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CLIENT'S COPY

TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING

June 30, 2013

Prepared for	Union Hospital of Cecil County, Inc. 106 Bow Street Elkton, MD 21921-5596
Prepared by	ParenteBeard LLC 1650 Market Street, Suite 4500 Philadelphia, PA 19103
Amount due or refund	Not applicable
Make check payable to	Not applicable
Mail tax return and check (if applicable) to	Not applicable
Return must be mailed on or before	Not applicable
Special Instructions	This return has qualified for electronic filing. After you have reviewed the return for completeness and accuracy, please sign, date and return Form 8879-EO to our office. We will transmit the return electronically to the IRS and no further action is required. Return Form 8879-EO to us by May 15, 2014.

Return of Organization Exempt From Income Tax

2012

Department of the Treasury
Internal Revenue Service

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

Open to Public Inspection

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

A For the 2012 calendar year, or tax year beginning JUL 1, 2012 and ending JUN 30, 2013

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization UNION HOSPITAL OF CECIL COUNTY, INC.		D Employer identification number 52-0607945
	Doing Business As		E Telephone number (410) 398-4000
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	
	City, town, or post office, state, and ZIP code ELKTON, MD 21921-5596		G Gross receipts \$ 162,769,500.
F Name and address of principal officer: KENNETH S. LEWIS, MD, JD SAME AS C ABOVE		H(a) Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		H(b) Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No	
J Website: WWW.UHCC.COM		H(c) Group exemption number ▶	
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		L Year of formation: 1903 M State of legal domicile: MD	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: PROVIDE HEALTHCARE SERVICES TO THE RESIDENTS OF CECIL COUNTY, MD, AND THE SURROUNDING AREA.
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.
	3 Number of voting members of the governing body (Part VI, line 1a) 3 16
	4 Number of independent voting members of the governing body (Part VI, line 1b) 4 15
	5 Total number of individuals employed in calendar year 2012 (Part V, line 2a) 5 1286
	6 Total number of volunteers (estimate if necessary) 6 426
	7a Total unrelated business revenue from Part VIII, column (C), line 12 7a 982,579.
b Net unrelated business taxable income from Form 990-T, line 34 7b -571,243.	

		Prior Year	Current Year
		8 Contributions and grants (Part VIII, line 1h)	358,066.	520,133.
9 Program service revenue (Part VIII, line 2g)	147,528,194.	151,762,502.	
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	-1,015,994.	1,412,315.	
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	909,475.	3,949,188.	
12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	147,779,741.	157,644,138.	
13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	3,652,832.	4,738,934.	
14 Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.	
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	69,543,149.	75,246,162.	
16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.	
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.			
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	74,113,793.	76,658,317.	
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	147,309,774.	156,643,413.	
19 Revenue less expenses. Subtract line 18 from line 12	469,967.	1,000,725.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year 185,901,825.	End of Year 188,229,305.
	21 Total liabilities (Part X, line 26)	100,850,222.	99,544,828.
	22 Net assets or fund balances. Subtract line 21 from line 20	85,051,603.	88,684,477.

Part II Signature Block

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

Sign Here	Signature of officer	Date			
	LAURIE R. BEYER, CPA, SENIOR VP/CFO Type or print name and title				
Paid Preparer Use Only	Print/Type preparer's name JULIUS C. GREEN, CPA, JD	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN P00350393
	Firm's name ▶ PARENTEBEARD LLC	Firm's EIN ▶ 23-2932984			
	Firm's address ▶ 1650 MARKET STREET, SUITE 4500 PHILADELPHIA, PA 19103	Phone no. (215) 972-0701			

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: UNION HOSPITAL OF CECIL COUNTY'S MISSION IS TO PROVIDE 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 [X] No

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

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 \$ 152,974,263. including grants of \$ 4,738,934.) (Revenue \$ 151,772,348.) UNION HOSPITAL OF CECIL COUNTY'S MISSION IS TO PROVIDE HEALTH CARE SERVICES TO THE RESIDENTS OF CECIL COUNTY, MARYLAND, WESTERN NEW CASTLE COUNTY, DELAWARE, AND SOUTHERN CHESTER COUNTY, PENNSYLVANIA, THAT REPRESENT QUALITY AND VALUE AND ARE PROVIDED WITH MODERN TECHNOLOGY, COMPASSIONATE NURSES AND STAFF, AND CONVENIENT TO THE CITIZENS OF OUR COMMUNITY. THESE HEALTHCARE SERVICES ARE PROVIDED REGARDLESS OF RACE, CREED, SEX, NATIONAL ORIGIN, HANDICAP, AGE, OR ABILITY TO PAY. ALTHOUGH REIMBURSEMENT FOR SERVICES RENDERED IS VITALLY IMPORTANT TO THE OPERATION, STABILITY, AND VIABILITY OF UNION HOSPITAL OF CECIL COUNTY, WE RECOGNIZE THAT NOT ALL MEMBERS OF OUR COMMUNITY ARE IN THE FINANCIAL POSITION TO PURCHASE ESSENTIAL MEDICAL SERVICES. THEREFORE, CONSISTENT WITH UNION HOSPITAL'S COMMITMENT TO SERVE ALL MEMBERS OF CECIL COUNTY,

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

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

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

4e Total program service expenses 152,974,263.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

Note. All Form 990 filers are required to complete Schedule O

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Main form area containing questions 1a through 14b with input fields and Yes/No columns.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (16), 1b (15), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

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

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization:
DERON G. BROWN, DIRECTOR OF FINANCE - (410) 398-4000
106 BOW STREET, ELKTON, MD 21921

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) JACK GOLDSTEIN CHAIRMAN	0.40 0.50	X		X				0.	0.	0.
(2) MARTIN J. HEALY VICE CHAIRMAN	0.40 0.50	X		X				0.	0.	0.
(3) RICHARD GUTTENDORF TREASURER	0.40 0.50	X		X				0.	0.	0.
(4) RONALD GRAYBEAL SECRETARY	0.50 0.50	X		X				0.	0.	0.
(5) ALFONSO BASILE, MD DIRECTOR	0.50 0.50	X						0.	0.	0.
(6) MARY BOLT, PH.D. DIRECTOR	0.50 0.50	X						0.	0.	0.
(7) RON CULLIS DIRECTOR	0.50 0.50	X						0.	0.	0.
(8) PHILLIP FARMER DIRECTOR	0.50 0.50	X						0.	0.	0.
(9) RAYMOND HAMM DIRECTOR	0.50 0.50	X						0.	0.	0.
(10) RAYMOND HEIDEL DIRECTOR	0.30 0.70	X						0.	0.	0.
(11) MARTHA HOSFORD, MD DIRECTOR	0.50 0.50	X						0.	0.	0.
(12) TARI MOORE DIRECTOR	0.50 0.50	X						0.	0.	0.
(13) HENRY PASSI DIRECTOR	0.50 0.50	X						0.	0.	0.
(14) SHEELMOHAN SACHDEV, MD DIRECTOR	0.60 0.40	X						0.	0.	0.
(15) MICHAEL SCIBINICO DIRECTOR	0.50 0.50	X						0.	0.	0.
(16) KENNETH S. LEWIS, MD, JD PRESIDENT/CEO	30.00 10.00	X		X				0.	721,506.	144,960.
(17) LAURIE R. BEYER, CPA SENIOR VP/CFO	28.00 12.00			X				0.	308,570.	84,480.

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 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			
(18) CYDNEY TEAL VP MEDICAL AFFAIRS	39.90 0.10				X			0.	296,876.	28,900.
(19) TERRANCE LOVELL VP HUMAN RESOURCES	40.00				X			164,085.	0.	16,696.
(20) DAVID GIPSON SENIOR VP/COO	28.60 11.40				X			0.	325,305.	85,433.
(21) CAREN LEWIS SR. VP CARE SVCS (THROUGH 6.15.13)	39.10 0.90				X			0.	226,865.	54,740.
(22) ROHIT SINGHANIA PHYSICIAN	40.00					X		426,827.	0.	13,479.
(23) IRFAN M. HISAMUDDIN, MD PHYSICIAN	40.00					X		416,246.	0.	20,192.
(24) JUSTIN SAUSVILLE PHYSICIAN	40.00					X		394,870.	0.	23,771.
(25) JAGDEEP HUNDAL PHYSICIAN	40.00					X		368,569.	0.	23,561.
(26) BERNARD J HYNES PHYSICIAN	40.00					X		367,864.	0.	19,805.
1b Sub-total								2,138,461.	1,879,122.	516,017.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								2,138,461.	1,879,122.	516,017.

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 **82**

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
OWENS & MINOR, INC. PO BOX 79171, BALTIMORE, MD 21279	MEDICAL SUPPLY DISTRIBUTOR	3,710,338.
RADCARE/EMCARE PO BOX 368, PERRY HALL, MD 21128	IMAGING READINGS	2,703,710.
MEDICAL INFORMATION TECHNOLOGY, INC. PO BOX 74569, CHICAGO, IL 60696	SOFTWARE	2,699,777.
CLEARPATH SOLUTIONS GROUP, LLC 2465 CENTERVILLE ROAD, HERNDON, VA 20171	HARDWARE AND MAINTENANCE	2,697,158.
NAVIN, HAFFTY, & ASSOC., LLC 1900 WEST PARK DRIVE, WESTBOROUGH, MA 01581	SOFTWARE CONSULTING	2,494,415.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization **95**

Part VIII Statement of Revenue

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

			(A)	(B)	(C)	(D)	
			Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512, 513, or 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d	480,133.				
	e Government grants (contributions)	1e					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	40,000.				
	g Noncash contributions included in lines 1a-1f: \$						
	h Total. Add lines 1a-1f			520,133.			
	Program Service Revenue	2 a NET PATIENT SERVICE REVENUE	Business Code 621990	150,282,645.	150,282,645.		
b OTHER OPERATING REVENUE		621990	849,519.	849,519.			
c ADULT DAY CARE		623990	540,577.	540,577.			
d LIFELINE		900099	89,761.	89,761.			
e							
f All other program service revenue							
g Total. Add lines 2a-2f				151,762,502.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		1,324,410.			1,324,410.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real	167,604.				
		(ii) Personal					
		b Less: rental expenses	34,829.				
		c Rental income or (loss)	132,775.				
	d Net rental income or (loss)		132,775.			132,775.	
	7 a Gross amount from sales of assets other than inventory	(i) Securities	5,178,438.				
		(ii) Other					
		b Less: cost or other basis and sales expenses	5,090,533.				
		c Gain or (loss)	87,905.				
	d Net gain or (loss)		87,905.			87,905.	
	8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a					
		b Less: direct expenses					
c Net income or (loss) from fundraising events							
9 a Gross income from gaming activities. See Part IV, line 19	a						
	b Less: direct expenses						
	c Net income or (loss) from gaming activities						
10 a Gross sales of inventory, less returns and allowances	a						
	b Less: cost of goods sold						
	c Net income or (loss) from sales of inventory						
Miscellaneous Revenue		Business Code					
11 a MEANINGFUL USE REVENUE		900099	1,997,301.			1,997,301.	
	b LABORATORY REVENUE	621500	972,733.		972,733.		
	c CAFETERIA/FOOD SERVICE	722210	773,133.			773,133.	
	d All other revenue	900099	73,246.		9,846.	63,400.	
	e Total. Add lines 11a-11d			3,816,413.			
12 Total revenue. See instructions.			157,644,138.	151,762,502.	982,579.	4,378,924.	

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21	4,738,934.	4,738,934.		
2 Grants and other assistance to individuals in the United States. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	2,572,233.	2,572,233.		
7 Other salaries and wages	61,139,628.	60,311,795.	827,833.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	960,928.	811,691.	149,237.	
9 Other employee benefits	6,238,319.	6,136,302.	102,017.	
10 Payroll taxes	4,335,054.	4,284,363.	50,691.	
11 Fees for services (non-employees):				
a Management	2,070,605.	1,035,302.	1,035,303.	
b Legal	290,439.		290,439.	
c Accounting	101,664.		101,664.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	63,111.		63,111.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	19,621,779.	18,897,011.	724,768.	
12 Advertising and promotion	479,112.	479,112.		
13 Office expenses	1,966,464.	1,888,451.	78,013.	
14 Information technology	426,990.	426,990.		
15 Royalties				
16 Occupancy	2,437,680.	2,437,680.		
17 Travel	309,543.	280,504.	29,039.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	22,436.	8,143.	14,293.	
20 Interest	2,688,829.	2,688,829.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	8,970,371.	8,970,371.		
23 Insurance	2,515,823.	2,515,823.		
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES/DRUGS	18,918,168.	18,918,168.		
b BAD DEBT	9,628,002.	9,628,002.		
c REPAIRS & MAINTENANCE	2,336,946.	2,336,946.		
d FOOD/DIETARY SUPPLIES	1,059,133.	1,059,133.		
e All other expenses	2,751,222.	2,548,480.	202,742.	
25 Total functional expenses. Add lines 1 through 24e	156,643,413.	152,974,263.	3,669,150.	0.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

Check here if following SOP 98-2 (ASC 958-720)

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year	
Assets	1 Cash - non-interest-bearing	298,522.	1	5,405,023.	
	2 Savings and temporary cash investments	9,013,704.	2	784,061.	
	3 Pledges and grants receivable, net		3		
	4 Accounts receivable, net	18,298,560.	4	15,574,231.	
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5		
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6		
	7 Notes and loans receivable, net	1,158,970.	7	561,214.	
	8 Inventories for sale or use	1,805,445.	8	1,759,420.	
	9 Prepaid expenses and deferred charges	1,619,387.	9	2,253,892.	
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 179,685,973.			
	b Less: accumulated depreciation	10b 93,292,117.	79,944,732.	10c	86,393,856.
	11 Investments - publicly traded securities	63,033,266.	11	63,626,059.	
	12 Investments - other securities. See Part IV, line 11	5,060,977.	12	5,112,129.	
	13 Investments - program-related. See Part IV, line 11		13		
	14 Intangible assets		14		
	15 Other assets. See Part IV, line 11	5,668,262.	15	6,759,420.	
16 Total assets. Add lines 1 through 15 (must equal line 34)	185,901,825.	16	188,229,305.		
Liabilities	17 Accounts payable and accrued expenses	11,415,256.	17	15,108,507.	
	18 Grants payable		18		
	19 Deferred revenue		19		
	20 Tax-exempt bond liabilities	81,847,367.	20	74,136,484.	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21		
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22		
	23 Secured mortgages and notes payable to unrelated third parties		23		
	24 Unsecured notes and loans payable to unrelated third parties		24		
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	7,587,599.	25	10,299,837.	
	26 Total liabilities. Add lines 17 through 25	100,850,222.	26	99,544,828.	
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27 Unrestricted net assets	84,203,884.	27	87,623,004.	
	28 Temporarily restricted net assets	847,719.	28	1,061,473.	
	29 Permanently restricted net assets		29		
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.				
	30 Capital stock or trust principal, or current funds		30		
	31 Paid-in or capital surplus, or land, building, or equipment fund		31		
	32 Retained earnings, endowment, accumulated income, or other funds		32		
	33 Total net assets or fund balances	85,051,603.	33	88,684,477.	
34 Total liabilities and net assets/fund balances	185,901,825.	34	188,229,305.		

Part XI Reconciliation of Net Assets

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

Table with 10 rows for reconciliation of net assets. Line 1: Total revenue 157,644,138. Line 2: Total expenses 156,643,413. Line 3: Revenue less expenses 1,000,725. Line 4: Net assets at beginning 85,051,603. Line 5: Net unrealized gains 3,169,351. Line 9: Other changes -537,202. Line 10: Net assets at end 88,684,477.

Part XII Financial Statements and Reporting

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

Table with 3 columns: Question, Yes, No. Row 1: Accounting method (Accrual checked). Row 2a: Financial statements compiled (No checked). Row 2b: Financial statements audited (Yes checked). Row 2c: Committee oversight (Yes checked). Row 3a: Federal award audit (No checked). Row 3b: Required audit (No checked).

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

OMB No. 1545-0047

2012

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 11, check only one box.)

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

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

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

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2012 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2011 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2012. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 33 1/3% support test - 2011. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2012. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2011. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2012 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2011 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2012 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2011 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2012. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

b 33 1/3% support tests - 2011. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

Schedule B
(Form 990, 990-EZ,
or 990-PF)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2012

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 foundation

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

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

General Rule

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

Special Rules

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

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

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

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2012)

Name of organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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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	MARYLAND HOSPITAL ASSOCIATION 6820 DEERPATH RD. ELKRIDGE, MD 21075	\$ 40,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
2	UNION HOSPITAL OF CECIL COUNTY FOUNDATION, INC. 106 BOW STREET ELKTON, MD 21921	\$ 480,133.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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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
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Part III *Exclusively* religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than \$1,000 for the year. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this information once.) ▶ \$ _____
 Use duplicate copies of Part III if additional space is needed.

