Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2015, or fiscal year beginning JUL 1 , 2015, and ending JUN 30 ,20 16

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

▶ **Information about Form 8879-EO and its instructions is at *www.irs.gov/form8879eo.***

OMB No. 1545-1878

2015

Name of exempt organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Name and title of officer

LAURIE R. BEYER, CPA
SR VP/CHIEF FINANCIAL OFFICER

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 ▶ [X]	**b** **Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	**1b**	166,095,050.
2a Form 990-EZ check here ▶ [ ]	**b** **Total revenue,** if any (Form 990-EZ, line 9)	**2b**	
3a Form 1120-POL check here ▶ [ ]	**b** **Total tax** (Form 1120-POL, line 22)	**3b**	
4a Form 990-PF check here ▶ [ ]	**b** **Tax based on investment income** (Form 990-PF, Part VI, line 5)	**4b**	
5a Form 8868 check here ▶ [ ]	**b** **Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	**5b**	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2015 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize BAKER TILLY VIRCHOW KRAUSE, LLP 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 2015 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 2015 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ _____ Date ▶ _____

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. 24298358001

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2015 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

EXTENDED TO MAY 15, 2017

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

▶ **Information about Form 990 and its instructions is at *www.irs.gov/form990.***

OMB No. 1545-0047

2015

Open to Public Inspection

A For the 2015 calendar year, or tax year beginning JUL 1, 2015 **and ending** JUN 30, 2016

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/ terminated
- ☐ Amended return
- ☐ Application pending

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

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
106 BOW STREET

City or town, state or province, country, and ZIP or foreign postal code
ELKTON, MD 21921-5596

F Name and address of principal officer: RICHARD C. SZUMEL, MD
SAME AS C ABOVE

D Employer identification number
52-0607945

E Telephone number
(410) 398-4000

G Gross receipts $ 180,304,783.

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

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

H(c) Group exemption number ▶

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

J Website: ▶ WWW.UHCC.COM

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ 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,

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

3	Number of voting members of the governing body (Part VI, line 1a)	3	14
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	13
5	Total number of individuals employed in calendar year 2015 (Part V, line 2a)	5	1359
6	Total number of volunteers (estimate if necessary)	6	241
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	1,897,553.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	-32,535.

		Prior Year	Current Year
Revenue			
8	Contributions and grants (Part VIII, line 1h)	2,360,946.	277,147.
9	Program service revenue (Part VIII, line 2g)	156,204,081.	159,157,991.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	2,534,753.	3,230,261.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,963,097.	3,429,651.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	165,062,877.	166,095,050.
Expenses			
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	1,790,991.	4,468,260.
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)	80,458,877.	80,161,134.
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)	77,180,025.	79,570,046.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	159,429,893.	164,199,440.
19	Revenue less expenses. Subtract line 18 from line 12	5,632,984.	1,895,610.

		Beginning of Current Year	End of Year
Net Assets or Fund Balances			
20	Total assets (Part X, line 16)	193,142,014.	188,348,000.
21	Total liabilities (Part X, line 26)	92,744,500.	89,916,005.
22	Net assets or fund balances. Subtract line 21 from line 20	100,397,514.	98,431,995.

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, SR. VP/CHIEF FINANCIAL OFFICER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
JULIUS C. GREEN, CPA			☐	P00350393

Firm's name ▶ BAKER TILLY VIRCHOW KRAUSE, LLP — Firm's EIN ▶ 39-0859910

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:
UNION HOSPITAL OF CECIL COUNTY'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 ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ..... ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

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

4a (Code:) (Expenses $ 160,563,863. including grants of $ 4,468,260.) (Revenue $ 159,157,991.)
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 ▶ 160,563,863.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	X	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
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? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25a*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a		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)? *If "Yes," complete Schedule R, Part V, line 2*	35b		
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	196		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	1359		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?	9a			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	14		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	13		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2			X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6		X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			X

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

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

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.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

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, address, and telephone number of the person who possesses the organization's books and records: ▶

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 or note to any line 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) MARTIN J. HEALY	0.50									
CHAIRMAN	0.60	X		X				0.	0.	0.
(2) RAYMOND HAMM	0.50									
VICE CHAIRMAN/TREASURER	0.60	X		X				0.	0.	0.
(3) RONALD GRAYBEAL	0.50									
SECRETARY	0.50	X		X				0.	0.	0.
(4) KENNETH S. LEWIS, MD, JD	30.00									
PRESIDENT & CEO (UNTIL 12/31/15)	10.00	X		X				0.	1,012,714.	248,368.
(5) RICHARD C. SZUMEL, MD	30.00									
PRESIDENT & CEO (AS OF 1/1/16)	10.00	X		X				0.	0.	0.
(6) KELLY ALBANESE BEDDER	0.50									
DIRECTOR	1.50	X						0.	0.	0.
(7) CHRISTY DRYER	0.50									
DIRECTOR (AS OF 3/2016)	0.50	X						0.	0.	0.
(8) RYAN GERACIMOS, MD	0.50									
DIRECTOR (AS OF 7/2015)	0.50	X						0.	0.	0.
(9) MARY BOLT, PH.D.	0.50									
DIRECTOR	0.50	X						0.	0.	0.
(10) RONALD CULLIS	0.50									
DIRECTOR	0.50	X						0.	0.	0.
(11) DAVID FERGUSON	0.50									
DIRECTOR	0.50	X						0.	0.	0.
(12) STEPHANIE GARRITY	0.50									
DIRECTOR	0.50	X						0.	0.	0.
(13) MARTHA HOSFORD, MD	0.50									
DIRECTOR (UNTIL 5/2016)	0.50	X						0.	0.	0.
(14) CARL ROBERTS	0.50									
DIRECTOR	0.50	X						0.	0.	0.
(15) SHEELMOHAN SACHDEV, MD	0.50									
DIRECTOR	0.50	X						0.	0.	0.
(16) DWIGHT THOMEY	0.50									
DIRECTOR (AS OF 2/2016)	0.50	X						0.	0.	0.
(17) LAURIE R. BEYER, CPA	31.00									
SENIOR VP/CHIEF FINANCIAL OFFICER	9.00			X				0.	376,333.	83,083.

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	39.00									
VP MEDICAL AFFAIRS	1.00				X			0.	387,061.	20,363.
(19) DAVID GIPSON	33.00									
SENIOR VP/CHIEF OPERATING OFFICER	7.00				X			0.	216,205.	16,701.
(20) KHADIJATU BOSTON	39.00									
SENIOR VP/CHIEF NURSING OFFICER	1.00				X			0.	226,907.	7,111.
(21) TERRANCE LOVELL	40.00									
VP HUMAN RESOURCES					X			240,708.	0.	63,483.
(22) JUSTIN SAUSVILLE	40.00									
PHYSICIAN						X		550,540.	0.	27,030.
(23) MICHAEL BASS	40.00									
PHYSICIAN						X		424,917.	0.	24,407.
(24) ROGER WU	40.00									
PHYSICIAN						X		396,713.	0.	21,071.
(25) OSCAR GALVIS	40.00									
PHYSICIAN						X		375,862.	0.	26,688.
(26) EUGENIA GRAY	40.00									
PHYSICIAN						X		364,566.	0.	15,863.
1b Sub-total ▶								2,353,306.	2,219,220.	554,168.
c Total from continuation sheets to Part VII, Section A ▶								0.	0.	0.
d Total (add lines 1b and 1c) ▶								2,353,306.	2,219,220.	554,168.

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 ▶ 100

		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*	3		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*	4	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*	5		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
UNION RADIOLOGISTS, LLC 106 BOW STREET, ELKTON, MD 21921	RADIOLOGISTS	3,183,522.
WHITING-TURNER CONTRACTING CO. P.O. BOX 17596, BALTIMORE, MD 21297	CONTRACTOR	2,855,286.
MDICS AT UNION CECIL COUNTY, LLC 7250 PARKWAY DRIVE, HANOVER, MD 21076	CONTRACTOR	2,165,855.
UNIVERSITY OF MARYLAND MEDICAL 22 SOUTH GREENE STREET, BALTIMORE, MD 21201	ADVISORY SERVICES	902,207.
INSIGHT INVESTMENTS LLC, 611 ANTON BLVD, SUITE 700, COSTA MESA, CA 92626	IT INFRASTRUCTURE	868,001.

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 ▶ 108

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d	246,480.			
	e Government grants (contributions)	1e				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	30,667.			
	g Noncash contributions included in lines 1a-1f: $					
	h **Total.** Add lines 1a-1f		277,147.			
Program Service Revenue		**Business Code**				
	2a NET PATIENT SERVICE REVENUE	621990	157,675,670.	157,675,670.		
	b OTHER OPERATING REVENUE	621990	853,641.	853,641.		
	c ADULT DAY CARE	623990	628,680.	628,680.		
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a-2f		159,157,991.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		2,604,102.		3,726.	2,600,376.
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
		(i) Real / (ii) Personal				
	6a Gross rents: 43,236. /					
	b Less: rental expenses: 14,287. /					
	c Rental income or (loss): 28,949. /					
	d Net rental income or (loss)		28,949.			28,949.
		(i) Securities / (ii) Other				
	7a Gross amount from sales of assets other than inventory: 14,774,426. / 47,179.					
	b Less: cost or other basis and sales expenses: 14,183,049. / 12,397.					
	c Gain or (loss): 591,377. / 34,782.					
	d Net gain or (loss)		626,159.			626,159.
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	a				
	b Less: direct expenses	b				
	c Net income or (loss) from fundraising events					
	9a Gross income from gaming activities. See Part IV, line 19	a				
	b Less: direct expenses	b				
	c Net income or (loss) from gaming activities					
	10a Gross sales of inventory, less returns and allowances	a				
	b Less: cost of goods sold	b				
	c Net income or (loss) from sales of inventory					
	Miscellaneous Revenue	**Business Code**				
	11a LABORATORY REVENUE	621500	1,893,827.		1,893,827.	
	b CAFETERIA/FOOD SERVICE	722210	812,188.			812,188.
	c MEANINGFUL USE REVENUE	900099	558,187.			558,187.
	d All other revenue	900099	136,500.			136,500.
	e **Total.** Add lines 11a-11d		3,400,702.			
	12 **Total revenue.** See instructions.		166,095,050.	159,157,991.	1,897,553.	4,762,359.

Part IX Statement of Functional Expenses

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

Check if Schedule O contains a response or note to any line in this Part IX 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 domestic organizations and domestic governments. See Part IV, line 21	4,468,260.	4,468,260.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	329,806.		329,806.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	67,458,068.	66,698,504.	759,564.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	743,583.	714,916.	28,667.	
9 Other employee benefits	6,967,130.	6,910,121.	57,009.	
10 Payroll taxes	4,662,547.	4,600,614.	61,933.	
11 Fees for services (non-employees):				
a Management	1,899,642.	949,821.	949,821.	
b Legal	274,589.		274,589.	
c Accounting	109,467.		109,467.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	53,877.		53,877.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	23,890,061.	23,264,698.	625,363.	
12 Advertising and promotion	510,403.	510,403.		
13 Office expenses	866,383.	859,175.	7,208.	
14 Information technology	246,019.	246,019.		
15 Royalties				
16 Occupancy	2,982,268.	2,982,268.		
17 Travel	264,549.	214,816.	49,733.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	49,314.	19,927.	29,387.	
20 Interest	1,951,158.	1,951,158.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	11,135,283.	11,135,283.		
23 Insurance	2,966,353.	2,966,353.		
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	19,407,111.	19,404,162.	2,949.	
b BAD DEBTS	6,826,331.	6,826,331.		
c REPAIRS & MAINTENANCE	2,750,959.	2,750,959.		
d DIETARY	1,083,904.	1,025,140.	58,764.	
e All other expenses	2,302,375.	2,064,935.	237,440.	
25 **Total functional expenses.** Add lines 1 through 24e	164,199,440.	160,563,863.	3,635,577.	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 or note to any line in this Part X ☐

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	7,622,571.	1	2,982,884.
	2	Savings and temporary cash investments	2,225,164.	2	956,144.
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	13,294,247.	4	15,088,409.
	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		7	
	8	Inventories for sale or use	1,974,105.	8	2,065,581.
	9	Prepaid expenses and deferred charges	2,893,481.	9	3,520,101.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 210,596,749.			
	b	Less: accumulated depreciation — 10b: 117,036,933.	94,568,035.	10c	93,559,816.
	11	Investments - publicly traded securities	56,528,098.	11	53,675,995.
	12	Investments - other securities. See Part IV, line 11	6,030,772.	12	5,814,578.
	13	Investments - program-related. See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	8,005,541.	15	10,684,492.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	193,142,014.	16	188,348,000.
Liabilities	17	Accounts payable and accrued expenses	12,681,544.	17	9,482,516.
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	66,398,857.	20	64,045,962.
	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	13,664,099.	25	16,387,527.
	26	**Total liabilities.** Add lines 17 through 25	92,744,500.	26	89,916,005.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	98,057,789.	27	95,806,742.
	28	Temporarily restricted net assets	2,339,725.	28	2,625,253.
	29	Permanently restricted net assets		29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	100,397,514.	33	98,431,995.
	34	Total liabilities and net assets/fund balances	193,142,014.	34	188,348,000.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI ..... [X]

1	Total revenue (must equal Part VIII, column (A), line 12)	1	166,095,050.
2	Total expenses (must equal Part IX, column (A), line 25)	2	164,199,440.
3	Revenue less expenses. Subtract line 2 from line 1	3	1,895,610.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	100,397,514.
5	Net unrealized gains (losses) on investments	5	-3,506,242.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-354,887.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	98,431,995.

Part XII Financial Statements and Reporting

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

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

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.**

▶ **Information about Schedule A (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990.*

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization	**Employer identification number**
UNION HOSPITAL OF CECIL COUNTY, INC.	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 (Form 990 or 990-EZ).)

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 in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**

b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

f Enter the number of supported organizations .....

