
<b>b</b> Legal . . . . .	101,413.	18,022.	83,391.	NONE
<b>c</b> Accounting . . . . .	137,488.	NONE	137,488.	NONE
<b>d</b> Lobbying . . . . .	NONE			
<b>e</b> Professional fundraising services. See Part IV, line 17 . . . . .	NONE			
<b>f</b> Investment management fees . . . . .	128,740.	NONE	128,740.	NONE
<b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Schedule O.) . . . . .	18,732,173.	17,331,442.	1,400,731.	NONE
<b>12</b> Advertising and promotion . . . . .	197,685.	45,073.	152,612.	NONE
<b>13</b> Office expenses . . . . .	1,829,099.	998,668.	830,431.	NONE
<b>14</b> Information technology . . . . .	2,555,767.	320,770.	2,234,997.	NONE
<b>15</b> Royalties . . . . .	NONE			
<b>16</b> Occupancy . . . . .	4,411,034.	3,750,429.	660,605.	NONE
<b>17</b> Travel . . . . .	174,567.	168,461.	6,106.	NONE
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .	NONE			
<b>19</b> Conferences, conventions, and meetings . . . . .	150,845.	134,462.	16,383.	NONE
<b>20</b> Interest . . . . .	2,414,935.	1,995,702.	419,233.	NONE
<b>21</b> Payments to affiliates . . . . .	NONE			
<b>22</b> Depreciation, depletion, and amortization . . . . .	8,570,030.	5,049,026.	3,521,004.	NONE
<b>23</b> Insurance . . . . .	1,974,983.	1,955,745.	19,238.	NONE
<b>24</b> Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.)				
<b>a</b> MEDICAL SUPPLIES . . . . .	21,516,755.	21,372,268.	144,487.	NONE
<b>b</b> REPAIRS & MAINTENANCE . . . . .	3,387,409.	3,341,988.	45,421.	NONE
<b>c</b> DUES & PERIODICALS . . . . .	757,667.	178,446.	579,221.	NONE
<b>d</b> DIETARY . . . . .	730,422.	721,027.	9,395.	NONE
<b>e</b> All other expenses . . . . .	835,508.	781,887.	53,621.	
<b>25</b> Total functional expenses. Add lines 1 through 24e . . . . .	193,299,124.	167,294,867.	26,004,257.	NONE
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) . . . . .				

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing . . . . .	NONE	<b>1</b>	NONE
	<b>2</b> Savings and temporary cash investments. . . . .	17,608,186.	<b>2</b>	26,711,352.
	<b>3</b> Pledges and grants receivable, net . . . . .	NONE	<b>3</b>	NONE
	<b>4</b> Accounts receivable, net . . . . .	26,368,053.	<b>4</b>	28,131,548.
	<b>5</b> Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons . . . . .	NONE	<b>5</b>	NONE
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B). . . . .	NONE	<b>6</b>	NONE
	<b>7</b> Notes and loans receivable, net . . . . .	NONE	<b>7</b>	NONE
	<b>8</b> Inventories for sale or use . . . . .	3,952,561.	<b>8</b>	4,736,732.
	<b>9</b> Prepaid expenses and deferred charges . . . . .	3,219,190.	<b>9</b>	4,874,360.
	<b>10 a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D . . . . .	<b>10a</b> 195,722,648.		
	<b>b</b> Less: accumulated depreciation. . . . .	<b>10b</b> 136,316,710.		
		59,286,726.	<b>10c</b>	59,405,938.
	<b>11</b> Investments - publicly traded securities. . . . .	NONE	<b>11</b>	NONE
	<b>12</b> Investments - other securities. See Part IV, line 11. . . . .	51,737,013.	<b>12</b>	57,652,757.
	<b>13</b> Investments - program-related. See Part IV, line 11. . . . .	NONE	<b>13</b>	NONE
	<b>14</b> Intangible assets . . . . .	NONE	<b>14</b>	NONE
<b>15</b> Other assets. See Part IV, line 11 . . . . .	23,895,138.	<b>15</b>	27,654,362.	
<b>16</b> <b>Total assets.</b> Add lines 1 through 15 (must equal line 33) . . . . .	186,066,867.	<b>16</b>	209,167,049.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses. . . . .	28,768,329.	<b>17</b>	27,255,155.
	<b>18</b> Grants payable . . . . .	NONE	<b>18</b>	NONE
	<b>19</b> Deferred revenue . . . . .	2,444,392.	<b>19</b>	52,303.
	<b>20</b> Tax-exempt bond liabilities . . . . .	46,814,552.	<b>20</b>	44,456,291.
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D . . . . .	NONE	<b>21</b>	NONE
	<b>22</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons . . . . .	NONE	<b>22</b>	NONE
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	NONE	<b>23</b>	NONE
	<b>24</b> Unsecured notes and loans payable to unrelated third parties. . . . .	NONE	<b>24</b>	NONE
	<b>25</b> 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 . . . . .	78,011,313.	<b>25</b>	95,878,884.
	<b>26</b> <b>Total liabilities.</b> Add lines 17 through 25. . . . .	156,038,586.	<b>26</b>	167,642,633.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here and complete lines 27, 28, 32, and 33.</b> <input checked="" type="checkbox"/>			
	<b>27</b> Net assets without donor restrictions. . . . .	26,126,386.	<b>27</b>	38,436,965.
	<b>28</b> Net assets with donor restrictions. . . . .	3,901,895.	<b>28</b>	3,087,451.
	<b>Organizations that do not follow FASB ASC 958, check here and complete lines 29 through 33.</b> <input type="checkbox"/>			
	<b>29</b> Capital stock or trust principal, or current funds . . . . .		<b>29</b>	
	<b>30</b> Paid-in or capital surplus, or land, building, or equipment fund . . . . .		<b>30</b>	
	<b>31</b> Retained earnings, endowment, accumulated income, or other funds . . . . .		<b>31</b>	
	<b>32</b> Total net assets or fund balances . . . . .	30,028,281.	<b>32</b>	41,524,416.
	<b>33</b> Total liabilities and net assets/fund balances. . . . .	186,066,867.	<b>33</b>	209,167,049.

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12) . . . . .	<b>1</b>	194,522,015.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25) . . . . .	<b>2</b>	193,299,124.
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1 . . . . .	<b>3</b>	1,222,891.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A)) . . . . .	<b>4</b>	30,028,281.
<b>5</b>	Net unrealized gains (losses) on investments . . . . .	<b>5</b>	1,844,947.
<b>6</b>	Donated services and use of facilities . . . . .	<b>6</b>	
<b>7</b>	Investment expenses . . . . .	<b>7</b>	
<b>8</b>	Prior period adjustments . . . . .	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain on Schedule O). . . . .	<b>9</b>	8,428,297.
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B)) . . . . .	<b>10</b>	41,524,416.

**Part XII Financial Statements and Reporting**

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

- 1** Accounting method used to prepare the Form 990: ☐ Cash ☒ **X** Accrual ☐ Other \_\_\_\_\_  
If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.
- 2a** 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:  
☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis
- 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:  
☐ Separate basis ☒ **X** Consolidated basis ☐ Both consolidated and separate basis
- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? . . . .  
If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Uniform Guidance, 2 C.F.R. Part 200, Subpart F? . . . . .
- 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 on Schedule O and describe any steps taken to undergo such audits . . .

	Yes	No
<b>2a</b>		<b>X</b>
<b>2b</b>	<b>X</b>	
<b>2c</b>	<b>X</b>	
<b>3a</b>		<b>X</b>
<b>3b</b>		

Form **990** (2023)

**SCHEDULE A**  
**(Form 990)**Department of the Treasury  
Internal Revenue Service**Public Charity Status and Public Support**

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

Attach to Form 990 or Form 990-EZ.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023****Open to Public  
Inspection**

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

**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 12, check only one box.)

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 ☐ A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E (Form 990).)
- 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 agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: \_\_\_\_\_
- 10 ☐ 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.)
- 11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 12 ☐ 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 on lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
- a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
- b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
- c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
- d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
- e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
- f Enter the number of supported organizations . . . . .
- g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
(A)						
(B)						
(C)						
(D)						
(E)						
<b>Total</b>						

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

Schedule A (Form 990) 2023



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

**Section A. Public Support**

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") . . . . .						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf . . . . .						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge . . . . .						
<b>4</b> <b>Total.</b> Add lines 1 through 3. . . . .						
<b>5</b> 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). . . . .						
<b>6</b> <b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
<b>7</b> Amounts from line 4 . . . . .						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources . . . . .						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on . . . . .						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . . . . .						
<b>11</b> <b>Total support.</b> Add lines 7 through 10 . . . . .						
<b>12</b> Gross receipts from related activities, etc. (see instructions) . . . . .					<b>12</b>	
<b>13</b> <b>First 5 years.</b> 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 <b>stop here</b> . . . . .						<input type="checkbox"/>

**Section C. Computation of Public Support Percentage**

<b>14</b> Public support percentage for 2023 (line 6, column (f), divided by line 11, column (f)) . . . . .	<b>14</b>	%
<b>15</b> Public support percentage from 2022 Schedule A, Part II, line 14 . . . . .	<b>15</b>	%
<b>16a</b> <b>33 1/3% support test - 2023.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here</b> . The organization qualifies as a publicly supported organization. . . . .		<input type="checkbox"/>
<b>b</b> <b>33 1/3% support test - 2022.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here</b> . The organization qualifies as a publicly supported organization . . . . .		<input type="checkbox"/>
<b>17a</b> <b>10%-facts-and-circumstances test - 2023.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and <b>stop here</b> . Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization. . . . .		<input type="checkbox"/>
<b>b</b> <b>10%-facts-and-circumstances test - 2022.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and <b>stop here</b> . Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization. . . . .		<input type="checkbox"/>
<b>18</b> <b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . .		<input type="checkbox"/>

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

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II.  
If the organization fails to qualify under the tests listed below, please complete Part II.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose . . . . .						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 . . . . .						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf . . . . .						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge . . . . .						
<b>6 Total.</b> Add lines 1 through 5. . . . .						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons . . . . .						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year . . . . .						
<b>c</b> Add lines 7a and 7b. . . . .						
<b>8 Public support.</b> (Subtract line 7c from line 6.) . . . . .						

**Section B. Total Support**

Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
<b>9</b> Amounts from line 6. . . . .						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources . . . . .						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 . . . . .						
<b>c</b> Add lines 10a and 10b . . . . .						
<b>11</b> Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on. . . . .						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . . . . .						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.) . . . . .						
<b>14 First 5 years.</b> 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 <b>stop here</b> . . . . . <input type="checkbox"/>						

**Section C. Computation of Public Support Percentage**

<b>15</b> Public support percentage for 2023 (line 8, column (f), divided by line 13, column (f)) . . . . .	<b>15</b>	%
<b>16</b> Public support percentage from 2022 Schedule A, Part III, line 15 . . . . .	<b>16</b>	%

**Section D. Computation of Investment Income Percentage**

<b>17</b> Investment income percentage for <b>2023</b> (line 10c, column (f), divided by line 13, column (f)) . . . . .	<b>17</b>	%
<b>18</b> Investment income percentage from <b>2022</b> Schedule A, Part III, line 17 . . . . .	<b>18</b>	%

- 19a 33 1/3% support tests - 2023.** 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 - 2022.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization . . ☐
- 20 Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions . . ☐

**Part IV Supporting Organizations**

(Complete only if you checked a box on line 12 of Part I. If you checked box 12a, Part I, complete Sections A and B. If you checked box 12b, Part I, complete Sections A and C. If you checked box 12c, Part I, complete Sections A, D, and E. If you checked box 12d, Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

	Yes	No
<b>1</b> Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
<b>2</b> Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
<b>3a</b> Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer lines 3b and 3c below.</i>		
<b>b</b> Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in <b>Part VI</b> when and how the organization made the determination.</i>		
<b>c</b> Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in <b>Part VI</b> what controls the organization put in place to ensure such use.</i>		
<b>4a</b> Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.</i>		
<b>b</b> Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
<b>c</b> Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in <b>Part VI</b> what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
<b>5a</b> Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in <b>Part VI</b>, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
<b>b Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
<b>c Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?		
<b>6</b> Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in <b>Part VI</b>.</i>		
<b>7</b> Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
<b>8</b> Did the organization make a loan to a disqualified person (as defined in section 4958) not described on line 7? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
<b>9a</b> Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in <b>Part VI</b>.</i>		
<b>b</b> Did one or more disqualified persons (as defined on line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in <b>Part VI</b>.</i>		
<b>c</b> Did a disqualified person (as defined on line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in <b>Part VI</b>.</i>		
<b>10a</b> Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>		
<b>b</b> Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

**Section D. All Type III Supporting Organizations**

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

**Section E. Type III Functionally Integrated Supporting Organizations**

	Yes	No
<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).		
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete <b>line 2</b> below.		
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete <b>line 3</b> below.		
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in <b>Part VI</b> how you supported a governmental entity (see instructions).		
<b>2</b> Activities Test. Answer lines 2a and 2b below.		
<b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in <b>Part VI</b> identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.		
<b>b</b> Did the activities described on line 2a, above, constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in <b>Part VI</b> the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.		
<b>3</b> Parent of Supported Organizations. Answer lines 3a and 3b below.		
<b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? If "Yes" or "No," provide details in <b>Part VI</b> .		
<b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in <b>Part VI</b> the role played by the organization in this regard.		
<b>2a</b>		
<b>2b</b>		
<b>3a</b>		
<b>3b</b>		

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
<b>1</b> Net short-term capital gain	<b>1</b>		
<b>2</b> Recoveries of prior-year distributions	<b>2</b>		
<b>3</b> Other gross income (see instructions)	<b>3</b>		
<b>4</b> Add lines 1 through 3.	<b>4</b>		
<b>5</b> Depreciation and depletion	<b>5</b>		
<b>6</b> Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	<b>6</b>		
<b>7</b> Other expenses (see instructions)	<b>7</b>		
<b>8 Adjusted Net Income</b> (subtract lines 5, 6, and 7 from line 4)	<b>8</b>		
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
<b>1</b> Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
<b>a</b> Average monthly value of securities	<b>1a</b>		
<b>b</b> Average monthly cash balances	<b>1b</b>		
<b>c</b> Fair market value of other non-exempt-use assets	<b>1c</b>		
<b>d Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>		
<b>e Discount</b> claimed for blockage or other factors ( <i>explain in detail in Part VI</i> ):			
<b>2</b> Acquisition indebtedness applicable to non-exempt-use assets	<b>2</b>		
<b>3</b> Subtract line 2 from line 1d.	<b>3</b>		
<b>4</b> Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	<b>4</b>		
<b>5</b> Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>		
<b>6</b> Multiply line 5 by 0.035.	<b>6</b>		
<b>7</b> Recoveries of prior-year distributions	<b>7</b>		
<b>8 Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>		
Section C - Distributable Amount			Current Year
<b>1</b> Adjusted net income for prior year (from Section A, line 8, column A)	<b>1</b>		
<b>2</b> Enter 0.85 of line 1.	<b>2</b>		
<b>3</b> Minimum asset amount for prior year (from Section B, line 8, column A)	<b>3</b>		
<b>4</b> Enter greater of line 2 or line 3.	<b>4</b>		
<b>5</b> Income tax imposed in prior year	<b>5</b>		
<b>6 Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	<b>6</b>		
<b>7</b> <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).			