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

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open to Public
Inspection

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

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

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

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

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

Preservation of land for public use (e.g., recreation or education) Preservation of an historically important land area

Protection of natural habitat Preservation of a certified historic structure

Preservation of open space

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

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

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

Yes No

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

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1

▶ \$ _____

(ii) Assets included in Form 990, Part X

▶ \$ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1

▶ \$ _____

b Assets included in Form 990, Part X

▶ \$ _____

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

- 3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):
- a Public exhibition
 - b Scholarly research
 - c Preservation for future generations
 - d Loan or exchange programs
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

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

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b If "Yes," explain the arrangement in Part XIII and complete the following table:
- | | Amount |
|---------------------------------|--------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a Did the organization include an amount on Form 990, Part X, line 21? Yes No
- b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII

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

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

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment _____ %
 - b Permanent endowment _____ %
 - c Temporarily restricted endowment _____ %
- The percentages in lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|--------|----|
| (i) unrelated organizations | 3a(i) | |
| (ii) related organizations | 3a(ii) | |
| b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R? | 3b | |

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,134,905.		1,134,905.
b Buildings		70,711,838.	27,255,835.	43,456,003.
c Leasehold improvements		774,439.	644,543.	129,896.
d Equipment		95,102,987.	64,346,149.	30,756,838.
e Other		11,961,804.	1,045,590.	10,916,214.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				86,393,856.

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

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

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

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

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

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

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) THIRD PARTY ADVANCES	2,073,357.
(3) CAPITAL LEASE OBLIGATIONS	696,808.
(4) ESTIMATED MEDICAL MALPRACTICE	
(5) CLAIMS LIABILITY	6,289,313.
(6) DUE TO AFFILIATES	1,240,359.
(7)	
(8)	
(9)	
(10)	
(11)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	10,299,837.

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

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

1	Total revenue, gains, and other support per audited financial statements	1	150,532,531.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains on investments	2a	3,169,351.
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIII.)	2d	-10,217,847.
e	Add lines 2a through 2d	2e	-7,048,496.
3	Subtract line 2e from line 1	3	157,581,027.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	63,111.
b	Other (Describe in Part XIII.)	4b	
c	Add lines 4a and 4b	4c	63,111.
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)	5	157,644,138.

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

1	Total expenses and losses per audited financial statements	1	146,899,657.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIII.)	2d	
e	Add lines 2a through 2d	2e	0.
3	Subtract line 2e from line 1	3	146,899,657.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	63,111.
b	Other (Describe in Part XIII.)	4b	9,680,645.
c	Add lines 4a and 4b	4c	9,743,756.
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)	5	156,643,413.

Part XIII Supplemental Information

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

PART X, LINE 2: THE HOSPITAL ACCOUNTS FOR UNCERTAINTY IN INCOME TAXES

BY PRESCRIBING A RECOGNITION THRESHOLD OF MORE-LIKELY-THAN-NOT TO BE

SUSTAINED UPON EXAMINATION BY THE APPROPRIATE TAXING AUTHORITY.

MEASUREMENT OF THE TAX UNCERTAINTY OCCURS IF THE RECOGNITION THRESHOLD HAS

BEEN MET. THERE WERE NO TAX UNCERTAINTIES THAT MET THE RECOGNITION

THRESHOLD IN 2013 AND 2012.

THE HOSPITAL'S FEDERAL EXEMPT ORGANIZATION BUSINESS INCOME TAX RETURNS FOR

Schedule D (Form 990) 2012

Part XIII Supplemental Information (continued)

YEARS AFTER 2009 REMAIN SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

CHANGE IN INTEREST IN NET ASSETS OF FOUNDATION & SUBSIDIARY	-167,878.
LOSS ON REFINANCING	-322,110.
PROVISION FOR BAD DEBTS NETTED AGAINST REVENUE ON FINANCIAL STATEMENTS	-9,628,002.
CHANGE IN PROVISION FOR UNCOLLECTIBLE PLEDGES	-47,214.
BANK FEES NETTED ON FINANCIAL STATEMENTS	-52,643.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	-10,217,847.

PART XII, LINE 4B - OTHER ADJUSTMENTS:

PROVISION FOR BAD DEBTS NETTED AGAINST REVENUE ON FINANCIAL STATEMENTS	9,628,002.
BANK FEES NETTED ON FINANCIAL STATEMENTS	52,643.
TOTAL TO SCHEDULE D, PART XII, LINE 4B	9,680,645.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2012

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

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

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

7 Financial Assistance and Certain Other Community Benefits at Cost						
Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			3,767,210.		3,767,210.	2.56%
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			3,767,210.		3,767,210.	2.56%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			487,087.	120,756.	366,331.	.25%
f Health professions education (from Worksheet 5)			293,786.		293,786.	.20%
g Subsidized health services (from Worksheet 6)			11,659,981.	5,918,978.	5,741,003.	3.91%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			575,619.	135,202.	440,417.	.30%
j Total. Other Benefits			13,016,473.	6,174,936.	6,841,537.	4.66%
k Total. Add lines 7d and 7j			16,783,683.	6,174,936.	10,608,747.	7.22%

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.

Table with 7 columns: (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. Rows include Physical improvements and housing, Economic development, Community support, Environmental improvements, Leadership development and training for community members, Coalition building, Community health improvement advocacy, Workforce development, Other, and Total.

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

Table for Section A. Bad Debt Expense with columns Yes and No. Includes questions 1-4 regarding bad debt reporting, methodology, and financial statement footnotes. Values include 7,906,949 and 203,754.

Section B. Medicare

Table for Section B. Medicare with columns Yes and No. Includes questions 5-8 regarding Medicare revenue, allowable costs, and shortfall treatment. Values include 63,796,787.

Section C. Collection Practices

Table for Section C. Collection Practices with columns Yes and No. Includes questions 9a and 9b regarding debt collection policies.

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

Table for Part IV Management Companies and Joint Ventures with 5 columns: (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 %.

Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, and primary website address

1 UNION HOSPITAL OF CECIL COUNTY, INC.
106 BOW STREET
ELKTON, MD 21921

Table with columns: Licensed hospital, General medical & surgical, Children's hospital, Teaching hospital, Critical access hospital, Research facility, ER-24 hours, ER-other, Other (describe), Facility reporting group. Row 1 contains 'X' marks in the first three columns and 'X' in the ER-24 hours column.

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

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

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

	Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)		
1 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <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		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Part VI)		
2 Indicate the tax year the hospital facility last conducted a CHNA: <u>20 12</u>		
3 In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
4 Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI		X
5 Did the hospital facility make its CHNA report widely available to the public?	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website		
b <input checked="" type="checkbox"/> Available upon request from the hospital facility		
c <input type="checkbox"/> Other (describe in Part VI)		
6 If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):		
a <input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA		
b <input checked="" type="checkbox"/> Execution of the implementation strategy		
c <input type="checkbox"/> Participation in the development of a community-wide plan		
d <input type="checkbox"/> Participation in the execution of a community-wide plan		
e <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans		
f <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA		
g <input checked="" type="checkbox"/> Prioritization of health needs in its community		
h <input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i <input checked="" type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs		X
8a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
8b If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ <u> </u>		

Part V Facility Information (continued) UNION HOSPITAL OF CECIL COUNTY, INC.

Financial Assistance Policy		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free care</i> ?	X	
If "Yes," indicate the FPG family income limit for eligibility for free care: <u>200</u> %			
If "No," explain in Part VI the criteria the hospital facility used.			
11	Used FPG to determine eligibility for providing <i>discounted care</i> ?	X	
If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>300</u> %			
If "No," explain in Part VI the criteria the hospital facility used.			
12	Explained the basis for calculating amounts charged to patients?	X	
If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	<input checked="" type="checkbox"/> Income level		
b	<input checked="" type="checkbox"/> Asset level		
c	<input type="checkbox"/> Medical indigency		
d	<input checked="" type="checkbox"/> Insurance status		
e	<input checked="" type="checkbox"/> Uninsured discount		
f	<input checked="" type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input type="checkbox"/> Other (describe in Part VI)		
13	Explained the method for applying for financial assistance?	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input checked="" type="checkbox"/> The policy was attached to billing invoices		
c	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> Other (describe in Part VI)		
Billing and Collections			
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine patient's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?		X
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		

Part V Facility Information (continued) **UNION HOSPITAL OF CECIL COUNTY, INC.**

- 18** Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):
- a Notified individuals of the financial assistance policy on admission
 - b Notified individuals of the financial assistance policy prior to discharge
 - c Notified individuals of the financial assistance policy in communications with the patients regarding the patients' bills
 - d Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy
 - e Other (describe in Part VI)

Policy Relating to Emergency Medical Care

19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

	Yes	No
19	<input checked="" type="checkbox"/>	

If "No," indicate why:

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

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- a The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d Other (describe in Part VI)

21 During the tax year, did the hospital facility charge any of its FAP-eligible individuals, to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?

If "Yes," explain in Part VI.

21		<input checked="" type="checkbox"/>
22		<input checked="" type="checkbox"/>

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

If "Yes," explain in Part VI.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.
- 8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

PART I, LINE 7: ALL INFORMATION IS BASED ON ACTUAL COST PLUS OVERHEAD. OVERHEAD IS A HOSPITAL AVERAGE PERCENTAGE OF OVERHEAD TO DIRECT COSTS. DIRECT COSTS EXCLUDE BAD DEBT EXPENSE.

PART I, LN 7 COL(F): THE AMOUNT OF BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25 BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS \$9,628,002.

PART II: ECONOMIC DEVELOPMENT (F2)
MEMBERS OF UNION HOSPITAL'S EXECUTIVE MANAGEMENT TEAM ATTENDED MEETINGS WITH THE FOLLOWING ENTITIES:

1) ECONOMIC DEVELOPMENT COMMISSION FOR CECIL COUNTY. THIS COMMISSION PROMOTES ECONOMIC DEVELOPMENT IN CECIL COUNTY, FOCUSING ON BUSINESS AND INDUSTRY DEVELOPMENT BY BUILDING RELATIONSHIPS WITH LOCAL AND EXTERNAL PARTNERS. UNION HOSPITAL COLLABORATES WITH THIS COMMISSION TO PROMOTE STABILITY WITHIN THE HOSPITAL'S WORKFORCE OF HEALTH PROFESSIONALS AND TO BRING MUCH NEEDED PRACTITIONERS TO THE AREA, ESPECIALLY IN AREAS WHERE

Part VI Supplemental Information

THERE ARE TOO FEW PROVIDERS OR SERVICE GAPS.

2) ELKTON ALLIANCE. ELKTON ALLIANCE WORKS TOGETHER WITH THE LOCAL GOVERNMENT AND BUSINESS COMMUNITY TO RESTORE, PROMOTE AND MAINTAIN THE DIVERSE HISTORIC DOWNTOWN AREA, WHILE ATTRACTING NEW ENTERPRISES FOR THE BENEFIT OF COMMUNITY RESIDENTS, BUSINESSES, AND VISITORS. IN COLLABORATING WITH ELKTON ALLIANCE, UNION HOSPITAL SEEKS TO MAINTAIN A POSITIVE PRESENCE IN THE COMMUNITY BY HELPING TO ADDRESS ANY COMMUNITY DEVELOPMENT ISSUES.

3) AMER-INDO ORGANIZATION. THIS IS A NON-PROFIT ORGANIZATION THAT SEEKS MUTUAL BUSINESS OPPORTUNITIES BETWEEN AMERICAN & INDONESIAN CULTURES. AS A SUPPORTER OF CULTURAL DIVERSITY, UNION HOSPITAL'S CEO BEGAN MEETING WITH THIS ORGANIZATION TO LEARN MORE ABOUT THE BARRIERS AND NEEDS THAT INDONESIAN PEOPLES IN CECIL COUNTY FACE IN THE CURRENT ECONOMY.

COMMUNITY SUPPORT (F3)

MEMBERS OF UNION HOSPITAL'S EXECUTIVE MANAGEMENT TEAM, AS WELL AS ADMINISTRATIVE STAFF, WORK CLOSELY WITH UNITED WAY OF CECIL COUNTY TO BUILD FUNDING AND PROGRAM CAPACITY FOR COMMUNITY-BASED PROGRAMMING FOR UNDERSERVED YOUTH IN THE COUNTY. HAVING HEALTHY YOUTH IS AN IMPORTANT FACET OF A STRONG COMMUNITY AND UNION HOSPITAL CONTINUES TO UPHOLD THIS IMPORTANCE BY FACILITATING A COLLABORATIVE PARTNERSHIP WITH UNITED WAY OF CECIL COUNTY.

WORKFORCE DEVELOPMENT (F8)

THERE WERE SEVERAL ACTIVITIES REPORTED UNDER WORKFORCE DEVELOPMENT DURING FISCAL YEAR 2013:

Part VI Supplemental Information

1) HOLLY EMMONS, DIRECTOR OF FOOD SERVICES AT UNION HOSPITAL, AND HER STAFF MENTORED 97 MENTALLY-CHALLENGED HIGH SCHOOL STUDENTS FROM ELKTON HIGH SCHOOL AND PERRYVILLE HIGH SCHOOL AS PART OF UNION HOSPITAL'S AND CECIL COUNTY PUBLIC SCHOOLS' PARTNER PROGRAM: THE HIGH SCHOOL WORK ENRICHMENT PROGRAM. THIS PROGRAM PROVIDES WORK ASSIGNMENTS AND APPROPRIATE TRAINING IN FOOD SERVICE ACTIVITIES, LIKE DEVELOPING CULINARY SKILLS FOR FOOD PREPARATION AND DEVELOPING SANITATION RESPONSIBILITIES (DISHWARE WASHING, SANITIZATION, TRASH DISPOSAL, AND RECYCLING). THE PROGRAM IS AN IMPORTANT FACET OF THE WORK ENRICHMENT EXPERIENCE BECAUSE IT PROVIDES DIRECTION, IMPORTANT LIFE SKILLS AND ALLOWS STUDENTS TO FEEL NEEDED, USEFUL, AND CAPABLE, ESPECIALLY IN A BUSY WORK ENVIRONMENT. STUDENTS ENJOY THEIR ROLES AND LEARN THE VALUE OF PRODUCTIVITY AND TASK COMPLETION BOTH WORKING INDIVIDUALLY AND AS PART OF A TEAM.

2) HUMAN RESOURCES STAFF MEMBERS PARTICIPATED IN WORKSHOPS WHERE THEY PROVIDED NEEDS-BASED CAREER COUNSELING FOR COMMUNITY MEMBERS. THIS INCLUDED HOW TO CONSTRUCT A RESUME, PROVIDING INTERVIEWING SKILLS, AND DISCUSSING WORKFORCE RESOURCES. STAFF PARTICULARLY VOLUNTEERED FOR THIS WORK BECAUSE THEY WERE SEEKING TO SHARE KNOWLEDGE AND PROVIDE INSIGHT FOR THE LESS FORTUNATE WHO WERE TRYING TO BETTER THEIR LIFE SITUATIONS BY GETTING JOBS OR AT LEAST BEING PREPARED FOR GETTING A JOB. FOR THE HUMAN RESOURCES STAFF THIS WAS ALSO A WAY FOR THEM TO PROMOTE THE VALUE OF SHARED LEARNING THAT UNION HOSPITAL EMPHASIZES ALL STAFF SHOULD DEMONSTRATE.

3) A MEMBER OF UNION HOSPITAL'S EXECUTIVE MANAGEMENT TEAM ATTENDS MEETINGS WITH THE SUSQUEHANNA WORKFORCE BOARD IN CECIL COUNTY. SUSQUEHANNA

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WORKFORCE IS A NON-PROFIT ORGANIZATION THAT PLANS WORKFORCE DEVELOPMENT PROGRAMS AND SERVICES FOR INDIVIDUALS AND BUSINESSES IN CECIL COUNTY AND HARTFORD COUNTY. UNION HOSPITAL CONTINUES TO UPHOLD THE NECESSITY OF THIS RESOURCE IN THE CECIL COUNTY COMMUNITY.

4) A MEMBER OF UNION HOSPITAL'S EXECUTIVE MANAGEMENT TEAM ATTENDS MEETINGS WITH THE BUSINESS EDUCATION PARTNERSHIP ADVISORY COUNCIL (BEPAC), WHICH SERVES TO IDENTIFY STRENGTHS, NEEDS AND TRENDS IN JOB READINESS AS IT CORRELATES TO STUDENT SUCCESS UPON GRADUATION FROM HIGH SCHOOL. BEPAC STRIVES TO PREPARE STUDENTS TO MEET JOB MARKET NEEDS, SELECT SATISFYING CAREERS, AND BE GOOD CITIZENS IN THEIR COMMUNITIES. UNION HOSPITAL HAS BEEN A PARTNER IN THIS PROCESS FOR SEVERAL YEARS.

5) UNION HOSPITAL REPORTS PHYSICIAN RECRUITMENT UNDER WORKFORCE DEVELOPMENT BECAUSE IT ADDRESSES GAPS IN SERVICES, ESPECIALLY WHERE THERE ARE TOO FEW PROVIDERS TO PRACTICE (IN UNDERSERVED AREAS, ETC.).

PART III, LINE 4: COSTING METHODOLOGY USED IN DETERMINING BAD DEBT EXPENSE AMOUNTS: THE METHODOLOGY ASSUMES THAT THE PERCENTAGE OF CHARITY CARE TO TOTAL REVENUE CAN BE APPLIED TO THE AMOUNT OF BAD DEBT EXPENSE FOR THE YEAR. OTHER BAD DEBT AMOUNTS ARE NOT INCLUDED IN COMMUNITY BENEFITS.