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
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) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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 VI.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2015 (line 6, column (f) divided by line 11, column (f)) 14 %

15 Public support percentage from 2014 Schedule A, Part II, line 14 15 %

16a **33 1/3% support test - 2015.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test - 2014.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10% -facts-and-circumstances test - 2015.** 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 VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10% -facts-and-circumstances test - 2014.** 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 VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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) 2011	(b) 2012	(c) 2013	(d) 2014	(e) 2015	(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 VI.)						
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 2015 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2014 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2015** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2014** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2015.** 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 - 2014.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

Part IV Supporting Organizations

(Complete only if you checked a box in line 11 on Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

			Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? *If "No" describe in* ***Part VI*** *how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* ***Part VI*** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes," and if you checked 11a or 11b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If "Yes," describe in* ***Part VI*** *how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.*	4b		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in* ***Part VI,*** *including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).*	5a		
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in* ***Part VI.***	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If "Yes," provide detail in* ***Part VI.***	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* ***Part VI.***	9b		
c	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* ***Part VI.***	9c		
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? *If "Yes," answer 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)*	10b		

Part IV **Supporting Organizations** *(continued)*

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1 *Check the box next to the method that the organization used to satisfy the Integral Part Test during the yea* ***(see instructions):***

a ☐ The organization satisfied the Activities Test. *Complete* ***line 2*** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* ***line 3*** *below.*

c ☐ The organization supported a governmental entity. *Describe in Part VI how you supported a government entity (see instructions).*

			Yes	No
2	Activities Test. ***Answer (a) and (b) below.***			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	2b		
3	Parent of Supported Organizations. ***Answer (a) and (b) below.***			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in ***Part VI.***	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in ***Part VI*** *the role played by the organization in this regard.*	3b		

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	**1**		
2 Recoveries of prior-year distributions	**2**		
3 Other gross income (see instructions)	**3**		
4 Add lines 1 through 3	**4**		
5 Depreciation and depletion	**5**		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	**6**		
7 Other expenses (see instructions)	**7**		
8 **Adjusted Net Income** (subtract lines 5, 6 and 7 from line 4)	**8**		

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
a Average monthly value of securities	**1a**		
b Average monthly cash balances	**1b**		
c Fair market value of other non-exempt-use assets	**1c**		
d **Total** (add lines 1a, 1b, and 1c)	**1d**		
e **Discount** claimed for blockage or other factors (explain in detail in **Part VI**):			
2 Acquisition indebtedness applicable to non-exempt-use assets	**2**		
3 Subtract line 2 from line 1d	**3**		
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	**4**		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	**5**		
6 Multiply line 5 by .035	**6**		
7 Recoveries of prior-year distributions	**7**		
8 **Minimum Asset Amount** (add line 7 to line 6)	**8**		

Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	**1**		
2 Enter 85% of line 1	**2**		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	**3**		
4 Enter greater of line 2 or line 3	**4**		
5 Income tax imposed in prior year	**5**		
6 **Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	**6**		

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	
4	Amounts paid to acquire exempt-use assets	
5	Qualified set-aside amounts (prior IRS approval required)	
6	Other distributions (describe in **Part VI**). See instructions.	
7	**Total annual distributions.** Add lines 1 through 6.	
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions.	
9	Distributable amount for 2015 from Section C, line 6	
10	Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2015	(iii) Distributable Amount for 2015
1	Distributable amount for 2015 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2015 (reasonable cause required-see instructions)			
3	Excess distributions carryover, if any, to 2015:			
a				
b				
c				
d	From 2013			
e	From 2014			
f	**Total** of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2015 distributable amount			
i	Carryover from 2010 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2015 from Section D, line 7: $			
a	Applied to underdistributions of prior years			
b	Applied to 2015 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2015, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6	Remaining underdistributions for 2015. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7	**Excess distributions carryover to 2016.** Add lines 3j and 4c.			
8	Breakdown of line 7:			
a				
b				
c	Excess from 2013			
d	Excess from 2014			
e	Excess from 2015			

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions.)

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

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at *www.irs.gov/form990* .

OMB No. 1545-0047

2015

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, contributions totaling $5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

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

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

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

Caution. An organization that 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 its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

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

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	MARYLAND HEALTH CARE COMMISSION 4160 PATTERSON AVE BALTIMORE, MD 21215	$ 10,067.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2	UNION HOSPITAL OF CECIL COUNTY FOUNDATION, INC. 106 BOW STREET ELKTON, MD 21921	$ 246,480.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

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

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

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

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

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

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

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

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

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

Part III *Exclusively* **religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than $1,000 for the year from any one contributor.** Complete columns **(a)** through **(e) and** the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of $1,000 or less for the year. (Enter this info. 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" on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Information about Schedule D (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2015

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" on Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

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

Part II Conservation Easements. Complete if the organization answered "Yes" on 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 a 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, handling of violations, and enforcing conservation easements during the year ▶ _____

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

8 Does each conservation easement reported on line 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" on 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) Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

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

a Revenue included on 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" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

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

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

		Amount
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, for escrow or custodial account liability? ☐ Yes ☐ No

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
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 on lines 2a, 2b, and 2c should equal 100%.

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

		Yes	No
(i) unrelated organizations	3a(i)		
(ii) related organizations	3a(ii)		
b If "Yes" on line 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.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,221,305.		1,221,305.
b Buildings		83,303,394.	34,402,158.	48,901,236.
c Leasehold improvements		567,132.	163,457.	403,675.
d Equipment		120,291,463.	81,133,573.	39,157,890.
e Other		5,213,455.	1,337,745.	3,875,710.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ▶				93,559,816.

Schedule D (Form 990) 2015

532052
09-21-15

Part VII Investments - Other Securities.

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

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

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) OTHER ASSETS	601,294.
(2) LOAN ISSUANCE COSTS	584,710.
(3) INSURANCE CLAIMS RECEIVABLE	9,473,438.
(4) DUE FROM AFFILIATES	25,050.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	10,684,492.

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) THIRD PARTY ADVANCES	3,637,293.
(3) CAPITAL LEASE OBLIGATIONS	2,266,010.
(4) ESTIMATED MEDICAL MALPRACTICE	
(5) CLAIMS LIABILITY	10,484,224.
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	16,387,527.

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

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

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	155,353,713.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains (losses) on investments	2a	-3,506,242.		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d	-7,235,095.		
e	Add lines **2a** through **2d**			2e	-10,741,337.
3	Subtract line **2e** from line **1**			3	166,095,050.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	0.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	166,095,050.

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

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	157,319,232.
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	157,319,232.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b	6,880,208.		
c	Add lines **4a** and **4b**			4c	6,880,208.
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	164,199,440.

Part XIII Supplemental Information.

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 2016 AND 2015.

THE HOSPITAL'S POLICY IS TO RECOGNIZE INTEREST RELATED TO UNRECOGNIZED TAX BENEFITS IN INTEREST EXPENSE AND PENALTIES IN OPERATING EXPENSES.

THE HOSPITAL'S FEDERAL EXEMPT ORGANIZATION BUSINESS INCOME TAX RETURNS FOR THE YEARS AFTER 2013 REMAIN SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE

Part XIII Supplemental Information *(continued)*

SERVICE.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

CHANGE IN INTEREST IN NET ASSETS OF SUBSIDIARIES	-322,101.
PROVISION FOR BAD DEBTS NETTED AGAINST REVENUE ON FINANCIAL STATEMENTS	-6,826,331.
BANK FEES NETTED ON FINANCIAL STATEMENTS	-53,877.
NET ASSETS RELEASED	-32,786.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	-7,235,095.

PART XII, LINE 4B - OTHER ADJUSTMENTS:

PROVISION FOR BAD DEBTS NETTED AGAINST REVENUE ON FINANCIAL STATEMENTS	6,826,331.
BANK FEES NETTED ON FINANCIAL STATEMENTS	53,877.
TOTAL TO SCHEDULE D, PART XII, LINE 4B	6,880,208.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990* .

OMB No. 1545-0047

2015

Open to Public Inspection

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

Employer identification number 52-0607945

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			899,826.		899,826.	.57%
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			899,826.		899,826.	.57%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		5,960	215,928.	256.	215,672.	.14%
f Health professions education (from Worksheet 5)		693	488,740.	200.	488,540.	.31%
g Subsidized health services (from Worksheet 6)		104	10,635,618.	6,562,026.	4,073,592.	2.59%
h Research (from Worksheet 7)			7,568.		7,568.	.00%
i Cash and in-kind contributions for community benefit (from Worksheet 8)		40,527	380,848.	178,801.	202,047.	.13%
j **Total.** Other Benefits		47,284	11,728,702.	6,741,283.	4,987,419.	3.17%
k **Total.** Add lines 7d and 7j		47,284	12,628,528.	6,741,283.	5,887,245.	3.74%

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

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development		525	16,514.		16,514.	.01%
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members		22	3,240.		3,240.	.00%
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development		230	109,187.		109,187.	.07%
9	Other						
10	**Total**		777	128,941.		128,941.	.08%

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2 5,781,902.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3 36,264.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

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

Section C. Collection Practices

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

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

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, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	Gen. medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 UNION HOSPITAL OF CECIL COUNTY, INC. 106 BOW STREET ELKTON, MD 21921 WWW.UHCC.COM 07-005	X	X					X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

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

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[ ] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 15			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		X
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	X	
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): WWW.UHCC.COM/ABOUT-US/COMMUNITY-BENEFIT/R			
b	[ ] Other website (list url):			
c	[X] Made a paper copy available for public inspection without charge at the hospital facility			
d	[ ] Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 15			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): WWW.UHCC.COM/ABOUT-US/COMMUNITY-BENEFIT/REPORTS/			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		X
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	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)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

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

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:		
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	X	
	If "Yes," indicate the eligibility criteria explained in the FAP:		
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 300 %		
b	[X] Income level other than FPG (describe in Section C)		
c	[X] Asset level		
d	[ ] Medical indigency		
e	[X] Insurance status		
f	[X] Underinsurance status		
g	[X] Residency		
h	[ ] Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance?	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application		
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	[X] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	[ ] Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility?	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a	[X] The FAP was widely available on a website (list url): SEE PART V, PAGE 7		
b	[X] The FAP application form was widely available on a website (list url): SEE PART V, PAGE 7		
c	[X] A plain language summary of the FAP was widely available on a website (list url): SEE PART V, PAGE 7		
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	[ ] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	[ ] A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	[ ] Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	[ ] Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	[X] Other (describe in Section C)		

Billing and Collections

17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	[ ] Reporting to credit agency(ies)		
b	[ ] Selling an individual's debt to another party		
c	[ ] Actions that require a legal or judicial process		
d	[ ] Other similar actions (describe in Section C)		
e	[X] None of these actions or other similar actions were permitted		

Part V Facility Information *(continued)*

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

		Yes	No
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19		X
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ Actions that require a legal or judicial process			
d ☐ Other similar actions (describe in Section C)			

20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):

- **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 individuals regarding the individuals' bills
- **d** ☒ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** ☐ Other (describe in Section C)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

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

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

22 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 Section C)

23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?	23		X
If "Yes," explain in Section C.			
24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	24		X
If "Yes," explain in Section C.			

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 5: UNION HOSPITAL COLLABORATED WITH THE CECIL COUNTY HEALTH DEPARTMENT TO CONDUCT THE NEWEST COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WHOSE COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) COVERS FISCAL YEARS 2017 - 2019. THE CHNA PLANNING TEAM INCLUDED STAFF FROM UNION HOSPITAL: THE COMMUNITY BENEFITS COORDINATOR, THE DIRECTOR OF MARKETING, AND A PHYSICIAN FROM OCCUPATIONAL HEALTH (MASTER OF PUBLIC HEALTH (MPH) INTERN), AS WELL AS STAFF FROM THE CECIL COUNTY HEALTH DEPARTMENT: THE HEALTH POLICY ANALYST, THE HEALTH OFFICER, THE DEPUTY HEALTH OFFICER, AND THE PUBLIC AFFAIRS OFFICER. THE CHNA PLANNING TEAM WAS RESPONSIBLE TO FACILITATE ALL COMPONENT PARTS OF THE CHNA PROCESS, INCLUDING WRITING AND SUBMITTING THE REPORTS TO THE INTERNAL REVENUE SERVICE (IRS). ULTIMATELY, THE CHNA/CHIP PROCESS REFLECTED COLLABORATION OF COMMUNITY PARTNERS WORKING TOGETHER TO ACHIEVE THE SAME HEALTH IMPROVEMENT GOALS FOR CECIL COUNTY.

PLANNING THE CHNA OCCURRED FROM FEBRUARY 2015 - JUNE 2015. THE CHNA/CHIP WAS APPROVED BY BOTH THE UNION HOSPITAL BOARD (FEBRUARY 2015) AND THE COMMUNITY HEALTH ADVISORY COMMITTEE (CHAC) (JULY 2015). PRIMARY DATA COLLECTION OCCURRED FROM JULY 2015 - SEPTEMBER 2015 VIA THREE FOCUS GROUPS AND ADMINISTRATION OF AN ONLINE COMMUNITY SURVEY. SECONDARY DATA WAS TAKEN FROM A VARIETY OF RELIABLE NATIONAL AND LOCAL DATA SOURCES. ANALYSIS OF PRIMARY AND SECONDARY DATA COLLECTED OCCURRED FROM NOVEMBER 2015 THROUGH MID-JANUARY 2016.

THE THREE FOCUS GROUPS WERE CONDUCTED WITH ADULT POPULATIONS WITHOUT

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

ACCESS TO THE INTERNET TO TAKE THE ONLINE SURVEY (HOMELESS, SENIORS, AND SPANISH-SPEAKING MIGRANT WORKERS). EACH FOCUS GROUP SESSION INCLUDED A DESCRIPTION OF THE CHNA, THE PURPOSE OF THE FOCUS GROUP, AN INTRODUCTION OF THE FACILITATORS, AND THE RULES OF ENGAGEMENT. ALL MATERIALS WERE TRANSLATED INTO SPANISH FOR THE FOCUS GROUP WITH MIGRANT, SPANISH-SPEAKING WORKERS, AND A SPANISH INTERPRETER WAS PROVIDED BY THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE. PARTICIPANTS WERE ASKED TO RESPOND TO THE FOLLOWING QUESTIONS:

1) WHAT ARE THE GREATEST STRENGTHS OF OUR COMMUNITY?

2) WHAT DO YOU THINK ARE THE MOST IMPORTANT HEALTH ISSUES IN CECIL COUNTY?

3) WHAT WOULD MOST IMPROVE THE QUALITY OF LIFE IN CECIL COUNTY?

4) WHAT ARE THE MOST SIGNIFICANT BARRIERS TO ACCESSING HEALTH CARE IN CECIL COUNTY?