Schedule A (Form 990) 2023

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

Section D - Distributions		Current Year
<b>1</b>	Amounts paid to supported organizations to accomplish exempt purposes	<b>1</b>
<b>2</b>	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	<b>2</b>
<b>3</b>	Administrative expenses paid to accomplish exempt purposes of supported organizations	<b>3</b>
<b>4</b>	Amounts paid to acquire exempt-use assets	<b>4</b>
<b>5</b>	Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i> )	<b>5</b>
<b>6</b>	Other distributions ( <i>describe in Part VI</i> ). See instructions.	<b>6</b>
<b>7</b>	<b>Total annual distributions.</b> Add lines 1 through 6.	<b>7</b>
<b>8</b>	Distributions to attentive supported organizations to which the organization is responsive ( <i>provide details in Part VI</i> ). See instructions.	<b>8</b>
<b>9</b>	Distributable amount for 2023 from Section C, line 6	<b>9</b>
<b>10</b>	Line 8 amount divided by line 9 amount	<b>10</b>

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2023	(iii) Distributable Amount for 2023
<b>1</b>	Distributable amount for 2023 from Section C, line 6			
<b>2</b>	Underdistributions, if any, for years prior to 2023 (reasonable cause required - <i>explain in Part VI</i> ). See instructions.			
<b>3</b>	Excess distributions carryover, if any, to 2023			
<b>a</b>	From 2018 . . . . .			
<b>b</b>	From 2019 . . . . .			
<b>c</b>	From 2020 . . . . .			
<b>d</b>	From 2021 . . . . .			
<b>e</b>	From 2022 . . . . .			
<b>f</b>	<b>Total</b> of lines 3a through 3e			
<b>g</b>	Applied to underdistributions of prior years			
<b>h</b>	Applied to 2023 distributable amount			
<b>i</b>	Carryover from 2018 not applied (see instructions)			
<b>j</b>	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
<b>4</b>	Distributions for 2023 from Section D, line 7: \$			
<b>a</b>	Applied to underdistributions of prior years			
<b>b</b>	Applied to 2023 distributable amount			
<b>c</b>	Remainder. Subtract lines 4a and 4b from line 4.			
<b>5</b>	Remaining underdistributions for years prior to 2023, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>6</b>	Remaining underdistributions for 2023. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>7</b>	<b>Excess distributions carryover to 2024.</b> Add lines 3j and 4c.			
<b>8</b>	Breakdown of line 7:			
<b>a</b>	Excess from 2019 . . . .			
<b>b</b>	Excess from 2020 . . . .			
<b>c</b>	Excess from 2021 . . . .			
<b>d</b>	Excess from 2022 . . . .			
<b>e</b>	Excess from 2023 . . . .			

Schedule A (Form 990) 2023

**Schedule B  
(Form 990)**Department of the Treasury  
Internal Revenue Service**Schedule of Contributors**Attach to Form 990, 990-EZ, or 990-PF.  
Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2023**

Name of the organization

Employer identification number

UNION HOSPITAL OF CECIL COUNTY, INC.

52-0607945

**Organization type** (check one):**Filers of:****Section:**

Form 990 or 990-EZ

☒ 501(c)( 3 ) (enter number) organization☐ 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation☐ 527 political organization

Form 990-PF

☐ 501(c)(3) exempt private foundation☐ 4947(a)(1) nonexempt charitable trust treated as a private foundation☐ 501(c)(3) taxable private foundationCheck 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, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

**Special Rules**

- ☐
- For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of
- (1)**
- \$5,000; or
- (2)**
- 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

- ☐
- For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000
- exclusively*
- for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.

- ☐
- For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions
- exclusively*
- for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an
- exclusively*
- religious, charitable, etc., purpose. Don't complete any of the parts unless the
- General Rule**
- applies to this organization because it received
- nonexclusively*
- religious, charitable, etc., contributions totaling \$5,000 or more during the year . . . . . \$ \_\_\_\_\_

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

Name of organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

**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	UNION HOSP. OF CECIL COUNTY FDN., INC. 4000 NEXUS DR. NW3-100 WILMINGTON, DE 19803	\$ 76,785.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	AFFINITY HEALTH ALLIANCE, INC. 4000 NEXUS DR. NW3-100 WILMINGTON, DE 19803	\$ 96,551.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)



Name of organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

**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
   	   	\$  	  
   	   	\$  	  
   	   	\$  	  
   	   	\$  	  
   	   	\$  	  
   	   	\$  	  
   	   	\$  	  

Name of organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

**Part III** **Exclusively** religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this information once. See instructions.) \$ \_\_\_\_\_

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

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(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)**Department of the Treasury  
Internal Revenue Service

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

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

Attach to Form 990.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023****Open to Public  
Inspection**

Employer identification number

52-0607945

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

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

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year . . . . .		
2 Aggregate value of contributions to (during year) . . . . .		
3 Aggregate value of grants from (during year) . . . . .		
4 Aggregate value at end of year . . . . .		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? . . . . .		<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? . . . . .		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Part II Conservation Easements**

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

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

<input type="checkbox"/> Preservation of land for public use (for example, recreation or education)	<input type="checkbox"/> Preservation of a historically important land area
<input type="checkbox"/> Protection of natural habitat	<input type="checkbox"/> Preservation of a certified historic structure
<input type="checkbox"/> Preservation of open space	

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

	Held at the End of the Tax Year
a Total number of conservation easements . . . . .	2a
b Total acreage restricted by conservation easements . . . . .	2b
c Number of conservation easements on a certified historic structure included on line 2a . . . . .	2c
d Number of conservation easements included on line 2c acquired after July 25, 2006, and not on a historic structure listed in the National Register . . . . .	2d

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

4 Number of states where property subject to conservation easement is located \_\_\_\_\_

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

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

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year \_\_\_\_\_

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

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

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

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

1a If the organization elected, as permitted under FASB 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 FASB ASC 958, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenue included on 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 FASB ASC 958 relating to these items:

a Revenue included on 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) 2023

**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 make 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 program

**e** ☐ Other \_\_\_\_\_

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

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

**Part IV Escrow and Custodial Arrangements**

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

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

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

	Amount
<b>c</b> Beginning balance . . . . .	<b>1c</b>
<b>d</b> Additions during the year . . . . .	<b>1d</b>
<b>e</b> Distributions during the year . . . . .	<b>1e</b>
<b>f</b> Ending balance . . . . .	<b>1f</b>

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

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

**Part V Endowment Funds**

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

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

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

**a** Board designated or quasi-endowment \_\_\_\_\_ %

**b** Permanent endowment \_\_\_\_\_ %

**c** Term endowment \_\_\_\_\_ %

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

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

**(i)** Unrelated organizations? . . . . .

**(ii)** Related organizations? . . . . .

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

	Yes	No
<b>3a(i)</b>		
<b>3a(ii)</b>		
<b>3b</b>		

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

**Part VI Land, Buildings, and Equipment**

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land . . . . .		1,134,904.		1,134,904.
<b>b</b> Buildings . . . . .		60,226,297.	36,907,278.	23,319,019.
<b>c</b> Leasehold improvements . . . . .		1,094,894.	650,873.	444,021.
<b>d</b> Equipment . . . . .		98,900,635.	77,305,107.	21,595,528.
<b>e</b> Other . . . . .		34,365,918.	21,453,452.	12,912,466.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, line 10c, column (B)) . . . . .				59,405,938.

**Part VII Investments - Other Securities**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives . . . . .		
(2) Closely held equity interests . . . . .	6,952,609.	SEE SUPPLEMENTAL PAGE
(3) Other		
(A) MANAGED HEDGE FUNDS	2,662,094.	FMV
(B) INVESTMENTS	48,038,054.	FMV
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, line 12, col. (B)) . . .	57,652,757.	

**Part VIII Investments - Program Related**

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

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

**Part IX Other Assets**

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

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	19,010,164.
(2) IN HOUSE LEASES	3,367,654.
(3) ROU LEASES	2,688,366.
(4) INSURANCE CLAIMS RECOVERABLE	2,542,560.
(5) SECURITY DEPOSITS	25,618.
(6) OTHER ASSETS	20,000.
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, line 15, col. (B)). . . . .	27,654,362.

**Part X Other Liabilities**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) INTERCOMPANY PAYABLES	87,695,204.
(3) EST. MEDICAL MALPRACTICE LIABI	4,175,807.
(4) ROU LEASES	3,978,096.
(5) CAPITAL LEASE OBLIGATIONS	29,777.
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, line 25, col. (B)). . . . .	95,878,884.

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



Part XIII

Supplemental Information (continued)

Part XIII

Supplemental Information (continued)

SCHEDULE D, PART VII - INVESTMENTS - CLOSELY HELD EQUITY INTERESTS

=====

DESCRIPTION	BOOK VALUE	COST OR FMV
-----	-----	-----
CLOSELY-HELD EQUITY INTERESTS	6,952,609.	COST
	-----	
TOTALS	6,952,609.	
	=====	



**SCHEDULE H  
(Form 990)**Department of the Treasury  
Internal Revenue Service**Hospitals**

Complete if the organization answered "Yes" on Form 990, Part IV, question 20a.  
 Attach to Form 990.  
 Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023****Open to Public  
Inspection**

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

**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 . . . . .	<input checked="" type="checkbox"/>	
<b>1b</b> If "Yes," was it a written policy? . . . . .	<input checked="" type="checkbox"/>	
<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 checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<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 _____ %	<input checked="" type="checkbox"/>	
<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 type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
<b>c</b> If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
<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"? . . . . .	<input checked="" type="checkbox"/>	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	
<b>5b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .	<input checked="" type="checkbox"/>	
<b>5c</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? . . . . .		<input checked="" type="checkbox"/>
<b>6a</b> Did the organization prepare a community benefit report during the tax year? . . . . .	<input checked="" type="checkbox"/>	
<b>6b</b> If "Yes," did the organization make it available to the public? . . . . .	<input checked="" type="checkbox"/>	

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

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

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . .			1,815,310.	NONE	1,815,310.	0.94
<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 Total.</b> Financial Assistance and Means-Tested Government Programs . . .			1,815,310.	NONE	1,815,310.	0.94
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) .			473,463.	NONE	473,463.	0.24
<b>f</b> Health professions education (from Worksheet 5) . . . .			262,018.	NONE	262,018.	0.14
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .			23,242,944.	10,812,078.	12,430,866.	6.43
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			178,899.	NONE	178,899.	0.09
<b>j Total.</b> Other Benefits . . . .			24,157,324.	10,812,078.	13,345,246.	6.90
<b>k Total.</b> Add lines 7d and 7j .			25,972,634.	10,812,078.	15,160,556.	7.84

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

Schedule H (Form 990) 2023

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development			1,255.		1,255.	
3 Community support			1,464.		1,464.	
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development			7,395.		7,395.	
9 Other						
10 Total			10,114.		10,114.	

**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	2,705,521.
6 Enter Medicare allowable costs of care relating to payments on line 5 . . . . .	6	1,872,310.
7 Subtract line 6 from line 5. This is the surplus (or shortfall) . . . . .	7	833,211.
8 Describe in Part VI the extent to which any shortfall reported on 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** (continued)**Section B. Facility Policies and Practices**

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

Name of hospital facility or letter of facility reporting group: UNION HOSPITAL OF CECIL COUNTY, INC.

Line number of hospital facility, or line numbers of hospital

facilities in a facility reporting group (from Part V, Section A): 1

	Yes	No
<b>Community Health Needs Assessment</b>		
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .	<b>1</b>	X
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . .	<b>2</b>	X
<b>3</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 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	<b>3</b>	X
<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 significant 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"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA: 2021		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . .	<b>5</b>	X
<b>6a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	X
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	<b>6b</b>	X
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply):	<b>7</b>	X
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url): SEE PART V, SECTION C		
<b>b</b> <input checked="" type="checkbox"/> Other website (list url): SEE PART V, SECTION C		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . .	<b>8</b>	X
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy: 2022		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	<b>10</b>	X
<b>a</b> If "Yes," (list url): SEE PART V, SECTION C		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	X
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
<b>12a</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)? . . . . .	<b>12a</b>	X
<b>b</b> If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

Name of hospital facility or letter of facility reporting group: UNION HOSPITAL OF CECIL COUNTY, INC.

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	<b>X</b>	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>400.0000</u> %		
<b>b</b>	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance status		
<b>g</b>	<input checked="" type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	<b>X</b>	
<b>15</b>	Explained the method for applying for financial assistance? . . . . .	<b>X</b>	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of their application		
<b>b</b>	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of their application		
<b>c</b>	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . .	<b>X</b>	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b>	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
<b>j</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		

Schedule H (Form 990) 2023

**Part V Facility Information** (continued)

**Billing and Collections**

Name of hospital facility or letter of facility reporting group: UNION HOSPITAL OF CECIL COUNTY, INC.

	Yes	No
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	<b>17</b>	X
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b> <input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
<b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process		
<b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	<b>19</b>	X
If "Yes," check all actions in which the hospital facility or a third party engaged:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b> <input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
<b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process		
<b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
<b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
<b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
<b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
<b>e</b> <input type="checkbox"/> Other (describe in Section C)		
<b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . .	<b>21</b>	X
If "No," indicate why:		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
<b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing		
<b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

Name of hospital facility or letter of facility reporting group: UNION HOSPITAL OF CECIL COUNTY, INC.

	Yes	No
<b>22</b> 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:		
<b>a</b> <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
<b>b</b> <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
<b>c</b> <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
<b>d</b> <input checked="" type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
<b>23</b> During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . . If "Yes," explain in Section C.	<b>23</b>	<b>X</b>
<b>24</b> During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . . If "Yes," explain in Section C.	<b>24</b>	<b>X</b>

Schedule H (Form 990) 2023

**Part V Facility Information** (continued)

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

PART V, SECTION B, LINES 5, 6A & 6B (INPUT FROM COMMUNITY; JOINT CHNA)

THE 2022 CHNA WAS THE FOURTH CHNA UNION HOSPITAL HAS UNDERTAKEN IN COLLABORATION WITH THE CECIL COUNTY HEALTH DEPARTMENT (CCHD). WE ARE GRATEFUL FOR THEIR EXPERTISE AND CONTINUED PARTNERSHIP AS WE WORK TOGETHER TO SERVE CECIL COUNTY.