HOW THE ORGANIZATION ACCOUNTS FOR DISCOUNTS AND PAYMENTS ON PATIENT ACCOUNTS IN DETERMINING BAD DEBT EXPENSE: DISCOUNTS AND PAYMENTS ARE OFFSET AGAINST BAD DEBT EXPENSE.

METHOD USED TO DETERMINE THE AMOUNT THAT REASONABLY COULD BE ATTRIBUTABLE TO PATIENTS WHO LIKELY WOULD QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE

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HOSPITAL'S FINANCIAL ASSISTANCE POLICY: THE HOSPITAL USES THE AVERAGE CHARITY CARE WRITE-OFF PER CHARITY CASE MULTIPLIED BY THE NUMBER OF CASES NOT APPROVED DUE TO LACK OF DOCUMENTATION.

FOOTNOTE TO THE ORGANIZATION'S FINANCIAL STATEMENTS THAT DESCRIBES BAD DEBT EXPENSE: ACCOUNTS RECEIVABLE, PATIENTS ARE REPORTED AT NET REALIZABLE VALUE. ACCOUNTS ARE WRITTEN OFF WHEN THEY ARE DETERMINED TO BE UNCOLLECTIBLE BASED UPON MANAGEMENT'S ASSESSMENT OF INDIVIDUAL ACCOUNTS. THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IS ESTIMATED BASED UPON A PERIODIC REVIEW OF THE ACCOUNTS RECEIVABLE AGING, PAYOR CLASSIFICATIONS AND APPLICATION OF HISTORICAL WRITE-OFF PERCENTAGES.

PART III, LINE 8: 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.

PART III, LINE 9B: IN ACCORDANCE WITH THE COLLECTION POLICY, BAD DEBT ACCOUNTS WILL BE ELIGIBLE FOR A CHARITY CARE DISCOUNT IF THE PATIENT MEETS CHARITY CARE POLICY GUIDELINES. THE PATIENT WILL NEED TO SUPPLY INCOME INFORMATION IN ORDER TO DETERMINE ELIGIBILITY FOR CHARITY CARE PER POLICY. ALSO SEE RESPONSE TO PART III LINE 4 ABOVE.

UNION HOSPITAL OF CECIL COUNTY, INC.:

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PART V, SECTION B, LINE 3: CONDUCTING THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WAS A COLLABORATIVE EFFORT BETWEEN UNION HOSPITAL OF CECIL COUNTY AND THE CECIL COUNTY HEALTH DEPARTMENT. UNION HOSPITAL'S COMMUNITY BENEFITS COORDINATOR MET WITH CECIL COUNTY HEALTH DEPARTMENT'S PUBLIC HEALTH OFFICER, DEPUTY PUBLIC HEALTH OFFICER, AND EPIDEMIOLOGIST TO CONDUCT THE COMMUNITY HEALTH NEEDS ASSESSMENT. THIS TEAM FACILITATED A SERIES OF MEETINGS WITH BOTH COMMUNITY LEADERS AND COMMUNITY RESIDENTS TO GAIN FIRST-HAND KNOWLEDGE OF IMPORTANT HEALTH NEEDS IN CECIL COUNTY. THE CHNA PROCESS BEGAN IN JANUARY 2012 (DURING THE 3RD QUARTER OF FISCAL YEAR 2012). SECONDARY DATA WAS ANALYZED AND USED IN CONJUNCTION WITH ALL COMMUNITY MEETINGS AS PART OF THE SUPPORTING DATA PLATFORM. USE OF SECONDARY DATA WAS ALSO INTEGRAL TO THE HEALTH NEEDS PRIORITIZATION PROCESS CONDUCTED BY UNION HOSPITAL.

INPUT FROM COMMUNITY PARTNERS ENGAGED IN CECIL COUNTY'S LOCAL HEALTH IMPROVEMENT COALITION MEETINGS WAS INCLUDED TO FURTHER VERIFY AND SUPPORT CONDUCTION OF THE CHNA. THE COMMUNITY PARTNERS CONSULTED WERE AS FOLLOWS:

AMERICAN CANCER SOCIETY

CECIL COLLEGE

CECIL COUNTY COMMISSIONERS

CECIL COUNTY DEPARTMENT OF EMERGENCY SERVICES

CECIL COUNTY DEPARTMENT OF JUVENILE SERVICES

CECIL COUNTY DEPARTMENT OF SOCIAL SERVICES

CECIL COUNTY HEALTH DEPARTMENT

CECIL COUNTY LIQUOR BOARD

CECIL COUNTY LOCAL MANAGEMENT BOARD

CECIL COUNTY PARKS AND RECREATIONAL SERVICES

CECIL COUNTY PUBLIC SCHOOLS

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CECIL COUNTY SHERIFF'S OFFICE

ELKTON HOUSING AUTHORITY

JOHNS HOPKINS HEALTH CARE

MARYLAND STATE DELEGATION

MARYLAND STATE SENATE

PRIVATE HEALTH CARE PROVIDERS

PROJECT CROSSROAD

UNION HOSPITAL EMPLOYED PROVIDERS, STAFF, AND EXECUTIVE MANAGEMENT

UNIVERSITY OF MARYLAND STATEWIDE HEALTH NETWORK

UPPER BAY COUNSELING AND SUPPORT SERVICES

WEST CECIL HEALTH CENTER (FQHC)

MCA

THE LOCAL HEALTH IMPROVEMENT COALITION WAS SURVEYED TO DETERMINE WHICH HEALTH NEEDS WERE PROMINENT IN CECIL COUNTY. DATA GATHERED FROM THE SURVEY REFLECTED CONCERNS RELATED TO PRESCRIPTION DRUG AND SUBSTANCE ABUSE, MENTAL HEALTH ACCESS, CHILD ABUSE, AND CHILDHOOD OBESITY.

FOUR FOCUS GROUPS WERE ALSO CONDUCTED WITH COMMUNITY RESIDENTS. THESE FOCUS GROUPS INCLUDED RESIDENTS FROM ELKTON, CHARLESTOWN, NORTH EAST, CHESAPEAKE CITY, CECILTON, PERRYVILLE, RISING SUN, AND PORT DEPOSIT. FOCUS GROUP PARTICIPANTS INCLUDED YOUNG ADULTS, SENIOR CITIZENS, MEMBERS FROM VARIOUS LOCAL COMMUNITY ORGANIZATIONS AND CHURCHES, HOMEMAKERS, SMALL BUSINESS OWNERS, LIFE COACHES, RETIREES, AND COMMUNITY ORGANIZERS. THE FOCUS GROUPS WERE FACILITATED/MODERATED BY UNION HOSPITAL'S COMMUNITY BENEFITS COORDINATOR AND CECIL COUNTY HEALTH DEPARTMENT'S PUBLIC HEALTH OFFICER. THE HEALTH DEPARTMENT'S EPIDEMIOLOGIST PROVIDED TECHNICAL SUPPORT AND TRANSCRIPTION OF MEETING NOTES.

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EACH FOCUS GROUP SESSION BEGAN WITH A DESCRIPTION OF THE CHNA. PARTICIPANTS WERE THEN PRESENTED WITH DATA GATHERED FROM THE LOCAL HEALTH IMPROVEMENT COALITION SURVEY MEETINGS AND OTHER SECONDARY HEALTH DATA. AFTER REVIEW OF THE DATA, PARTICIPANTS WERE ASKED TO RESPOND BASED ON THEIR OWN PERSONAL UNDERSTANDING OF HEALTH IN THEIR COMMUNITIES AND WHAT NEEDED TO BE DONE TO ADDRESS IDENTIFIED HEALTH NEEDS. LISTED BELOW ARE THE DIFFERENT HEALTH NEEDS IDENTIFIED PER FOCUS GROUP.

FOCUS GROUP	HEALTH NEEDS IDENTIFIED
ELKTON FOCUS GROUP	SUBSTANCE ABUSE
	MENTAL HEALTH CARE ACCESS
	HOMELESSNESS
	SMOKING
	NUTRITION
	LUNG CANCER
CHESAPEAKE CITY FOCUS GROUP	GERIATRIC CARE IMPROVEMENTS
	MEDICAL TRANSPORTATION ACCESS
	CANCER
	TOBACCO USE
	SUBSTANCE ABUSE
	OBESITY
	MENTAL HEALTH CARE ACCESS
	GENERAL ACCESS TO HEALTH CARE FOR RESIDENTS THAT LIVE BELOW THE C & D CANAL

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PERRYVILLE FOCUS GROUP

CANCER

SMOKING

OBESITY

ACCESS TO HEALTHIER FOODS

MENTAL HEALTH CARE ACCESS

CHILD NEGLECT

SUBSTANCE ABUSE

RISING SUN FOCUS GROUP

MENTAL HEALTH CARE ACCESS

SUICIDE PREVENTION

CANCER

OBESITY

DIABETES

PRESCRIPTION DRUG ABUSE

HEALTH COMMUNICATION IMPROVEMENTS

ADDRESSING HEALTH DISPARITIES

DATA FROM THE FOCUS GROUPS WAS ANALYZED, COMPARED TO SECONDARY HEALTH DATA FROM LOCAL, STATE AND NATIONAL SOURCES, AND PRESENTED TO UNION HOSPITAL'S INTERNAL COMMUNITY BENEFITS WORKGROUP TO COMPLETE THE HEALTH NEEDS PRIORITIZATION PROCESS.

SECONDARY HEALTH DATA PROVIDED BY HEALTHY COMMUNITIES INSTITUTE FOR CECIL COUNTY FROM A VARIETY OF LOCAL, STATE AND NATIONAL SOURCES WAS ANALYZED ACCORDING TO HEALTH INDICATORS IDENTIFIED AS HIGH RISK FOR THE CECIL COUNTY POPULATION.

UNION HOSPITAL'S INTERNAL COMMUNITY BENEFITS WORKGROUP WAS ESTABLISHED TO

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MONITOR THE PROGRESSION OF COMMUNITY BENEFITS PLANNING AND REPORTING ACTIVITIES. IT WAS ALSO ESTABLISHED TO SET THE FRAMEWORK FOR ACCOUNTABILITY AND TRANSPARENCY BOTH INTERNALLY AND EXTERNALLY TO THE HOSPITAL. THE WORKGROUP'S MAIN ROLE DURING THE CHNA WAS TO HELP PRIORITIZE HEALTH NEEDS IDENTIFIED FROM BOTH THE COMMUNITY AND THE ANALYSIS OF SECONDARY HEALTH DATA SOURCES. THE FINAL PRIORITIZATION OF HEALTH NEEDS WAS BASED ON THE FOLLOWING CRITERIA:

- SIZE. THE NUMBER OF PERSONS AFFECTED BY THE HEALTH NEED (INCIDENCE AND PREVALENCE).
- SERIOUSNESS. LEVEL OF SEVERITY AS INDICATED BY MORBIDITY AND MORTALITY RATES AND ECONOMIC AND/OR SOCIAL IMPACT.
- ECONOMIC FEASIBILITY. COSTS OF INTERNAL RESOURCES AND POTENTIAL COSTS OF EXTERNAL RESOURCES.
- POTENTIAL FOR IMPACT. COULD THE HOSPITAL MAKE AN IMPORTANT CONTRIBUTION? DID IT HAVE THE EXPERTISE, TIME, AND RESOURCES FOR PLANNING, IMPLEMENTATION OF PROGRAMS/ACTIVITIES, AND EVALUATION OF ALL INITIATIVES?
- AVAILABILITY OF COMMUNITY ASSETS. WERE THERE PROGRAMS ALREADY IN EXISTENCE THAT WERE ADDRESSING THE IDENTIFIED HEALTH NEEDS?
- PROBABILITY OF SUCCESS. WHAT WAS THE LIKELIHOOD OF ACHIEVING OBJECTIVES AND GOALS CREATED FOR A COMMUNITY BENEFIT IMPLEMENTATION PLAN?
- VALUE. SUBJECTIVE MEASURES THAT INDICATED IMPORTANCE.

AFTER CAREFUL CONSIDERATION OF ALL DATA AND PRIORITIZATION CRITERIA, THE INTERNAL COMMUNITY BENEFITS WORKGROUP CHOSE THE FOLLOWING TOP THREE RANKED HEALTH PRIORITIES FOR CECIL COUNTY:

- 1) RESPIRATORY HEALTH;
- 2) HEART DISEASE; AND
- 3) OBESITY.

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UNION HOSPITAL WILL ADDRESS THESE HEALTH PRIORITIES THROUGH THE COMMUNITY BENEFIT IMPLEMENTATION PLAN OVER THE NEXT THREE FISCAL YEARS.

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 6I: COLLABORATIVE COMMUNITY PARTNERS HAVE ALSO BEEN IDENTIFIED IN THE IMPLEMENTATION PLAN.

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 7: HEALTH NEEDS IDENTIFIED BUT NOT ADDRESSED

THE CHNA REVEALED SEVERAL HEALTH NEEDS THAT WERE NOT SELECTED FOR PRIORITIZATION BY UNION HOSPITAL. BELOW WE DISCUSS WHICH NEEDS WERE IDENTIFIED AND WHY THEY WERE NOT CHOSEN FOR PRIORITIZATION.

HEALTH NEEDS NOT INCLUDED AND REASONS HEALTH NEEDS WERE NOT PRIORITIZED LOCAL HEALTH IMPROVEMENT COALITION HEALTH NEEDS:

PRESCRIPTION DRUG ABUSE

SUBSTANCE ABUSE

MENTAL HEALTH ACCESS TO TREATMENT

CHILD NEGLECT

THESE HEALTH NEEDS WERE NOT PRIORITIZED BECAUSE THE LOCAL HEALTH IMPROVEMENT COALITION WAS ABLE TO PRODUCE A COMMUNITY HEALTH ACTION PLAN TO ADDRESS THEM. MEMBER ORGANIZATIONS IN THE COALITION ARE CURRENTLY WORKING TOGETHER TO INCORPORATE STRATEGIES TO ADDRESS THESE HEALTH NEEDS, AS WELL AS ACHIEVE MEASURABLE OUTCOMES. UNION HOSPITAL IS REPRESENTED ON

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THE COALITION AND IS CURRENTLY WORKING IN PARTNERSHIP WITH SEVERAL
COMMUNITY PARTNERS ON ALL OF THESE HEALTH NEEDS.

ØSUICIDE PREVENTION

UNION HOSPITAL RESPONDS TO SUICIDAL TENDENCIES EXHIBITED BY PATIENTS ON AN
INPATIENT LEVEL. HOWEVER, MORE WORK IS BEING DONE TO ADDRESS THESE
PATIENTS IN THEIR HOME BY WORKING IN PARTNERSHIP WITH MOBILE HEALTH
CRISIS, A TEAM OF MENTAL HEALTH PROFESSIONALS DEDICATED TO ADDRESSING
CRISIS ONSITE IN THE PATIENT'S HOME.

ØHOMELESSNESS

THE ELKTON ALLIANCE (CHAMBER OF COMMERCE) HAS DEVELOPED A COALITION TO
BETTER IDENTIFY AND ADDRESS THE HEALTH AND SOCIAL NEEDS OF THE HOMELESS
POPULATION IN CECIL COUNTY. UNION HOSPITAL STAFF ACTIVELY PARTICIPATES ON
THIS COALITION.

ØACCESS TO CARE

ADDRESSING ACCESS TO CARE ISSUES, INCLUDING TRANSPORTATION NEEDS, IS A
MISSION DRIVEN CONCERN FOR UNION HOSPITAL, AND IS ADDRESSED ON A DAILY
BASIS. OTHER HEALTH BASED ORGANIZATIONS IN CECIL COUNTY ALSO WORK TO
PROVIDE ADEQUATE ACCESS TO CARE (I.E., THE CECIL COUNTY HEALTH DEPARTMENT,
SCHOOL-BASED HEALTH CENTERS IN BAINBRIDGE AND GILPIN ELEMENTARY SCHOOLS,
AND WEST CECIL HEALTH CENTER, A FEDERALLY QUALIFIED HEALTH CENTER).

ØACCESS TO HEALTHY FOODS

ACCESS TO HEALTHY FOODS COULD BE INCLUDED IN STRATEGIES TO REDUCE OBESITY,
WHICH IS A PRIORITY HEALTH NEED FOR BOTH UNION HOSPITAL AND THE LOCAL
HEALTH IMPROVEMENT COALITION'S COMMUNITY HEALTH ACTION PLAN. PROMOTION OF
HEALTHY FOOD ACCESS CAN ALSO BE PROMOTED IN THE WORKPLACE, AT SCHOOL, AND

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AT HOME.