5) RELATED TO HEALTH AND QUALITY OF LIFE, WHAT RESOURCES OR SERVICES DO YOU THINK ARE MISSING IN CECIL COUNTY?

THE ONLINE COMMUNITY SURVEY WAS DEVELOPED BY THE HEALTH POLICY ANALYST (CECIL COUNTY HEALTH DEPARTMENT) WITH INPUT FROM CHAC MEMBER ORGANIZATIONS. THE SURVEY WAS CREATED USING SURVEY MONKEY AND CONSISTED OF TWENTY QUESTIONS - MULTIPLE CHOICE, LIKERT SCALE SELECTIONS, AND FREE TEXT ENTRY. THE SURVEY WAS DIVIDED INTO FOUR SECTIONS: 1) DEMOGRAPHICS, 2) COMMUNITY HEALTH, 3) QUALITY OF LIFE, AND 4) ACCESS TO HEALTH CARE. THE SURVEY TOOK APPROXIMATELY 15 TO 20 MINUTES TO COMPLETE AND 506 PEOPLE COMPLETED THE SURVEY.

INPUT FROM COMMUNITY PARTNERS ENGAGED IN CECIL COUNTY'S CHAC MEETINGS, ALSO KNOWN AS THE LOCAL HEALTH IMPROVEMENT COALITION, WAS INTEGRAL TO THE

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

PROCESS OF SELECTING THE HEALTH PRIORITIES FOR THE COUNTY AND CREATING THE CHIP. CHAC MEMBER ORGANIZATIONS THAT PARTICIPATED IN THE PRIORITIZATION AND STRATEGIC PLANNING PROCESSES INCLUDED:

AFFILIATED SANT GROUP (MOBILE CRISIS), AMERICAN CANCER SOCIETY, CECIL COUNTY DEPT OF EMERGENCY SERVICES, CECIL COUNTY DEPT OF JUVENILE SERVICES, CECIL COUNTY DEPT OF SOCIAL SERVICES, CECIL COUNTY DIRECTOR OF ADMINISTRATION, CECIL COUNTY EXECUTIVE OFFICE, CECIL COUNTY HEALTH DEPT., CECIL COUNTY LIQUOR BOARD, CECIL COUNTY PUBLIC SCHOOLS, CECIL COUNTY SHERIFF'S OFFICE, COUNTY COUNCIL MEMBERS, DHMH - OFFICE OF POPULATION HEALTH IMPROVEMENT, CECIL COLLEGE, CECIL COUNTY DEPT OF COMMUNITY SERVICES, CECIL COUNTY DEPT OF CORRECTIONS, CECIL COUNTY HOUSING, DEEP ROOTS, ELKTON COMMUNITY KITCHEN, ELKTON POLICE DEPARTMENT, ELKTON PRESBYTERIAN CHURCH, ELKTON HOUSING AUTHORITY, MARYLAND STATE DELEGATES, MARYLAND STATE SENATORS, MEADOW WOOD BEHAVIORAL HEALTH SYSTEM, PRIVATE CITIZENS, PRIVATE EDUCATION ORGANIZATIONS, PRIVATE HEALTH CARE PROFESSIONALS, SEVENTH DAY ADVENTIST CHURCH, UNION HOSPITAL OF CECIL COUNTY, UPPER BAY COUNSELING & SUPPORT SERVICES, WEST CECIL HEALTH CENTER, YOUTH EMPOWERMENT SOURCE, IMMACULATE CONCEPTION MEETING GROUND, ON OUR OWN OF CECIL COUNTY, PARIS FOUNDATION, SERENITY HEALTH, STONE RUN FAMILY MEDICINE, WIN FAMILY SERVICES, & YMCA.

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 6B: UNION HOSPITAL COLLABORATED WITH THE CECIL COUNTY HEALTH DEPARTMENT TO CONDUCT THE NEWEST COMMUNITY HEALTH NEEDS ASSESSMENT.

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 11: IN 2016, CECIL COUNTY HEALTH DEPARTMENT, UNION HOSPITAL OF CECIL COUNTY, AND PARTNER ORGANIZATIONS IN CHAC BEGAN A COMMUNITY HEALTH IMPROVEMENT PROCESS TO IDENTIFY HEALTH PRIORITIES FOR CECIL COUNTY. THE FOLLOWING THREE HEALTH PRIORITIES WERE SELECTED FOR CECIL COUNTY:

1. BEHAVIORAL HEALTH

2. CHRONIC DISEASE

3. DETERMINANTS OF HEALTH

BEHAVIORAL HEALTH

GOAL: REDUCE THE PREVALENCE OF SUBSTANCE USE DISORDERS IN CECIL COUNTY

OBJECTIVE: BY JUNE 30, 2019, REDUCE THE DRUG-INDUCED DEATH RATE BY 5%

STRATEGIES:

1) CONTINUE TO PROVIDE NARCAN TRAINING TO LAW ENFORCEMENT OFFICERS AND THE PUBLIC

2) PROVIDE EDUCATION AT PHARMACIES AND PHYSICIANS' OFFICES ON PRESCRIPTION DRUG ABUSE AND NARCAN TRAINING

3) ADVOCATE FOR THE DEVELOPMENT OF MORE TREATMENT OPTIONS FOR ADULTS AND ADOLESCENTS IN THE COUNTY

4) PARTNER WITH PROVIDERS TO INCREASE THE UTILIZATION OF EXISTING SERVICES

5) WORK WITH THE SCHOOL SYSTEM TO REACH AT-RISK ADOLESCENTS

6) INCREASE PARTICIPATION IN PREVENTION AND EDUCATION PROGRAMS SUCH AS "MY FAMILY MATTERS" AND "STRENGTHENING FAMILIES"

7) PROVIDE INCENTIVES FOR ATTENDING PROGRAMS

8) PROMOTE THE CREATION OF EDUCATIONAL MESSAGES FOCUSING ON PREVENTION

9) IMPLEMENT RECOMMENDATIONS OF CECIL COUNTY'S LOCAL OVERDOSE FATALITY

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

REVIEW TEAM (LOFRT)

OBJECTIVE: BY JUNE 30, 2019 REDUCE THE PERCENTAGE OF YOUTH IN GRADES 9-12 REPORTING THE USE OF ALCOHOL ON ONE OR MORE OF THE PAST 30 DAYS TO NO MORE THAN 33.8%

STRATEGIES:

1) PARTNER WITH MARYLAND STRATEGIC PREVENTION FRAMEWORK 2 (MSPF2) TO IMPLEMENT STRATEGIES IDENTIFIED THROUGH A NEEDS ASSESSMENT

2) CONTINUE TO SUPPORT AND EXPAND LIFE SKILLS TRAINING IN CECIL COUNTY PUBLIC SCHOOLS

GOAL: IMPROVE THE MENTAL HEALTH AND WELL-BEING OF CECIL COUNTY RESIDENTS

OBJECTIVE: BY JUNE 30, 2019, REDUCE THE PERCENTAGE OF YOUTH IN GRADES 9-12 WHO FELT SAD OR HOPELESS ALMOST EVERY DAY FOR TWO WEEKS OR MORE DURING THE PAST 12 MONTHS TO NO MORE THAN 24.8%

STRATEGIES:

1) PROMOTE DEPRESSION SCREENING DURING WELLNESS CHECKUPS

2) RESEARCH PROGRAMMING TO PROMOTE THE HEALTH AND WELL-BEING OF YOUTH

3) PROMOTE BEHAVIORAL HEALTH INTEGRATION IN PEDIATRIC PRIMARY CARE

OBJECTIVE: BY JUNE 30, 2019, DECREASE THE SUICIDE RATE IN CECIL COUNTY BY 5%.

STRATEGIES:

1) PROMOTE THE AVAILABILITY OF CRISIS AND SUICIDE HOTLINES

2) CONTINUE TO SUPPORT, PROMOTE THE UTILIZATION OF, AND EXPAND MOBILE CRISIS SERVICES IN CECIL COUNTY

3) PROMOTE REGULAR SCREENING FOR DEPRESSION DURING PRIMARY CARE PROVIDER VISITS

4) PROMOTE MENTAL HEALTH FIRST AID (MHFA) TRAINING

GOAL: IMPROVE ACCESS TO BEHAVIORAL HEALTH SERVICES IN CECIL COUNTY

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

OBJECTIVE: BY JUNE 30, 2019, DECREASE THE RATE OF EMERGENCY DEPARTMENT VISITS RELATED TO MENTAL HEALTH CONDITIONS BY 10% AND EMERGENCY DEPARTMENT VISITS RELATED TO SUBSTANCE USE DISORDERS BY 5%

STRATEGIES:

1) PROVIDE EDUCATION TO REDUCE THE STIGMA SURROUNDING BEHAVIORAL HEALTH DISORDERS

2) INCREASE AWARENESS OF BEHAVIORAL HEALTH RESOURCES AND SERVICES IN THE COMMUNITY

3) CONTINUE TO SUPPORT OUTREACH EFFORTS TO ENROLL UNINSURED RESIDENTS IN HEALTH INSURANCE/MEDICAL ASSISTANCE

4) REDUCE THE HEALTH IMPACT OF VIOLENCE AND TRAUMA BY INTEGRATING TRAUMA-INFORMED CARE THROUGHOUT THE HEALTH CARE AND BEHAVIORAL HEALTH SYSTEMS

5) EXPAND OPTIONS FOR INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH TREATMENT FOR CECIL COUNTY RESIDENTS

6) PARTNER IN THE DEVELOPMENT OF A REGIONAL CRISIS CENTER

7) PROMOTE A SYSTEM OF CARE THAT INTEGRATES SOMATIC AND BEHAVIORAL HEALTH CARE

8) CONTINUE TO HOLD MONTHLY ER DIVERSION MEETINGS

CHRONIC DISEASE

GOAL: REDUCE THE MORBIDITY OF DIABETES IN CECIL COUNTY

OBJECTIVE: BY JUNE 30, 2019, INCREASE PHYSICIAN PRACTICE SITES MAKING REFERRALS TO CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS BY 2 SITES

STRATEGIES:

1) ENGAGE 2 PHYSICIAN PRACTICE SITES TO PARTICIPATE

2) TRACK THE NUMBER OF REFERRALS MADE

OBJECTIVE: BY JUNE 30, 2019, INCREASE THE NUMBER OF SITES HOSTING CHRONIC

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

DISEASE SELF-MANAGEMENT PROGRAMS BY 5 SITES

STRATEGIES:

1) ENGAGE 5 ADDITIONAL SITES TO HOST CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS

OBJECTIVE: BY JUNE 30, 2019, CREATE 1 COUNTY-WIDE WALKING PROGRAM

STRATEGIES:

1) USING THE DELAWARE WALKING PROGRAM AS A MODEL, CREATE AND IMPLEMENT A WALKING PROGRAM THAT TRACKS THE NUMBER OF PARTICIPATING INDIVIDUALS, TESTIMONIALS RECEIVED, AND TOTAL MILES WALKED

2) IF SUCCESSFUL, CREATE A PLAN FOR FUTURE WALKING PROGRAMS (IF NOT SUCCESSFUL, INDICATE IN ANNUAL REPORTING AND PROVIDE LESSONS LEARNED)

GOAL: REDUCE MORTALITY FROM LUNG CANCER IN CECIL COUNTY

OBJECTIVE: BY JUNE 30, 2017, INCREASE THE NUMBER OF INDIVIDUALS RECEIVING LOW-DOSE LUNG CT SCREENINGS BY 5% IN ORDER TO INCREASE AWARENESS FOR LUNG CANCER PREVENTION

STRATEGIES:

1) ADVERTISE AND PROMOTE THE LOW-DOSE LUNG CT SCREENING PROGRAM IN THE COMMUNITY

2) SUPPORT RECOMMENDATIONS OF THE UNION HOSPITAL CANCER PROGRAM'S COMMUNITY OUTREACH PLAN FOR LOW-DOSE LUNCH CT SCREENING

OBJECTIVE: BY JUNE 30, 2019, REDUCE THE PREVALENCE OF TOBACCO USE AMOUNG ADOLESCENTS BY 5% AND CIGARETTE SMOKING AMONG ADULTS BY 5%

STRATEGIES:

1) PROMOTE COMMUNITY SMOKING CESSATION

2) EDUCATE ADULTS ABOUT COMMUNITY-BASED AND STATE-BASED SMOKING CESSATION AND PREVENTION RESOURCES

3) SUPPORT RECOMMENDATIONS OF THE CECIL COUNTY TOBACCO TASK FORCE

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

GOAL: REDUCE MORBIDITY AND MORTALITY OF HEART DISEASE AND STROKE IN CECIL COUNTY

OBJECTIVE: BY JUNE 30, 2019, REDUCE HIGH BLOOD PRESSURE AMONG ADULTS BY 5%, IN ORDER TO REDUCE THE INCIDENCE OF STROKE IN CECIL COUNTY

STRATEGIES:

1) EDUCATE AND SUPPORT HEALTH CARE PROVIDERS ON HOW TO WRITE PRESCRIPTIONS FOR PHYSICAL ACTIVITY

2) PROVIDE A COMMUNITY-WIDE CAMPAIGN TO TARGET REDUCING SODIUM INTAKE (ALSO SUPPORTS HEALTHY EATING FOR YOUTH)

3) SUPPORT RECOMMENDATIONS FROM THE UNION HOSPITAL STROKE PROGRAM FOR STROKE PREVENTION IN THE COMMUNITY.