TO RECEIVE COMMUNITY INPUT FOR THE 2022 CHNA, WE HOSTED FOUR VIRTUAL MEETINGS WITH THE PARTICIPATION OF 43 COMMUNITY STAKEHOLDERS WHO REPRESENTED THE CCHD AND OTHER GOVERNMENT AGENCIES, NON-PROFIT ORGANIZATIONS, LOCAL BUSINESSES, HEALTH CARE PROVIDERS, AND THE SCHOOL SYSTEM. UNFORTUNATELY, THOSE MEETINGS HAD TO BE HELD VIRTUALLY DUE TO THE RISING NUMBERS OF COVID CASES IN THE COMMUNITY. WE ALSO MET WITH FOUR TEENAGERS PARTICIPATING IN THE CECIL COUNTY PUBLIC LIBRARY'S YOUTH ADVISORY COUNCIL. WE WANTED TO LEARN FROM YOUNG COMMUNITY MEMBERS AS THEY ARE ALSO PART OF THE COMMUNITY WE SERVE AND MAY HAVE DIFFERENT PERSPECTIVES THAN THOSE OF THE ADULTS.

FINALLY, WE ALSO HELD A MEETING FOR UNION CAREGIVERS REPRESENTING ADMINISTRATION, NURSING, CASE MANAGEMENT, SOCIAL SERVICES, AND PROJECT MANAGEMENT. THE INTENT OF THE MEETING WAS TO GAIN THE CAREGIVERS' PERSPECTIVE ON THE COMMUNITY'S MOST SIGNIFICANT CHALLENGES AS WELL AS PROVIDE THEM WITH MORE INSIGHT INTO THE COMMUNITY. 16 CAREGIVERS ATTENDED THIS MEETING.

EACH MEETING FOLLOWED THE SAME FORMAT. THE CHNA PROCESS AND THE PURPOSE OF THE MEETING WERE EXPLAINED, AND SECONDARY DATA WERE PRESENTED INCLUDING A SUMMARY OF UNFAVORABLE COMMUNITY HEALTH INDICATORS. WE ASKED MEETING PARTICIPANTS FOR THEIR REACTIONS TO THE SECONDARY DATA ANALYSIS AND TO IDENTIFY COMMUNITY HEALTH ISSUES THAT MAY NOT HAVE BEEN INCLUDED IN THE DATA. AT THE CONCLUSION OF EACH MEETING, PARTICIPANTS WERE ASKED TO IDENTIFY THREE TO FIVE COMMUNITY HEALTH ISSUES THEY CONSIDER TO BE MOST SIGNIFICANT.

AN ONLINE COMMUNITY HEALTH SURVEY WAS ALSO CONDUCTED IN FEBRUARY AND MARCH 2022. THE SURVEY HAD TWENTY QUESTIONS ON THE FOLLOWING TOPICS: DEMOGRAPHICS, COMMUNITY HEALTH, QUALITY OF LIFE, AND ACCESS TO HEALTH CARE SERVICES. 544 PARTICIPANTS COMPLETED THE SURVEY. MOST SURVEY RESPONDENTS WERE FEMALE (87%) AND 64% OF THE SURVEY RESPONDENTS WERE FROM NORTH EAST AND ELKTON.

SEVEN KEY STAKEHOLDERS, HEALTH OFFICERS FROM THE CCHD AND ADMINISTRATIVE AND CLINICAL STAFF FROM WEST CECIL HEALTH CENTER, A FEDERALLY QUALIFIED HEALTH CENTER, WERE ALSO INTERVIEWED TO GATHER THEIR INPUT ON COMMUNITY HEALTH ISSUES. THE STAKEHOLDERS WERE ASKED TO IDENTIFY AND DISCUSS COMMUNITY HEALTH ISSUES PRIOR TO THE COVID-19 PANDEMIC AND THEN DESCRIBE THE PANDEMIC'S IMPACTS ON THE COMMUNITY AND WHAT HAS BEEN LEARNED ABOUT



**Part V Facility Information** (continued)

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

THE COMMUNITY'S HEALTH GIVEN THOSE IMPACTS. THE STAKEHOLDERS WERE ALSO ASKED TO DESCRIBE THE TYPES OF INITIATIVES, PROGRAMS, AND INVESTMENTS THAT SHOULD BE IMPLEMENTED TO ADDRESS THE COMMUNITY'S HEALTH ISSUES AND TO BE BETTER PREPARED FOR FUTURE RISKS.

CHRISTIANACARE CONTRACTED WITH VERITÉ HEALTHCARE CONSULTING, LLC (VERITÉ) TO COMPLETE ITS 2022 CHNA. IN COOPERATION WITH CHRISTIANACARE'S OFFICE OF HEALTH EQUITY AND THE CCHD, VERITÉ CONDUCTED THE RESEARCH, PRIMARY AND SECONDARY DATA COLLECTION, REVIEW, AND ANALYSIS, TO DEVELOP THE CHNA.

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SCHEDULE H, PART V, SECTION B, LINE 7A & B (CHNA AVAILABILITY)

UNION HOSPITAL OF CECIL COUNTY, INC.'S CHNA IS AVAILABLE ON ITS WEBSITE AT: [HTTPS://WWW.UHCC.COM/ABOUT-US/COMMUNITY-BENEFIT/REPORTS/](https://www.uhcc.com/about-us/community-benefit/reports/)

UNION HOSPITAL OF CECIL COUNTY, INC.'S CHNA IS ALSO AVAILABLE AT: [HTTPS://CECILCOUNTYHEALTH.ORG/RESOURCES/HEALTH-ADVISORY-COMMITTEE/](https://cecilcountyhealth.org/resources/health-advisory-committee/)

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SCHEDULE H, PART V, SECTION B, LINE 10 (IMP. STRATEGY PUBLIC AVAILABILITY)

UNION HOSPITAL OF CECIL COUNTY, INC.'S CHIP IS AVAILABLE ON ITS WEBSITE AT: [HTTP://WWW.UHCC.COM/ABOUT-US/COMMUNITY-BENEFIT/REPORTS/](http://www.uhcc.com/about-us/community-benefit/reports/)

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SCHEDULE H, PART V, SECTION B, LINE 11 (ADDRESSING NEEDS FROM THE CHNA)

UNION'S 2022 CHNA IDENTIFIED THE FOLLOWING AS SIGNIFICANT AREAS OF NEED IN CECIL COUNTY:

- . ACCESS TO HEALTH SERVICES
- . CANCER
- . CHILDHOOD TRAUMA/ADVERSE CHILDHOOD EXPERIENCES (ACE)
- . LGBTQIA+ HEALTH DISPARITIES
- . MENTAL HEALTH
- . NUTRITION, OBESITY, AND PHYSICAL INACTIVITY
- . SMOKING, TOBACCO, AND VAPE PRODUCT USE
- . SUBSTANCE USE DISORDERS

OF THESE SIGNIFICANT NEEDS, UNION PRIORITIZED:

**Part V Facility Information** (continued)

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

- . ACCESS TO HEALTH SERVICES
- . CANCER
- . LGBTQIA+ HEALTH DISPARITIES
- . SUBSTANCE USE DISORDERS

SELECTION FOR PRIORITIZATION WAS BASED ON RESOURCE AVAILABILITY AND PROGRAMMING UNDERWAY OR PLANNED. UNION ADDRESSES ALL THE IDENTIFIED SIGNIFICANT AREAS OF NEED, BUT DID NOT PRIORITIZE THE FOLLOWING AREAS OF NEED:

- . CHILDHOOD TRAUMA/ADVERSE CHILDHOOD EXPERIENCES (ACE)
- . MENTAL HEALTH
- . NUTRITION, OBESITY, AND PHYSICAL INACTIVITY
- . SMOKING, TOBACCO, AND VAPE PRODUCT USE

THESE AREAS WERE NOT PRIORITIZED BECAUSE WE WERE UNABLE TO CREATE NEW OR EXPANDED COMMUNITY BENEFIT PROGRAMMING IN THESE AREAS. HOWEVER, WE ARE PLEASED TO REPORT THAT CAREGIVERS IN OUR CANCER PROGRAM WORKED TO DEVELOP AND IMPLEMENT A SMOKING CESSATION PROGRAM THAT WILL BEGIN ACCEPTING PATIENTS IN 2025.

#### ACCESS TO HEALTH SERVICES

CECIL COUNTY HAS A LOW PER-CAPITA SUPPLY OF PRIMARY CARE, DENTAL HEALTH, AND MENTAL HEALTH PROFESSIONALS COMPARED TO NATIONAL AVERAGES, WHICH CREATES SIGNIFICANT BARRIERS TO CARE. UNION, LIKE RURAL HOSPITALS ACROSS THE COUNTRY, HAS ALSO EXPERIENCED CHALLENGES RECRUITING AND RETAINING PROVIDERS. CHRISTIANACARE CONTINUES TO RESPOND TO THIS CHALLENGE WITH A DIVERSITY OF ONGOING RECRUITMENT EFFORTS.

UNFORTUNATELY, ACCESS BARRIERS ARE COMPLEX AND WILL NOT BE RESOLVED ENTIRELY WITH MORE PROVIDERS ALTHOUGH MORE PROVIDERS ARE CERTAINLY NEEDED. LACK OF TRANSPORTATION PRESENTS AN ISSUE FOR MANY IN CECIL COUNTY. IN FY2022 UNION BEGAN TO UTILIZE ROUNDTrip, A COMPANY THAT PROVIDES A DIGITAL TRANSPORTATION MARKETPLACE TO CONNECT PATIENTS FACING TRANSPORTATION BARRIERS WITH NON-EMERGENCY MEDICAL TRANSPORTATION. WE LAUNCHED ROUNDTrip FOR OUR PATIENTS PARTICIPATING IN OUR CARE TRANSFORMATION INITIATIVE (CTI), CHRONIC DISEASE NAVIGATION PROGRAM. SINCE THEN, WE HAVE EXPANDED THE USE OF ROUNDTrip TO OUR PRIMARY CARE PRACTICES. IN FY2024, 117 ROUNDTrip RIDES WERE PROVIDED TO 22 PATIENTS. THIS IS A SIGNIFICANT INCREASE FROM THE 12 RIDES PROVIDED THROUGH ROUNDTrip IN FY2023. FOR MANY YEARS, UNION HAS ALSO PROVIDED TAXI VOUCHERS TO INPATIENTS AT DISCHARGE WHO HAVE NO TRANSPORTATION HOME. IN FY2024, UNION PAID \$3,807 TO TRANSPORT PATIENTS HOME IN TAXIS.

TO ADDRESS ADDITIONAL SOCIAL BARRIERS TO ACCESSING CARE, UNION CONTINUES TO USE UNITE MARYLAND, A COORDINATED NETWORK THAT CONNECTS HEALTH AND SOCIAL SERVICE ORGANIZATIONS THROUGH A SHARED TECHNOLOGY PLATFORM, UNITE

**Part V Facility Information** (continued)

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

US, TO SEND AND RECEIVE TRACKABLE REFERRALS ON BEHALF OF PATIENTS. UNITE MARYLAND ALLOWS PROVIDERS TO SERVE THE WHOLE PERSON BY REFERRING PATIENTS TO SOCIAL SERVICES. CHRISTIANACARE'S PARTNERSHIP WITH UNITE US NOT ONLY ALLOWS OUR CAREGIVERS AT UNION TO USE THE NETWORK, BUT ALSO ANY COMMUNITY ORGANIZATION IN CECIL COUNTY. OUR EXPECTATION IS THAT BY ADDRESSING PATIENTS' SOCIAL NEEDS, PATIENTS WILL BE MORE ABLE TO IMPROVE THEIR HEALTH AND REDUCE HOSPITAL UTILIZATION. IN FY2024, APPROXIMATELY 500 REFERRALS WERE SENT ON BEHALF OF UNION PATIENTS.

IN FY2024, UNION ALSO HIRED TWO ACUTE CARE CONNECTORS (ACC) TO IDENTIFY AND ADDRESS PATIENT SOCIAL NEEDS. ADMITTED PATIENTS ARE PRE-SCREENED FOR SOCIAL DRIVERS OF HEALTH (SDOH) THROUGH VARIOUS ADMISSION AND ASSESSMENT DOCUMENTATION. IF THERE ARE POSITIVE FINDINGS ON THE PRESCREEN, THE ACCS WILL COMPLETE A FULL IN-DEPTH SDOH SCREENING AND PLACE REFERRALS, OFTEN USING UNITE MARYLAND, AS NEEDED. THE ACCS ARE HEALTHCARE PROFESSIONALS TRAINED IN SCREENING AND CONNECTING PATIENTS WITH RESOURCES TO ADDRESS SOCIAL CARE NEEDS. IN FY2024, THE ACCS SCREENED 769 PATIENTS.

IN FY2023, UNION BEGAN PARTICIPATING IN THE MARYLAND PRIMARY CARE PROGRAM (MDPCP). THROUGH THIS PROGRAM, UNION RECEIVES FUNDING TO ADDRESS THE SOCIAL NEED OF MEDICARE PATIENTS. HEALTH EQUITY ADVANCEMENT RESOURCE AND TRANSFORMATION (HEART) PAYMENTS ARE ALSO USED TO PROVIDE PARTICIPATING PATIENTS WITH HYPERTENSION, DIABETES, AND CONGESTIVE HEART FAILURE WITH MEDICALLY TAILORED FOODS, SELF-MONITORING EQUIPMENT, AND TRANSPORTATION THROUGH ROUNDTrip TO THEIR MEDICAL APPOINTMENTS AND SERVICES. IN FY2024, UNION ENROLLED OVER 100 PATIENTS IN THIS PROGRAM AND PROVIDED 950 FOOD BOXES AND 21,000 MEALS TO THESE PATIENTS.

UNION'S CHILDBIRTH AND EARLY EDUCATION TEAM AND PEDIATRIC NURSES CONTINUE TO RESPOND TO OUR COMMUNITY NEEDS BY PROVIDING CHILDBIRTH AND INFANT CARE EDUCATION ON-SITE AND IN THE COMMUNITY. IN FY2024, UNION PROVIDED WEEKLY BREASTFEEDING CLASSES, BREASTFEEDING CONSULTATIONS UPON REQUEST, AND BI-MONTHLY CHILDBIRTH EDUCATION CLASSES. EACH CLASS HAD 2 TO 16 PARTICIPANTS. UNION CAREGIVERS ALSO PROVIDED FOUR CHILDBIRTH EDUCATION CLASSES AT THE ELKTON HERITAGE PREGNANCY AND FAMILY HEALTH CENTER AT THE REQUEST OF THE CECIL COUNTY HEALTH DEPARTMENT. EACH CLASS HAD 11 PARTICIPANTS. THE ELKTON SITE OF THE HERITAGE PREGNANCY AND FAMILY HEALTH CENTER LATER CLOSED DURING FY2024, AND SO UNION'S CONTINUED OFFERING OF THIS EDUCATION AT UNION, WITHIN A MILE OF THE PREVIOUS HERITAGE PREGNANCY AND FAMILY HEALTH CENTER LOCATION, IS ENSURING A NEED IN THE COMMUNITY CONTINUES TO BE ADDRESSED. IN DECEMBER 2023, UNION ALSO HELD OUR INAUGURAL COMMUNITY BABY SHOWER WHICH PROVIDED EXPECTANT PARENTS WITH NEEDED SUPPLIES SUCH AS DIAPERS AND WIPES AND ITEMS LIKE CAR SEATS. CONNECTIONS TO COMMUNITY AND CLINICAL RESOURCES AND INFANT EDUCATION WERE ALSO AVAILABLE. 50 INDIVIDUALS WERE SERVED AND ALL EXPRESSED THEIR GRATITUDE FOR RECEIVING ITEMS THAT WOULD HAVE BEEN IMPOSSIBLE OR DIFFICULT FOR THEM TO GET OTHERWISE.