⊙ ACCESS TO MEDICAL TRANSPORTATION

THE CECIL COUNTY HEALTH DEPARTMENT OFFERS MEDICAL TRANSPORTATION FOR INDIVIDUALS WITH INSURANCE THAT COVERS IT. ALSO, SOME PRIVATE ORGANIZATIONS OFFER MEDICAL TRANSPORT ACCORDING TO BOTH INSURANCE COVERAGE AND LOCAL NEED. UNION HOSPITAL DOES NOT HAVE TRANSPORT VEHICLES NOR THE CAPITAL TO START AND MAINTAIN SUCH AN ENDEAVOR. RESOURCE ALLOCATION IS BETTER SERVED BY COLLABORATING WITH OTHER ENTITIES THAT HAVE VEHICLES OR BRINGING ISSUES OF ACCESS TO THE LOCAL GOVERNMENT TO ADVOCATE FOR BETTER PUBLIC TRANSPORTATION.

⊙ GERIATRIC CARE IMPROVEMENTS

GERIATRIC CARE IMPROVEMENTS REFLECT CONCERNS RELATED TO FALLS, ISOLATION, DEPRESSION, IMPROPER DIET AND POOR CHRONIC DISEASE MANAGEMENT. INCIDENTALLY, THE CECIL COUNTY HEALTH DEPARTMENT AND SEVERAL LOCAL COMMUNITY ORGANIZATIONS HAVE PROGRAMS TAILORED TO ADDRESSING, DEPRESSION, ISOLATION, CHRONIC DISEASE MANAGEMENT AND FALLS PREVENTION. UNION HOSPITAL ALSO WORKS ON CHRONIC DISEASE MANAGEMENT AMONG THE ELDERLY AND FALLS PREVENTION.

⊙ DIABETES

PREVENTION OF AND AWARENESS AROUND DIABETES IS ALREADY INCORPORATED IN MANY OF THE NUTRITION EDUCATION PROGRAMS AND ACTIVITIES THAT UNION HOSPITAL PROVIDES IN THE COMMUNITY. DIABETES CARE, MANAGEMENT, AND AWARENESS ARE ALSO INTEGRAL PARTS OF ACTIVITIES BEING CONSIDERED FOR THE 2ND AND 3RD HEALTH PRIORITIES OF HEART DISEASE AND OBESITY IN THE COMMUNITY BENEFIT IMPLEMENTATION PLAN.

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ØCANCER

UNION HOSPITAL ALREADY PROVIDES FREE CANCER SCREENINGS FOR THE COMMUNITY AND IS CONTINUOUSLY WORKING ON NEW WAYS TO SCREEN AND IDENTIFY SYMPTOMS FOR VARIOUS CANCERS. UNION HOSPITAL STAFF ALSO COLLABORATES WITH COMMUNITY PARTNERS AND AGENCIES TO BRING ACCESS TO CANCER CARE TO THE COMMUNITY.

ØHEALTH COMMUNICATION IMPROVEMENTS

EFFORTS TO IMPROVE HEALTH COMMUNICATION ARE A CONSTANT TASK FOR UNION HOSPITAL AND ALL COMMUNITY ORGANIZATIONS. IT DOES NOT GO UNNOTICED.

ØADDRESSING DISPARITIES IN HEALTH CARE

HEALTH DISPARITIES HAVE BEEN IDENTIFIED WHERE APPLICABLE IN THE LOCAL HEALTH IMPROVEMENT COALITION'S COMMUNITY HEALTH ACTION PLAN. UNION HOSPITAL ACTIVELY SEEKS TO REDUCE HEALTH DISPARITIES BOTH IN ITS DAILY FUNCTIONING AND IN PARTNERSHIP WITH CECIL COUNTY'S LOCAL HEALTH IMPROVEMENT COALITION.

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 20D: MARYLAND IS AN ALL-PAYOR STATE AND THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) SETS THE RATES FOR UNION HOSPITAL.

PART VI, LINE 2: CONDUCTING THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WAS A COLLABORATIVE EFFORT BETWEEN UNION HOSPITAL OF CECIL COUNTY AND THE CECIL COUNTY HEALTH DEPARTMENT. UNION HOSPITAL'S COMMUNITY

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BENEFITS COORDINATOR MET WITH CECIL COUNTY HEALTH DEPARTMENT'S PUBLIC HEALTH OFFICER, DEPUTY PUBLIC HEALTH OFFICER, AND EPIDEMIOLOGIST TO CONDUCT THE COMMUNITY HEALTH NEEDS ASSESSMENT. THIS TEAM FACILITATED A SERIES OF MEETINGS WITH BOTH COMMUNITY LEADERS AND COMMUNITY RESIDENTS TO GAIN FIRST-HAND KNOWLEDGE OF IMPORTANT HEALTH NEEDS IN CECIL COUNTY. THE CHNA PROCESS BEGAN IN JANUARY 2012 (DURING THE 3RD QUARTER OF FISCAL YEAR 2012). SECONDARY DATA WAS ANALYZED AND USED IN CONJUNCTION WITH ALL COMMUNITY MEETINGS AS PART OF THE SUPPORTING DATA PLATFORM. USE OF SECONDARY DATA WAS ALSO INTEGRAL TO THE HEALTH NEEDS PRIORITIZATION PROCESS CONDUCTED BY UNION HOSPITAL.

SEE ADDITIONAL DETAIL REGARDING THE NEEDS ASSESSMENT IN OUR RESPONSE TO PART V, SECTION B, LINE 3.

PART VI, LINE 3: UNION HOSPITAL OF CECIL COUNTY UTILIZES A COMMUNITY FINANCIAL ASSISTANCE (CHARITY CARE) POLICY TO ENSURE THAT THE HOSPITAL'S STAFF FOLLOWS A CONSISTENT AND EQUITABLE PROCESS IN GRANTING CHARITY CARE/FINANCIAL ASSISTANCE TO APPROPRIATE PATIENTS, WHILE RESPECTING THE INDIVIDUAL'S DIGNITY. THE POLICY IS IN AGREEMENT WITH THE ESTABLISHED MARYLAND STATE FINANCIAL ASSISTANCE GUIDELINES REGARDING CHARITY CARE.

THE POLICY DESCRIBES THE APPLICATION PROCESS FOR THE FINANCIAL ASSISTANCE PROGRAM, THE INFORMATION REQUIRED TO VERIFY INCOME AND ASSETS, THE TIMELINE FOR APPLICATION REVIEW AND TIERED ADJUSTMENTS BASED ON FEDERAL POVERTY GUIDELINES.

THE APPLICATION FOR FINANCIAL ASSISTANCE IS AVAILABLE TO ALL UNDERINSURED AND UNINSURED PATIENTS OF UNION HOSPITAL. APPLICATIONS AND SIGNAGE ARE

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LOCATED THROUGHOUT THE HOSPITAL, EMERGENCY ROOM, AND OUTPATIENT AREAS.

THE FINANCIAL ASSISTANCE APPLICATION AND BROCHURE (IN ENGLISH AND SPANISH) ARE AVAILABLE ON THE HOSPITAL'S WEBSITE:

[HTTP://WWW.UHCC.COM/ABOUT/PATIENTS-VISITORS/ADMISSION/FINANCIAL-ASSISTANCE](http://www.uhcc.com/about/patients-visitors/admission/financial-assistance)

IN ADDITION, THE HOSPITAL PLACES AN ADVERTISEMENT TWICE A YEAR IN THE LOCAL NEWSPAPERS OUTLINING ITS FINANCIAL ASSISTANCE POLICY.

ALL FINANCIAL ASSISTANCE APPLICATIONS RECEIVED ARE PROCESSED FOR ELIGIBILITY. PATIENTS WHO ARE NOT ELIGIBLE FOR CHARITY CARE ARE REFERRED TO CECIL COUNTY HEALTH DEPARTMENT TO DETERMINE IF OTHER ASSISTANCE IS AVAILABLE. ANY INDIVIDUAL WHO PRESENTS TO THE BUSINESS OFFICE OF UNION HOSPITAL IN PERSON TO DISCUSS HIS/HER BILL IS PROVIDED WITH A FINANCIAL ASSISTANCE APPLICATION. ALL INPATIENT, SELF-PAY PATIENTS ARE VISITED BY FINANCE STAFF AND SCREENED FOR THE FINANCIAL ASSISTANCE PROGRAM, AS WELL AS FOR MEDICAID AND OTHER STATE AND COUNTY PROGRAMS. FOLLOWING DISCHARGE FROM THE HOSPITAL, EACH PATIENT RECEIVES A SUMMARY OF CHARGES WHICH INCLUDES NOTICE OF THE FINANCIAL ASSISTANCE PROGRAM AND A DESIGNATED CONTACT TELEPHONE NUMBER.

PART VI, LINE 4: UNION HOSPITAL'S COMMUNITY BENEFIT SERVICE AREA (CBSA) INCLUDES THE TOWNS OF ELKTON, ELK MILLS, CHILDS, CHESAPEAKE CITY, EARLEVILLE, WARWICK, CECILTON, NORTH EAST, CHARLESTOWN, PERRYVILLE, AND RISING SUN. UNION HOSPITAL ALSO SERVES TOWNS IN WESTERN CECIL COUNTY: CONOWINGO, COLORA, PORT DEPOSIT, AND PERRY POINT. UNION HOSPITAL IS THE ONLY HOSPITAL IN CECIL COUNTY.

IN 2013, THE TOTAL POPULATION OF CECIL COUNTY IS 102,349 PERSONS. OF THE TOTAL COUNTY POPULATION, 50.3% IS FEMALE (49.7% MALE). THE MEDIAN AGE IS

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39 YEARS. THE RACIAL MAKE-UP OF THE COUNTY IS AS FOLLOWS:

-WHITE: 88.19%

-BLACK/AFRICAN AMERICAN: 6.76%

-AMERICAN INDIAN/ALASKAN NATIVE: 0.28%

-ASIAN: 1.17%

THERE ARE 37,360 HOUSEHOLDS. THE MEDIAN HOUSEHOLD INCOME IS \$62,660.

APPROXIMATELY 7.11% OF HOUSEHOLDS AND 5.92% OF FAMILIES WITH CHILDREN LIVE BELOW THE POVERTY LEVEL. DATA FROM THE 2011 AMERICAN COMMUNITY SURVEY SHOWS THAT 10.2% OF THE POPULATION IN CECIL COUNTY IS UNINSURED AND 15.3% RECEIVE MEDICAID.

PART VI, LINE 5: EACH FISCAL YEAR, UNION HOSPITAL SERVES THE CECIL COUNTY COMMUNITY BY PROVIDING ACTIVITIES, PROGRAMS, AND INITIATIVES THAT AIM TO IMPROVE COMMUNITY HEALTH, SERVING UNDERSERVED AREAS. THE FOLLOWING IS A BRIEF SUMMARY OF SOME OF THE COMMUNITY BENEFIT ACTIVITIES, PROGRAMS, AND INITIATIVES THAT UNION HOSPITAL PROVIDED DURING FISCAL YEAR 2013:

* COMMUNITY HEALTH EDUCATION

- A VARIETY OF HEALTH EDUCATION TOPICS HELD IN THE COMMUNITY
- EXPLORER POST AT UNION HOSPITAL FOR HIGH SCHOOL STUDENTS SEEKING EXPOSURE TO MEDICAL OR HEALTH SCIENCE EXPERIENCES
- SUPPORT GROUPS TO SUPPORT VARIOUS HEALTH NEEDS
- HEALTH FAIRS IN THE COMMUNITY

* COMMUNITY-BASED CLINICAL SERVICES

- FREE SCREENINGS FOR CANCERS, DIABETES, AND HEARING LOSS
- A FREE HEALTH CARE CLINIC FOR UNINSURED PERSONS
- SPORTS PHYSICALS IN UNDERSERVED AREAS

* HEALTH CARE SUPPORT SERVICES

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- COMMUNITY ASSISTED MEDICATIONS PROGRAM
- PROVIDING CARE COORDINATION FOR VULNERABLE PERSONS OUTSIDE OF THE HOSPITAL VISIT
- PROVIDING LIFE LINE INSTALLATIONS
- FACILITATING A PEER COUNSELOR PARTNERSHIP WITH THE EMERGENCY DEPARTMENT AND THE CECIL COUNTY HEALTH DEPARTMENT
- PROVIDING SCHOOL-BASED HEALTH CENTERS IN TWO TITLE 1 ELEMENTARY SCHOOLS
- PROVIDING TRANSPORTATION DONATIONS FOR NEEDS-BASED PATIENTS AND THEIR FAMILIES

*** SOCIAL AND ENVIRONMENTAL IMPROVEMENTS**

- HOSPITAL STAFF VOLUNTEER TO PARTICIPATE WITH THE FOLLOWING OUTDOOR AND/OR LABOR-INTENSIVE INITIATIVES:
 - > HABITAT-FOR-HUMANITY
 - > CHRISTMAS IN APRIL
 - > PROJECT ECHO
 - > ADOPT-A-HIGHWAY
- HOSPITAL STAFF ALSO VOLUNTEER TO MENTOR AT-RISK YOUTH DURING THE SCHOOL DAY
- HOSPITAL STAFF PROVIDE LEADERSHIP DEVELOPMENT IN CONJUNCTION WITH THE CECIL LEADERSHIP INSTITUTE
- HOSPITAL STAFF ALSO SERVES ON THE FOLLOWING COMMUNITY BOARDS THAT SEEK TO IMPROVE THE SOCIAL DETERMINANTS OF HEALTH:
 - > CECIL HUMAN SERVICES AGENCY
 - > FAMILY SERVICES ASSOCIATION
 - > DEPARTMENT OF SOCIAL SERVICES
 - > HOMELESSNESS COALITION

*** HEALTH PROFESSIONS EDUCATION**

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- UNION HOSPITAL PRECEPTS AND MENTORS STUDENTS THROUGH A VARIETY OF STUDENT EXPERIENCES, FROM NURSING AND OTHER MEDICAL/CLINICAL ROTATIONS TO GRADUATE STUDENT INTERNSHIPS TO HIGH SCHOOL CAPSTONE PROJECTS.

*** MISSION DRIVEN HEALTH SERVICES**

- UNION HOSPITAL PROVIDES THESE SERVICES EVEN THOUGH THEY OPERATE AT A LOSS. THE FOLLOWING SERVICES ARE PROVIDED BECAUSE THEY MEET IDENTIFIED NEEDS IN THE COMMUNITY:

- > A FREE OSTOMY CLINIC
- > ACCESS TO PEDIATRIC HOSPITALISTS
- > ADULT DAY SERVICES
- > OUTPATIENT PALLIATIVE CARE SERVICES

*** FINANCIAL/IN-KIND CONTRIBUTIONS**

- UNION HOSPITAL PROVIDED DONATIONS OF TIME (STAFF VOLUNTEER HOURS) AND MONEY (CASH AND EQUIPMENT DONATIONS) FOR THE LOCAL COMMUNITY AND FOREIGN ONES. EXAMPLES OF SOME IN-KIND CONTRIBUTIONS IN THE LOCAL COMMUNITY INCLUDE:

- > PROVISION OF FREE AMBULANCE SERVICES AND SUPPLIES
- > BLOOD DONATIONS
- > ATTENDING MEETINGS FOR COMMUNITY HEALTH IMPROVEMENT
- > SERVING THE HOMELESS
- > PROVIDING MEALS ON WHEELS
- > PROVIDING FREE NOTARY SERVICES FOR THE COMMUNITY
- > VOLUNTEERING WITH LOCAL ORGANIZATIONS TO IMPROVE COMMUNITY HEALTH

*** FUNDRAISING FOR COMMUNITY BENEFIT PROGRAMMING**

- UNION HOSPITAL, IN CONJUNCTION WITH THE CECIL COUNTY HEALTH DEPARTMENT, PARTICIPATED IN SEVERAL GRANT-WRITING OPPORTUNITIES

Part VI Supplemental Information

TO SUPPORT LOCAL INITIATIVES TO IMPROVE ACCESS TO CARE IN CECIL COUNTY. THE GRANTS SUBMITTED WERE AS FOLLOWS:

> LOCAL HEALTH IMPROVEMENT COALITION - 1ST ROUND FUNDING

(GRANTED)

> LOCAL HEALTH IMPROVEMENT COALITION - 2ND ROUND FUNDING TO SUPPORT COUNTY MENTAL HEALTH SERVICE ACCESS (GRANTED)

> LOCAL HEALTH IMPROVEMENT COALITION - 2ND ROUND FUNDING TO SUPPORT THE UNION HOSPITAL/CECIL COUNTY HEALTH DEPARTMENT COMMUNITY CASE MANAGEMENT PILOT (GRANTED)

> HEALTH ENTERPRISE ZONE (NOT GRANTED)

SURPLUS FUNDS OF THE HOSPITAL ARE USED TO DEVELOP EMPLOYEES AND FURTHER EDUCATE STAFF TO KEEP UP WITH THE EVER CHANGING HEALTHCARE TECHNOLOGY AND NEW TREATMENT PLANS FOR DISEASES, AS WELL AS TO PROVIDE FOR CAPITAL NEEDS OF THE ORGANIZATION TO KEEP THE NECESSARY NEW MEDICAL EQUIPMENT AVAILABLE TO BETTER TREAT THE PATIENTS OF THE COMMUNITY.