OBJECTIVE: BY JUNE 30, 2019, INCREASE THE PERCENTAGE OF STUDENTS WHO EAT VEGETABLES ONE OR MORE TIMES PER DAY BY 5%, IN ORDER TO REDUCE THE INCIDENCE OF HEART DISEASE IN CECIL COUNTY

STRATEGIES:

1) PARTNER WITH SCHOOLS, DAY CARES, AND THE "HEAD START" PROGRAM TO PROVIDE EDUCATION TO STAFF AND COMMUNITY MEMBERS ON NUTRITION FOR YOUTH

2) SUPPORT THE TRANSITION FROM THE SCHOOL YEAR TO THE SUMMER BY WORKING WITH SUMMER FOOD PROGRAM PROVIDERS TO INCREASE ACCESS TO AND AWARENESS OF SUMMER FOOD PROGRAMS IN THE COMMUNITY

3) ADVOCATE FOR THE INCORPORATION OF HEALTHY FOODS INTO SCHOOL LESSONS

4) UTILIZE A LOCAL NEWSPAPER TO PROVIDE HELPFUL TIPS, RECIPES, AND/OR NEWS STORIES ON HEALTHY LIFESTYLE CHOICES AS THEY PERTAIN TO THE "CHIP" OBJECTIVES

OBJECTIVE: BY JUNE 30, 2019, IMPLEMENT A WELLNESS PROGRAM FOR ONE LOCAL SMALL BUSINESS

STRATEGIES:

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

1) IMPLEMENT A WELLNESS PROGRAM THAT PROVIDES WELLNESS CHALLENGES FOR EMPLOYEES TO PARTICIPATE IN

2) REQUIRE THE PARTNERING SMALL BUSINESS TO PROVIDE PRIZES/AWARDS FOR ITS STAFF THAT WINS THE CHALLENGES

DETERMINANTS OF HEALTH

GOAL: REDUCE THE BURDEN OF POVERTY IN CECIL COUNTY TO IMPROVE THE OVERALL HEALTH OF CECIL COUNTY RESIDENTS

OBJECTIVE: BY OCTOBER 30, 2016, RESEARCH EXISTING AND NEW OR INNOVATIVE ANTI- POVERTY PROGRAMS/INITIATIVES FOR IMPLEMENTATION IN CECIL COUNTY

STRATEGIES:

1) GET INFORMATION ON THE ANTI-POVERTY PROGRAM RECENTLY PRESENTED AT THE BHA CHILD/ADOLESCENT CONFERENCE

2) IDENTIFY & RESEARCH EXISTING ANTI-POVERTY PROGRAMS IN THE COUNTY

3) COLLECT INFORMATION FROM FAITH-BASED ANTI-POVERTY INITIATIVES

4) INVESTIGATE CARROLL COUNTY'S PROGRAM MODEL

5) REVIEW ALL OPTIONS AS A GROUP

GOAL: REDUCE THE PREVALENCE OF HOMELESSNESS IN CECIL COUNTY TO IMPROVE THE OVERALL HEALTH OF THE COMMUNITY AND ITS RESIDENTS

OBJECTIVE: BY JUNE 2018, EXPAND SERVICES AND INTERVENTIONS FOR HOMELESS INDIVIDUALS/FAMILIES TO DECREASE PREVALENCE OF HOMELESSNESS IN CECIL COUNTY BY 10%. SERVICES/INTERVENTIONS WILL BE BASED ON THREE TIERS, INCLUDING 1) EMERGENCY/IMMEDIATE ASSISTANCE, 2) INTERMEDIATE/SHORT-TERM ASSISTANCE, 3) LONGER-TERM ASSISTANCE GEARED TOWARD THOSE EXPERIENCING CHRONIC HOMELESSNESS.

STRATEGIES:

1) IMPLEMENT A COUNTY-WIDE COORDINATED ASSESSMENT SYSTEM FOR EFFICIENT LINKAGE TO SERVICES AND HOUSING OPTIONS FOR ALL.

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

2) PARTICIPATE IN TECHNICAL ASSISTANCE FROM HUD TO DEVELOP A BY-NAME LIST TO END VETERAN'S HOMELESSNESS.

3) SEEK FUNDING FOR OR DEVELOP CASE MANAGEMENT/HOUSING SEARCH SERVICES WHOSE SOLE ELIGIBILITY CRITERIA IS THAT OF BEING HOMELESS.

4) EXPLORE THE POSSIBILITY OF A MULTIDISCIPLINARY MEETING TO REVIEW THOSE AT RISK OF HOMELESSNESS OR THOSE WITH COMPLEX HOUSING NEEDS.

5) CREATE THE AVAILABILITY OF 24-HOUR RESOURCE ASSISTANCE TO PEOPLE EXPERIENCING HOMELESSNESS, INCLUING EMERGENCY SHELTER DURING EXTREME WEATHER EVENTS.

6) ESTABLISH LIASIONS BETWEEN LAW ENFORCEMENT AND PROVIDER AGENCIES

7) ESTABLISH A COMMUNITY FURNITURE BANK TO ASSIST THOSE TRANSITIONING FROM HOMELESSNESS BACK INTO STABLE HOUSING.

SOME HEALTH NEEDS WERE IDENTIFIED BUT NOT PRIORITIZED BY UHCC AS THERE ARE OTHERS IN THE AREA THAT ARE MORE SUITED TO MEET THEM SUCH AS DENTAL HEALTH, PROBLEM GAMBLING, & INFECTIOUS DISEASE.

UNION HOSPITAL OF CECIL COUNTY, INC.

PART V, LINE 16A, FAP WEBSITE:

HTTPS://WWW.UHCC.COM/ABOUT-US/PATIENTS-GUESTS/ADMISSION-TO-THE-HOSPITAL/FIN

UNION HOSPITAL OF CECIL COUNTY, INC.

PART V, LINE 16B, FAP APPLICATION WEBSITE:

HTTPS://WWW.UHCC.COM/ABOUT-US/PATIENTS-GUESTS/ADMISSION-TO-THE-HOSPITAL/FIN

UNION HOSPITAL OF CECIL COUNTY, INC.

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

HTTPS://WWW.UHCC.COM/ABOUT-US/PATIENTS-GUESTS/ADMISSION-TO-THE-HOSPITAL/FIN

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 16I: INFORMATION ABOUT OUR FAP APPLICATION IS PLACED IN THE LOCAL NEWSPAPER TWO TIMES PER YEAR TO NOTIFY THE PUBLIC OF AVAILABILITY OF FINANCIAL ASSISTANCE.

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 22D: MARYLAND IS AN ALL-PAYOR STATE AND THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) SETS THE RATES FOR UNION HOSPITAL.

Part V **Facility Information** *(continued)*

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 0

Name and address	Type of Facility (describe)

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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.

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 $6,826,331.

PART II, COMMUNITY BUILDING ACTIVITIES:

ECONOMIC DEVELOPMENT (F2)

IN FISCAL YEAR 2016, UNION HOSPITAL SUPPORTED THE FOLLOWING ECONOMIC DEVELOPMENT ORGANIZATIONS IN CECIL COUNTY:

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 PARTNERS. UNION HOSPITAL COLLABORATES WITH THIS COMMISSION TO PROMOTE STABILITY WITHIN THE

Part VI **Supplemental Information** *(Continuation)*

HOSPITAL'S WORKFORCE AND TO BRING MUCH NEEDED PRACTITIONERS TO THE AREA, ESPECIALLY WHERE THERE ARE TOO FEW PROVIDERS OR IDENTIFIED SERVICE GAPS. UNION HOSPITAL'S EXECUTIVE MANAGEMENT STAFF ATTEND BOARD MEETINGS.

2) ELKTON ALLIANCE - ELKTON ALLIANCE WORKS TOGETHER WITH THE LOCAL GOVERNMENT AND BUSINESS COMMUNITIES TO RESTORE, PROMOTE, AND MAINTAIN THE DIVERSE HISTORIC DOWNTOWN ELKTON 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 COMMUNITY DEVELOPMENT ISSUES. UNION HOSPITAL'S EXECUTIVE MANAGEMENT STAFF ATTEND BOARD MEETINGS.

3) CECIL COUNTY SCHOOL EMPLOYEES FEDERAL CREDIT UNION BOARD - THE CREDIT UNION'S BOARD PROMOTES FINANCIAL LITERACY AND EDUCATION FOR ITS MEMBERS AND FOR LOCAL ELEMENTARY SCHOOL STUDENTS, WHICH CONTRIBUTES TO REDUCING FINANCIAL BARRIERS THAT CAN BE EXACERBATED BY SOCIAL DETERMINANTS OF HEALTH. UNION HOSPITAL FINANCE STAFF ATTEND BOARD MEETINGS.

LEADERSHIP DEVELOPMENT AND TRAINING FOR COMMUNITY MEMBERS (F5)

IN FISCAL YEAR 2016, UNION HOSPITAL SUPPORTED THE FOLLOWING LEADERSHIP DEVELOPMENT AND TRAINING EFFORTS IN CECIL COUNTY:

1) CECIL LEADERSHIP INSTITUTE - THE CECIL LEADERSHIP INSTITUTE (CLI) IS HOSTED BY CECIL COLLEGE AND PROVIDES A FRAMEWORK WHERE EXISTING AND EMERGING LEADERS IN BUSINESS, GOVERNMENT, AND TOURISM ENGAGE, COLLABORATE, AND COMMIT TO CECIL COUNTY'S ONGOING DEVELOPMENT. UNION HOSPITAL PARTNERS WITH CECIL COLLEGE TO PROVIDE A LEARNING ENVIRONMENT AT THE HOSPITAL FOR CLI PARTICIPANTS. PARTICIPANTS ENGAGE WITH HEALTH CARE PROFESSIONALS THROUGH QUESTION AND ANSWER SESSIONS, PRESENTATIONS BY HOSPITAL LEADERSHIP STAFF, AND TOURS OF THE DIFFERENT HOSPITAL SERVICE LINES, PROGRAMS, AND

Part VI **Supplemental Information** *(Continuation)*

MODALITIES.

2) PROFESSIONAL DEVELOPMENT FOR CECIL COUNTY PUBLIC SCHOOLS NURSING STAFF - UNION HOSPITAL'S AFFINITY HEALTH INSTITUTE (AHI) UTILIZES ITS CLINICAL EDUCATION STAFF TO PROVIDE NURSING SKILLS REFRESHERS AND LEADERSHIP TRAININGS FOR COMMUNITY ORGANIZATIONS. IN FISCAL YEAR 2016, AHI STAFF MET WITH THE NURSING COORDINATOR FOR CECIL COUNTY PUBLIC SCHOOLS (CCPS) TO BEGIN A CONVERSATION AROUND HOW UNION HOSPITAL COULD PROVIDE LEADERSHIP DEVELOPMENT TOOLS THAT COULD BE FACILITATED THROUGH WORKSHOPS DURING CCPS PROFESSIONAL DEVELOPMENT DAYS. LEADERSHIP DEVELOPMENT AND TRAINING SUPPORT FROM THE HOSPITAL'S CLINICAL EDUCATION TEAM WILL ESTABLISH AND GROW CLINICAL AND LEADERSHIP COMPETENCIES FOR CCPS NURSES AND WILL SET A PRECEDENCE FOR THIS TYPE OF SUPPORT FOR FUTURE COMMUNITY PARTNERS SEEKING GUIDANCE.

WORKFORCE DEVELOPMENT (F8)

IN FISCAL YEAR 2016, UNION HOSPITAL SUPPORTED THE FOLLOWING WORKFORCE DEVELOPMENT PROGRAMS/ENTITIES IN CECIL COUNTY:

1) HIGH SCHOOL WORK ENRICHMENT PROGRAM - UNION HOSPITAL FOOD SERVICES STAFF MENTORED 140 DEVELOPMENTALLY DISABLED HIGH SCHOOL STUDENTS FROM ELKTON HIGH SCHOOL AND PERRYVILLE HIGH SCHOOL AS PART OF THE HIGH SCHOOL WORK ENRICHMENT PROGRAM, A PARTNERSHIP PROGRAM BETWEEN UNION HOSPITAL AND CECIL COUNTY PUBLIC HIGH SCHOOLS. THIS PROGRAM PROVIDES FOOD SERVICES WORK ASSIGNMENTS AND TRAINING FOR DEVELOPMENTALLY-DISABLED STUDENTS, LIKE DEVELOPING SKILLS FOR FOOD PREPARATION AND FOOD SANITATION. THE PROGRAM PROVIDES DIRECTION AND IMPORTANT LIFE SKILLS, ALLOWING STUDENTS TO FEEL NEEDED, USEFUL, AND CAPABLE WITHIN A BUSY WORK ENVIRONMENT. STUDENTS LEARN THE VALUE OF PRODUCTIVITY AND TASK COMPLETION AND WORK INDIVIDUALLY AND AS PART OF A TEAM.

Part VI **Supplemental Information** *(Continuation)*

2) SUSQUEHANNA WORKFORCE BOARD - SUSQUEHANNA WORKFORCE IS A NON-PROFIT ORGANIZATION THAT PLANS WORKFORCE DEVELOPMENT PROGRAMS AND SERVICES FOR INDIVIDUALS AND BUSINESSES IN CECIL AND HARFORD COUNTIES. UNION HOSPITAL'S EXECUTIVE MANAGEMENT STAFF ATTEND BOARD MEETINGS.

3) PHYSICIAN RECRUITMENT - RECRUITMENT COSTS WERE REPORTED IN FISCAL YEAR 2016 FOR HOSPITAL OUTPATIENT SERVICES THAT BRIDGED ACCESS TO HEALTH CARE SERVICE GAPS IN CECIL COUNTY. THESE HOSPITAL OUTPATIENT SERVICES INCLUDED: ENDOCRINOLOGY, PULMONOLOGY, FAMILY MEDICINE, AND PSYCHIATRY.

PART III, LINE 2:

THE COSTING METHODOLOGY USED IN DETERMINING BAD DEBT EXPENSE AT COST IS BAD DEBT EXPENSE TIMES THE COST TO CHARGE RATIO.

PART III, LINE 3:

THE METHODOLOGY ASSUMES THAT THE PERCENTAGE OF CHARITY CARE TO TOTAL REVENUE CAN BE APPLIED TO THE AMOUNT OF BAD DEBT EXPENSE (AT COST) FOR THE YEAR. UNION HOSPITAL OF CECIL COUNTY PROVIDES CARE TO ALL PATIENTS WHO NEED IT, REGARDLESS OF THEIR ABILITY TO PAY. THIS IS PART OF THE HOSPITAL'S MISSION.

PART III, LINE 4:

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. IN EVALUATING THE COLLECTABILITY OF PATIENT ACCOUNTS RECEIVABLE, THE HOSPITAL ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR

Part VI **Supplemental Information** *(Continuation)*

DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE (WHICH INCLUDES PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HOSPITAL ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY. FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS, THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE BILLED RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

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

Part VI **Supplemental Information** *(Continuation)*

ORDER TO DETERMINE ELIGIBILITY FOR CHARITY CARE PER POLICY. WITHIN 2 BUSINESS DAYS FOLLOWING A PATIENT'S REQUEST FOR CHARITY CARE SERVICES THE HOSPITAL WILL MAKE A CONDITIONAL DETERMINATION OF PROBABLE ELIGIBILITY. FINAL DETERMINATION WILL BE MADE BASED UPON A COMPLETED AND ACCURATE APPLICATION. PATIENTS WILL BE NOTIFIED VIA LETTER INDICATING THE LEVEL AT WHICH THE APPLICATION WAS APPROVED OR THE REASON FOR DENIAL. ANY PORTION OF THE PATIENT'S BALANCE THAT DOES NOT MEET THE GUIDELINES/QUALIFY FOR FINANCIAL ASSISTANCE DISCOUNT, WILL FOLLOW THE HOSPITAL'S NORMAL COLLECTION PROCESS INCLUDING 3 PATIENT ACCOUNT STATEMENTS. AFTER 90 DAYS, IF STILL UNPAID, THE BALANCE IS TRANSFERRED TO OUR COLLECTIONS AGENCY.