**Part V Facility Information** (continued)

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

IN FY2024, UNION ALSO CONTINUED TO PROVIDE EDUCATION ON-SITE AT THE COMMUNITY TREATMENT PROVIDER, SERENITY HEALTH, AND BEGAN TO OFFER EDUCATION AT ANOTHER TREATMENT PROVIDER, BRANTWOOD FAMILY SERVICES, BOTH IN ELKTON. THOSE WHO ARE PREGNANT AND RECEIVING TREATMENT ATTEND THESE CLASSES TO LEARN ABOUT CHILDBIRTH AND INFANT CARE, AND ARE ALSO PROVIDED INFORMATION ABOUT THE PROGRAM EAT, SLEEP, CONSOLE WHICH IS AN APPROACH TO CARING FOR BABIES BORN WITH NEONATAL ABSTINENCE SYNDROME (NAS) THAT CAN REDUCE THE NEED FOR MEDICAL INTERVENTION. EACH SESSION HAD 1 TO 5 PARTICIPANTS.

FOR NEARLY 20 YEARS, UNION HAS PARTNERED WITH CECIL COUNTY PUBLIC SCHOOLS TO OFFER A FREE SPORTS PHYSICAL EVENT FOR CECIL COUNTY PUBLIC SCHOOL STUDENTS. GIVEN THE PROVIDER SHORTAGE IN CECIL COUNTY, THIS EVENT IS SIGNIFICANT IN ENSURING STUDENTS CAN RECEIVE A PHYSICAL AND PROVIDING RELIEF TO CECIL COUNTY PRACTICES. ON JUNE 5, 2024, 540 STUDENTS WERE ABLE TO COMPLETE THEIR PHYSICALS. AT THE EVENT, ATTENDEES WERE ALSO PROVIDED INFORMATION ABOUT COMMUNITY RESOURCES AND HELPED WITH ENROLLMENT WITH A PRIMARY CARE PROVIDER IF THEY HAD NONE.

FINALLY, IN FY2024, UNION PARTNERED WITH THE PARIS FOUNDATION TO OFFER MONTHLY MOBILE HEALTH OUTREACH IN HOLLINGSWORTH MANOR IN ELKTON. DURING THIS MONTHLY OUTREACH, INDIVIDUALS RECEIVE BLOOD PRESSURE AND VISION SCREENINGS AS WELL AS CONNECTIONS TO CLINICAL AND COMMUNITY RESOURCES. AT LEAST 10 INDIVIDUALS HAVE BEEN SERVED BY THIS OUTREACH EACH MONTH.

**CANCER**

CANCER RATES IN CECIL COUNTY REMAIN ABOVE THE MARYLAND AND UNITED STATES AVERAGES. THE CANCER INCIDENCE RATE PER 100,000 IN CECIL COUNTY IS 499, WHILE THE RATE FOR MARYLAND IS 446.8 AND THE NATIONAL RATE IS 444.4. THE MORTALITY RATE FOR LUNG AND BRONCHUS CANCER IN CECIL COUNTY HAS BEEN CONSIDERABLY ABOVE THE UNITED STATES AVERAGE AT 87.1 PER 100,000 IN COMPARISON TO 57.3 PER 100,000. UNION HAS PARTNERED CLOSELY WITH THE CECIL COUNTY CANCER TASK FORCE TO CRAFT AND IMPLEMENT PUBLIC OUTREACH TO PROMOTE CANCER SCREENINGS, WITH A FOCUS ON LOW DOSE COMPUTED TOMOGRAPHY (LDCT) SCREENING, AND OTHER PREVENTION ACTIVITIES.

UNION CAREGIVERS PROVIDED INFORMATION AND EDUCATION AT COMMUNITY AND CAMPUS EVENTS THROUGHOUT THE YEAR TO PROMOTE CANCER SCREENING AND PREVENTION. UNION ALSO PARTNERED WITH CECIL COUNTY PUBLIC SCHOOLS (CCPS) TO HOLD TWO TARGETED SCREENING DATES FOR MAMMOGRAPHY FOR CCPS STAFF. IN FY2024, 513 COMMUNITY MEMBERS RECEIVED INFORMATION AND EDUCATION FROM UNION CAREGIVERS AT COMMUNITY AND CAMPUS EVENTS.

FY2024 WAS ALSO THE FIRST FULL YEAR OF EMPLOYMENT FOR OUR CANCER PROGRAM'S LUNG HEALTH NAVIGATOR. UNION CREATED THIS PART TIME POSITION IN RESPONSE TO THE NEED IN CECIL COUNTY FOR MORE LUNG CANCER SCREENING. THE NAVIGATOR HELPS CONNECT PATIENTS DIRECTLY TO SCREENING AND HELPS THEM

**Part V Facility Information** (continued)

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

ADDRESS BARRIERS TO SCREENING. IN FY2024, UNION PERFORMED 537 LDCT SCREENINGS, A SIGNIFICANT INCREASE FROM THE PRIOR YEAR AND A DEMONSTRATION OF THE EFFECTIVENESS OF THE NAVIGATOR.

IN FY2024, UNION ALSO WORKED TO DEVELOP A SMOKING CESSATION PROGRAM THAT WILL BE OFFERED IN 2025. AS WITH THE CREATION OF THE NAVIGATOR POSITION, THIS PROGRAM WAS ALSO DEVELOPED TO ADDRESS A NEED IN THE COMMUNITY AND IMPROVE HEALTH.

**LGBTQIA+ HEALTH DISPARITIES**

THE LESBIAN, GAY, TRANSGENDER, QUEER/QUESTIONING, INTERSEX AND ASEXUAL, ETC. (LGBTQIA+) COMMUNITY IN CECIL COUNTY HAVE SIGNIFICANT HEALTH DISPARITIES. WHILE COUNTY LEVEL DATA IS NOT AVAILABLE, FROM STATE LEVEL DATA, WE KNOW THAT LGBTQIA+ INDIVIDUALS IN MARYLAND ARE MORE LIKELY TO BE UNINSURED AND FOOD INSECURE THAN HETEROSEXUAL INDIVIDUALS. THE STAKEHOLDERS INTERVIEWED IN THE 2022 CHNA ALSO IDENTIFIED AS SIGNIFICANT THE DISCRIMINATION IN HEALTHCARE FACED BY THE LGBTQIA+ COMMUNITY, WHICH LEADS TO AVOIDING HEALTH CARE SERVICES.

TO BEGIN TO ADDRESS THOSE DISPARITIES, THE PRIDE AMBASSADORS PROGRAM, CREATED BY CHRISTIANACARE'S OFFICE OF HEALTH EQUITY, IS AVAILABLE TO UNION CAREGIVERS. THE PRIDE AMBASSADORS PROGRAM OFFERS SIX HOURS OF INSTRUCTION INCLUDING EXPLORATION OF LGBTQIA+ HEALTH TOPICS AS THEY RELATE TO CREATING MORE EQUITABLE HEALTHCARE FOR OUR LGBTQIA+ PATIENTS AND FAMILIES. IN FY2024, TWO UNION CAREGIVERS RECEIVED THIS TRAINING. WE ALSO MADE THIS TRAINING AVAILABLE TO COMMUNITY PROVIDERS, AT NO COST. WE WERE PLEASED THAT TWO CECIL COUNTY HEALTH DEPARTMENT EMPLOYEES ALSO COMPLETED THE PRIDE AMBASSADORS PROGRAM. ADDITIONALLY, AS A PART OF NEW NURSING ORIENTATION OFFERED BI-WEEKLY, ALL PARTICIPANTS RECEIVE AN INTRODUCTION TO LGBTQIA+ HEALTH. CHRISTIANACARE'S WE ASK BECAUSE WE CARE PROJECT, IMPLEMENTED SYSTEMWIDE LAST YEAR, ALSO GIVES US THE ORGANIZATIONAL CAPACITY TO IDENTIFY, TRACK, AND ADDRESS DISPARITIES FOR THIS POPULATION.

**SUBSTANCE USE DISORDERS**

SUBSTANCE USE DISORDER (SUD) HAS BEEN AN INTRACTABLE COMMUNITY ISSUE IN CECIL COUNTY. TO ADDRESS IT, UNION HAS LONG PARTNERED WITH CCHD'S ALCOHOL & DRUG RECOVERY CENTER TO MAKE AVAILABLE A DESIGNATED PEER RECOVERY SPECIALIST FOR REFERRALS ON BEHALF OF UNION PATIENTS. LAST YEAR, THE SUPPORT OFFERED TO PATIENTS THROUGH THIS PARTNERSHIP WAS GREATLY EXPANDED WITH THE AWARD OF A NACCHO GRANT, SUSTAINING PEERS IN THE EMERGENCY DEPARTMENT, TO CCHD. THERE ARE NOW NINE PEERS, EMPLOYED BY CCHD AND VOICES OF HOPE, A COMMUNITY ORGANIZATION, AVAILABLE IN THE HOSPITAL TO PROVIDE BEDSIDE CONSULTS FOR PATIENTS STRUGGLING WITH ADDICTION. THE PEERS PROVIDE COVERAGE FROM 8 A.M. TO 1 A.M. EVERY DAY OF THE WEEK. UNLIKE IN PREVIOUS YEARS, THE PEERS ARE FOCUSED ON MORE THAN JUST

**Part V Facility Information** (continued)

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

PATIENTS IN THE ED. WE HAVE EXPANDED THE EDUCATION AND REFERRAL PATTERNS ACROSS ALL MEDICAL FLOORS AND STAFF TO INCREASE REFERRAL PATTERNS AND SUPPORT FOR OUR PATIENTS.

BY ENGAGING WITH THE PEER, INDIVIDUALS SUFFERING FROM SUBSTANCE USE DISORDER WILL BE ENCOURAGED TO CONSIDER TREATMENT AND PROVIDED WITH HARM REDUCTION STRATEGIES. IF THEY WANT TO PURSUE TREATMENT, THE PEER WILL SUPPORT THEM IN MEETING THAT GOAL. THIS PROGRAM BEGAN ON SEPTEMBER 2023. IN FY2024, 512 PATIENTS WERE SERVED WITH 369 OF THOSE REFERRED TO TREATMENT OR RECOVERY SUPPORTS. OF THOSE, 144 PATIENTS WERE CONFIRMED TO HAVE ENGAGED IN BEHAVIORAL HEALTH TREATMENT DEMONSTRATING THIS PROGRAM'S EFFECTIVENESS.

AS PREVIOUSLY DESCRIBED, UNION CAREGIVERS ALSO PROVIDE CHILDBIRTH AND INFANT EDUCATION TO PREGNANT WOMEN RECEIVING SUBSTANCE USE DISORDER TREATMENT AT SERENITY HEALTH AND BRANTWOOD FAMILY SERVICES IN ELKTON. A REGISTERED NURSE GOES TO THESE COMMUNITY TREATMENT PROVIDERS TO PROVIDE EDUCATIONAL SESSIONS ON TOPICS SUCH AS BREASTFEEDING, NEONATAL ABSTINENCE SYNDROME (NAS), AND SAFE SLEEP, AMONG OTHERS.

ON BEHALF OF UNION, CAREGIVERS ALSO ATTEND LOCAL OVERDOSE FATALITY REVIEW TEAMS (LORFT) MEETINGS TO DISCUSS AND CASE REVIEW ALL UNINTENTIONAL OVERDOSE DEATHS RELATED TO STREET DRUGS AND ALCOHOL IN CECIL COUNTY. MEMBERS ARE STAKEHOLDERS FROM LAW ENFORCEMENT, THE COMMUNITY, GOVERNMENT AGENCIES, AND PROVIDERS. UNION'S PROGRAM DIRECTOR FOR OUTPATIENT BEHAVIORAL HEALTH ALSO ATTENDED CECIL COUNTY BEHAVIORAL HEALTH PROVIDER MEETINGS WHICH SERVE TO INCREASE COMMUNICATION, COLLABORATION, AND COORDINATION AMONG LOCAL BEHAVIORAL HEALTH PROVIDERS. THESE MEETINGS ARE INTENDED TO ALLOW PROVIDERS TO LEARN FROM ONE ANOTHER AND ULTIMATELY, IMPROVE SERVICE TO THE COMMUNITY.

SCHEDULE H, PART V, SECTION B, LINE 13B (DETAIL OF INCOME LEVEL)

PATIENTS WITH A HOUSEHOLD INCOME UP TO 500% OF FPL AND WITH A FINANCIAL HARDSHIP (MEDICAL DEBT, INCURRED BY A FAMILY OVER A 12-MONTH PERIOD THAT EXCEEDS 25 PERCENT OF THE FAMILY INCOME) WILL RECEIVE A 25% ADJUSTMENT.

SCHEDULE H, PART V, SECTION B, LINE 16A (FAP AVAILABILITY)

**Part V Facility Information** (continued)

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

FAP WEBSITE:

HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/  
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SCHEDULE H, PART V, SECTION B, LINE 16B (FAP APPLICATION AVAILABILITY)

FAP APPLICATION WEBSITE:

HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/  
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SCHEDULE H, PART V, SECTION B, LINE 16C (FAP PLS AVAILABILITY)

FAP PLAIN LANGUAGE SUMMARY WEBSITE:

HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/  
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SCHEDULE H, PART V, SECTION B, LINE 16J (FAP OTHER AVAILABILITY)

UNION HOSPITAL PLACES AN ADVERTISEMENT ONCE A YEAR IN THE LOCAL  
NEWSPAPERS OUTLINING THE FAP AND HOW TO APPLY. FAP IS PUBLICIZED ON ALL  
BILLING STATEMENTS, INVOICES, AND FINANCIAL CONSENT FORMS. FAP IS  
COMMUNICATED TO PATIENTS UPON DISCHARGE FROM INPATIENT, OBSERVATION, AND  
SURGICAL SERVICES.  
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**Part V** Facility Information *(continued)*

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

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

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



**Part VI** Supplemental Information

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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 7 (BAD DEBT EXPENSE, COSTING METHODOLOGY USED)

IMPLICIT PRICE CONCESSIONS ARE TREATED AS A CONTRA-REVENUE ITEM ON THE STATEMENT OF REVENUE. AS A RESULT, THERE ARE NO BAD DEBT EXPENSES INCLUDED ON FORM 990, PART IX THAT NEED TO BE SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGES LISTED.