PART VI, LINE 6: UNION HOSPITAL OF CECIL COUNTY, INC. IS PART OF AN AFFILIATED HEALTH CARE SYSTEM IN WHICH AFFINITY HEALTH ALLIANCE, INC. IS THE PARENT ENTITY. AFFINITY HEALTH ALLIANCE, INC.'S PURPOSE IS TO SUPPORT THE UNION HOSPITAL OF CECIL COUNTY IN 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

Part VI Supplemental Information

CECIL COUNTY FOUNDATION, INC., CECIL COUNTY BREEDERS FAIR AND UNION
HOSPITAL OF CECIL COUNTY HEALTH SERVICES, 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.

CECIL COUNTY BREEDERS FAIR, INC. IS ORGANIZED FOR THE PURPOSE OF
SUPPORTING THE UNION HOSPITAL OF CECIL COUNTY THROUGH FUNDRAISING
ACTIVITIES CONSISTING OF THE RUNNING OF THE FAIR HILL RACES.

UNION HOSPITAL OF CECIL COUNTY HEALTH SERVICES, INC.'S MISSION IS TO OWN,
MANAGE AND MAINTAIN PROPERTIES FOR HEALTH RELATED VENTURES TO SERVE CECIL
COUNTY AND THE SURROUNDING AREAS. THE ACTIVITIES OF THIS CORPORATION
COMPLEMENT AND AUGMENT THE HEALTH CARE ACTIVITIES OF THE HOSPITAL.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

MD

**SCHEDULE I
(Form 990)**

Department of the Treasury
Internal Revenue Service

**Grants and Other Assistance to Organizations,
Governments, and Individuals in the United States**
Complete if the organization answered "Yes" to Form 990, Part IV, line 21 or 22.
▶ **Attach to Form 990.**

OMB No. 1545-0047

2012

**Open to Public
Inspection**

Name of the organization **UNION HOSPITAL OF CECIL COUNTY, INC.** Employer identification number **52-0607945**

Part I General Information on Grants and Assistance

- 1** Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No
- 2** Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Governments and Organizations in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNION HOSPITAL OF CECIL COUNTY HEALTH SERVICES, INC. - 106 BOW STREET - ELKTON, MD 21921	52-1794553	501(C)(3)	4,115,149.	0.			CHARITABLE ACTIVITIES
UNION HOSPITAL OF CECIL COUNTY VENTURES, INC. - 106 BOW STREET - ELKTON, MD 21921	52-1793691		623,785.	0.			CAPITAL CONTRIBUTION

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ▶ 1.

3 Enter total number of other organizations listed in the line 1 table ▶ 1.

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

Schedule I (Form 990) (2012)

Part III Grants and Other Assistance to Individuals in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 22.
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

SCHEDULE I, PART I, LINE 2: THE ORGANIZATION ONLY PROVIDES ASSISTANCE TO
ITS AFFILIATED ENTITIES. IT DOES NOT PROVIDE GRANTS TO OTHER ORGANIZATIONS.
USE OF FUNDS IS MONITORED BY MANAGEMENT.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Part I Questions Regarding Compensation

	Yes	No								
<p>1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.</p> <table border="0"> <tr> <td><input type="checkbox"/> First-class or charter travel</td> <td><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input checked="" type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input checked="" type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<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 checked="" type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	<input checked="" type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
<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 checked="" type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees									
<input checked="" type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)									
<p>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</p>	X									
<p>2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?</p>	X									
<p>3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> Compensation committee</td> <td><input checked="" type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input checked="" type="checkbox"/> Independent compensation consultant</td> <td><input checked="" type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input type="checkbox"/> Form 990 of other organizations</td> <td><input checked="" type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input checked="" type="checkbox"/> Compensation committee	<input checked="" type="checkbox"/> Written employment contract	<input checked="" type="checkbox"/> Independent compensation consultant	<input checked="" type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Approval by the board or compensation committee				
<input checked="" type="checkbox"/> Compensation committee	<input checked="" type="checkbox"/> Written employment contract									
<input checked="" type="checkbox"/> Independent compensation consultant	<input checked="" type="checkbox"/> Compensation survey or study									
<input type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Approval by the board or compensation committee									
<p>4 During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:</p> <p>a Receive a severance payment or change-of-control payment?</p> <p>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p> <p>c Participate in, or receive payment from, an equity-based compensation arrangement?</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p>										
		X								
	X									
		X								
<p>Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.</p>										
<p>5 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes" to line 5a or 5b, describe in Part III.</p>										
		X								
		X								
<p>6 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes" to line 6a or 6b, describe in Part III.</p>										
		X								
		X								
<p>7 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III</p>	X									
<p>8 Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III</p>		X								
<p>9 If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>										

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

Schedule J (Form 990) 2012

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) KENNETH S. LEWIS, MD, JD PRESIDENT/CEO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	478,821.	102,839.	139,846.	111,750.	33,210.	866,466.	0.
(2) LAURIE R. BEYER, CPA SENIOR VP/CFO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	242,996.	45,198.	20,376.	58,066.	26,414.	393,050.	0.
(3) CYDNEY TEAL VP MEDICAL AFFAIRS	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	235,346.	49,769.	11,761.	3,472.	25,428.	325,776.	0.
(4) TERRANCE LOVELL VP HUMAN RESOURCES	(i)	133,349.	23,813.	6,923.	0.	16,696.	180,781.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) DAVID GIPSON SENIOR VP/COO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	251,625.	46,305.	27,375.	58,885.	26,548.	410,738.	0.
(6) CAREN LEWIS SR. VP CARE SVCS (THROUGH 6.15.13)	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	188,750.	28,213.	9,902.	43,480.	11,260.	281,605.	0.
(7) ROHIT SINGHANIA PHYSICIAN	(i)	398,755.	21,895.	6,177.	3,750.	9,729.	440,306.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) IRFAN M. HISAMUDDIN, MD PHYSICIAN	(i)	384,245.	31,802.	199.	0.	20,192.	436,438.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) JUSTIN SAUSVILLE PHYSICIAN	(i)	359,920.	14,773.	20,177.	3,750.	20,021.	418,641.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) JAGDEEP HUNDAL PHYSICIAN	(i)	323,014.	45,333.	222.	3,750.	19,811.	392,130.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) BERNARD J HYNES PHYSICIAN	(i)	330,783.	36,859.	222.	0.	19,805.	387,669.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

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

PART I, LINE 1A: THE ORGANIZATION'S PRESIDENT & CEO, DR. KENNETH LEWIS,

HAS A DISCRETIONARY SPENDING ACCOUNT FOR FLEXIBLE BENEFITS WHICH INCLUDED:

A) LEASED CAR PAYMENTS, GAS, REPAIRS AND INSURANCE

B) TAX RETURN PREPARATION

C) ATTORNEY REGISTRATION FEE

D) MEDICAL LICENSE RENEWAL

E) FINGERPRINTING/CRIMINAL INVESTIGATION FOR DELAWARE PHYSICIAN LICENSE

F) BJ'S MEMBERSHIP

G) CASH

ALL BENEFITS HAVE BEEN INCLUDED IN TAXABLE WAGES.

PART I, LINE 4B: THE FOLLOWING PEOPLE PARTICIPATE IN A SUPPLEMENTAL,

NON-QUALIFIED RETIREMENT PLAN UNDER SECTION 457(F) OF THE INTERNAL REVENUE

CODE:

DR. KENNETH LEWIS, PRESIDENT & CEO

LAURIE BEYER, SENIOR VP/CFO

DAVID GIPSON, SENIOR VP/COO

Part III Supplemental Information

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

CAREN LEWIS, SENIOR VP OF PATIENT CARE SERVICES

THE FOLLOWING PAYMENTS HAVE BEEN CONTRIBUTED TO THE PLAN EACH CALENDAR YEAR

SINCE 2007:

12/31/2007 - \$90,000 (DR. KENNETH LEWIS)

12/31/2008 - \$90,000 (DR. KENNETH LEWIS)

12/31/2009 - \$90,000 (DR. KENNETH LEWIS)

12/31/2010 - \$90,000 (DR. KENNETH LEWIS)

12/31/2011 - \$108,000 (DR. KENNETH LEWIS)

12/31/2012 - \$108,000 (DR. KENNETH LEWIS)

12/31/2011 - \$51,431 (LAURIE BEYER)

12/31/2012 - \$54,576 (LAURIE BEYER)

12/31/2011 - \$51,968 (DAVID GIPSON)

12/31/2012 - \$55,135 (DAVID GIPSON)

12/31/2011 - \$35,649 (CAREN LEWIS)

12/31/2012 - \$40,178 (CAREN LEWIS)

THE RIGHT TO RECEIVE PAYMENTS UNDER THE PLAN SHALL BE FORFEITED IN THE

Part III Supplemental Information

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

EVENT THAT EMPLOYMENT WITH THE HOSPITAL TERMINATES PRIOR TO THE VESTING

DATE FOR ANY REASON OTHER THAN INVOLUNTARY TERMINATION WITHOUT CAUSE,

DEATH, OR DISABILITY.

CAREN LEWIS LEFT THE ORGANIZATION ON JUNE 15TH, 2013. SHE RECEIVED

SEVARANCE PAY THROUGH OCTOBER 1, 2013 IN THE AMOUNT OF \$45,509. SHE ALSO

RECEIVED, DURING THIS TIME, THE BALANCE OF HER PTO IN THE AMOUNT OF \$9,098

AND A BONUS IN THE AMOUNT OF \$33,150 THAT HAD BEEN EARNED PRIOR TO HER

LEAVING.

PART I, LINE 7: A PORTION OF THE BONUSES AND MERIT INCREASE ARE TIED

TO THE ORGANIZATIONAL GOALS, SUCH AS PATIENT SATISFACTION, QUALITY,

EMPLOYEE TURNOVER, ETC.

A PORTION OF THE BONUSES AND MERIT INCREASE ARE ALSO TIED TO EXPENSES PER

EQUIVALENT INPATIENT DAYS OF UNION HOSPITAL OF CECIL COUNTY.

Supplemental Information on Tax-Exempt Bonds

ENTITY 1

OMB No. 1545-0047

2012
Open to Public
Inspection

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

Name of the organization **UNION HOSPITAL OF CECIL COUNTY, INC.** Employer identification number **52-0607945**

Part I Bond Issues SEE PART VI FOR COLUMN (A) CONTINUATIONS

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AU	52-0936091	5742168A8	07/14/05	31,401,189.	SEE PART VI		X		X		X
B TOWN OF ELKTON	52-6000790	NONE	05/18/12	10,000,000.	SEE PART VI		X		X		X
C TOWN OF ELKTON	52-6000790	NONE	05/18/12	8,662,336.	SEE PART VI		X		X		X
D TOWN OF ELKTON	52-6000790	NONE	05/18/12	9,000,000.	SEE PART VI		X		X		X

Part II Proceeds

	A		B		C		D	
1 Amount of bonds retired								
2 Amount of bonds legally defeased								
3 Total proceeds of issue	35,836,388.		10,000,000.		8,662,336.		9,000,000.	
4 Gross proceeds in reserve funds	3,933,718.							
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows								
7 Issuance costs from proceeds	576,473.							
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds	33,640,038.							
11 Other spent proceeds			10,000,000.		8,662,336.		9,000,000.	
12 Other unspent proceeds								
13 Year of substantial completion	2007		2012		2012		2012	
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?		X	X		X		X	
15 Were the bonds issued as part of an advance refunding issue?		X		X		X		X
16 Has the final allocation of proceeds been made?	X		X		X		X	
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III Private Business Use

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

Supplemental Information on Tax-Exempt Bonds

ENTITY 2

OMB No. 1545-0047

2012
Open to Public
Inspection

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

Name of the organization **UNION HOSPITAL OF CECIL COUNTY, INC.** Employer identification number **52-0607945**

Part I Bond Issues SEE PART VI FOR COLUMN (A) CONTINUATIONS											
(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AU	52-0936091	NONE	07/18/12	9,924,000.	SEE PART VI		X		X		X
B MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AU	52-0936091	NONE	07/18/12	4,007,000.	SEE PART VI		X		X		X
C											
D											

Part II Proceeds									
	A		B		C		D		
1 Amount of bonds retired									
2 Amount of bonds legally defeased									
3 Total proceeds of issue	9,924,000.		4,007,000.						
4 Gross proceeds in reserve funds									
5 Capitalized interest from proceeds									
6 Proceeds in refunding escrows									
7 Issuance costs from proceeds									
8 Credit enhancement from proceeds									
9 Working capital expenditures from proceeds									
10 Capital expenditures from proceeds									
11 Other spent proceeds	9,924,000.		4,007,000.						
12 Other unspent proceeds									
13 Year of substantial completion	2012		2012						
	Yes	No	Yes	No	Yes	No	Yes	No	
14 Were the bonds issued as part of a current refunding issue?	X		X						
15 Were the bonds issued as part of an advance refunding issue?		X		X					
16 Has the final allocation of proceeds been made?	X		X						
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X						

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

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X		X		X	
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X		X		X	
c Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government .....	.00 %		.00 %		.00 %		.00 %	
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government .....	.00 %		.00 %		.00 %		.00 %	
6 Total of lines 4 and 5 .....	.00 %		.00 %		.00 %		.00 %	
7 Does the bond issue meet the private security or payment test?		X		X		X		X
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		X
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 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

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T?		X		X		X		X
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X		X		X
b Exception to rebate?		X	X		X		X	
c No rebate due?	X			X		X		X
If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X		X		X		X
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X			X		X		X
b Name of provider	BANK OF AMERICA, N.A							
c Term of hedge	35.0000000							
d Was the hedge superintegrated?		X						
e Was the hedge terminated?		X						

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X					
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X					
c Are there any research agreements that may result in private business use of bond-financed property?		X		X				
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government .....	.00 %		.00 %					
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government .....	.00 %		.00 %					
6 Total of lines 4 and 5 .....	.00 %		.00 %					
7 Does the bond issue meet the private security or payment test?		X		X				
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X					

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X				
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X				
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X					

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X		X					

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

SCHEDULE K, PART I, BOND ISSUES:

(A) ISSUER NAME: MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AUTHORITY

(A) ISSUER NAME: MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AUTHORITY

(A) ISSUER NAME: MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AUTHORITY

SCHEDULE K, PART IV, ARBITRAGE, LINE 2C:

(A) ISSUER NAME: MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AUTHORITY

DATE THE REBATE COMPUTATION WAS PERFORMED: 07/01/2010

PART I, COLUMN (F)

PURPOSE OF BONDS

ISSUE A: THE PURPOSE OF THE ISSUE WAS FINANCING AND REFINANCING THE ACQUISITION, CONSTRUCTION, RENOVATION AND EQUIPPING OF HOSPITAL FACILITIES.

ISSUE B: TO REFUND PORTION OF SERIES 2009 BONDS.

ISSUE C: TO REFUND REMAINING PORTION OF SERIES 2009 BONDS AND ALL OF SERIES 2000 BONDS.

Part VI Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K.

ISSUE D: TO FUND AN ESCROW WHICH REPAYS A PORTION OF THE SERIES 2002 BONDS AND INTEREST THEREON.

ISSUE E: TO REFUND REMAINING PORTION OF SERIES 2002 BONDS.

ISSUE F: TO FINANCE ACQUISITION OF EQUIPMENT AND CLOSING COSTS.

PART II, LINE 3

DIFFERENCE IN PROCEEDS

ISSUE A: THIS NUMBER REPRESENTS SALE PROCEEDS PLUS INVESTMENT EARNINGS IN THE CONSTRUCTION FUND, PLUS INVESTMENT EARNINGS IN THE COST OF ISSUANCE FUND, PLUS INVESTMENT EARNINGS IN THE DEBT SERVICE RESERVE FUND DURING THE CONSTRUCTION PERIOD.

PART II, LINE 10

CAPITAL EXPENDITURES FROM PROCEEDS

ISSUE A: THIS NUMBER REPRESENTS TOTAL PROCEEDS LESS PROCEEDS DEPOSITED INTO A RESERVE FUND LESS PROCEEDS SPENT ON ISSUANCE COSTS.

PART IV, LINES 3(B) AND 3(C)

HEDGE

ISSUE A: THE ORGANIZATION ENTERED INTO AN INTEREST RATE HEDGE WITH BANK OF AMERICA, N.A. ON MARCH 28, 2005. THE TERM OF THE HEDGE WAS FROM JUNE 22, 2005 THROUGH JULY 1, 2040. THE HEDGE WAS TERMINATED IN CONNECTION WITH THE ISSUANCE OF THE BONDS.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2012

Open to Public
Inspection

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

MARYLAND, FREE CARE AND/OR SUBSIDIZED CARE AND HEALTH ACTIVITIES AND

PROGRAMS TO SUPPORT THE COMMUNITY WILL BE CONSIDERED WHERE THE NEED

AND/OR AN INDIVIDUAL'S INABILITY TO PAY COEXISTS. THESE ACTIVITIES

INCLUDE COMMUNITY EDUCATION, SPECIAL PROGRAMS FOR THE ELDERLY, SPECIAL

PROGRAMS FOR THE PHYSICALLY/MENTALLY CHALLENGED, MEDICALLY UNDERSERVED

AND A VARIETY OF BROAD COMMUNITY SUPPORT ACTIVITIES.