PART VI, LINE 2:

THE CHNA REFLECTS THE CURRENT STATUS OF THE MEDICAL AND SOCIAL DETERMINANTS OF HEALTH FOR CECIL COUNTY AND PROVIDES QUALITATIVE FEEDBACK ON KEY HEALTH ISSUES. THE CHNA IS COMPRISED OF AN ANALYSIS OF BOTH PRIMARY AND SECONDARY DATA. PRIMARY DATA WAS TAKEN FROM RESULTS FROM AN ONLINE COMMUNITY SURVEY CONDUCTED WITH ADULT (AGED 18 YEARS OR OLDER) CECIL COUNTY RESIDENTS AND THREE FOCUS GROUPS CONDUCTED WITH COMMUNITY RESIDENTS. SECONDARY DATA WAS TAKEN FROM A VARIETY OF RELIABLE NATIONAL AND LOCAL DATA SOURCES (LOCAL DATA WAS COMPARED, WHEN POSSIBLE, AGAINST STATE AND NATIONAL TRENDS). IN ADDITION, TWO COMMUNITY HEALTH ADVISORY COMMITTEE (CHAC) MEETINGS WERE HELD TO HELP SELECT THE HEALTH PRIORITIES FOR CECIL COUNTY AND BEGIN FORMATION OF STRATEGIES TO ADDRESS THEM. THE CHNA WAS CONDUCTED FROM QUARTER 3 OF FISCAL YEAR 2015 THROUGH QUARTER 3 OF FISCAL YEAR 2016. THE CHNA PROCESS REFLECTS COLLABORATION OF COMMUNITY PARTNERS WORKING TOGETHER TO ACHIEVE THE SAME HEALTH IMPROVEMENT GOALS FOR CECIL COUNTY.

Part VI **Supplemental Information** *(Continuation)*

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 FINANCIAL ASSISTANCE POLICY (FAP) TO ENSURE THAT THE HOSPITAL'S STAFF FOLLOWS A CONSISTENT AND EQUITABLE PROCESS IN GRANTING FINANCIAL ASSISTANCE TO PATIENTS, WHILE RESPECTING THE INDIVIDUAL'S DIGNITY. THE POLICY IS IN AGREEMENT WITH THE ESTABLISHED MARYLAND STATE FINANCIAL ASSISTANCE GUIDELINES. IN FACT, IN FISCAL YEAR 2015, UNION HOSPITAL'S FINANCE DEPARTMENT DIVISIONS OF MANAGED CARE, REVENUE CYCLE, AND BILLING BEGAN WORKING ON CHANGES TO THE FAP TO REFLECT THE ACA'S HEALTH CARE COVERAGE EXPANSION OPTION EFFECTIVE JANUARY 1, 2014. THE RESULTING REVISED FAP IS MORE COMPREHENSIVE IN THAT IT INCLUDES MORE DESCRIPTIONS, PATIENT EXPECTATIONS, AND CONTENT THAT IS EASY TO FOLLOW AND DIGEST. NEW SECTIONS THAT GIVE THE FAP MORE DEPTH INCLUDE: DEFINITIONS, SCOPE, PRESUMPTIVE ELIGIBILITY, ELIGIBILITY PERIOD, RECONSIDERATION OF DENIAL OF FREE OR REDUCED-COST CARE, MEDICAL DEBT DETERMINATION (LIMIT ON CHARGES), ACTION IN THE EVENT OF NON-PAYMENT, ENSURING COMPLIANCE, PLAIN LANGUAGE SUMMARY, AND REFERENCES.

THE FAP CLEARLY DEFINES PATIENT EXPECTATIONS, OFFERS A STEP-BY-STEP PROCESS FOR PATIENT APPLICATION, DOCUMENT REVIEW, AND REQUEST FOR MORE INFORMATION. ANY INDIVIDUAL WHO PRESENTS TO UNION HOSPITAL IN PERSON TO DISCUSS HIS/HER BILL IS PROVIDED WITH A FINANCIAL ASSISTANCE APPLICATION. ALL INPATIENT, SELF-PAY PATIENTS ARE VISITED BY FINANCIAL ASSISTANCE NAVIGATORS AND ARE 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

Part VI **Supplemental Information** *(Continuation)*

INCLUDES NOTICE OF THE FINANCIAL ASSISTANCE PROGRAM AND A DESIGNATED CONTACT TELEPHONE NUMBER AND EMAIL. PATIENT BILLING ALSO INCLUDES INFORMATION ON HOW TO APPLY FOR FINANCIAL ASSISTANCE.

THE FINANCIAL ASSISTANCE APPLICATION IS AVAILABLE TO ALL UNDERINSURED AND UNINSURED PATIENTS OF UNION HOSPITAL. ALL FINANCIAL ASSISTANCE APPLICATIONS RECEIVED ARE PROCESSED FOR ELIGIBILITY. PATIENTS WHO ARE NOT ELIGIBLE FOR FINANCIAL ASSISTANCE ARE REFERRED TO THE CECIL COUNTY HEALTH DEPARTMENT, OTHER STATE PROGRAMS, THE MARYLAND HEALTH CONNECTION, AND MEDICAID TO DETERMINE IF OTHER ASSISTANCE IS AVAILABLE.

FINANCIAL ASSISTANCE APPLICATIONS AND FAP SIGNAGE ARE LOCATED THROUGHOUT THE HOSPITAL, EMERGENCY ROOM, AND OUTPATIENT AREAS. THE FINANCIAL ASSISTANCE APPLICATION AND BROCHURE (ENGLISH AND SPANISH) ARE AVAILABLE ON THE HOSPITAL'S WEBSITE: HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/. IN ADDITION, UNION HOSPITAL PLACES AN ADVERTISEMENT ONCE A YEAR IN THE LOCAL NEWSPAPERS OUTLINING THE FAP, HOW TO ACCESS FINANCIAL ASSISTANCE MATERIALS, AND HOW TO APPLY FOR FINANCIAL ASSISTANCE.

PART VI, LINE 4:

UNION HOSPITAL IS THE ONLY HOSPITAL IN CECIL COUNTY AND SERVES THE ENTIRE COUNTY. THEREFORE, THE HOSPITAL'S COMMUNITY BENEFIT SERVICE AREA (CBSA) IS INCLUSIVE OF THE HOSPITAL'S PRIMARY AND SECONDARY SERVICE AREAS. THE PRIMARY SERVICE AREAS INCLUDE ELKTON, NORTH EAST, CHILDS, ELK MILLS, CHESAPEAKE CITY, CHARLESTOWN, RISING SUN, WARWICK, CECILTON, & EARLEVILLE. THE SECONDARY SERVICE AREAS INCLUDE PERRYPOINT, PERRYVILLE, PORT DEPOSIT, COLORA, CONOWINGO, & GEORGETOWN.

Part VI **Supplemental Information** *(Continuation)*

A MAJORITY OF UNION HOSPITAL'S COMMUNITY BENEFIT RESOURCES ARE FOCUSED WITHIN ELKTON (21921) AND NORTH EAST (21901) - HOSPITAL UTILIZATION SHOWS THAT 60% OF THE HOSPITAL'S PATIENTS COME FROM ELKTON AND NORTH EAST. DATA FOR OVERUTILIZATION OF THE HOSPITAL'S EMERGENCY DEPARTMENT AND READMISSIONS ALSO CORROBORATE THAT A MAJORITY OF HOSPITAL UTILIZATION COMES FROM ELKTON AND NORTH EAST.

GEOGRAPHY PLAYS A SIGNIFICANT ROLE IN VULNERABILITY AND POVERTY IN CECIL COUNTY. THERE IS POVERTY IN THE MORE RURAL AREAS, LIKE CONOWINGO, EARLEVILLE, AND CECILTON, BUT ALSO IN ELKTON WHICH IS MORE URBAN-RURAL. IN ADDITION, PEOPLE THAT RESIDE IN THE AREAS BELOW THE C & D CANAL (WARWICK, CHESAPEAKE CITY, CECILTON, EARLEVILLE, AND GEORGETOWN) AND WEST OF NORTH EAST (PERRY POINT, PERRYVILLE, PORT DEPOSIT, CHARLESTOWN, COLORA, AND CONOWINGO) OFTEN HAVE THE MOST DIFFICULTY ACCESSING SERVICES BECAUSE OF THE DISTANCE NEEDED TO TRAVEL TO THE NEAREST SERVICE PROVIDER AND THE LACK OF RELIABLE TRANSPORTATION.

THE ESTIMATED TOTAL POPULATION OF CECIL COUNTY IN 2014 WAS 101,803 PEOPLE. OF THE TOTAL COUNTY POPULATION, 50.3% WAS FEMALE AND 49.7% WAS MALE. THE MEDIAN AGE WAS 39.7 YEARS.

IN 2014, THE ESTIMATED RACIAL MAKE-UP OF CECIL COUNTY WAS:

- WHITE: 89.3%
- BLACK/AFRICAN AMERICAN: 6.9%
- AMERICAN INDIAN/ALASKAN NATIVE: 0.2%
- ASIAN: 1.3%
- NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER: 0%

Part VI **Supplemental Information** *(Continuation)*

- OTHER: 0.7%

- 2+ RACES: 1.6%

IN 2014 IT WAS ESTIMATED THAT 96% OF CECIL COUNTY WAS NON-HISPANIC/LATINO WITH 96% OF THE ADULT POPULATION SPEAKING ENGLISH AS A FIRST LANGUAGE (US CENSUS BUREAU, 2010-2014 AMERICAN COMMUNITY SURVEY 5-YEAR ESTIMATES).

IN 2015, THE MEDIAN HOUSEHOLD INCOME WAS ESTIMATED TO BE $70,676. IN 2015, IT WAS ESTIMATED THAT 6.7% OF FAMILIES LIVED BELOW THE POVERTY LEVEL. THESE ESTIMATES ALSO SHOWED THAT 4.5% OF THE POPULATION IN CECIL COUNTY WAS UNINSURED AND 32.1% RECEIVED MEDICAID (US CENSUS BUREAU, 2015 AMERICAN COMMUNITY SURVEY 1-YEAR ESTIMATES).

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, ESPECIALLY SERVING UNDERSERVED AREAS AND VULNERABLE POPULATIONS. THE FOLLOWING IS A SUMMARY OF THE COMMUNITY BENEFIT ACTIVITIES, PROGRAMS, AND INITIATIVES THAT UNION HOSPITAL PROVIDED IN CECIL COUNTY DURING FISCAL YEAR 2016:

A1: COMMUNITY HEALTH EDUCATION

UNION HOSPITAL STAFF PROVIDED:

- A VARIETY OF HEALTH EDUCATION PRESENTATIONS AND ACTIVITIES IN THE COMMUNITY

- FREE BASIC LIFE SUPPORT (BLS) INSTRUCTION IN THE COMMUNITY

- EXPLORER POST AT UNION HOSPITAL FOR HIGH SCHOOL STUDENTS SEEKING

Part VI **Supplemental Information** *(Continuation)*

EXPOSURE TO MEDICAL OR HEALTH SCIENCE EXPERIENCES

- SUPPORT GROUPS FOR VARIOUS HEALTH NEEDS

- HEALTH FAIRS IN THE COMMUNITY

- HEALTH LITERACY ACTIVITIES IN PARTNERSHIP WITH THE LOCAL LIBRARY AND HEALTH DEPARTMENT

A2: COMMUNITY-BASED CLINICAL SERVICES

UNION HOSPITAL STAFF PROVIDED:

- FREE SCREENINGS FOR SKIN CANCER, PROSTATE CANCER, AND DIABETES

- FREE SPORTS PHYSICALS CLINIC FOR COUNTY PUBLIC AND PRIVATE HIGH SCHOOL STUDENTS

A3: HEALTH CARE SUPPORT SERVICES

UNION HOSPITAL STAFF PROVIDED:

- INTERPRETING SERVICES BEYOND THE STANDARD OF CARE (FACILITATED THROUGH THE HOSPITAL'S QUALIFIED BILINGUAL STAFF PROGRAM)

- DEVELOPED/IMPLEMENTED ACCESS TO THE TOBACCO CESSATION SERVICE ASSISTANCE FOR PREGNANT WOMEN THROUGH THE PREGNANCY AND TOBACCO CESSATION HELP (PATCH) GRANT ACTIVITIES (FACILITATED IN PARTNERSHIP WITH CECIL COUNTY HEALTH DEPARTMENT'S DIVISION OF HEALTH PROMOTIONS)

- PROVIDED MEDICAL EXAMINATIONS FOR ABUSED CHILDREN IN CONJUNCTION WITH DEPARTMENT OF SOCIAL SERVICES AND THE CECIL COUNTY CHILD ADVOCACY CENTER

UNION HOSPITAL:

- SUPPORTED THE PEER RECOVERY ADVOCATE PROGRAM PARTNERSHIP BETWEEN THE ALCOHOL AND DRUG RECOVERY CENTER AT CECIL COUNTY HEALTH DEPARTMENT AND

Part VI **Supplemental Information** *(Continuation)*

UNION HOSPITAL'S EMERGENCY DEPARTMENT AND PSYCH UNIT/CRISIS

- PROVIDED TRANSPORTATION DONATIONS FOR ELIGIBLE PATIENTS AND THEIR FAMILIES

- PROVIDED ACCESS TO PEDIATRIC PATIENT BEHAVIORAL HEALTH RESOURCES FOR PRIMARY CARE PROVIDERS THROUGH B-HIPP SERVICES

A4: SOCIAL AND ENVIRONMENTAL IMPROVEMENTS

UNION HOSPITAL STAFF:

- PARTICIPATED IN TWO BUILD DAYS WITH HABITAT-FOR-HUMANITY

- MENTORED AT-RISK YOUTH WITH DISTRICT-PARTNERED SCHOOLS

- SUPPORTED THE HOSPITAL'S PARTNER IN EDUCATION, GILPIN MANOR ELEMENTARY SCHOOL, THROUGH DONATIONS, MENTOR SUPPORT, AND COMMUNITY HEALTH EDUCATION OPPORTUNITIES FOR FAMILIES

- SUPPORTED AT-RISK ADULTS BY OFFERING GED TUTORING THROUGH THE JUDY CENTER

B: HEALTH PROFESSIONS EDUCATION

UNION HOSPITAL STAFF PRECEPTED AND MENTORED STUDENTS THROUGH A VARIETY OF STUDENT EXPERIENCES FROM NURSING AND OTHER MEDICAL RESIDENCY AND CLINICAL ROTATIONS TO GRADUATE STUDENT INTERNSHIPS, ALLIED HEALTH STUDENT EXPERIENCES, AND HIGH SCHOOL TECHNOLOGY AND APPLIED SCIENCES PROGRAMS.