THE COSTING METHODOLOGY USED IN CALCULATING THE AMOUNTS REPORTED ON THE LINE 7 TABLE ARE BASED ON ACTUAL COST PLUS OVERHEAD. OVERHEAD IS A HOSPITAL AVERAGE PERCENTAGE OF OVERHEAD TO DIRECT COSTS. DIRECT COSTS EXCLUDE BAD DEBT EXPENSE.

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**Part VI Supplemental Information**

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PART II (DETAIL OF COMMUNITY BUILDING ACTIVITIES)

IN FY2024, UNION HOSPITAL REPORTED EXPENDITURE IN THE COMMUNITY BUILDING CATEGORIES OF ECONOMIC DEVELOPMENT, COMMUNITY SUPPORT, AND WORKFORCE DEVELOPMENT.

THE ECONOMIC DEVELOPMENT AND COMMUNITY SUPPORT EXPENDITURE REPRESENTS TIME SPENT BY THE CAMPUS EXECUTIVE DIRECTOR PARTICIPATING ON THE BOARD OF THE ECONOMIC DEVELOPMENT COMMISSION AND CECIL COUNTY'S LOCAL MANAGEMENT BOARD.

THE ECONOMIC DEVELOPMENT COMMISSION OF THE CECIL COUNTY OFFICE OF ECONOMIC FOCUSES ON BUSINESS AND INDUSTRY DEVELOPMENT BY BUILDING RELATIONSHIPS WITH LOCAL PARTNERS IN CECIL COUNTY. LOCAL MANAGEMENT BOARDS (LMBS) IDENTIFY COMMUNITY DRIVEN PRIORITIES AND TARGET RESOURCES FOR THEIR COMMUNITIES, AS WELL AS SERVE AS THE COORDINATOR OF COLLABORATION FOR CHILD AND FAMILY SERVICES. LOCAL MANAGEMENT BOARDS ARE IN EACH COUNTY IN MARYLAND.

**Part VI Supplemental Information**

Provide the following information.

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THE WORKFORCE DEVELOPMENT EXPENDITURE REPRESENTS TIME SPENT BY THE DIRECTOR OF HUMAN RESOURCES PARTICIPATING ON THE BOARD OF THE SUSQUEHANNA WORKFORCE NETWORK. THE SUSQUEHANNA WORKFORCE NETWORK OVERSEES, COORDINATORS, AND PLANS WORKFORCE DEVELOPMENT PROGRAMS AND SERVICES FOR BUSINESSES AND INDIVIDUALS IN CECIL AND HARFORD COUNTIES. IT IDENTIFIES NEEDS AND DEVELOPS SOLUTIONS THAT MAXIMIZE REGIONAL ECONOMIC SUCCESS AND WORKER POTENTIAL.

ANOTHER WORKFORCE DEVELOPMENT EXPENSE WE REPORTED IN FY2024 WAS FOR OUR CAMP SCRUBS PROGRAM IN PARTNERSHIP WITH CECIL COLLEGE. CAMP SCRUBS PROVIDES INTERESTED STUDENTS, AGED 11 TO 16, WITH THE OPPORTUNITY FOR FIRSTHAND HOSPITAL EXPERIENCE AS A HEALTH CARE PROFESSIONAL IN ACTIVITIES SUCH AS PRACTICING LAPAROSCOPIC SURGICAL SKILLS ON ORANGES, DELIVERING FOOD, AND SWADDLING A NEWBORN. IN JUNE 2023 THERE WERE 8 PARTICIPANTS AND DUE TO THE INCREASING POPULARITY OF THIS PROGRAM, UNION AND CECIL COLLEGE OFFERED TWO CAMPS IN JUNE 2024 AND AUGUST 2024 SERVING A TOTAL OF 40 STUDENTS. OUR EXPECTATION IS THAT EARLY EXPOSURE TO CAREERS IN HEALTH

**Part VI** Supplemental Information

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CARE WILL ENCOURAGE SOME OF THESE STUDENTS TO PURSUE A CAREER IN THE  
HEALTH CARE FIELD.

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PART III, SECTION A, LINE 2 (IMPLICIT PRICE CONCESSIONS/BAD DEBT EXPENSE)

THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNTS REPORTED ON LINES  
2 AND 3 ARE BASED ON ACTUAL CHARGES WRITTEN OFF (AMOUNTS THAT ARE DEEMED  
TO BE UNCOLLECTIBLE AND RECORDED AS IMPLICIT PRICE CONCESSIONS UNDER  
ACCOUNTING PRONOUNCEMENT ASC 606) TIMES THE COST TO CHARGE RATIO.

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**Part VI** Supplemental Information

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PART III, SECTION A, LINE 3 (IMPLICIT PRICE CONCESSION METHODOLOGY)

THE IMPLICIT PRICE CONCESSION METHODOLOGY ASSUMES THAT THE PERCENTAGE OF CHARITY CARE TO TOTAL REVENUE CAN BE APPLIED TO THE AMOUNT OF IMPLICIT PRICE CONCESSIONS FOR THE YEAR. OTHER IMPLICIT PRICE CONCESSION AMOUNTS ARE NOT INCLUDED IN COMMUNITY BENEFITS.

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PART III, SECTION A, LINE 4 (IMPLICIT PRICE CONCESSION FOOTNOTE)

THE TEXT OF THE IMPLICIT PRICE CONCESSION (BAD DEBT EXPENSE) FOOTNOTE CAN BE FOUND STARTING ON PAGE 13 OF THE ELECTRONICALLY ATTACHED AUDITED FINANCIAL STATEMENTS.

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**Part VI** Supplemental Information

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PART III, SECTION B, LINE 8 (COSTING METHODOLOGY, MEDICARE SHORTFALL)

COSTING METHODOLOGY USED TO DETERMINE AMOUNT OF MEDICARE ALLOWABLE COSTS:

MEDICARE ALLOWABLE COSTS EQUAL MEDICARE REVENUE ADJUSTED FOR THE HOSPITAL

TOTAL RATIO OF PATIENT CARE COSTS TO CHARGES DUE TO THE FACT THAT

MEDICARE PAYS FULL CHARGES IN MARYLAND.

EXTENT TO WHICH MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY

BENEFIT: IN THE STATE OF MARYLAND, MEDICARE PAYS FULL CHARGES. THERE IS

NO SHORTFALL THAT SHOULD BE TREATED AS A COMMUNITY BENEFIT.

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**Part VI Supplemental Information**

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PART III, SECTION B, LINE 9B (COLLECTION PRACTICES)

UNION HOSPITAL'S F-416 CREDIT AND COLLECTION POLICY AND PROCEDURE HAS A SECTION CALLED, "INTERNAL COLLECTION EFFORTS" WHICH STATES: "UPON DISCHARGE, PATIENTS RECEIVE AN ITEMIZED BILL FOR INPATIENT ADMISSIONS IN ACCORDANCE WITH THE MARYLAND HOSPITAL COST REVIEW COMMISSION REQUIREMENTS. WHEN INSURANCE PAYMENTS ARE RECEIVED LEAVING A SELF-PAY BALANCE, OR THE ACCOUNT IS STRICTLY SELF-PAY, IT IS OUTSOURCED FOR FOLLOW-UP BUT REMAINS ON THE HOSPITAL'S ACTIVE ACCOUNTS RECEIVABLE. AGENTS WORK THE ACCOUNTS IN THE HOSPITAL'S NAME AND REPRESENTATIVES ARE DIRECTED TO ACCEPT MONTHLY PAYMENTS UNTIL THE ACCOUNT IS PAID IN FULL. COLLECTION EFFORTS CONSIST OF PHONE CALLS AND MONTHLY STATEMENTS. THE PATIENT MAY ALSO APPLY FOR FINANCIAL ASSISTANCE AT ANY TIME DURING THIS PROCESS (SEE POLICY F-415, FINANCIAL ASSISTANCE)." IN THE F-415 FINANCIAL ASSISTANCE POLICY AND PROCEDURE, UNDER SECTION, "ACTION IN THE EVENT OF NON-PAYMENT," IT IS EXPLAINED THAT: "A. UNION HOSPITAL MAY CONTRACT WITH OUTSIDE COLLECTION SERVICES TO PURSUE COLLECTION OF DELINQUENT ACCOUNTS. ALL UNPAID ACCOUNTS WITHOUT EXCEPTION OR PAYMENT ARRANGEMENTS ARE PLACED

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IN OUTSIDE COLLECTION AFTER A MINIMUM OF 90 DAYS FROM THE INITIAL BILLING STATEMENT AND DELIVERY OF ALL SCHEDULED PATIENT ACCOUNT STATEMENTS TO THE PATIENT/GUARANTOR. B. UNION HOSPITAL DOES NOT CONDUCT, OR PERMIT COLLECTION AGENCIES TO CONDUCT ON THEIR BEHALF, EXTRAORDINARY COLLECTIONS EFFORTS AGAINST INDIVIDUALS."

IN ADDITION, IN THE F-416 POLICY, UNDER THE SECTION, "EXTERNAL COLLECTION (BAD DEBT WRITE-OFF)," IT EXPLAINS THAT PATIENTS WITH BALANCES BEING COLLECTED BY AN ASSIGNED COLLECTION AGENCY WILL HAVE THEIR BALANCES WRITTEN OFF IF THEY ARE DETERMINED TO BE INDIGENT.

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PART VI, LINE 2 (NEEDS ASSESSMENT)

ACUTE CARE CONNECTORS AT UNION UTILIZE A SDOH SCREENING INSTRUMENT WHICH  
ALLOWS US INSIGHT INTO THE CHALLENGES OF OUR PATIENTS AND COMMUNITY AS  
WELL AS PROVIDES US WITH THE OPPORTUNITY TO HELP THEM ADDRESS THOSE  
NEEDS. TO BETTER MEET THE NEEDS OF OUR COMMUNITY, WE ALSO HAVE A STRONG  
PARTNERSHIP WITH THE CECIL COUNTY HEALTH DEPARTMENT WHICH ALLOWS US TO  
BOTH COORDINATE EFFORTS AND FURTHER OUR UNDERSTANDING ABOUT THE NEEDS OF  
CECIL COUNTY. UNION'S COMMUNITY ENGAGEMENT MANAGER IS ALSO FOCUSED ON  
DEVELOPING PARTNERSHIPS WITH ORGANIZATIONS TO ALSO LEARN MORE ABOUT AND  
RESPOND TO THE NEEDS OF OUR COMMUNITY.

SINCE 2022, CHRISTIANACARE HAS INVITED CECIL COUNTY COMMUNITY  
ORGANIZATIONS TO APPLY TO OUR COMMUNITY INVESTMENT FUND PROGRAM WHICH  
OFFERS FUNDING TO SUPPORT THEIR INITIATIVES DESIGNED TO MEET COMMUNITY  
NEEDS RELATED TO FOOD ACCESS, HOUSING INSECURITY, AND ENVIRONMENTAL  
HEALTH. IN FY2024, CHRISTIANACARE AWARDED A TOTAL OF \$130,900 TO THE  
COMMUNITY ORGANIZATIONS, DEEP ROOTS, A HOMELESS SHELTER FOR FAMILIES, AND

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BAYSIDE COMMUNITY NETWORK WHICH SERVES ADULTS PRIMARILY WITH DEVELOPMENTAL DISABILITIES. WHILE WE WERE NOT ABLE TO FUND EVERY CECIL COUNTY ORGANIZATION THAT APPLIED FOR FUNDING, THEIR APPLICATIONS PROVIDED US FURTHER INFORMATION ABOUT THE CHALLENGES OUR COMMUNITIES FACE AND HOW COMMUNITY ORGANIZATIONS ARE HELPING INDIVIDUALS TO MEET THOSE CHALLENGES.

UNION CAREGIVERS PARTICIPATE IN CECIL COUNTY'S COMMUNITY HEALTH ADVISORY COMMITTEE (CHAC) AND ITS TASK FORCES CREATED TO ADDRESS PROMINENT ISSUES IN THE COUNTY SUCH AS THE HEALTHY LIFESTYLES AND TOBACCO TASK FORCES. FOR SEVERAL YEARS, A UNION CAREGIVER HAS CHAIRED THE CECIL COUNTY CANCER TASK FORCE.

FINALLY, UNION CAREGIVERS ALSO PARTICIPATE IN DIFFERENT COMMUNITY BOARDS AND COMMITTEES THAT FOCUS ON DIFFERENT AREAS OF COMMUNITY NEED AND ALSO ALLOW US TO BETTER UNDERSTAND OUR COMMUNITY. UNION CAREGIVERS ALSO PARTICIPATED IN THESE ADDITIONAL COMMUNITY GROUPS:

. CECIL COUNTY BEHAVIORAL HEALTH PROVIDER MEETINGS

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- . CECIL COUNTY CHILD ADVOCACY CENTER
- . CECIL COUNTY ECONOMIC DEVELOPMENT COMMISSION
- . CHILD FATALITY REVIEW BOARD
- . JUDY CENTER STEERING COMMITTEE
- . LOCAL MANAGEMENT BOARD
- . LOCAL OVERDOSE FATALITY REVIEW TEAM
- . WEST CECIL HEALTH CENTER BOARD

PART VI, LINE 3 (PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE)

UNION'S FINANCIAL ASSISTANCE POLICY (FAP) ENSURES A UNIFORM AND EQUITABLE PROCESS IN GRANTING FINANCIAL ASSISTANCE TO APPROPRIATE PATIENTS WHILE RESPECTING THE INDIVIDUAL'S DIGNITY. THE FAP ALIGNS WITH FEDERAL AND STATE REGULATIONS. INDIVIDUALS WHO NEED EMERGENCY OR MEDICALLY NECESSARY TREATMENT AND HAVE A HOUSEHOLD INCOME BELOW 400% OF THE FEDERAL POVERTY LEVEL (FPL) ARE ELIGIBLE FOR FREE OR DISCOUNTED CARE. UNION DOES NOT

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PURSUE EXTRAORDINARY COLLECTION ACTIONS AGAINST ANY INDIVIDUAL.