UNION HOSPITAL OF CECIL COUNTY SERVICED 5,762 ADMISSIONS PROVIDING

20,994 PATIENT DAYS TO INPATIENTS IN FISCAL YEAR 2013 OF WHICH:

1) PATIENTS COVERED UNDER THE MEDICARE PROGRAM WERE 2,554 ADMISSIONS

AND 10,737 PATIENT DAYS

2) PATIENTS COVERED UNDER THE MEDICAID PROGRAM WERE 92 ADMISSIONS AND

316 PATIENT DAYS

3) PATIENTS COVERED UNDER THE MEDICAID HMO PROGRAM WERE 1,189

ADMISSIONS AND 3,634 PATIENT DAYS

4) PATIENTS COVERED UNDER THE MEDICARE HMO PROGRAM WERE 135 ADMISSIONS

AND 610 PATIENT DAYS

CHARITY CARE IS ALSO PROVIDED THROUGH MANY REDUCED PRICE SERVICES AND

FREE PROGRAMS OFFERED THROUGHOUT THE YEAR BASED UPON ACTIVITIES AND

SERVICES THAT UNION HOSPITAL OF CECIL COUNTY BELIEVES WILL SERVE A BONA

FIDE COMMUNITY NEED. THESE INCLUDE:

A) ADULT DAY CARE SERVICES FOR THE ELDERLY AND PHYSICALLY/MENTALLY

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

Schedule O (Form 990 or 990-EZ) (2012)

232211
01-04-13

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
--	--

CHALLENGED

- B) SUPPORT GROUPS FOR CANCER PATIENTS AND FAMILIES, DIABETES, ALCOHOLICS ANONYMOUS, OSTOMY, AND SMOKELESS
- C) OFFERING AND CONDUCTING FREE BLOOD PRESSURE, CHOLESTEROL SCREENINGS, AND PROSTATE SCREENINGS
- D) IN CONJUNCTION WITH THE STATE OF MARYLAND AND THE LOCAL DEPARTMENT OF HEALTH, OFFERING AND CONDUCTING A CANCER SCREENING PROGRAM FOR INDIGENT FEMALES
- E) PROVIDING MEETING FACILITIES FOR A VARIETY OF NONPROFITS AND VOLUNTEER FIRE COMPANIES
- F) HOSPITAL STAFF VOLUNTEERS ON NONPROFIT ORGANIZATION BOARDS SUCH AS THE AMERICAN CANCER SOCIETY

DURING THE YEAR, UNION HOSPITAL OF CECIL COUNTY PROVIDED \$13,136,000 IN UNCOMPENSATED CARE.

FORM 990, PART VI, SECTION A, LINE 6: AFFINITY HEALTH ALLIANCE, INC. ("AHA"), A TAX-EXEMPT ORGANIZATION, IS THE SOLE MEMBER OF THE UNION HOSPITAL OF CECIL COUNTY, INC.

FORM 990, PART VI, SECTION A, LINE 7A: THE BYLAWS OF THE HOSPITAL PROVIDE THAT ITS DIRECTORS ARE APPOINTED BY ITS SOLE MEMBER, AHA.

FORM 990, PART VI, SECTION A, LINE 7B: THE BYLAWS OF THE HOSPITAL PROVIDE THAT ITS SOLE MEMBER (AHA) MAY AMEND ITS BYLAWS.

FORM 990, PART VI, SECTION B, LINE 11: THE FORM 990 IS REVIEWED BY THE CHIEF FINANCIAL OFFICER. IT IS THEN PRESENTED TO THE BOARD AT THE NEXT

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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BOARD MEETING PRIOR TO FILING WITH THE INTERNAL REVENUE SERVICE.

FORM 990, PART VI, SECTION B, LINE 12C: BOARD MEMBERS ARE REQUIRED TO ANNUALLY DISCLOSE ANY POTENTIAL CONFLICT OF INTEREST. THE ORGANIZATION'S CEO REVIEWS THE SIGNED ANNUAL DISCLOSURES. THE CORPORATE COMPLIANCE OFFICER IS MADE AWARE OF ANY DISCLOSED CONFLICT, INVESTIGATES THE CONFLICT, AND REPORTS BACK TO THE BOARD OF DIRECTORS. THE BOARD CONSIDERS THE FACTS AND MAKES AN APPROPRIATE FINDING. ANY BOARD MEMBER WITH A CONFLICT MUST ABSTAIN FROM BOARD DELIBERATIONS AND VOTING ON THE MATTER.

ALL VICE PRESIDENTS ANNUALLY RECEIVE A LIST OF THE INDIVIDUALS UNDER THEIR SUPERVISION WHO MAY HAVE A POTENTIAL CONFLICT OF INTEREST. THE LIST IS COMPRISED OF ALL MANAGERS, CERTAIN PROFESSIONAL STAFF WHO MAY HAVE RESPONSIBILITY NEGOTIATING WITH VENDORS, AND ANY OTHER PERSONS THAT HOSPITAL EXECUTIVES DEEM APPROPRIATE. EACH VICE PRESIDENT REVIEWS THE CONFLICT OF INTEREST POLICY WITH THEIR DESIGNATED EMPLOYEES, AND EACH EMPLOYEE IS REQUIRED TO SIGN A FORM STIPULATING WHETHER OR NOT THEY HAVE A CONFLICT. THE FORMS ARE REVIEWED BY THE VICE PRESIDENT OF HUMAN RESOURCES. IF A CONFLICT IS NOTED, IT IS BROUGHT TO THE ATTENTION OF THE APPROPRIATE VICE PRESIDENT AND THE CEO TO DETERMINE WHETHER OPERATIONAL CHANGES NEED TO OCCUR BECAUSE OF THE POTENTIAL CONFLICT.

FORM 990, PART VI, SECTION B, LINE 15: THE COMPENSATION COMMITTEE OF THE ORGANIZATION'S BOARD OF DIRECTORS IS RESPONSIBLE FOR SETTING THE OVERALL COMPENSATION PHILOSOPHY OF THE ORGANIZATION, AS WELL AS SETTING, MONITORING AND REVIEWING THE COMPENSATION PACKAGE OF THE ORGANIZATION'S CEO AND OTHER MEMBERS OF THE EXECUTIVE MANAGEMENT TEAM. THE COMMITTEE USES RELEVANT MARKET INFORMATION, INCLUDING THE USE OF AN INDEPENDENT COMPENSATION

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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CONSULTANT AND COMPENSATION STUDIES OR SURVEYS, TO SET COMPENSATION. DURING THE FISCAL YEAR ENDED JUNE 30, 2012, AN INDEPENDENT COMPENSATION CONSULTANT PROVIDED THE FOLLOWING SERVICES: EXECUTIVE COMPENSATION AND PERFORMANCE EVALUATION.

COMPENSATION REVIEW AND APPROVAL IS DOCUMENTED VIA BOARD MINUTES.

FORM 990, PART VI, SECTION C, LINE 19: THE ORGANIZATION WILL MAKE ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.

FORM 990, PART IX, LINE 11G, OTHER FEES:

CONTRACTED SERVICES:

PROGRAM SERVICE EXPENSES	4,753,559.
MANAGEMENT AND GENERAL EXPENSES	724,768.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	5,478,327.

PROFESSIONAL FEES:

PROGRAM SERVICE EXPENSES	4,817,893.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	4,817,893.

PHYSICIAN FEES:

PROGRAM SERVICE EXPENSES	4,788,960.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	4,788,960.

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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PURCHASED SERVICES:

PROGRAM SERVICE EXPENSES	1,569,828.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,569,828.

AGENCY EMPLOYEES:

PROGRAM SERVICE EXPENSES	2,328,650.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	2,328,650.

TRANSCRIPTION:

PROGRAM SERVICE EXPENSES	435,769.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	435,769.

RECORD FILE STORAGE:

PROGRAM SERVICE EXPENSES	202,352.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	202,352.

TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	19,621,779.
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FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

CHANGE IN INTEREST IN NET ASSETS OF FOUNDATION & SUBSIDIARY	-167,878.
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Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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LOSS ON REFINANCING	-322,110.
CHANGE IN PROVISION FOR UNCOLLECTIBLE PLEDGES	-47,214.
TOTAL TO FORM 990, PART XI, LINE 9	-537,202.

STATEMENT PURSUANT TO SECTION 1.351-3(A):
STATEMENT PURSUANT TO SECTION 1.351-3(A) BY
SCHUYLKILL MEDICAL CENTER - SOUTH JACKSON STREET
23-1352202

(1) NAME AND EMPLOYER IDENTIFICATION NUMBER OF THE TRANSFEREE
CORPORATION:

NAME: UNION HOSPITAL OF CECIL COUNTY, INC.
EIN: 52-0607945

(2) DATE(S) OF TRANSFER(S) OF ASSETS:

TRANSFER DATE(S):
VARIOUS FROM 7/1/12 THROUGH 6/30/13

(3) AGGREGATE FAIR MARKET VALUE AND BASIS OR PROPERTY TRANSFERRED:

FAIR MARKET VALUE: \$1,582,248
BASIS: \$1,582,248

(4) DATE AND CONTROL NUMBER OF PRIVATE LETTER RULING(S) ISSUED BY THE
IRS IN CONNECTION WITH THE EXCHANGE:

Name of the organization
UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number
52-0607945

DATE(S) AND CONTROL NUMBER(S): NONE

Multiple horizontal lines for additional information.

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

Name of the organization **UNION HOSPITAL OF CECIL COUNTY, INC.** Employer identification number **52-0607945**

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
UNION HOSPITAL OF CECIL COUNTY FOUNDATION, INC. - 52-1794552, 106 BOW STREET, ELKTON, MD 21921	FUNDRAISING & SUPPORT	MARYLAND	501(C)(3)	LINE 11C, III-FI	AFFINITY HEALTH ALLIANCE, INC.		X
UNION HOSPITAL OF CECIL COUNTY HEALTH SERVICES, INC. - 52-1794553, 106 BOW STREET, ELKTON, MD 21921	HEALTHCARE PROPERTY MANAGEMENT	MARYLAND	501(C)(3)	LINE 9	AFFINITY HEALTH ALLIANCE, INC.		X
CECIL COUNTY BREEDERS FAIR, INC. - 51-6018180, 106 BOW STREET, ELKTON, MD 21921	FUNDRAISING & SUPPORT	MARYLAND	501(C)(4)		UNION HOSPITAL OF CECIL COUNTY FOUNDATION, INC.		X
AFFINITY HEALTH ALLIANCE, INC. - 52-1794697 106 BOW STREET ELKTON, MD 21921	MANAGEMENT & SUPPORT	MARYLAND	501(C)(3)	LINE 11C, III-FI	N/A		X

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

Schedule R (Form 990) 2012

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

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

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

	Yes	No
a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to related organization(s)	X	
c Gift, grant, or capital contribution from related organization(s)	X	
d Loans or loan guarantees to or for related organization(s)		X
e Loans or loan guarantees by related organization(s)		X
f Dividends from related organization(s)		X
g Sale of assets to related organization(s)		X
h Purchase of assets from related organization(s)		X
i Exchange of assets with related organization(s)		X
j Lease of facilities, equipment, or other assets to related organization(s)		X
k Lease of facilities, equipment, or other assets from related organization(s)	X	
l Performance of services or membership or fundraising solicitations for related organization(s)		X
m Performance of services or membership or fundraising solicitations by related organization(s)	X	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
o Sharing of paid employees with related organization(s)	X	
p Reimbursement paid to related organization(s) for expenses		X
q Reimbursement paid by related organization(s) for expenses		X
r Other transfer of cash or property to related organization(s)	X	
s 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 other organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

Part VII Supplemental Information

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

Multiple horizontal lines for supplemental information.

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

..... June 30, 2013

Prepared for	Union Hospital of Cecil County, Inc. 106 Bow Street Elkton, MD 21921-5596
Prepared by	ParenteBeard LLC 1650 Market Street, Suite 4500 Philadelphia, PA 19103
Amount due or refund	No amount is due.
Make check payable to	No amount is due.
Mail tax return and check (if applicable) to	Department of the Treasury Internal Revenue Service Center Ogden, UT 84201-0027
Return must be mailed on or before	May 15, 2014
Special Instructions	The return should be signed and dated.

Exempt Organization Business Income Tax Return
(and proxy tax under section 6033(e))

2012

Department of the Treasury
Internal Revenue Service

For calendar year 2012 or other tax year beginning **JUL 1, 2012** and ending **JUN 30, 2013**

Open to Public Inspection for
501(c)(3) Organizations Only

A <input type="checkbox"/> Check box if address changed		Name of organization (<input type="checkbox"/> Check box if name changed and see instructions.)	D Employer identification number (Employees' trust, see instructions.)
B Exempt under section <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 408(e) <input type="checkbox"/> 220(e) <input type="checkbox"/> 408A <input type="checkbox"/> 530(a) <input type="checkbox"/> 529(a)	Print or Type	UNION HOSPITAL OF CECIL COUNTY, INC.	52-0607945
		Number, street, and room or suite no. If a P.O. box, see instructions. 106 BOW STREET	E Unrelated business activity codes (See instructions)
		City or town, state, and ZIP code ELKTON, MD 21921-5596	621500 541900
C Book value of all assets at end of year 188,229,305.	F Group exemption number (see instructions) ▶	G Check organization type <input checked="" type="checkbox"/> 501(c) corporation <input type="checkbox"/> 501(c) trust <input type="checkbox"/> 401(a) trust <input type="checkbox"/> Other trust	

H Describe the organization's primary unrelated business activity. **▶ LABORATORY SERVICES TO NON-PATIENTS**

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? Yes No
If "Yes," enter the name and identifying number of the parent corporation. **▶**

J The books are in care of **▶ DERON G. BROWN, DIRECTOR OF FINANC** Telephone number **▶ (410) 398-4000**

Part I Unrelated Trade or Business Income	(A) Income	(B) Expenses	(C) Net
1 a Gross receipts or sales 1,196,348.			
b Less returns and allowances 223,615. c Balance ▶	1c 972,733.		
2 Cost of goods sold (Schedule A, line 7)	2		
3 Gross profit. Subtract line 2 from line 1c	3 972,733.		972,733.
4 a Capital gain net income (attach Schedule D)	4a		
b Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b		
c Capital loss deduction for trusts	4c		
5 Income (loss) from partnerships and S corporations (attach statement)	5 9,846.	STMT 1	9,846.
6 Rent income (Schedule C)	6		
7 Unrelated debt-financed income (Schedule E)	7		
8 Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8		
9 Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9		
10 Exploited exempt activity income (Schedule I)	10		
11 Advertising income (Schedule J)	11		
12 Other income (see instructions; attach statement)	12		
13 Total. Combine lines 3 through 12	13 982,579.		982,579.

Part II Deductions Not Taken Elsewhere (see instructions for limitations on deductions)
(except for contributions, deductions must be directly connected with the unrelated business income)

14 Compensation of officers, directors, and trustees (Schedule K)	14	
15 Salaries and wages	15	321,032.
16 Repairs and maintenance	16	15,775.
17 Bad debts	17	33,181.
18 Interest (attach statement)	18	
19 Taxes and licenses	19	
20 Charitable contributions (see instructions for limitation rules)	20	
21 Depreciation (attach Form 4562)	21	
22 Less depreciation claimed on Schedule A and elsewhere on return	22a	22b
23 Depletion	23	
24 Contributions to deferred compensation plans	24	
25 Employee benefit programs	25	59,531.
26 Excess exempt expenses (Schedule I)	26	
27 Excess readership costs (Schedule J)	27	
28 Other deductions (attach statement) SEE STATEMENT 2	28	1,124,303.
29 Total deductions. Add lines 14 through 28	29	1,553,822.
30 Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13	30	-571,243.
31 Net operating loss deduction (limited to the amount on line 30) SEE STATEMENT 3	31	
32 Unrelated business taxable income before specific deduction. Subtract line 31 from line 30	32	-571,243.
33 Specific deduction (generally \$1,000, but see instructions for exceptions)	33	1,000.
34 Unrelated business taxable income. Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32	34	-571,243.

Part III Tax Computation

Table with 2 columns: Description and Amount. Rows include Organizations taxable as corporations, Trusts taxable at trust rates, Proxy tax, Alternative minimum tax, and Total.

Part IV Tax and Payments

Table with 2 columns: Description and Amount. Rows include Foreign tax credit, Other credits, General business credit, Total credits, Other taxes, Total tax, Payments (A 2011 overpayment credited to 2012, 2012 estimated tax payments, Tax deposited with Form 8868, Foreign organizations, Backup withholding, Credit for small employer health insurance premiums, Other credits and payments), Total payments, Estimated tax penalty, Tax due, Overpayment, and Enter the amount of line 48 you want.

Part V Statements Regarding Certain Activities and Other Information (see instructions)

Table with 3 columns: Question, Yes, No. Questions include: 1. At any time during the 2012 calendar year, did the organization have an interest in or a signature or other authority over a financial account... 2. During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? 3. Enter the amount of tax-exempt interest received or accrued during the tax year.

Schedule A - Cost of Goods Sold. Enter method of inventory valuation N/A

Table with 2 columns: Description and Amount. Rows include Inventory at beginning of year, Purchases, Cost of labor, Additional section 263A costs, Other costs, Total, Inventory at end of year, Cost of goods sold, and Do the rules of section 263A apply to the organization?