C: MISSION DRIVEN HEALTH SERVICES

UNION HOSPITAL PROVIDED THESE SERVICES TO MEET IDENTIFIED NEEDS IN THE COMMUNITY, EVEN THOUGH THEY OPERATE AT A LOSS:

- A FREE OSTOMY CLINIC (C3)

Part VI **Supplemental Information** *(Continuation)*

- EMPLOYED PHYSICIAN PRACTICE SUBSIDIES (C3)

- ADULT DAY SERVICES FOR OLDER ADULT CLIENTS WITH DEMENTIA AND OTHER NEUROLOGICAL DISORDERS (C7)

- FREE HOSPICE SUPPORT (C9)

D1: CLINICAL RESEARCH

UNION HOSPITAL MAINTAINED A CANCER REGISTRY THROUGH THE CANCER PROGRAM THAT WAS AVAILABLE TO HEALTH SERVICE PROVIDERS AND RESEARCHERS.

E1-3: FINANCIAL/IN-KIND CONTRIBUTIONS

UNION HOSPITAL STAFF PROVIDED DONATIONS OF TIME (STAFF HOURS) AND MONEY (EQUIPMENT/SUPPLIES DONATIONS) FOR THE CECIL COUNTY COMMUNITY BY:

- PROVIDING FREE AMBULANCE TRANSPORTS AND FREE SUPPLIES FOR AMBULANCE STOCK-UPS

- GIVING BLOOD AT HOSPITAL AND OTHER COMMUNITY BLOOD DRIVES AND OTHER LOCAL DONOR LOCATIONS

- FACILITATING THE COORDINATED APPROACH TO CHILD HEALTH (CATCH) KIDS CLUB IN THE AFTER-SCHOOL SETTING FOR YOUTH IN THE COMMUNITY TO INCREASE PHYSICAL ACTIVITY AND HEALTHY EATING HABITS

- ATTENDING MEETINGS FOR COMMUNITY HEALTH IMPROVEMENT (LOCAL HEALTH IMPROVEMENT COALITION, COMMUNITY BOARDS, ETC.)

- SERVING AND EDUCATING THE HOMELESS

- CONNECTING LOW-INCOME, PREGNANT WOMEN TO PRE- AND POST-NATAL RESOURCES

- PROVIDING FOOD FOR MINISTRIES, LIKE THE HOME DELIVERED MEALS PROGRAM IN PARTNERSHIP WITH THE CECIL COUNTY DEPARTMENT OF COMMUNITY SERVICES, LOCAL CHURCHES, AND OTHER LOW-INCOME AND POOR SERVING MINISTRIES

- PROVIDING FREE NOTARY SERVICES FOR THE COMMUNITY

- VOLUNTEERING WITH LOCAL ORGANIZATIONS TO PROVIDE A DIRECT IMPACT ON

Part VI **Supplemental Information** *(Continuation)*

COMMUNITY HEALTH

- MEETING WITH OTHER HOSPITAL AND COMMUNITY PARTNERS TO DEVELOP A COMMUNITY-BASED CARE COORDINATION HEALTH CARE DELIVERY MODEL TO MANAGE HIGH-RISK, MEDICARE CLIENTS IN THE COMMUNITY SETTING, IN ORDER TO CREATE PATIENT SELF-MANAGEMENT SKILLS, ESTABLISH SOLID SUPPORT LINKAGES BETWEEN PATIENTS AND PRIMARY CARE PROVIDERS, AND PREVENT OVERUTILIZATION OF THE EMERGENCY DEPARTMENT AND INPATIENT READMISSIONS (OFFSET BY GRANT DOLLARS)

J: FOUNDATION FUNDED COMMUNITY BENEFIT

THE UNION HOSPITAL FOUNDATION PROVIDED FUNDING FOR THE COMMUNITY ASSISTED MEDICATIONS PROGRAM (CAMP) WHICH PROVIDES REDUCED-COST MEDICATIONS TO PATIENTS THAT QUALIFY FOR HOSPITAL FINANCIAL ASSISTANCE.

PART VI, LINE 6:

UNION HOSPITAL OF CECIL COUNTY, INC. IS PART OF AN AFFILIATED HEALTH CARE SYSTEM IN WHICH AFFINITY HEALTH ALLIANCE, INC. (AHA) IS THE PARENT ENTITY. AHA'S PURPOSE IS TO SUPPORT THE UNION HOSPITAL OF CECIL COUNTY IN PROVIDING HEALTH CARE AND HEALTH CARE RELATED SERVICES THROUGH THE EFFECTIVE MANAGEMENT OF ALL AFFILIATED CORPORATIONS. SPECIFICALLY, THIS INVOLVES COORDINATING SYSTEM WIDE POLICIES, FUNDRAISING AND STRATEGIC PLANNING PROGRAMS TO PROVIDE HEALTH CARE SERVICES IN RESPONSE TO THE MEDICAL, HUMAN AND RELATED SERVICE NEEDS OF THE COMMUNITY.

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

THE FOUNDATION CONDUCTS AND SUPERVISES FUNDRAISING ACTIVITIES ON BEHALF OF

Part VI **Supplemental Information** *(Continuation)*

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

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

UNION HOSPITAL OF CECIL COUNTY VENTURES, INC. IS A FOR-PROFIT STOCK CORPORATION. ITS PURPOSE IS TO ENGAGE IN ANY BUSINESS OR TRANSACTION WHICH WILL BENEFIT THE ACTIVITIES AND GOALS OF ITS AFFILIATES. OPERATIONS CONSIST PRIMARILY OF PROVIDING MANAGEMENT SUPPORT SERVICES FOR PHYSICIAN PRACTICES AND PROVIDING IMAGING SERVICES TO PHYSICIANS AND HEALTH CENTERS THROUGH ITS WHOLLY OWNED SUBSIDIARIES, TRIANGLE ALIANCE LLC AND OPEN MRI AND IMAGING CENTER OF ELKTON LLC.

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" on Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

▶ **Information about Schedule I (Form 990) and its instructions is at *www.irs.gov/form990.***

OMB No. 1545-0047

2015

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? ..... [X] 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 Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on 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)	3,894,862.	0.			CHARITABLE ACTIVITIES
TRIANGLE HEALTH ALLIANCE, INC. (WHOLLY OWNED SUB OF UHCC VENTURES, INC.) - 106 BOW STREET - ELKTON, MD 21921	01-0789341		350,920.	0.			CAPITAL CONTRIBUTION
OPEN MRI & IMAGING CENTER, LLC. (WHOLLY OWNED SUB OF UHCC VENTURES, INC.) - 106 BOW STREET - ELKTON, MD 21921	20-2119977		222,478.	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 ..... ▶ 2.

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on 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.** Provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

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" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.**

▶ **Information about Schedule J (Form 990) and its instructions is at *www.irs.gov/form990.***

OMB No. 1545-0047

2015

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
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.		
	☐ First-class or charter travel ☐ Housing allowance or residence for personal use		
	☐ Travel for companions ☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments ☐ Health or social club dues or initiation fees		
	☒ Discretionary spending account ☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain **1b**	X	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a? **2**	X	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.		
	☒ Compensation committee ☐ Written employment contract		
	☒ Independent compensation consultant ☒ Compensation survey or study		
	☐ Form 990 of other organizations ☒ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:		
a	Receive a severance payment or change-of-control payment? **4a**		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b**	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement? **4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.		
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.		
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:		
a	The organization? **5a**		X
b	Any related organization? **5b**		X
	If "Yes" to line 5a or 5b, describe in Part III.		
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:		
a	The organization? **6a**		X
b	Any related organization? **6b**		X
	If "Yes" on line 6a or 6b, describe in Part III.		
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described on lines 5 and 6? If "Yes," describe in Part III **7**	X	
8	Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III **8**		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? **9**		

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

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that 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 in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) KENNETH S. LEWIS, MD, JD	(i)	0.	0.	0.	0.	0.	0.	0.
PRESIDENT & CEO (UNTIL 12/31/15)	(ii)	560,717.	0.	451,997.	228,248.	20,120.	1,261,082.	0.
(2) LAURIE R. BEYER, CPA	(i)	0.	0.	0.	0.	0.	0.	0.
SENIOR VP/CHIEF FINANCIAL OFFICER	(ii)	279,290.	75,877.	21,166.	63,149.	19,934.	459,416.	0.
(3) CYDNEY TEAL	(i)	0.	0.	0.	0.	0.	0.	0.
VP MEDICAL AFFAIRS	(ii)	300,783.	61,343.	24,935.	6,575.	13,788.	407,424.	0.
(4) DAVID GIPSON	(i)	0.	0.	0.	0.	0.	0.	0.
SENIOR VP/CHIEF OPERATING OFFICER	(ii)	114,117.	59,992.	42,096.	6,181.	10,520.	232,906.	0.
(5) KHADIJATU BOSTON	(i)	0.	0.	0.	0.	0.	0.	0.
SENIOR VP/CHIEF NURSING OFFICER	(ii)	183,009.	30,345.	13,553.	5,370.	1,741.	234,018.	0.
(6) TERRANCE LOVELL	(i)	192,040.	32,391.	16,277.	44,323.	19,160.	304,191.	0.
VP HUMAN RESOURCES	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) JUSTIN SAUSVILLE	(i)	387,630.	142,424.	20,486.	6,575.	20,455.	577,570.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) MICHAEL BASS	(i)	396,314.	28,096.	507.	3,975.	20,432.	449,324.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) ROGER WU	(i)	274,062.	122,219.	432.	6,575.	14,496.	417,784.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) OSCAR GALVIS	(i)	328,040.	45,500.	2,322.	6,575.	20,113.	402,550.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) EUGENIA GRAY	(i)	346,846.	16,875.	845.	3,975.	11,888.	380,429.	0.
PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

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

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) DEA REGISTRATION

E) 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

TERRENCE LOVELL, VP HUMAN RESOURCES

Part III Supplemental Information

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

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)

12/31/2013 - $108,000 (DR. KENNETH LEWIS)

12/31/2014 - $108,000 (DR. KENNETH LEWIS)

12/31/2015 - $216,000 (DR. KENNETH LEWIS)

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

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

12/31/2013 - $59,861 (LAURIE BEYER)

12/31/2014 - $62,999 (LAURIE BEYER)

12/31/2015 - $56,574 (LAURIE BEYER)

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

Part III Supplemental Information

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

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

12/31/2013 - $60,606 (DAVID GIPSON)

12/31/2014 - $63,775 (DAVID GIPSON)

12/31/2014 - $38,993 (TERRANCE LOVELL)

12/31/2015 - $38,731 (TERRANCE LOVELL)

NO ONE RECEIVED A PAYMENT FROM THE PLAN IN CALENDAR YEAR 2015.

THE RIGHT TO RECEIVE PAYMENTS UNDER THE PLAN SHALL BE FORFEITED IN THE EVENT THAT EMPLOYMENT WITH THE HOSPITAL TERMINATES PRIOR TO THE VESTING DATE FOR ANY REASON OTHER THAN INVOLUNTARY TERMINATION WITHOUT CAUSE, DEATH, OR DISABILITY.

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.

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ Information about Schedule K (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047
2015
Open to Public Inspection

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	12/01/14	30,778,000.	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	180,000.	1,268,486.	2,096,631.	
2	Amount of bonds legally defeased				
3	Total proceeds of issue	30,778,000.	10,000,000.	8,662,336.	9,000,000.
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	30,778,000.	10,000,000.	8,662,336.	9,000,000.
12	Other unspent proceeds				
13	Year of substantial completion	2014	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

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ Information about Schedule K (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047
2015
Open to Public Inspection

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	3,603,523.	1,202,673.		
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		4,007,000.		
11	Other spent proceeds	9,924,000.			
12	Other unspent proceeds				
13	Year of substantial completion	2012	2012		

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X		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

		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				
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, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		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 "Yes" to 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								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								

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, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		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 "Yes" to 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		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		X		X
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		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		X		X	

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions).

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.** 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

PART I, COLUMN (F)
ISSUE A: TO REFINANCE THE 2005 BONDS.

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.

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.

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.

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

OMB No. 1545-0047

2015

Open to Public Inspection

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

Employer identification number: 52-0607945

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

AND THE SURROUNDING AREA.

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 5,763 ADMISSIONS PROVIDING 21,221 PATIENT DAYS TO INPATIENTS IN FISCAL YEAR 2016 OF WHICH:

1) PATIENTS COVERED UNDER THE MEDICARE PROGRAM WERE 2,888 ADMISSIONS AND 11,542 PATIENT DAYS

2) PATIENTS COVERED UNDER THE MEDICAID PROGRAM WERE 206 ADMISSIONS AND 886 PATIENT DAYS

3) PATIENTS COVERED UNDER THE MEDICAID HMO PROGRAM WERE 1,391 ADMISSIONS AND 4,597 PATIENT DAYS

4) PATIENTS COVERED UNDER THE MEDICARE HMO PROGRAM WERE 73 ADMISSIONS AND 275 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:

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

A) ADULT DAY CARE SERVICES FOR THE ELDERLY AND PHYSICALLY/MENTALLY 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 $7,726,157 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.