A PLAIN LANGUAGE SUMMARY OF THE FAP, THE FULL POLICY, THE FINANCIAL ASSISTANCE APPLICATION IN ENGLISH AND SPANISH, AND THE MOST RECENT FINANCIAL ASSISTANCE SCALE ARE ALL AVAILABLE ON UNION'S WEBSITE AT: [HTTPS://WWW.UHCC.COM/ABOUT-US/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/](https://www.uhcc.com/about-us/patient-financial-services/financial-assistance/)

UNION'S WEBSITE ALSO PROVIDES PATIENTS WITH DETAILED DESCRIPTIONS OF HOW THEY CAN OBTAIN THE FAP AND APPLICATION IN PERSON AND GET HELP IN THE APPLICATION PROCESS. UNION FINANCIAL COUNSELORS ARE AVAILABLE MONDAY THROUGH FRIDAY, FROM 8 A.M. TO 4:30 P.M. TO DISCUSS THE APPLICATION PROCESS BY PHONE OR AT THE HOSPITAL. THE WEBSITE ALSO PROVIDES A MAILING ADDRESS, TELEPHONE NUMBER, EMAIL ADDRESS, AND IN-PERSON LOCATIONS WHERE INDIVIDUALS CAN RECEIVE OR REQUEST THE FAP AND APPLICATION. INFORMATION ABOUT THE FAP IS INCLUDED ON THE FINANCIAL CONSENT FORM, ON BILLING STATEMENTS/INVOICES, UPON DISCHARGE FROM INPATIENT, OBSERVATION, OR SURGICAL SERVICES, AND ON ELECTRONIC AND PAPER SIGNS AT REGISTRATION

**Part VI** Supplemental Information

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LOCATIONS IN THE HOSPITAL.

PATIENTS RECEIVE FINANCIAL COUNSELING, REFERRALS, AND ASSISTANCE TO IDENTIFY PUBLIC OR PRIVATE HEALTHCARE PROGRAMS TO ASSIST WITH LONG TERM NEEDS. IF THE PATIENT IS UNINSURED, THEY WILL BE ASSISTED IN DETERMINING MARYLAND MEDICAID OR QUALIFIED HEALTH PLAN ELIGIBILITY THROUGH THE APPROPRIATE MARYLAND HEALTH CONNECTION CONNECTOR ENTITY OR OTHER QUALIFIED HEALTH INSURANCE MARKETPLACE.

PART VI, LINE 4 (COMMUNITY INFORMATION)

UNION PRIMARILY SERVES CECIL COUNTY, MARYLAND. IN FY23, OVER 80% OF THE HOSPITAL'S TOTAL INPATIENT VOLUMES AND EMERGENCY DEPARTMENT VISITS WERE CECIL COUNTY RESIDENTS. BESIDES THE PERRY POINT VA MEDICAL CENTER, UNION HOSPITAL IS THE ONLY HOSPITAL IN THE COUNTY. UNION IS LOCATED IN ELKTON, THE MOST POPULOUS TOWN IN CECIL COUNTY. CECIL COUNTY IS RURAL AND BORDERS

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

DELAWARE AND PENNSYLVANIA.

IN 2020, THE TOTAL POPULATION OF CECIL COUNTY WAS 103,098 PEOPLE. BETWEEN 2020 AND 2030, THE CECIL COUNTY POPULATION IS EXPECTED TO GROW BY 8% WITH THE POPULATION OF THOSE 65 YEARS AND OLDER PROJECTED TO GROW BY 30.3%. THE CECIL COUNTY POPULATION IS 84.5% WHITE, 6.8% BLACK, AND 4.9% HISPANIC.

FROM 2016 TO 2020, THE POVERTY RATE IN CECIL COUNTY (9.5%) WAS SLIGHTLY ABOVE THE MARYLAND POVERTY RATE (9%), BUT BELOW THE UNITED STATES AVERAGE (12.8%). SIGNIFICANT DISPARITIES EXIST IN CECIL COUNTY WITH THE POVERTY RATES FOR BLACK (15.8%) AND HISPANIC (18.1%) PEOPLE SIGNIFICANTLY HIGHER THAN THOSE FOR WHITE (8.5%) RESIDENTS. LOW-INCOME CENSUS TRACTS ARE MOST PREVALENT IN ELKTON, NORTH EAST, AND PORT DEPOSIT.

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**Part VI Supplemental Information**

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART VI, LINE 5 (INFORMATION REGARDING PROMOTION OF COMMUNITY HEALTH)

CHRISTIANACARE IS CENTERED ON IMPROVING HEALTH OUTCOMES, MAKING  
HIGH-QUALITY CARE MORE ACCESSIBLE, AND LOWERING HEALTH CARE COSTS. GUIDED  
BY OUR VALUES, LOVE AND EXCELLENCE, UNION CONTINUES TO SERVE OUR CECIL  
COUNTY NEIGHBORS AS THEIR COMMUNITY HOSPITAL.

EACH FISCAL YEAR, UNION SERVES CECIL COUNTY BY PROVIDING ACTIVITIES,  
PROGRAMS, AND INITIATIVES THAT SEEK TO IMPROVE COMMUNITY HEALTH. THE  
FOLLOWING IS A SUMMARY OF THE COMMUNITY BENEFIT ACTIVITIES, PROGRAMS, AND  
INITIATIVES THAT UNION HOSPITAL PROVIDED IN CECIL COUNTY DURING FY2024:

A1: COMMUNITY HEALTH EDUCATION

- UNION HOSPITAL PROVIDED HEALTH EDUCATION INFORMATION AND PRESENTATIONS  
IN THE COMMUNITY ON TOPICS SUCH AS DIABETES AND NUTRITION, CANCER  
PREVENTION AND SCREENING, CHILDBIRTH AND INFANT EDUCATION INCLUDING  
NEONATAL ABSTINENCE SYNDROME AND LACTATION SUPPORT, AND INFORMATION ON  
MARYLAND HEALTH CONNECTION.

**Part VI Supplemental Information**

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

## A2: COMMUNITY-BASED CLINICAL SERVICES

- MONTHLY MOBILE HEALTH BLOOD PRESSURE AND EYE SCREENINGS
- A FREE ANNUAL SPORTS PHYSICALS CLINIC FOR CECIL COUNTY 6TH THROUGH 12TH GRADE STUDENTS.

## A2: HEALTH CARE SUPPORT SERVICES

- PARTNERSHIP WITH CCHD TO SUPPORT THE PEER RECOVERY ADVOCATES PROGRAM WHICH PROVIDES CONNECTIONS TO PEERS IN THE HOSPITAL AND COMMUNITY
- ACUTE CARE CONNECTORS IDENTIFICATION AND ASSISTANCE IN RESOLVING SOCIAL NEEDS
- LUNG HEALTH NAVIGATOR FACILITATING CONNECTION TO CARE AND RESOURCES
- TRANSPORTATION DONATIONS FOR ELIGIBLE PATIENTS

## B1-B3: HEALTH PROFESSIONS EDUCATION

- UNION CAREGIVERS OFFERED TRADITIONAL CLINICAL ROTATIONS AND PRECEPTORSHIPS TO 194 UNDERGRADUATE NURSING STUDENTS.
- UNION RNS ALSO PROVIDED EDUCATION ON SUBSTANCE EXPOSED NEWBORNS TO STUDENT NURSES AT CECIL COMMUNITY COLLEGE

## C: MISSION DRIVEN HEALTH SERVICES

- UNION PROVIDED SUBSIDIZED OUTPATIENT SERVICES TO MEET IDENTIFIED NEEDS



**Part VI Supplemental Information**

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

IN THE COMMUNITY, EVEN THOUGH THEY OPERATE AT A LOSS. THESE INCLUDE

PRIMARY CARE, PSYCH-OUTPATIENT AND ENDOCRINOLOGY, AMONG OTHERS.

E3: IN-KIND CONTRIBUTIONS

- PROVIDED FREE AMBULANCE TRANSPORTS AND FREE SUPPLIES FOR AMBULANCE

STOCK-UPS

- PARTICIPATION IN COMMUNITY BOARDS/COMMITTEES/TASK FORCES AND OTHER

GROUPS

- COMMUNITY SERVICE BENEFIT - CHRISTIANACARE ALLOWS EMPLOYEES TO

VOLUNTEER FOR COMMUNITY ORGANIZATIONS DURING THEIR WORKDAY. IN FY2024, 25

EMPLOYEES DONATED A TOTAL OF 153 HOURS TO COMMUNITY ORGANIZATIONS.

PART VI, LINE 6 (AFFILIATED HEALTHCARE SYSTEM INFORMATION)

UNION HOSPITAL OF CECIL COUNTY, INC. IS PART OF AN AFFILIATED HEALTH CARE

SYSTEM IN WHICH AFFINITY HEALTH ALLIANCE, INC. (AHA) IS THE PARENT

ENTITY.

AHA'S PURPOSE IS TO SUPPORT THE UNION HOSPITAL OF CECIL COUNTY IN

**Part VI Supplemental Information**

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PROVIDING HEALTH CARE AND HEALTH CARE RELATED SERVICES THROUGH THE  
EFFECTIVE MANAGEMENT OF ALL AFFILIATED CORPORATIONS. SPECIFICALLY, THIS  
INVOLVES COORDINATING SYSTEM WIDE POLICIES, FUNDRAISING AND STRATEGIC  
PLANNING PROGRAMS TO PROVIDE HEALTH CARE SERVICES IN RESPONSE TO THE  
MEDICAL, HUMAN AND RELATED SERVICE NEEDS OF THE COMMUNITY.

OTHER TAX-EXEMPT ORGANIZATIONS IN THE GROUP INCLUDE THE UNION HOSPITAL OF  
CECIL COUNTY FOUNDATION, INC., UNION HOSPITAL OF CECIL COUNTY HEALTH  
SERVICES, INC., AND UNION HOSPITAL OF CECIL COUNTY ONCOLOGY, INC.

THE FOUNDATION CONDUCTS AND SUPERVISES FUNDRAISING ACTIVITIES ON BEHALF  
OF ITS TAX-EXEMPT AFFILIATES. THE FOUNDATION ENGAGES IN CORPORATE  
FUNDRAISING, CAPITAL CAMPAIGNS, SPECIAL EVENTS, ACTIVITIES, AND A  
MULTI-FACETED COMMUNICATION PROGRAM THAT APPEALS TO PRIVATE AND CORPORATE  
CONTRIBUTORS.

UNION HOSPITAL OF CECIL COUNTY HEALTH SERVICES, INC.'S MISSION IS TO OWN,  
MANAGE AND MAINTAIN PROPERTIES FOR HEALTH RELATED VENTURES TO SERVICE

**Part VI Supplemental Information**

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CECIL COUNTY AND THE SURROUNDING AREAS. THE ACTIVITIES OF THIS CORPORATION COMPLEMENT AND AUGMENT THE HEALTH CARE ACTIVITIES OF THE HOSPITAL.

UNION HOSPITAL OF CECIL COUNTY ONCOLOGY, INC'S ("UNION ONCOLOGY") DUTY AND MISSION IS TO PROVIDE HIGH QUALITY, ADVANCED RADIATION ONCOLOGY SERVICES TO THE CECIL COUNTY AREA IN ORDER TO FOSTER THE BEST CANCER TREATMENT PROCESS CLOSE TO HOME. CANCER-RELATED DEATHS ARE AMONG THE HIGHEST CAUSES OF MORTALITY IN CECIL COUNTY, SO IT IS UNION ONCOLOGY'S MISSION TO BRING SOME OF THE MOST ADVANCED RADIATION THERAPIES TO CECIL COUNTY TO PROVIDE THE MOST COMPREHENSIVE CANCER CARE POSSIBLE TO THE PEOPLE LIVING WITH CANCER HERE AND IN NEIGHBORING COMMUNITIES. BY OFFERING THESE ADVANCED CANCER TREATMENT OPTIONS, UNION ONCOLOGY FURTHERS ITS CHARITABLE PURPOSE OF PROVIDING MEDICAL SERVICES TO PROMOTE THE HEALTH AND WELFARE OF THE RESIDENTS OF CECIL COUNTY AND NEIGHBORING COMMUNITIES.

UNION HOSPITAL OF CECIL COUNTY VENTURES, INC. IS A FOR-PROFIT STOCK

**Part VI Supplemental Information**

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CORPORATION. ITS PURPOSE IS TO ENGAGE IN ANY BUSINESS OR TRANSACTION WHICH WILL BENEFIT THE ACTIVITIES AND GOALS OF ITS AFFILIATES. OPERATIONS CONSIST PRIMARILY OF PROVIDING MANAGEMENT SUPPORT SERVICES FOR PHYSICIAN PRACTICES AND PROVIDING IMAGING SERVICES TO PHYSICIANS AND HEALTH CENTERS THROUGH ITS WHOLLY OWNED SUBSIDIARIES, TRIANGLE ALLIANCE LLC AND OPEN MRI AND IMAGING CENTER OF ELKTON LLC.

ON JANUARY 1, 2020, AHA BECAME A MEMBER OF CHRISTIANA CARE HEALTH SYSTEM. CHRISTIANA CARE IS A MAJOR TEACHING HEALTH SYSTEM WITH MORE THAN 1,600 MEDICAL-STAFF MEMBERS AND 265 MEDICAL-DENTAL RESIDENTS AND FELLOWS AND INCLUDES A NUMBER OF ENTITIES INCLUDING CHRISTIANA CARE HEALTH SERVICES, INC.

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**Part VI Supplemental Information**

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART VI, LINE 7 (STATES FILING OF COMMUNITY BENEFIT REPORT)

LIST OF STATES RECEIVING 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" on Form 990, Part IV, line 23.  
Attach to Form 990.  
Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023****Open to Public  
Inspection**

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

**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 on 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 (such as 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 directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

**3** Indicate which, if any, of the following the 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 type="checkbox"/> Compensation committee              | <input type="checkbox"/> Written employment contract                     |
| <input type="checkbox"/> Independent compensation consultant | <input type="checkbox"/> Compensation survey or study                    |
| <input type="checkbox"/> Form 990 of other organizations     | <input type="checkbox"/> Approval by the board or compensation committee |

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

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

**Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.**

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

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

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

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

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

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

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

Yes No

1b

2

4a

X

4b

X

4c

X

5a

X

5b

X

6a

X

6b

X

7

X

8

X

9

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

Schedule J (Form 990) 2023

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

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't 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 and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
JENNIFER L. SCHWARTZ, 1 SECRETARY (EX-OFFICIO)	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	695,351.	207,032.	24,304.	59,243.	20,878.	1,006,808.	NONE
JOSE MA, MD 2 DIRECTOR - THRU 8/23	(i)	212,318.	38,225.	2,218.	NONE	12,506.	265,267.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
JUSTIN SAUSVILLE, MD 3 DIRECTOR	(i)	582,984.	180,857.	2,201.	NONE	20,878.	786,920.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
ROBERT ASANTE 4 DIRECTOR	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	194,529.	26,779.	5,620.	NONE	20,878.	247,806.	NONE
ROBERT MCMURRAY 5 TREASURER (EX-OFFICIO)	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	753,010.	228,558.	58,851.	68,103.	20,224.	1,128,746.	23,384.
RYAN GERACIMOS, MD 6 CHIEF MEDICAL OFF. - THRU 3/24	(i)	341,010.	68,868.	210,391.	NONE	15,122.	635,391.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
JOAN PIRRUNG, MSN, APR 7 CHIEF NURSING OFFICER	(i)	193,466.	33,539.	11,406.	NONE	20,878.	259,289.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
AMY MARSTON 8 DIRECTOR/CAMPUS OPS OFCR	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	269,164.	53,825.	8,756.	NONE	20,878.	352,623.	NONE
MICHELLE TWUM-DANSO 9 DIRECTOR HR - CECIL THRU 1/24	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	198,568.	27,641.	11,961.	NONE	13,910.	252,080.	NONE
DERON G. BROWN 10 FORMER FINANCE DIRECTOR	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	165,061.	22,892.	11,193.	NONE	NONE	199,146.	NONE
ROGER D. WU, MD 11 PHYSICIAN	(i)	558,218.	62,251.	2,598.	NONE	21,255.	644,322.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
FAHD RAHMAN, MD 12 PHYSICIAN	(i)	510,644.	238,140.	2,375.	NONE	20,878.	772,037.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
DONNA MALONEY 13 DIRECTOR OF FINANCE	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	195,472.	27,118.	23,671.	NONE	20,878.	267,139.	NONE
CLAIRE YI ZHANG 14 PHYSICIAN	(i)	460,803.	53,162.	2,164.	NONE	NONE	516,129.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
ARSALAN SHEIKH, MD 15 CHIEF MEDICAL OFF.- AS OF 1/24	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
GEORGE GIANNOUKOS 16 PHYSICIAN	(i)	453,003.	56,250.	2,315.	NONE	NONE	511,568.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE

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

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't 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 and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JAMES MICHEAL JARVIS PHYSICIAN	(i)	451,313.	42,450.	1,661.	NONE	NONE	495,424.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
2 SHARON T. KURFUERST FORMER PRESIDENT	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	196,269.	129,822.	985,276.	NONE	3,168.	1,314,535.	178,205.
3	(i)							
	(ii)							
4	(i)							
	(ii)							
5	(i)							
	(ii)							
6	(i)							
	(ii)							
7	(i)							
	(ii)							
8	(i)							
	(ii)							
9	(i)							
	(ii)							
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							



Part III Supplemental Information

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.