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 taxpayer) is based on all information of which preparer has any knowledge.

Sign Here: Signature of officer, Date, Title (SENIOR VP/CFO), and a box for 'May the IRS discuss this return with the preparer shown below (see instructions)?' with Yes/No options.

Paid Preparer Use Only: Print/Type preparer's name (JULIUS C. GREEN, CPA, JD), Preparer's signature, Date, Check self-employed, PTIN (P00350393), Firm's name (PARENTEBEARD LLC), Firm's EIN (23-2932984), Firm's address (1650 MARKET STREET, SUITE 4500 PHILADELPHIA, PA 19103), and Phone no. ((215) 972-0701).

Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property) (see instructions)

1. Description of property		
(1)		
(2)		
(3)		
(4)		
2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach statement)
(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)		
(2)		
(3)		
(4)		
Total	0.	Total
		0.
(c) Total income. Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A)		(b) Total deductions. Enter here and on page 1, Part I, line 6, column (B) ...
		0.

Schedule E - Unrelated Debt-Financed Income (see instructions)

1. Description of debt-financed property		2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property	
			(a) Straight line depreciation (attach statement)	(b) Other deductions (attach statement)
(1)				
(2)				
(3)				
(4)				
4. Amount of average acquisition debt on or allocable to debt-financed property (attach statement)	5. Average adjusted basis of or allocable to debt-financed property (attach statement)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)		%		
(2)		%		
(3)		%		
(4)		%		
Totals			0.	0.
Total dividends-received deductions included in column 8			0.	0.

Schedule F - Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions)

1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations			
		3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)					
(2)					
(3)					
(4)					
Nonexempt Controlled Organizations					
7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10	
(1)					
(2)					
(3)					
(4)					
Totals			0.	0.	
			0.	0.	

Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization
(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach statement)	4. Set-asides (attach statement)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
Totals	0.			0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income
(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals	0.	0.				0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5))	0.	0.				0.

Part II Income From Periodicals Reported on a Separate Basis (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I	0.	0.				0.
Totals, Part II (lines 1-5)	0.	0.				0.

Schedule K - Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14			0.

FORM 990-T INCOME (LOSS) FROM PARTNERSHIPS STATEMENT 1

DESCRIPTION	AMOUNT
PREMIER PURCHASING PARTNERS LP (EIN: 33-0387407)	9,846.
TOTAL TO FORM 990-T, PAGE 1, LINE 5	9,846.

FORM 990-T OTHER DEDUCTIONS STATEMENT 2

DESCRIPTION	AMOUNT
SUPPLIES	293,920.
PURCHASED SERVICES	150,150.
UTILITIES	1,097.
MINOR EQUIPMENT	672.
ACCREDITATION FEES	6,736.
POSTAGE	12.
EQUIPMENT RENTAL	4,518.
MISCELLANEOUS EXPENSE	8,560.
OVERHEAD ALLOCATION	658,638.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	1,124,303.

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 3

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
06/30/98	25,468.	0.	25,468.	25,468.
06/30/99	11,989.	0.	11,989.	11,989.
06/30/00	79,821.	0.	79,821.	79,821.
06/30/01	265,922.	0.	265,922.	265,922.
06/30/02	224,674.	0.	224,674.	224,674.
06/30/03	171,199.	0.	171,199.	171,199.
06/30/04	227,215.	0.	227,215.	227,215.
06/30/05	337,011.	0.	337,011.	337,011.
06/30/06	363,778.	0.	363,778.	363,778.
06/30/07	364,490.	0.	364,490.	364,490.
06/30/08	355,554.	0.	355,554.	355,554.
06/30/09	513,265.	0.	513,265.	513,265.
06/30/10	412,749.	0.	412,749.	412,749.
06/30/11	480,796.	0.	480,796.	480,796.
06/30/12	487,240.	0.	487,240.	487,240.
NOL CARRYOVER AVAILABLE THIS YEAR			4,321,171.	4,321,171.

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

(Rev. December 2012)
Department of the Treasury
Internal Revenue Service

▶ For more information about Form 5471, see www.irs.gov/form5471.
Information furnished for the foreign corporation's annual accounting period (tax year required by section 898) (see instructions) beginning **JAN 1**, 2012, and ending **DEC 31**, 2012

Attachment
Sequence No. **121**

Name of person filing this return UNION HOSPITAL OF CECIL COUNTY, INC. <small>Number, street, and room or suite no. (or P.O. box number if mail is not delivered to street address)</small> 106 BOW STREET City or town, state, and ZIP code ELKTON, MD 21921-5596	A Identifying number 52-0607945 B Category of filer (See instructions. Check applicable box(es): 1 (repealed) 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input checked="" type="checkbox"/>
Filer's tax year beginning JUL 1 , 2012, and ending JUN 30 , 2013	C Enter the total percentage of the foreign corporation's voting stock you owned at the end of its annual accounting period 16.67 %

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

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

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

1a Name and address of foreign corporation FREESTATE HEALTHCARE INSURANCE COMPANY, LTD P.O. BOX 10233 GRAND CAYMAN FC KY1-1002 CAYMAN ISLANDS		b(1) Employer identification number, if any 98-0464065
		b(2) Reference ID number (see instructions) _____
		c Country under whose laws incorporated CAYMAN ISLANDS
d Date of incorporation 12/14/04	e Principal place of business CAYMAN ISLANDS	f Principal business activity code number 525990
		g Principal business activity OTHER INSURANCE FUND
		h Functional currency U.S., DOLLAR

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

a Name, address, and identifying number of branch office or agent (if any) in the United States N/A	b If a U.S. income tax return was filed, enter:	
	(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)

c Name and address of foreign corporation's statutory or resident agent in country of incorporation KANE (CAYMAN) LTD P.O. BOX 10233 GRAND CAYMAN KY1-1102 CAYMAN ISLANDS	d Name and address (including corporate department, if applicable) of person (or persons) with custody of the books and records of the foreign corporation, and the location of such books and records, if different SAME AS 2C
--	--

Schedule A Stock of the Foreign Corporation		
(a) Description of each class of stock	(b) Number of shares issued and outstanding	
	(i) Beginning of annual accounting period	(ii) End of annual accounting period

Schedule E Income, War Profits, and Excess Profits Taxes Paid or Accrued

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

Schedule F Balance Sheet

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

Assets		(a) Beginning of annual accounting period	(b) End of annual accounting period
1	Cash	1	
2a	Trade notes and accounts receivable	2a	
b	Less allowance for bad debts	2b	() ()
3	Inventories	3	
4	Other current assets (attach statement)	4	
5	Loans to shareholders and other related persons	5	
6	Investment in subsidiaries (attach statement)	6	
7	Other investments (attach statement)	7	
8a	Buildings and other depreciable assets	8a	
b	Less accumulated depreciation	8b	() ()
9a	Depletable assets	9a	
b	Less accumulated depletion	9b	() ()
10	Land (net of any amortization)	10	
11	Intangible assets:		
a	Goodwill	11a	
b	Organization costs	11b	
c	Patents, trademarks, and other intangible assets	11c	
d	Less accumulated amortization for lines 11a, b, and c	11d	() ()
12	Other assets (attach statement)	12	
13	Total assets	13	
Liabilities and Shareholders' Equity			
14	Accounts payable	14	
15	Other current liabilities (attach statement)	15	
16	Loans from shareholders and other related persons	16	
17	Other liabilities (attach statement)	17	
18	Capital stock:		
a	Preferred stock	18a	
b	Common stock	18b	
19	Paid-in or capital surplus (attach reconciliation)	19	
20	Retained earnings	20	
21	Less cost of treasury stock	21	() ()
22	Total liabilities and shareholders' equity	22	

Schedule G Other Information

- | | | |
|--|--------------------------|-------------------------------------|
| | Yes | No |
| 1 During the tax year, did the foreign corporation own at least a 10% interest, directly or indirectly, in any foreign partnership? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If "Yes," see the instructions for required statement. | | |
| 2 During the tax year, did the foreign corporation own an interest in any trust? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3 During the tax year, did the foreign corporation own any foreign entities that were disregarded as entities separate from their owners under Regulations sections 301.7701-2 and 301.7701-3? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If "Yes," you are generally required to attach Form 8858 for each entity (see instructions). | | |
| 4 During the tax year, was the foreign corporation a participant in any cost sharing arrangement? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5 During the course of the tax year, did the foreign corporation become a participant in any cost sharing arrangement? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6 During the tax year, did the foreign corporation participate in any reportable transaction as defined in Regulations section 1.6011-4? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If "Yes," attach Form(s) 8886 if required by Regulations section 1.6011-4(c)(3)(i)(G). | | |
| 7 During the tax year, did the foreign corporation pay or accrue any foreign tax that was disqualified for credit under section 901(m)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8 During the tax year, did the foreign corporation pay or accrue foreign taxes to which section 909 applies, or treat foreign taxes that were previously suspended under section 909 as no longer suspended? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Schedule H Current Earnings and Profits

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

1 Current year net income or (loss) per foreign books of account	1		
2 Net adjustments made to line 1 to determine current earnings and profits according to U.S. financial and tax accounting standards (see instructions):			
	Net Additions	Net Subtractions	
a Capital gains or losses		107,563.	
b Depreciation and amortization			
c Depletion			
d Investment or incentive allowance			
e Charges to statutory reserves			
f Inventory adjustments			
g Taxes			
h Other (attach statement)	4,780,608.	5,647,183.	
3 Total net additions	4,780,608.		
4 Total net subtractions		5,754,746.	
5a Current earnings and profits (line 1 plus line 3 minus line 4)	5a		-974,138.
b DASTM gain or (loss) for foreign corporations that use DASTM	5b		
c Combine lines 5a and 5b	5c		-974,138.
d Current earnings and profits in U.S. dollars (line 5c translated at the appropriate exchange rate as defined in section 989(b) and the related regulations)	5d		-974,138.
Enter exchange rate used for line 5d ▶ 1.000000			

Schedule I Summary of Shareholder's Income From Foreign Corporation

If item D on page 1 is completed, a separate Schedule I must be filed for each Category 4 or 5 filer for whom reporting is furnished on this Form 5471. This schedule I is being completed for:

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

- | | | |
|--|--------------------------|-------------------------------------|
| • Was any income of the foreign corporation blocked? | Yes | No |
| • Did any such income become unblocked during the tax year (see section 964(b))? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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

FORM 5471

OTHER NET ADJUSTMENTS

STATEMENT 4

DESCRIPTION	NET ADDITIONS	NET SUBTRACTIONS
RELATED PARTY PREMIUMS		5,647,183.
REL. PARTY LOSS RESERVE/CLAIMS PD	4,780,608.	
TOTAL TO 5471, PAGE 4, SCHEDULE H, LINE 2H	4,780,608.	5,647,183.

Foreign Corporation FREESTATE HEALTHCARE INSURANCE COMPANY,

Schedule I Shareholder's Income From Foreign Corporation

Name of shareholder described in Category 5	Identifying number
Shareholder's income from foreign corporation	
1 Subpart F income	1 <u>0.</u>
2 Earnings invested in U.S. property	2 _____
3 Previously excluded subpart F income withdrawn from qualified investments	3 _____
4 Previously excluded export trade income withdrawn from investment in export trade assets	4 _____
5 Factoring income	5 _____
6 Total of lines 1 through 5	6 _____
7 Dividends received (translated at spot rate on payment date under section 989(b)(1))	7 _____
8 Exchange gain or (loss) on a distribution of previously taxed income	8 _____

**SCHEDULE J
(Form 5471)**

(Rev. December 2012)
Department of the Treasury
Internal Revenue Service

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

► Information about Schedule J (Form 5471) and its instructions is at www.irs.gov/form5471.
► Attach to Form 5471.

OMB No. 1545-0704

Name of person filing Form 5471

Identifying number

UNION HOSPITAL OF CECIL COUNTY, INC.

52-0607945

Name of foreign corporation

EIN (if any)

Reference ID number

FREESTATE HEALTHCARE INSURANCE COMPANY, LTD

98-0464065

Important: Enter amounts in functional currency.	(a) Post-1986 Undistributed Earnings (post-86 section 959(c)(3) balance)	(b) Pre-1987 E&P Not Previously Taxed (pre-87 section 959(c)(3) balance)	(c) Previously Taxed E&P (sections 959(c)(1) and (2) balances)			(d) Total Section 964(a) E&P (combine columns (a), (b), and (c))
			(i) Earnings Invested in U.S. Property	(ii) Earnings Invested in Excess Passive Assets	(iii) Subpart F Income	
1 Balance at beginning of year	-6,990,683.					-6,990,683.
2a Current year E&P						
b Current year deficit in E&P	974,138.					
3 Total current and accumulated E&P not previously taxed (line 1 plus line 2a or line 1 minus line 2b)	-7,964,821.					
4 Amounts included under section 951(a) or reclassified under section 959(c) in current year						
5a Actual distributions or reclassifications of previously taxed E&P						
b Actual distributions of nonpreviously taxed E&P						
6a Balance of previously taxed E&P at end of year (line 1 plus line 4, minus line 5a)						
b Balance of E&P not previously taxed at end of year (line 3 minus line 4, minus line 5b)	-7,964,821.					
7 Balance at end of year. (Enter amount from line 6a or line 6b, whichever is applicable.)	-7,964,821.					-7,964,821.

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 5471.

Schedule J (Form 5471) (Rev. 12-2012)

Application for Extension of Time To File an Exempt Organization Return

▶ **File a separate application for each return.**

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

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

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

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

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

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

Type or print	Name of exempt organization or other filer, see instructions. UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number (EIN) or 52-0607945
File by the due date for filing your return. See instructions.	Number, street, and room or suite no. If a P.O. box, see instructions. 106 BOW STREET	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. ELKTON, MD 21921-5596	

Enter the Return code for the return that this application is for (file a separate application for each return) 07

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

DERON G. BROWN, DIRECTOR OF FINANCE

- The books are in the care of ▶ **106 BOW STREET - ELKTON, MD 21921**
 Telephone No. ▶ **(410) 398-4000** FAX No. ▶ _____
- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until **MAY 15, 2014**, to file the exempt organization return for the organization named above. The extension is for the organization's return for:
 ▶ calendar year _____ or
 ▶ tax year beginning **JUL 1, 2012**, and ending **JUN 30, 2013**.

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

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

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

• If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** and check this box **X**

Note. Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.

• If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** (on page 1).

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

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number (EIN) or 52-0607945
	Number, street, and room or suite no. If a P.O. box, see instructions. 106 BOW STREET	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. ELKTON, MD 21921-5596	

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

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

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

DERON G. BROWN, DIRECTOR OF FINANCE

• The books are in the care of **106 BOW STREET - ELKTON, MD 21921**
Telephone No. **(410) 398-4000** FAX No.

• If the organization does not have an office or place of business in the United States, check this box

• If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) . If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until **MAY 15, 2014**.

5 For calendar year , or other tax year beginning **JUL 1, 2012**, and ending **JUN 30, 2013**.

6 If the tax year entered in line 5 is for less than 12 months, check reason: Initial return Final return
 Change in accounting period

7 State in detail why you need the extension
ADDITIONAL TIME IS NEEDED TO GATHER INFORMATION TO PREPARE A COMPLETE AND ACCURATE RETURN.

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

Signature and Verification must be completed for Part II only.

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

Signature Title Date

Form **8879-EO**

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

OMB No. 1545-1878

For calendar year 2012, or fiscal year beginning JUL 1, 2012, and ending JUN 30, 2013

2012

Department of the Treasury
Internal Revenue Service

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

Name of exempt organization

Employer identification number

UNION HOSPITAL OF CECIL COUNTY, INC.

52-0607945

Name and title of officer

**LAURIE R. BEYER, CPA
SENIOR VP/CFO**

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

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

1a Form 990 check here ▶ <input checked="" type="checkbox"/>	b Total revenue , if any (Form 990, Part VIII, column (A), line 12)	1b <u>157644138</u>
2a Form 990-EZ check here ▶ <input type="checkbox"/>	b Total revenue , if any (Form 990-EZ, line 9)	2b _____
3a Form 1120-POL check here ▶ <input type="checkbox"/>	b Total tax (Form 1120-POL, line 22)	3b _____
4a Form 990-PF check here ▶ <input type="checkbox"/>	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b _____
5a Form 8868 check here ▶ <input type="checkbox"/>	b Balance Due (Form 8868, Part I, line 3c or Part II, line 8c)	5b _____

Part II Declaration and Signature Authorization of Officer

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

Officer's PIN: check one box only

I authorize PARENTEBEARD LLC to enter my PIN 10085
ERO firm name Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ ******* THIS IS NOT A FILEABLE COPY ***** 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.