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

Employer identification number: 52-0607945

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

MANAGEMENT OF THE HOSPITAL REVIEWS THE 990 IN DETAIL BEFORE IT IS PRESENTED TO THE BOARD OF DIRECTORS OF THE ORGANIZATION. THE BOARD REVIEWS AND APPROVES THE FORM 990 PRIOR TO FILING WITH THE INTERNAL REVENUE SERVICE.

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

BOARD MEMBERS AND OFFICERS 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:

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

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 CONSULTANT AND COMPENSATION STUDIES OR SURVEYS, TO SET COMPENSATION. DURING 2015, 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	6,648,048.
MANAGEMENT AND GENERAL EXPENSES	337,364.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	6,985,412.

PHYSICIAN SERVICES AND FEES:

PROGRAM SERVICE EXPENSES	13,017,530.
MANAGEMENT AND GENERAL EXPENSES	280,528.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	13,298,058.

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

PURCHASED SERVICES:

PROGRAM SERVICE EXPENSES	1,531,510.
MANAGEMENT AND GENERAL EXPENSES	5,761.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,537,271.

AGENCY EMPLOYEES:

PROGRAM SERVICE EXPENSES	1,247,808.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,247,808.

TRANSCRIPTION:

PROGRAM SERVICE EXPENSES	217,113.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	217,113.

RECORD FILE STORAGE:

PROGRAM SERVICE EXPENSES	151,337.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	151,337.

CLEANING SERVICES:

PROGRAM SERVICE EXPENSES	5,575.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.

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

TOTAL EXPENSES	5,575.
BILLING & COLLECTIONS:	
PROGRAM SERVICE EXPENSES	445,777.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	445,777.
OTHER FEES:	
PROGRAM SERVICE EXPENSES	0.
MANAGEMENT AND GENERAL EXPENSES	1,710.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,710.
TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	23,890,061.
FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:	
CHANGE IN INTEREST IN NET ASSETS OF SUBSIDIARIES	-322,101.
NET ASSETS RELEASED FROM RESTRICTION	-32,786.
TOTAL TO FORM 990, PART XI, LINE 9	-354,887.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.

▶ Information about Schedule R (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2015

Open to Public Inspection

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" on Form 990, Part IV, line 33.

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? 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
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
UNION HOSPITAL OF CECIL COUNTY ONCOLOGY, INC. - 81-2662359, 106 BOW STREET, ELKTON, MD 21921	HEALTHCARE	MARYLAND	501(C)(2)	LINE 3	AFFINITY HEALTH ALLIANCE, INC.		X

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
UNION HOSPITAL OF CECIL COUNTY VENTURES, INC. - 52-1793691, 106 BOW STREET, ELKTON, MD 21921	MEDICAL SERVICES	MD	N/A	C CORP	N/A	N/A	N/A		X

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

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

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

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

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners sec. 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) NO	(k) Percentage ownership

Part VII **Supplemental Information**

Provide additional information for responses to questions on Schedule R (see instructions).

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

June 30, 2016

Prepared for	Union Hospital of Cecil County, Inc. 106 Bow Street Elkton, MD 21921-5596
Prepared by	Baker Tilly Virchow Krause, LLP 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, 2017
Special Instructions	The return should be signed and dated.

EXTENDED TO MAY 15, 2017

Form **990-T**

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

For calendar year 2015 or other tax year beginning JUL 1, 2015 , and ending JUN 30, 2016 .

▶ **Information about Form 990-T and its instructions is available at *www.irs.gov/form990t.***

▶ **Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).**

OMB No. 1545-0687

2015

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

Department of the Treasury
Internal Revenue Service

A ☐ Check box if address changed

B Exempt under section
☒ 501(c)(3)
☐ 408(e) ☐ 220(e)
☐ 408A ☐ 530(a)
☐ 529(a)

C Book value of all assets at end of year 188,348,000.

Print or Type

Name of organization (☐ Check box if name changed and see instructions.)
UNION HOSPITAL OF CECIL COUNTY, INC.

Number, street, and room or suite no. If a P.O. box, see instructions.
106 BOW STREET

City or town, state or province, country, and ZIP or foreign postal code
ELKTON, MD 21921-5596

D Employer identification number (Employees' trust, see instructions.)
52-0607945

E Unrelated business activity codes (See instructions.)
621500 541900

F Group exemption number (See instructions.) ▶

G Check organization type ▶ ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust

H Describe the organization's primary unrelated business activity. ▶ SEE STATEMENT 1

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
1a	Gross receipts or sales 2,036,970. b Less returns and allowances 143,143. c Balance ▶	1c	1,893,827.		
2	Cost of goods sold (Schedule A, line 7)	2			
3	Gross profit. Subtract line 2 from line 1c	3	1,893,827.		1,893,827.
4a	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	3,726.		3,726.
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 schedule)	12			
13	**Total.** Combine lines 3 through 12	13	1,897,553.		1,897,553.

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	562,912.
16	Repairs and maintenance			16	35,715.
17	Bad debts			17	25,820.
18	Interest (attach schedule)			18	
19	Taxes and licenses			19	
20	Charitable contributions (See instructions for limitation rules)			20	
21	Depreciation (attach Form 4562)	21	64,949.		
22	Less depreciation claimed on Schedule A and elsewhere on return	22a		22b	64,949.
23	Depletion			23	
24	Contributions to deferred compensation plans			24	
25	Employee benefit programs			25	95,598.
26	Excess exempt expenses (Schedule I)			26	
27	Excess readership costs (Schedule J)			27	
28	Other deductions (attach schedule) SEE STATEMENT 2			28	1,145,094.
29	**Total deductions.** Add lines 14 through 28			29	1,930,088.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13			30	-32,535.
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	-32,535.
33	Specific deduction (Generally $1,000, but see line 33 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	-32,535.

Part III Tax Computation

35	**Organizations Taxable as Corporations.** See instructions for tax computation. Controlled group members (sections 1561 and 1563) check here ▶ ☐ **See instructions** and:		
a	Enter your share of the $50,000, $25,000, and $9,925,000 taxable income brackets (in that order): (1) $ (2) $ (3) $		
b	Enter organization's share of: **(1)** Additional 5% tax (not more than $11,750) $ **(2)** Additional 3% tax (not more than $100,000) $		
c	Income tax on the amount on line 34 ▶	35c	0.
36	**Trusts Taxable at Trust Rates.** See instructions for tax computation. Income tax on the amount on line 34 from: ☐ Tax rate schedule or ☐ Schedule D (Form 1041) ▶	36	
37	**Proxy tax.** See instructions ▶	37	
38	Alternative minimum tax	38	
39	**Total.** Add lines 37 and 38 to line 35c or 36, whichever applies	39	0.

Part IV Tax and Payments

40a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	40a			
b	Other credits (see instructions)	40b			
c	General business credit. Attach Form 3800	40c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	40d			
e	**Total credits.** Add lines 40a through 40d			40e	
41	Subtract line 40e from line 39			41	0.
42	Other taxes. Check if from: ☐ Form 4255 ☐ Form 8611 ☐ Form 8697 ☐ Form 8866 ☐ Other (attach schedule)			42	
43	**Total tax.** Add lines 41 and 42			43	0.
44a	Payments: A 2014 overpayment credited to 2015	44a			
b	2015 estimated tax payments	44b			
c	Tax deposited with Form 8868	44c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	44d			
e	Backup withholding (see instructions)	44e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	44f			
g	Other credits and payments: ☐ Form 2439 ☐ Form 4136 ☐ Other Total ▶	44g			
45	**Total payments.** Add lines 44a through 44g			45	
46	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐			46	
47	**Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ▶			47	0.
48	**Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ▶			48	0.
49	Enter the amount of line 48 you want: **Credited to 2016 estimated tax** ▶ **Refunded** ▶			49	

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

		Yes	No
1	At any time during the 2015 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file FinCEN Form 114, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here ▶		X
2	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If YES, see instructions for other forms the organization may have to file.		X
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

1	Inventory at beginning of year	1		6	Inventory at end of year	6	
2	Purchases	2		7	**Cost of goods sold.** Subtract line 6 from line 5. Enter here and in Part I, line 2	7	
3	Cost of labor	3					
4a	Additional section 263A costs (att. schedule)	4a		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
b	Other costs (attach schedule)	4b					
5	**Total.** Add lines 1 through 4b	5					

Sign Here

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.

Signature of officer | Date | SR VP/CHIEF FINANCIAL OFFICER Title

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

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
JULIUS C. GREEN, CPA				P00350393

Firm's name ▶ BAKER TILLY VIRCHOW KRAUSE, LLP — Firm's EIN ▶ 39-0859910

Firm's address ▶ 1650 MARKET STREET, SUITE 4500 PHILADELPHIA, PA 19103 — 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 schedule)
	(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.	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) ▶ 0.

(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 schedule)	(b) Other deductions (attach schedule)
(1)			
(2)			
(3)			
(4)			

	4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5. Average adjusted basis of or allocable to debt-financed property (attach schedule)	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)			%		
				Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
Totals ▶				0.	0.
Total dividends-received deductions included in column 8 ▶					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)					
				Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).
Totals ▶				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 schedule)	4. Set-aside (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
Totals ▶	Enter here and on page 1, Part I, line 9, column (A). 0.			Enter here and on page 1, Part I, line 9, column (B). 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 ▶	Enter here and on page 1, Part I, line 10, col. (A). 0.	Enter here and on page 1, Part I, line 10, col. (B). 0.				Enter here and on page 1, Part II, line 26. 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) ▶	Enter here and on page 1, Part I, line 11, col. (A). 0.	Enter here and on page 1, Part I, line 11, col. (B). 0.				Enter here and on page 1, Part II, line 27. 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 DESCRIPTION OF ORGANIZATION'S PRIMARY UNRELATED BUSINESS ACTIVITY STATEMENT 1

LABORATORY SERVICES TO NON-PATIENTS
INCOME FROM PARTNERSHIPS

TO FORM 990-T, PAGE 1

FORM 990-T OTHER DEDUCTIONS STATEMENT 2

DESCRIPTION	AMOUNT
SUPPLIES	416,600.
PURCHASED SERVICES	232,445.
UTILITIES	972.
MINOR EQUIPMENT	1,847.
ACCREDITATION FEES	6,627.
EQUIPMENT RENTAL	8,537.
MISCELLANEOUS EXPENSE	16,197.
OVERHEAD ALLOCATION	461,759.
VEHICLE COSTS	83.
TRAVEL & CONFERENCE	27.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	1,145,094.

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 3

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
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.
06/30/13	571,243.	0.	571,243.	571,243.
06/30/14	788,791.	0.	788,791.	788,791.
06/30/15	344,190.	0.	344,190.	344,190.
NOL CARRYOVER AVAILABLE THIS YEAR			5,999,927.	5,999,927.

FORM 990-T INCOME (LOSS) FROM PARTNERSHIPS STATEMENT 4

PARTNERSHIP NAME	GROSS INCOME	DEDUCTIONS	NET INCOME OR (LOSS)
PREMIER HEALTHCARE ALLIANCE LP (EIN: 33-0387407)	3,741.	0.	3,741.
SECONDARY OPPORTUNITIES FUND II (EIN: 99-0383162)	2,908.	3,580.	-672.
BTAS 2015 PRIVATE INVESTORS US LP (EIN:	1,010.	353.	657.
TOTAL TO FORM 990-T, PAGE 1, LINE 5	7,659.	3,933.	3,726.

Form **5471**

(Rev. December 2015)

Department of the Treasury
Internal Revenue Service

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

▶ **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 , 2015, and ending DEC 31, 2015

OMB No. 1545-0704

Attachment Sequence No. **121**

Name of person filing this return

UNION HOSPITAL OF CECIL COUNTY, INC.

A **Identifying number**

52-0607945

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

106 BOW STREET

B Category of filer (See instructions. Check applicable box(es)):

1 (repealed) 2 ☐ 3 ☐ 4 ☐ 5 ☒

City or town, state, and ZIP code

ELKTON, MD 21921-5596

C Enter the total percentage of the foreign corporation's voting stock you owned at the end of its annual accounting period 20.00 %

Filer's tax year beginning JUL 1 , 2015 , and ending JUN 30 , 2016

D Check if any excepted specified foreign financial assets are reported on this form (see instructions) ☐

E 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 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	**e** Principal place of business	**f** Principal business activity code number	**g** Principal business activity	**h** Functional currency
12/14/04	CAYMAN ISLANDS	525990	OTHER INSURANC	UNITED STATES,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

ARTEX RISK SOLUTIONS (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

SEE STATEMENT 5 SEE STATEMENT 6

Schedule B U.S. Shareholders of Foreign Corporation

(a) Name, address, and identifying number of shareholder	(b) Description of each class of stock held by shareholder. **Note:** This description should match the corresponding description entered in Schedule A, column (a).	(c) Number of shares held at beginning of annual accounting period	(d) Number of shares held at end of annual accounting period	(e) Pro rata share of subpart F income (enter as a percentage)

Schedule C Income Statement

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

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

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? If "Yes," see the instructions for required statement.		X
2	During the tax year, did the foreign corporation own an interest in any trust?		X
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? If "Yes," you are generally required to attach Form 8858 for each entity (see instructions).		X
4	During the tax year, was the foreign corporation a participant in any cost sharing arrangement?		X
5	During the course of the tax year, did the foreign corporation become a participant in any cost sharing arrangement?		X
6	During the tax year, did the foreign corporation participate in any reportable transaction as defined in Regulations section 1.6011-4? If "Yes," attach Form(s) 8886 if required by Regulations section 1.6011-4(c)(3)(i)(G).		X
7	During the tax year, did the foreign corporation pay or accrue any foreign tax that was disqualified for credit under section 901(m)?		X
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?		X

Schedule H Current Earnings and Profits

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

		Net Additions	Net Subtractions		
1	Current year net income or (loss) per foreign books of account			1	
2	Net adjustments made to line 1 to determine current earnings and profits according to U.S. financial and tax accounting standards (see instructions):				
a	Capital gains or losses	863,021.			
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) STATEMENT 7	2,512,048.	4,640,917.		
3	Total net additions	3,375,069.			
4	Total net subtractions		4,640,917.		
5a	Current earnings and profits (line 1 plus line 3 minus line 4)			5a	-1,265,848.
b	DASTM gain or (loss) for foreign corporations that use DASTM			5b	
c	Combine lines 5a and 5b			5c	-1,265,848.
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	-1,265,848.