FORM 990, SCHEDULE J, PART I, LINE 3

TOP MANAGEMENT COMPENSATION

AS PROVIDED IN THE FORM 990, SCHEDULE J INSTRUCTIONS, SINCE THE ORGANIZATION RELIES ON A RELATED ORGANIZATION WHICH USES ONE OR MORE OF THE METHOD DESCRIBED IN LINE 3 TO ESTABLISH THE TOP MANAGEMENT OFFICIALS' COMPENSATION, THIS QUESTION HAS BEEN LEFT UNANSWERED. REFER TO SCHEDULE O FOR A DESCRIPTION OF THE COMPENSATION REVIEW AND APPROVAL PROCESS.

-----

FORM 990, SCHEDULE J, PART I, LINE 4A

DETAIL OF SEVERANCE PAYMENTS

RYAN GERACIMOS (FORMER KEY EMPLOYEE) RECEIVED A SEVERANCE PAYMENT OF \$123,609 DURING THE YEAR.

**Part III Supplemental Information**

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.

SHARON KURFUERST (FORMER PRESIDENT) RECEIVED A SEVERANCE PAYMENT OF  
\$532,729 DURING THE YEAR.

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FORM 990, SCHEDULE J, PART I, LINE 4B

SUPP. NONQUALIFIED PLAN PARTICIPATION

THIS ORGANIZATION IS AN AFFILIATE OF CHRISTIANA CARE HEALTH SERVICES, INC  
("CCHS"). CCHS MAINTAINS AN IRC SECTION 457(F) DEFERRED COMPENSATION  
PLAN. THE FOLLOWING INDIVIDUALS LISTED ON FORM 990, PART VII, SECTION A,  
LINE 1A PARTICIPATED AND/OR RECEIVED DISTRIBUTIONS FROM THE 457(F) PLAN  
DURING THE YEAR:

SHARON T. KURFUERST- \$263,888

ROBERT MCMURRAY- \$30,765

JENNIFER L. SCHWARTZ, ESQ.- NO DISTRIBUTION

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Part III Supplemental Information

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.

FORM 990, SCHEDULE J, PART I, LINE 7

NONFIXED PAYMENTS

THIS ORGANIZATION IS AN AFFILIATE OF CHRISTIANA CARE HEALTH SYSTEM, INC ("SYSTEM") AND CHRISTIANA CARE HEALTH SERVICES, INC. ("CCHS"). ALL OFFICER/TRUSTEE COMPENSATION ARRANGEMENTS, INCLUDING THE PAYMENT OF DISCRETIONARY BONUS AND/OR INCENTIVE COMPENSATION PAYMENTS TO ELIGIBLE EMPLOYEES, ARE DETERMINED BY THE SYSTEM BOARD AND PAID EITHER THROUGH CCHS OR THIS ORGANIZATION. PAYMENTS MADE TO ANY DISQUALIFIED PERSON ARE APPROVED BY THE COMPENSATION COMMITTEE OF SYSTEM THROUGH THE PROCESS DESCRIBED IN FORM 990, PART VI, SECTION B, LINE 15.

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**SCHEDULE K  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Information on Tax-Exempt Bonds**

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

Attach to Form 990.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2023**

**Open to Public  
Inspection**

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

**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> TOWN OF ELKTON - SERIES 2012A	52-6000790		05/18/2012	10,000,000.	REFUND PORTION OF SERIES 2009 BOND		X		X		X
<b>B</b> TOWN OF ELKTON - SERIES 2012B1/B2	52-6000790		05/18/2012	8,662,336.	REFUND SERIES 2009 & 2000 BONDS		X		X		X
<b>C</b> TOWN OF ELKTON - SERIES 2012C	52-6000790		05/18/2012	9,000,000.	REFUND ESCROW TO REPAY 2002 BOND		X		X		X
<b>D</b> MD HEALTH & HIGHER EDUCATION FACILITIES AUTHORITY	52-0936091		12/01/2014	30,778,000.	TO REFINANCE THE 2005 BONDS		X		X		X

**Part II Proceeds**

	A		B		C		D	
<b>1</b> Amount of bonds retired . . . . .	4,200,898.		5,273,333.		1,843,280.		2,502,000.	
<b>2</b> Amount of bonds legally defeased . . . . .	NONE		NONE		NONE		NONE	
<b>3</b> Total proceeds of issue . . . . .	10,000,000.		8,662,336.		9,000,000.		30,778,000.	
<b>4</b> Gross proceeds in reserve funds . . . . .	NONE		NONE		NONE		NONE	
<b>5</b> Capitalized interest from proceeds . . . . .	NONE		NONE		NONE		NONE	
<b>6</b> Proceeds in refunding escrows . . . . .	NONE		NONE		NONE		NONE	
<b>7</b> Issuance costs from proceeds . . . . .	NONE		NONE		NONE		NONE	
<b>8</b> Credit enhancement from proceeds . . . . .	NONE		NONE		NONE		NONE	
<b>9</b> Working capital expenditures from proceeds . . . . .	NONE		NONE		NONE		NONE	
<b>10</b> Capital expenditures from proceeds . . . . .	NONE		NONE		NONE		NONE	
<b>11</b> Other spent proceeds . . . . .	10,000,000.		8,662,336.		9,000,000.		30,778,000.	
<b>12</b> Other unspent proceeds . . . . .	NONE		NONE		NONE		NONE	
<b>13</b> Year of substantial completion . . . . .	2012		2012		2012		2014	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>14</b> Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)? . . . . .	X		X		X		X	
<b>15</b> Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)? . . . . .		X		X		X		X
<b>16</b> Has the final allocation of proceeds been made? . . . . .	X		X		X		X	
<b>17</b> Does the organization maintain adequate books and records to support the final allocation of proceeds? . . . . .	X		X		X		X	

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

Schedule K (Form 990) 2023

**Part III Private Business Use****TAX-EXEMPT BONDS**

	<b>A</b>		<b>B</b>		<b>C</b>		<b>D</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<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		X		X
<b>2</b> Are there any lease arrangements that may result in private business use of bond-financed property? . . . . .		X		X		X		X
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? . . . . .	X		X		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? . . . . .	X		X		X		X	
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? . . . . .		X		X		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 . . . . .	NONE %		NONE %		NONE %		NONE %	
<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 . . . . .	NONE %		NONE %		NONE %		NONE %	
<b>6</b> Total of lines 4 and 5 . . . . .	NONE %		NONE %		NONE %		NONE %	
<b>7</b> Does the bond issue meet the private security or payment test? . . . . .		X		X		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		X		X
<b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of . . . . .	NONE %		NONE %		NONE %		NONE %	
<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		X		X	

**Part IV Arbitrage**

	<b>A</b>		<b>B</b>		<b>C</b>		<b>D</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<b>1</b> Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? . . . . .		X		X		X		X
<b>2</b> If "No" to line 1, did the following apply?								
<b>a</b> Rebate not due yet? . . . . .		X		X		X		X
<b>b</b> Exception to rebate? . . . . .	X		X		X		X	
<b>c</b> No rebate due? . . . . .		X		X		X		X
If "Yes" to 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		X		X



SCHEDULE O  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

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.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No. 1545-0047

2023

Open to Public  
Inspection

Employer identification number

52-0607945

FORM 990, PART VI, SECTION A, LINES 6 & 7A,7B

GOVERNING BODY AND MANAGEMENT

CHRISTIANA CARE HEALTH SERVICES, INC. ("CCHS") IS THE SOLE MEMBER OF  
AFFINITY HEALTH ALLIANCE, INC. ("AHA"), THE SOLE MEMBER OF THE UNION  
HOSPITAL OF CECIL COUNTY, INC. ("UHCC"). CCHS AND AHA ARE BOTH TAX-EXEMPT  
ORGANIZATIONS. THE BOARD OF DIRECTORS OF CCHS ELECTS THE DIRECTORS OF  
UHCC AT ITS ANNUAL MEETING. THE ANNUAL OPERATING BUDGET OF UHCC IS  
APPROVED BY THE UHCC BOARD, THE FINANCE COMMITTEE OF THE CCHS BOARD, THE  
CCHS BOARD, THE FINANCE COMMITTEE OF THE BOARD OF CHRISTIANA CARE HEALTH  
SYSTEM, INC. ("SYSTEM"), THE SOLE MEMBER OF CCHS, AND THE SYSTEM BOARD.

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FORM 990, PART VI, SECTION B, LINE 11B

FORM 990 REVIEW PROCESS

INFORMATION RELATED TO THE UHCC FORM 990 IS GATHERED BY FINANCE STAFF AND  
PROVIDED TO PWC US TAX LLP FOR REVIEW. THE FINAL 2023 FORM 990 FOR THE  
FISCAL YEAR ENDING JUNE 30, 2024 WAS REVIEWED AND APPROVED BY VARIOUS  
SENIOR MANAGEMENT OFFICIALS. THE ORGANIZATION'S GOVERNING BOARD WAS ALSO  
PROVIDED ACCESS TO THE APPROVED 2023 FORM 990 VIA ITS BOARD OF DIRECTORS  
PORTAL.

-----

FORM 990, PART VI, SECTION B, LINE 12C

CONFLICT OF INTEREST POLICY

**SCHEDULE O**  
**(Form 990 or 990-EZ)**Department of the Treasury  
Internal Revenue Service

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

**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.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No. 1545-0047

**2023****Open to Public  
Inspection**

Employer identification number

52-0607945

OUR CONFLICT OF INTEREST ("COI") POLICY IS LOCATED IN THE CAREGIVER  
 RESOURCE CENTER ON THE EMPLOYEE PORTAL. THERE IS AN ANNUAL MANDATORY  
 EDUCATION FOR REQUIRED INDIVIDUALS, WHICH INCLUDES AN ELECTRONIC SIGN OFF  
 ACKNOWLEDGING COMPLETION OF THE EDUCATION, REPORTING OF A REAL OR  
 PERCEIVED CONFLICT OR THAT NO CONFLICTS OF INTEREST EXIST. THE  
 HR/EMPLOYEE RELATIONS TEAM FOLLOWS UP WITH ANYONE WHO HAS A CONFLICT OR  
 PERCEIVED CONFLICT OR DOES NOT COMPLETE THE EDUCATION IN ORDER TO  
 RESOLVE. THE EMPLOYEE HANDBOOK SETS EXPECTATIONS FOR EMPLOYEE CONFLICTS  
 OF INTEREST AND EXPECTATIONS. SEVERAL REPORTING MECHANISMS ALSO EXIST FOR  
 EMPLOYEES TO REPORT CONCERNS. THE BOARD OF DIRECTORS HAS THEIR OWN COI  
 POLICY. COI IS A STANDING AGENDA ITEM ON EACH BOARD OR BOARD COMMITTEE  
 MEETING. BOARD MEMBERS EXPECTATIONS FOR COI ARE CLEARLY COMMUNICATED.

-----

**FORM 990, PART VI, SECTION B, LINE 15**

COMPENSATION REVIEW AND APPROVAL PROCESS

THE BOARD OF DIRECTORS OF CHRISTIANA CARE HEALTH SYSTEM, INC. ("SYSTEM"),  
 THE SOLE MEMBER OF CHRISTIANA CARE HEALTH SERVICES, INC. ("CCHS"), THE  
 SOLE MEMBER OF UNION HOSPITAL OF CECIL COUNTY, INC. ("UHCC"), ESTABLISHES  
 UHCC'S COMPETITIVE TOTAL COMPENSATION POLICY AND PRACTICE. THE EXECUTIVE  
 COMPENSATION COMMITTEE ("ECC") OF THE SYSTEM BOARD ENGAGES AN INDEPENDENT  
 THIRD PARTY ANNUALLY WHO ASSESSES DATA FROM SEVERAL MAJOR SURVEYS TO  
 ENSURE TOTAL REMUNERATION IS MARKET COMPETITIVE AND QUALIFIES FOR THE  
 "REBUTTABLE PRESUMPTION OF REASONABLENESS" UNDER THE INTERMEDIATE  
 SANCTIONS RULE, SECTION 4958 OF THE INTERNAL REVENUE CODE. AFTER



SCHEDULE O  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

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.

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OMB No. 1545-0047

2023

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Inspection

Employer identification number

52-0607945

DELIBERATION, THE ECC DOCUMENTS THEIR DECISIONS IN MEETING MINUTES.

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FORM 990, PART VI, SECTION C, LINE 19

GOVERNANCE, MANAGEMENT & DISCLOSURE

THE GOVERNING DOCUMENTS, AUDITED FINANCIAL STATEMENTS, AND CONFLICT OF  
INTEREST POLICY ARE AVAILABLE TO THE PUBLIC UPON REQUEST.

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FORM 990, PART X

BALANCE SHEET

CERTAIN PRIOR YEAR BALANCES HAVE BEEN RESTATED TO CONFORM TO CURRENT YEAR  
REPORTING PRESENTATION.