23885158001
do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2012 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ _____

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

**Return by a U.S. Transferor of Property
 to a Foreign Corporation**

OMB No. 1545-0026

Attachment
 Sequence No. **128**

▶ **Attach to your income tax return for the year of the transfer or distribution.**

Part I U.S. Transferor Information (see instructions)

Name of transferor UNION HOSPITAL OF CECIL COUNTY, INC.	Identifying number (see instructions) 52-0607945
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- 1** If the transferor was a corporation, complete questions 1a through 1d.
- a** If the transfer was a section 361(a) or (b) transfer, was the transferor controlled (under section 368(c)) by 5 or fewer domestic corporations? Yes No
- b** Did the transferor remain in existence after the transfer? Yes No
- If not, list the controlling shareholder(s) and their identifying number(s):

Controlling shareholder	Identifying number

- c** If the transferor was a member of an affiliated group filing a consolidated return, was it the parent corporation? Yes No
- If not, list the name and employer identification number (EIN) of the parent corporation:

Name of parent corporation	EIN of parent corporation

- d** Have basis adjustments under section 367(a)(5) been made? Yes No

- 2** If the transferor was a partner in a partnership that was the actual transferor (but is not treated as such under section 367), complete questions 2a through 2d.

- a** List the name and EIN of the transferor's partnership:

Name of partnership	EIN of partnership

- b** Did the partner pick up its pro rata share of gain on the transfer of partnership assets? Yes No
- c** Is the partner disposing of its **entire** interest in the partnership? Yes No
- d** Is the partner disposing of an interest in a limited partnership that is regularly traded on an established securities market? Yes No

Part II Transferee Foreign Corporation Information (see instructions)

3 Name of transferee (foreign corporation) FREESTATE HEALTHCARE INSURANCE COMPANY, LTD.	4 Identifying number, if any 98-0464065
--	--

5 Address (including country)
P.O. BOX 10233
GRAND CAYMAN KY1-1002 CAYMAN ISLANDS

6 Country code of country of incorporation or organization
CJ

7 Foreign law characterization (see instructions)
CORPORATION

8 Is the transferee foreign corporation a controlled foreign corporation? Yes No

Part III Information Regarding Transfer of Property (see instructions)

Type of property	(a) Date of transfer	(b) Description of property	(c) Fair market value on date of transfer	(d) Cost or other basis	(e) Gain recognized on transfer
Cash	07/01/2012		1,582,248.		
Stock and securities					
Installment obligations, account receivables or similar property					
Foreign currency or other property denominated in foreign currency					
Inventory					
Assets subject to depreciation recapture (see Temp. Regs. sec. 1.367(a)-4T(b))					
Tangible property used in trade or business not listed under another category					
Intangible property					
Property to be leased (as described in final and temp. Regs. sec. 1.367(a)-4(c))					
Property to be sold (as described in Temp. Regs. sec. 1.367(a)-4T(d))					
Transfers of oil and gas working interests (as described in Temp. Regs. sec. 1.367(a)-4T(e))					
Other property					

Supplemental Information Required To Be Reported (see instructions):
SEE STATEMENT 5

Part IV Additional Information Regarding Transfer of Property (see instructions)

9 Enter the transferor's interest in the foreign transferee corporation before and after the transfer:

(a) Before 16.6700 % (b) After 16.6700 %

10 Type of nonrecognition transaction (see instructions) IRC SECTION 351

11 Indicate whether any transfer reported in Part III is subject to any of the following:

- a Gain recognition under section 904(f)(3)
b Gain recognition under section 904(f)(5)(F)
c Recapture under section 1503(d)
d Exchange gain under section 987

12 Did this transfer result from a change in the classification of the transferee to that of a foreign corporation?

13 Indicate whether the transferor was required to recognize income under final and temporary Regulations sections 1.367(a)-4 through 1.367(a)-6 for any of the following:

- a Tainted property
b Depreciation recapture
c Branch loss recapture
d Any other income recognition provision contained in the above-referenced regulations

14 Did the transferor transfer assets which qualify for the trade or business exception under section 367(a)(3)?

15 a Did the transferor transfer foreign goodwill or going concern value as defined in Temporary Regulations section 1.367(a)-1T(d)(5)(iii)?

b If the answer to line 15a is "Yes," enter the amount of foreign goodwill or going concern value transferred \$

16 Was cash the only property transferred?

17 a Was intangible property (within the meaning of section 936(h)(3)(B)) transferred as a result of the transaction?

b If "Yes," describe the nature of the rights to the intangible property that was transferred as a result of the transaction:

Horizontal lines for describing the nature of the rights to the intangible property.

FORM 926

STATEMENT 5

INSURANCE PREMIUMS RECEIVED FROM RELATED PARTIES CONSIDERED TO BE DEEMED CONTRIBUTIONS TO CAPITAL OF THE ABOVE CORPORATION OCCURRED ON VARIOUS DATES THROUGHOUT THE YEAR. THE TOTAL AMOUNT OF THESE DEEMED CONTRIBUTIONS WAS \$1,528,248.

NOTHING WAS RECEIVED IN CONSIDERATION IN EXCHANGE FOR DEEMED CASH CONTRIBUTIONS TO CAPITAL OF \$1,582,248. THE TAXPAYER OWNED 16.67% OF THE STOCK OF THE TRANSFEREE CORPORATION BOTH BEFORE AND AFTER THESE TRANSFERS.

TAX RETURN FILING INSTRUCTIONS

CALIFORNIA FORM 109

FOR THE YEAR ENDING

..... June 30, 2013

Prepared for	Union Hospital of Cecil County, Inc. 106 Bow Street Elkton, MD 21921-5596
Prepared by	ParenteBeard LLC 1650 Market Street, Suite 4500 Philadelphia, PA 19103
Amount due or refund	No payment required
Make check payable to	Not applicable
Mail tax return and check (if applicable) to	Franchise Tax Board P.O. Box 942857 Sacramento, CA 94257-0700
Return must be mailed on or before	June 16, 2014
Special Instructions	The return should be signed and dated by an authorized individual.

California Exempt Organization Business Income Tax Return

2012

FORM 109

Calendar Year 2012 or fiscal year beginning month JUL day 1 year 2012, and ending month JUN day 30 year 2013

Corporation/Organization Name UNION HOSPITAL OF CECIL COUNTY, INC. California corporation number 9612036

Address (suite, room, or PMB no.) 106 BOW STREET City ELKTON State MD ZIP Code 21921-5596 FEIN 52-0607945

City ELKTON State MD ZIP Code 21921-5596

City ELKTON State MD ZIP Code 21921-5596

A First Return Filed? Yes No X

B Is this an education IRA within the meaning of R&TC Section 23712? Yes No X

C Is the organization under audit by the IRS or has the IRS audited in a prior year? Yes No X

D Final Return? Dissolved Surrendered (Withdrawn) Merged/Reorganized (attach explanation) Enter date

E Amended Return Yes No X

F Accounting Method Used: (1) Cash (2) Accrual (3) Other X

G Nature of trade or business LP INVESTMENT

H Is the organization a non-exempt charitable trust as described in IRC Section 4947(a)(1)? Yes No X

I Is this organization claiming any Enterprise Zone (EZ), Los Angeles Revitalization Zone (LARZ), Local Agency Military Base Recovery Area (LAMBRA), Targeted Tax Area (TTA), or Manufacturing Enhancement Area (MEA) tax benefits? Yes No X

J Is this organization a qualified pension, profit-sharing, or stock bonus plan as described in IRC Section 401(a)? Yes No X

K Unrelated Business Activity (UBA) Code 621500

L Is this a Hospital? Yes No X

If "Yes," attach IRS Schedule H (Form 990)

Table with 3 columns: Description, Line Number, Amount. Includes lines 1-3 for Taxable Corporation.

Table with 3 columns: Description, Line Number, Amount. Includes lines 4-11 for Taxable Trust and Tax Computation.

Table with 3 columns: Description, Line Number, Amount. Includes lines 12-14 for Total Tax.

Table with 3 columns: Description, Line Number, Amount. Includes lines 15-19 for Payments.

Table with 3 columns: Description, Line Number, Amount. Includes lines 20-27 for Refund (Direct Deposit of Refund) or Amount Due.

Unrelated Business Taxable Income

Part I Unrelated Trade or Business Income

1	a Gross receipts or gross sales	b Less returns and allowances	c Balance	1c	00
2	Cost of goods sold and/or operations (Schedule A, line 7)			2	00
3	Gross profit. Subtract line 2 from line 1c			3	00
4	a Capital gain net income. See Specific Line Instructions - Trusts attach Schedule D (541)			4a	00
	b Net gain (loss) from Part II, Schedule D-1			4b	00
	c Capital loss deduction for trusts			4c	00
5	Income (or loss) from partnerships, limited liability companies, or S corporations. See specific line instructions. Attach Schedule K-1 (565, 568, or 100S) or similar schedule SEE STATEMENT 1			5	9,846.00
6	Rental income (Schedule C)			6	00
7	Unrelated debt-financed income (Schedule D)			7	00
8	Investment income of an R&TC Section 23701g, 23701i, or 23701n organization (Schedule E)			8	00
9	Interest, Annuities, Royalties and Rents from controlled organizations (Schedule F)			9	00
10	Exploited exempt activity income (Schedule G)			10	00
11	Advertising income (Schedule H, Part III, Column A)			11	00
12	Other income. Attach schedule			12	00
13	Total unrelated trade or business income. Add line 3 through line 12			13	9,846.00

Part II Deductions Not Taken Elsewhere (Except for contributions, deductions must be directly connected with the unrelated business income.)

14	Compensation of officers, directors, and trustees from Schedule I			14	00
15	Salaries and wages			15	00
16	Repairs			16	00
17	Bad debts			17	00
18	Interest			18	00
19	Taxes			19	00
20	Contributions			20	00
21	a Depreciation (Corporations and Associations - Schedule J) (Trusts - form FTB 3885F)	21a	00		
	b Less: depreciation claimed on Schedule A	21b	00	21	00
22	Depletion			22	00
23	a Contributions to deferred compensation plans			23a	00
	b Employee benefit programs			23b	00
24	Other deductions			24	00
25	Total deductions. Add line 14 through line 24			25	00
26	Unrelated business taxable income before allowable excess advertising costs. Subtract line 25 from line 13			26	9,846.00
27	Excess advertising costs (Schedule H, Part III, Column B)			27	00
28	Unrelated business taxable income before specific deduction. Subtract line 27 from line 26			28	9,846.00
29	Specific deduction			29	1,000.00
30	Unrelated business taxable income. Subtract line 29 from line 28. If line 28 is a loss, enter line 28			30	8,846.00

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 taxpayer) is based on all information of which preparer has any knowledge.

Sign Here	Signature of officer	Title SENIOR VP/CFO	Date	Telephone
Paid Preparer's Use Only	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN P00350393
	Firm's name (or yours, if self-employed) and address			FEIN 23-2932984 Telephone (215) 972-0701
May the FTB discuss this return with the preparer shown above? See instructions				<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Schedule A Cost of Goods Sold and/or Operations.

Method of inventory valuation (specify) N/A

1 Inventory at beginning of year	1	00
2 Purchases	2	00
3 Cost of labor	3	00
4 a Additional IRC Section 263A costs. Attach schedule	4a	00
b Other costs. Attach schedule	4b	00
5 Total. Add line 1 through line 4b	5	00
6 Inventory at end of year	6	00
7 Cost of goods sold and/or operations. Subtract line 6 from line 5. Enter here and on Side 2, Part I, line 2	7	00

Do the rules of IRC Section 263A (with respect to property produced or acquired for resale) apply to this organization? Yes No

Schedule B Tax Credits. Do not claim the New Jobs Credit on Schedule B.

1 Enter credit name _____ code no. _____	1	00	
2 Enter credit name _____ code no. _____	2	00	
3 Enter credit name _____ code no. _____	3	00	
4 Total. Add line 1 through line 3. If claiming more than 3 credits, enter the total of all claimed credits, except New Jobs Credit, on line 4. Enter here and on Side 1, line 11c	4	00	

Schedule K Add-On Taxes or Recapture of Tax.

1 Interest computation under the look-back method for completed long-term contracts. Attach form FTB 3834	1	00
2 Interest on tax attributable to installment: a Sales of certain timeshares or residential lots	2a	00
b Method for non-dealer installment obligations	2b	00
3 IRC Section 197(f)(9)(B)(ii) election to recognize gain on the disposition of intangibles	3	00
4 Credit recapture. Credit name _____	4	00
5 Total. Combine the amounts on line 1 through line 4	5	00

Schedule R Apportionment Formula Worksheet. Use only for unrelated trade or business amounts.

Is this organization electing the Alternate Method - Single-Sales Factor Formula?
If "Yes," complete Part B. If "No," complete Part A Yes No

Part A. Standard Method - Three Factor Formula. Complete if the corporation uses the three-factor formula. (The three-factor formula includes the double-weighted sales factor.)	(a) Total within and outside California	(b) Total within California	(c) Percent within California (b) ÷ (a)
1 Property factor:	• 165,186,184.	• 0.	• .0000%
2 Payroll factor: Wages and other compensation of employees	• 63,221,074.	• 0.	• .0000%
3 Sales factor: Gross sales and/or receipts less returns and allowances	• 9,846.	• 0.	• .0000%
4 Multiply the factor on line 3, column (c) by 2 .....			.0000%
5 Total percentage: Add the percentages in column (c), line 1, line 2, and line 4 .....			.0000%
6 Average apportionment percentage: Divide the factor on line 5 by 4 and enter the result here and on Form 109, Side 1, line 2. See instructions for exceptions .....			.0000%
Part B. Alternate Method - Single-Sales Factor Formula. Complete if the corporation elects the single-sales factor formula. This is an irrevocable annual election.	(a) Total within and outside California	(b) Total within California	(c) Percent within California (b) ÷ (a)
1 Total Sales	•	•	
2 Apportionment percentage. Divide total sales column (b) by total sales column (a) and enter the result here and on Form 109, Side 1, line 2			•

Schedule C Rental Income from Real Property and Personal Property Leased with Real Property

For rental income from debt-financed property, use Schedule D, R&TC Section 23701g, Section 23701i, and Section 23701n organizations. See instructions for exceptions.

1 Description of property	2 Rent received or accrued	3 Percentage of rent attributable to personal property		
		%		
		%		
		%		
4 Complete if any item in column 3 is more than 50%, or for any item if the rent is determined on the basis of profit or income		5 Complete if any item in column 3 is more than 10%, but not more than 50%		
(a) Deductions directly connected	(b) Income includible, column 2 less column 4(a)	(a) Gross income reportable, column 2 x column 3	(b) Deductions directly connected with personal property	(c) Net income includible, column 5(a) less column 5(b)
Add columns 4(b) and column 5(c). Enter here and on Side 2, Part I, line 6				

Schedule D Unrelated Debt-Financed Income

1 Description of debt-financed property		2 Gross income from or allocable to debt-financed property	3 Deductions directly connected with or allocable to debt-financed property		
			(a) Straight-line depreciation	(b) Other deductions	
4 Amount of average acquisition indebtedness on or allocable to debt-financed property	5 Average adjusted basis of or allocable to debt-financed property	6 Debt basis percentage, column 4 ÷ column 5	7 Gross income reportable, column 2 x column 6	8 Allocable deductions, total of columns 3(a) and 3(b) x column 6	9 Net income (or loss) includible, column 7 less column 8
		%			
		%			
		%			
Total. Enter here and on Side 2, Part I, line 7					

Schedule E Investment Income of an R&TC Section 23701g, Section 23701i, or Section 23701n Organization

1 Description	2 Amount	3 Deductions directly connected	4 Net investment income, column 2 less column 3	5 Set-asides	6 Balance of investment income, column 4 less column 5
Total. Enter here and on Side 2, Part I, line 8					
Enter gross income from members (dues, fees, charges, or similar amounts)					

Schedule F Interest, Annuities, Royalties and Rents from Controlled Organizations

Exempt Controlled Organizations					
1 Name of controlled organizations	2 Employer Identification Number	3 Net unrelated income (loss)	4 Total of specified payments made	5 Part of column (4) that is included in the controlling organization's gross income	6 Deductions directly connected with income in column (5)
1					
2					
3					
Nonexempt Controlled Organizations					
7 Taxable Income	8 Net unrelated income (loss)	9 Total of specified payments made	10 Part of column (9) that is included in the controlling organization's gross income	11 Deductions directly connected with income in column (10)	
1					
2					
3					
4 Add columns 5 and 10					
5 Add columns 6 and 11					
6 Subtract line 5 from line 4. Enter here and on Side 2, Part 1, line 9					

Schedule G Exploited Exempt Activity Income, other than Advertising Income

1 Description of exploited activity (attach schedule if more than one unrelated activity is exploiting the same exempt activity)	2 Gross unrelated business income from trade or business	3 Expenses directly connected with production of unrelated business income	4 Net income from unrelated trade or business, column 2 less column 3	5 Gross income from activity that is not unrelated business income	6 Expenses attributable to column 5	7 Excess exempt expense, column 6 less column 5 but not more than column 4	8 Net income includible, column 4 less column 7 but not less than zero
Total. Enter here and on Side 2, Part I, line 10							

FORM 109	INCOME (LOSS) FROM PARTNERSHIPS	STATEMENT	1
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DESCRIPTION	AMOUNT
PREMIER PURCHASING PARTNERS LP (EIN: 33-0387407)	9,846.
TOTAL TO FORM 109, PAGE 2, LINE 5	9,846.