-----

FORM 990, PART XI, LINE 9

OTHER CHANGES IN NET ASSETS OR FUND BALANCES

CHANGE IN NET ASSETS OF FOUNDATION	\$1,457,118
NET ASSETS RELEASED FROM RESTRICTION	\$943,936
TRANSFER TO AFFILIATE	\$6,027,243
-----	
TOTAL	\$8,428,297

-----

FORM 990, SCHEDULE C

DETAIL OF LOBBYING ACTIVITIES

SCHEDULE O  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

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.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No. 1545-0047

2023

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Inspection

Employer identification number

52-0607945

UHCC IS A MEMBER OF THE MARYLAND HOSPITAL ASSOCIATION ("MHA"). A PORTION  
OF THE MEMBERSHIP DUES PAID BY UHCC MAY BE USED BY MHA FOR LOBBYING  
PURPOSES.

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Name of the organization

Employer identification number

UNION HOSPITAL OF CECIL COUNTY, INC.

52-0607945

## FORM 990, PART III - PROGRAM SERVICE

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## LINE 4A, PROGRAM SERVICE

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UNION HOSPITAL OF CECIL COUNTY'S MISSION IS TO PROVIDE QUALITY HEALTH CARE SERVICES TO THE RESIDENTS OF CECIL COUNTY, MARYLAND AND NEIGHBORING COMMUNITIES. SERVICES ARE PROVIDED WITH MODERN TECHNOLOGY AND COMPASSIONATE CARE FROM HEALTH CARE PROFESSIONALS. SERVICES ARE PROVIDED REGARDLESS OF RACE, GENDER, ETHNICITY, AGE, DISABILITY, RELIGION, OR ABILITY TO PAY. ALTHOUGH REIMBURSEMENT FOR SERVICES RENDERED IS VITALLY IMPORTANT TO THE OPERATION, STABILITY, AND VIABILITY OF UNION HOSPITAL OF CECIL COUNTY, IT IS RECOGNIZED THAT NOT ALL MEMBERS OF THE COMMUNITY ARE IN THE FINANCIAL POSITION TO PURCHASE HEALTH CARE SERVICES. FOR ELIGIBLE INDIVIDUALS, UNION HOSPITAL OF CECIL COUNTY OFFERS FREE AND/OR SUBSIDIZED CARE, AS WELL AS ACCESS TO COMMUNITY FINANCIAL ASSISTANCE.

DURING THE YEAR, UNION HOSPITAL OF CECIL COUNTY PROVIDED \$3,815,100 IN UNCOMPENSATED CARE (CHARITY CARE).

IN ADDITION, COMMUNITY BENEFIT ACTIVITIES ARE PROVIDED TO SERVE VULNERABLE POPULATIONS (I.E. PEOPLE WITH LOW INCOMES, PREGNANT PEOPLE, PEOPLE WITH SUBSTANCE USE DISORDER) AND/OR TO ADDRESS A DEMONSTRATED COMMUNITY HEALTH-RELATED NEED. COMMUNITY NEEDS ARE IDENTIFIED IN OUR COMMUNITY HEALTH NEEDS ASSESSMENTS, COMPLETED EVERY THREE YEARS IN PARTNERSHIP WITH THE CECIL COUNTY HEALTH DEPARTMENT. COMMUNITY BENEFITS INCLUDE:

A) ACCESS TO HEALTH INITIATIVES INCLUDING THE PROVISION OF FREE TRANSPORTATION TO MEDICAL APPOINTMENTS FOR ELIGIBLE PATIENTS, ANNUAL SPORTS PHYSICALS FOR CECIL COUNTY PUBLIC SCHOOL YOUTH NOT CONNECTED TO PRIMARY CARE, AND MOBILE HEALTH MONTHLY OUTREACH WHICH OFFERS CONNECTION TO COMMUNITY AND CLINICAL RESOURCES, AS WELL AS BLOOD PRESSURE AND VISION SCREENINGS.

B) COMMUNITY SUPPORT GROUPS AND EDUCATION FOR PREGNANT PEOPLE ON THE TOPICS OF DELIVERY, INFANT CARE, AND BREASTFEEDING - INCLUDING SPECIALIZED EDUCATION FOR HOW TO CARE FOR BABIES WITH NEONATAL ABSTINENCE SYNDROME - OFFERED AT COMMUNITY TREATMENT CENTERS.

C) HEALTH EDUCATION ON PREVENTION AND SCREENING FOR CANCER, ESPECIALLY LUNG CANCER WHICH IS PREVALENT IN CECIL COUNTY.

Name of the organization

Employer identification number

UNION HOSPITAL OF CECIL COUNTY, INC.

52-0607945

## FORM 990, PART III - PROGRAM SERVICE

=====

D) ADDRESSING SUBSTANCE USE DISORDER THROUGH OUR PARTNERSHIP WITH CECIL COUNTY HEALTH DEPARTMENT AND VOICES OF HOPE, INC. TO OFFER NEARLY 24/7 ON-SITE CONNECTION FOR OUR PATIENTS TO PEERS IN RECOVERY WHO SERVE INDIVIDUALS WITH CONNECTIONS TO BEHAVIORAL HEALTH SUPPORTS AND TREATMENT.

E) SCREENING ADMITTED PATIENTS FOR SOCIAL NEEDS AND HELPING TO ADDRESS THOSE NEEDS THROUGH COMMUNITY PARTNERSHIPS AND UTILIZATION OF UNITE MARYLAND, A SOCIAL CARE REFERRAL NETWORK.

F) HOSPITAL STAFF PARTICIPATION ON COMMUNITY BOARDS AND COALITIONS, SUCH AS THE ECONOMIC DEVELOPMENT COMMISSION, CECIL COUNTY LOCAL MANAGEMENT BOARD, SUSQUEHANNA WORKFORCE NETWORK, AND WEST CECIL HEALTH CENTER.

UNION HOSPITAL OF CECIL COUNTY SERVICED 6,200 DISCHARGES PROVIDING 26,962 PATIENT DAYS TO INPATIENTS IN FISCAL YEAR 2024 OF WHICH:

- 1) PATIENTS COVERED UNDER THE MEDICARE PROGRAM WERE 2,292 DISCHARGES AND 10,765 PATIENT DAYS
- 2) PATIENTS COVERED UNDER THE MEDICAID PROGRAM WERE 159 DISCHARGES AND 686 PATIENT DAYS
- 3) PATIENTS COVERED UNDER THE MEDICAID HMO PROGRAM WERE 1,519 DISCHARGES AND 5,155 PATIENT DAYS
- 4) PATIENTS COVERED UNDER THE MEDICARE HMO PROGRAM WERE 918 DISCHARGES AND 4,558 PATIENT DAYS

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

## FORM 990, PART VII-COMPENSATION OF THE 5 HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS

DESCRIPTION OF SERVICES

COMPENSATION

UNION RADIOLOGISTS, LLC

106 BOW ST, RADIOLOGY OFFICE

ELKTON, MD 21921

RADIOLOGY SERVICES

3,461,708.

FRANCIS A. PALERMO, MD, PA

620 STANTON-CHRISTIANA RD, STE 301

NEWARK, DE 19713

PROVIDER SERVICES

554,047.

KOREE PARTNERS

8 WYETH LN

HOCKESSIN, DE 19707

STAFFING SERVICES

241,467.

MAYO COLLABORATIVE SERVICES INC.

PO BOX 9146

MINNEAPOLIS, MN 55480-9176

LAB SERVICES

222,311.

LOCUMTENENS.COM

PO BOX 405547

ATLANTA, GA 30384-5547

CONSULTING SERVICES

210,553.

SCHEDULE R  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Related Organizations and Unrelated Partnerships

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

Attach to Form 990.

Go to [www.irs.gov/Form990](https://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

2023

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Inspection

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52-0607945

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
SEE SUPPLEMENTAL PAGE							
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

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

UNION HOSPITAL OF CECIL COUNTY, INC. 52-0607945

PART II - IDENTIFICATION OF RELATED TAX-EXEMPT ORGANIZATIONS

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512 YES NO
-----						
UNION HOSPITAL OF CECIL COUNTY FDN, INC. 4000 NEXUS DR. NW3-100	52-1794552 WILMINGTON, DE 19803 FUNDRAISING	MD	501(C)(3)	7	AFFINITY	X
UNION HOSPITAL OF CECIL COUNTY HLTH SVCS 4000 NEXUS DR. NW3-100	52-1794553 WILMINGTON, DE 19803 PROPERTY MGMT	MD	501(C)(3)	10	AFFINITY	X
AFFINITY HEALTH ALLIANCE, INC. 4000 NEXUS DR. NW3-100	52-1794697 WILMINGTON, DE 19803 MANAGEMENT	MD	501(C)(3)	12B,II	CCH SERVICES	X
UNION HOSPITAL OF CECIL COUNTY ONCOLOGY 4000 NEXUS DR. NW3-100	81-2662359 WILMINGTON, DE 19803 HEALTHCARE	MD	501(C)(3)	3	AFFINITY	X
CHRISTIANA CARE HEALTH SYSTEM, INC. 4000 NEXUS DR. NW3-100	52-1479538 WILMINGTON, DE 19803 FUNDRAISING	DE	501(C)(3)	7	N/A	X
CHRISTIANA CARE HLTH INITIATIVES, INC. 4000 NEXUS DR. NW3-100	51-0295186 WILMINGTON, DE 19803 OUTPATIENT SV	DE	501(C)(3)	10	CCH SYSTEM	X
CHRISTIANA CARE HOME HEALTH & COM SRVCS 4000 NEXUS DR. NW3-100	51-0064334 WILMINGTON, DE 19803 HOME HLTHCARE	DE	501(C)(3)	7	CCH SYSTEM	X
CHRISTIANA CARE HEALTH SERVICES, INC. 4000 NEXUS DR. NW3-100	51-0103684 WILMINGTON, DE 19803 HOSPITAL	DE	501(C)(3)	3	CCH SYSTEM	X
CHRISTIANA CARE WEST GROVE, INC. 4000 NEXUS DR. NW3-100	88-3155785 WILMINGTON, DE 19803 HEALTHCARE	PA	501(C)(3)	PENDING	CCH SERVICES	X
CHRISTIANA CARE GENE EDITING INSTITUTE 4000 NEXUS DR., NW3-100	88-3110655 WILMINGTON, DE 19803 HEALTHCARE	DE	501(C)(3)	PENDING	CCH SYSTEM	X

UNION HOSPITAL OF CECIL COUNTY, INC. 52-0607945

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512
						YES NO
-----						
CHRISTIANA CARE PENNSYLVANIA, INC.	99-2607716					
4000 NEXUS DRIVE, NW3-100	WILMINGTON, DE 19803					
	HEALTHCARE	PA	501(C)(3)	PENDING	CCH SYSTEM	X



Schedule R (Form 990) 2023

UNION HOSPITAL OF CECIL COUNTY, INC.

52-0607945

Page **2****Part III Identification of Related Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
<b>(1)</b> CHRISTIANACARE GOHEALTH URGENT 5555 GLENRIDGE CONNECTOR	URGENT CARE SRVCS	DE	CCH SERVICES								X	
<b>(2)</b> CLINERGY, LLC 85-2698063 4755 OGLETOWN STANTON RD	GROUP PURCHASING	DE	CCH SERVICES								X	
<b>(3)</b> LEEWARD HEALTH, LLC 4000 NEXUS DRIVE, STE C3-300	MED ADV RISK	DE	CCH SYSTEM								X	
<b>(4)</b> CHRISTIANA CARE EMERGENCY PHYS 4000 NEXUS DRIVE, STE C3-300	MEDICAL SRVCS	DE	CCH SERVICES								X	
<b>(5)</b> SOUTHERN CHESTER COUNTY MOB I 1015 W BALTIMORE PK WEST GROVE	MOB	PA	CC WEST GROVE								X	
<b>(6)</b> SOUTHERN CHESTER COUNTY MED II 1015 W BALTIMORE PK WEST GROVE	MOB	PA	CC WEST GROVE								X	
<b>(7)</b>												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
<b>(1)</b> UNION HOSPITAL OF CECIL COUNTY VENTURES 52-1793691 4000 NEXUS DR. NW3-100 WILMINGTON, DE 19803	MEDICAL SERVICES	MD	AFFINITY	C CORP					X
<b>(2)</b> THE DE CTR FOR MAT FETAL MED OF CC, INC. 20-5891272 4000 NEXUS DR. NW3-100 WILMINGTON, DE 19803	HEALTHCARE	DE	CCH SERVICES	C CORP					X
<b>(3)</b> CHRISTIANA CARE HEALTH PLANS 51-0352728 4000 NEXUS DR. STE NW3-100 WILMINGTON, DE 19803	INSURANCE	DE	CCH SYSTEM	C CORP					X
<b>(4)</b> CHRISTIANA CARE DEFERRED COMP PLAN 81-6359549 4755 OGLETOWN STANTON RD NEWARK, DE 19718	DEF COMP PLAN	DE	CCH SERVICES	TRUST					X
<b>(5)</b> CHRISTIANA CARE EXEC DEFERRED COMP PLAN 35-7048822 4755 OGLETOWN STANTON RD NEWARK, DE 19718	DEF COMP PLAN	DE	CCH SERVICES	TRUST					X
<b>(6)</b> CARE ASSOCIATES DEFERRED COMP PLAN 35-7048714 4755 OGLETOWN STANTON RD NEWARK, DE 19718	DEF COMP PLAN	DE	CCH SERVICES	TRUST					X
<b>(7)</b> CHRISTIANA CARE INSURANCE CO, LTD 98-1489490 P.O. BOX 1159, 878 W. BAY RD GRAND CAYMAN, CJ KY1-1102	SELF-INSURANCE	CJ	CCH SERVICES	C CORP					X

Schedule R (Form 990) 2023

**Part V** **Transactions With Related Organizations.** Complete if the organization answered "Yes" on 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 . . . . .		X
<b>b</b> Gift, grant, or capital contribution to related organization(s) . . . . .		X
<b>c</b> Gift, grant, or capital contribution from related organization(s) . . . . .	X	
<b>d</b> Loans or loan guarantees to or for related organization(s) . . . . .		X
<b>e</b> Loans or loan guarantees by related organization(s) . . . . .	X	
<b>f</b> Dividends from related organization(s) . . . . .		X
<b>g</b> Sale of assets to related organization(s) . . . . .		X
<b>h</b> Purchase of assets from related organization(s) . . . . .		X
<b>i</b> Exchange of assets with related organization(s) . . . . .		X
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) . . . . .	X	
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) . . . . .	X	
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) . . . . .		X
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) . . . . .		X
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .	X	
<b>o</b> Sharing of paid employees with related organization(s) . . . . .	X	
<b>p</b> Reimbursement paid to related organization(s) for expenses . . . . .	X	
<b>q</b> Reimbursement paid by related organization(s) for expenses . . . . .	X	
<b>r</b> Other transfer of cash or property to related organization(s) . . . . .	X	
<b>s</b> Other transfer of cash or property from related organization(s) . . . . .	X	

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

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

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(e) Are all partners section 501(c)(3) organizations?		(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)													

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

Provide additional information for responses to questions on Schedule R. See instructions.