Enter exchange rate used for line 5d ▶ 1.000000

Schedule I Summary of Shareholder's Income From Foreign Corporation

If item E 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	

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

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

FORM 5471 AMOUNT AND TYPE OF INDEBTEDNESS OF FOREIGN CORPORATION TO THE RELATED PERSONS DESCRIBED IN REGULATIONS SECTION 1.6046-1(B)(11) STATEMENT 5

AMOUNT	DESCRIPTION
	N/A

FORM 5471 NAME, ADDRESS, IDENTIFYING NUMBER AND NUMBER OF SHARES SUBSCRIBED TO BY EACH SUBSCRIBER TO THE STOCK OF THE FOREIGN CORPORATION STATEMENT 6

NAME AND ADDRESS	IDENTIFYING NUMBER	NUMBER OF SHARES
N/A		

FORM 5471 OTHER NET ADJUSTMENTS STATEMENT 7

DESCRIPTION	NET ADDITIONS	NET SUBTRACTIONS
RELATED PARTY PREMIUMS		4,640,917.
REL. PARTY LOSS RESERVE/CLAIMS PD	2,512,048.	
TOTAL TO 5471, PAGE 4, SCHEDULE H, LINE 2H	2,512,048.	4,640,917.

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	-9,904,574.					-9,904,574.
2a Current year E&P						
b Current year deficit in E&P	1,265,848.					
3 Total current and accumulated E&P not previously taxed (line 1 plus line 2a **or** line 1 minus line 2b)	-11,170,422.					
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)	-11,170,422.					
7 Balance at end of year. (Enter amount from line 6a or line 6b, whichever is applicable.)	-11,170,422.					-11,170,422.

LHA **For Paperwork Reduction Act Notice, see the Instructions for Form 5471.** **Schedule J (Form 5471)** (Rev. 12-2012)

512421
04-01-15

Form **926**
(Rev. December 2013)
Department of the Treasury
Internal Revenue Service

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

▶ **Information about Form 926 and its separate instructions is at *www.irs.gov/form926.***
▶ **Attach to your income tax return for the year of the transfer or distribution.**

OMB No. 1545-0026

Attachment Sequence No. **128**

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

Name of transferor
UNION HOSPITAL OF CECIL COUNTY, INC.

Identifying number (see instructions)
52-0607945

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.

4a Identifying number, if any
98-0464065

5 Address (including country)
PO BOX 10233
GRAND CAYMAN, KY1-1002 CAYMAN ISLANDS

4b Reference ID number

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	07/01/2015		1,054,109.		
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 8

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 20.0000 % **(b)** After 20.0000 %

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)	☐ Yes	☒ No
b	Gain recognition under section 904(f)(5)(F)	☐ Yes	☒ No
c	Recapture under section 1503(d)	☐ Yes	☒ No
d	Exchange gain under section 987	☐ Yes	☒ No

12 Did this transfer result from a change in the classification of the transferee to that of a foreign corporation? ☐ Yes ☒ No

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	☐ Yes	☒ No
b	Depreciation recapture	☐ Yes	☒ No
c	Branch loss recapture	☐ Yes	☒ No
d	Any other income recognition provision contained in the above-referenced regulations	☐ Yes	☒ No

SEE STATEMENT 9

14 Did the transferor transfer assets which qualify for the trade or business exception under section 367(a)(3)? ☐ Yes ☒ No

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)? ☐ Yes ☒ No

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? ☒ Yes ☐ No

17 a Was intangible property (within the meaning of section 936(h)(3)(B)) transferred as a result of the transaction? ☐ Yes ☒ No

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

524533
04-01-15

FORM 926 STATEMENT 8

STATEMENT PURSUANT TO 1.351-3(A) BY UNION HOSPITAL OF CECIL COUNTY, INC., A SIGNIFICANT TRANSFEROR

(1)NAME AND EMPLOYER IDENTIFICATION NUMBER OF TRANSFEREE CORPORATION:
NAME: FREESTATE HEALTHCARE INSURANCE COMPANY, LTD.
EIN: 98-0464065

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

VARIOUS DATES BETWEEN JULY 1, 2015 AND JUNE 30, 2016

(3)AGGREGATE FAIR MARKET VALUE AND BASIS OF PROPERTY TRANSFERRED: FAIR MARKET VALUE: $1,054,109 (CASH)
BASIS: $1,054,109

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

FORM 926 ADDITIONAL INFORMATION REQUIRED BY TEMPORARY REGULATION SECTIONS 1.6038B-1T(C)(4)(III) AND (VII), AND 1.6038B-1T(C)(5) STATEMENT 9

1TRANSFEROR:
UNION HOSPITAL OF CECIL COUNTY, INC.
106 BOW STREET
ELKTON, MD 21921
EIN: 52-0607945

2(I) TRANSFEREE:
FREESTATE HEALTHCARE INSURANCE COMPANY, LTD.
PO BOX 10233
GRAND CAYMAN, KY1-1002, CAYMAN ISLANDS
EIN: 98-0464065
COUNTRY OF INCORPORATION: CAYMAN ISLANDS

ON VARIOUS DATES IN 2015, UNION HOSPITAL OF CECIL COUNTY MADE CONTRIBUTIONS TOTALLING USD 1,054,109 (HAVING A FAIR MARKET VALUE AND BASIS OF $1,054,109) TO THE CAPITAL OF FREESTATE HEALTHCARE INSURANCE COMPANY, LTD. NOTHING WAS RECEIVED IN CONSIDERATION IN EXCHANGE FOR DEEMED CASH CONTRIBUTIONS TO CAPITAL. UNION HOSPITAL OF CECIL COUNTY OWNED 20% OF THE STOCK OF THE TRANSFEREE CORPORATION BOTH BEFORE AND AFTER THESE TRANSFERS.

4PROPERTY TRANSFERRED:
A)CASH (VARIOUS DATES)
FAIR MARKET VALUE: $1,054,109
BASIS: $1,054,109
4(I)ACTIVE BUSINESS PROPERTY - N/A
4(II)STOCK OR SECURITIES TRANSFERRED - N/A
4(III)DEPRECIATED PROPERTY - N/A
4(IV)PROPERTY TO BE LEASED - N/A
4(V)PROPERTY TO BE SOLD - N/A
4(VI)TRANSFERS TO A FSC - N/A
4(VII)TAINTED PROPERTY - N/A
4(VIII)FOREIGN LOSS BRANCH -N/A
4(IX)OTHER INTANGIBLES - N/A

5TRANSFER OF FOREIGN LOSS BRANCH PROPERTY - N/A

5(I)BRANCH OPERATION - N/A
5(II)BRANCH PROPERTY - N/A
5(III)PREVIOUSLY DEDUCTED LOSSES - N/A
5(IV)CHARACTER OF GAIN - N/A

6ASSETS TRANSFERRED IN AN EXCHANGE DESCRIBED IN CODE SEC. 361(A) OR 361(B) - N/A

- 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.	Employer identification number (EIN) or
	UNION HOSPITAL OF CECIL COUNTY, INC.	52-0607945
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	106 BOW STREET	
	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) 0 1

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 (other than individual)	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.

- The books are in the care of ▶ DERON G. BROWN, DIRECTOR OF FINANCE 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, 2017.

5 For calendar year _____, or other tax year beginning JUL 1, 2015, and ending JUN 30, 2016.

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 Forms 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 Forms 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 ▶ CPA/AGENT Date ▶

Form **8868**
(Rev. January 2014)

Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File an Exempt Organization Return

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

▶ **Information about Form 8868 and its instructions is at *www.irs.gov/form8868* .**

OMB No. 1545-1709

- 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.

Enter filer's identifying number

Type or print	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
File by the due date for filing your return. See instructions.	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	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 (other than individual)	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

- The books are in the care of ▶ DERON G. BROWN, DIRECTOR OF FINANCE
  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, 2017, 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, 2015, and ending JUN 30, 2016.

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 Forms 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 Forms 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 funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

2015 TAX RETURN FILING INSTRUCTIONS

CALIFORNIA FORM 199

FOR THE YEAR ENDING

June 30, 2016

Prepared for	Union Hospital of Cecil County, Inc. 106 Bow Street Elkton, MD 21921-5596
Prepared by	Baker Tilly Virchow Krause, LLP 1650 Market Street, Suite 4500 Philadelphia, PA 19103
To be signed and dated by	The authorized individual(s).
Amount of tax	Total tax $ 10.00 Less: payments and credits $ 0.00 Plus: other amount $ 0.00 Plus: interest and penalties $ 0.00 Balance due $ 10.00
Overpayment	Credited to your estimated tax $ 0.00 Other amount $ 0.00 Refunded to you $ 0.00
Make check payable to	Franchise Tax Board
Mail tax return and check (if applicable) to	Franchise Tax Board P.O. Box 942857 Sacramento, CA 94257-0501
Return must be mailed on or before	June 15, 2017
Special Instructions	

TAXABLE YEAR **2015**

California Exempt Organization Annual Information Return

528941 11-25-15
FORM **199**

Calendar Year 2015 or fiscal year beginning (mm/dd/yyyy) 07/01/2015 , and ending (mm/dd/yyyy) 06/30/2016 .

Corporation/Organization name: UNION HOSPITAL OF CECIL COUNTY, INC.

California corporation number:

Additional information. See instructions.

FEIN: 52-0607945

Street address (suite or room): 106 BOW STREET

PMB no.:

City: ELKTON | State: MD | ZIP code: 21921-5596

Foreign country name | Foreign province/state/county | Foreign postal code

A First Return ..... ☐ Yes ☒ No
B Amended Return ..... ● ☐ Yes ☒ No
C IRC Section 4947(a)(1) trust ..... ☐ Yes ☒ No
D Final Information Return?
● ☐ Dissolved ☐ Surrendered (Withdrawn) ☐ Merged/Reorganized
Enter date: (mm/dd/yyyy) ●
E Check accounting method: (1) ☐ Cash (2) ☒ Accrual (3) ☐ Other
F Federal return filed? (1) ● ☒ 990T (2) ● ☐ 990-PF (3) ● ☒ Sch H (990) (4) ☒ Other 990 series
G Is this a group filing? See instructions ..... ● ☐ Yes ☒ No
H Is this organization in a group exemption ..... ☐ Yes ☒ No
If "Yes," what is the parent's name?
I Did the organization have any changes to its guidelines not reported to the FTB? See instructions ..... ● ☐ Yes ☒ No

J If exempt under R&TC Section 23701d, has the organization engaged in political activities? See instructions. ..... ● ☐ Yes ☒ No
K Is the organization exempt under R&TC Section 23701g? ● ☐ Yes ☒ No
If "Yes," enter the gross receipts from nonmember sources $
L If organization is exempt under R&TC Section 23701d and meets the filing fee exception, check box. No filing fee is required. ..... ● ☐
M Is the organization a Limited Liability Company? ..... ● ☐ Yes ☒ No
N Did the organization file Form 100 or Form 109 to report taxable income? ..... ● ☒ Yes ☐ No
O Is the organization under audit by the IRS or has the IRS audited in a prior year? ..... ● ☐ Yes ☒ No
P Is a federal Form 1023/1024 pending? ..... ☐ Yes ☒ No
Date filed with IRS

Part I Complete Part I unless not required to file this form. See General Instructions B and C.

Receipts and Revenues	1	Gross sales or receipts from other sources. From Side 2, Part II, line 8 ●		1	180,027,636. 00
	2	Gross dues and assessments from members and affiliates ●		2	00
	3	Gross contributions, gifts, grants, and similar amounts received STMT 1 ●		3	277,147. 00
	4	Total gross receipts for filing requirement test. Add line 1 through line 3. This line must be completed. If the result is less than $50,000, see General Instruction B ●		4	180,304,783. 00
	5	Cost of goods sold ●	5 00		
	6	Cost or other basis, and sales expenses of assets sold ●	6 14,195,446. 00		
	7	Total costs. Add line 5 and line 6		7	14,195,446. 00
	8	Total gross income. Subtract line 7 from line 4 ●		8	166,109,337. 00
Expenses	9	Total expenses and disbursements. From Side 2, Part II, line 18 ●		9	164,213,727. 00
	10	Excess of receipts over expenses and disbursements. Subtract line 9 from line 8 ●		10	1,895,610. 00
Filing Fee	11	Total payments ●		11	00
	12	Use tax. See General Instruction K ●		12	00
	13	Payment balance. If line 11 is more than line 12, subtract line 12 from line 11 ●		13	00
	14	Use tax balance. If line 12 is more than line 11, subtract line 11 from line 12 ●		14	00
	15	Filing fee $10 or $25. See General Instruction F		15	10. 00
	16	Penalties and Interest. See General Instruction J		16	00
	17	**Balance due.** Add line 12, line15, and line 16. Then subtract line 11 from the result ◉		17	10. 00

Sign Here

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.

Signature of officer ▶ | Title: SR. VP/CHIEF F | Date | ● Telephone

Paid Preparer's Use Only

Preparer's signature ▶ | Date | Check if self-employed ▶ ☐ | ● PTIN: P00350393

Firm's name (or yours, if self-employed) and address ▶ BAKER TILLY VIRCHOW KRAUSE, LLP
1650 MARKET STREET, SUITE 4500
PHILADELPHIA, PA 19103

● FEIN: 39-0859910
● Telephone: (215) 972-0701

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

Part II **Organizations with gross receipts of more than $50,000 and private foundations regardless of amount of gross receipts - complete Part II or furnish substitute information.**

	1	Gross sales or receipts from all business activities. See instructions	1	00
	2	Interest	2	2,604,102. 00
	3	Dividends	3	00
Receipts	4	Gross rents	4	43,236. 00
from	5	Gross royalties	5	00
Other	6	Gross amount received from sale of assets (See Instructions) STATEMENT 2	6	14,821,605. 00
Sources	7	Other income SEE STATEMENT 3	7	162,558,693. 00
	8	**Total** gross sales or receipts from other sources. Add line 1 through line 7. Enter here and on Side 1, Part I, line 1	8	180,027,636. 00
	9	Contributions, gifts, grants, and similar amounts paid	9	4,468,260. 00
	10	Disbursements to or for members	10	00
	11	Compensation of officers, directors, and trustees SEE STATEMENT 4	11	329,806. 00
	12	Other salaries and wages	12	67,458,068. 00
Expenses	13	Interest	13	1,951,158. 00
and	14	Taxes	14	4,662,547. 00
Disburse-	15	Rents	15	2,982,268. 00
ments	16	Depreciation and depletion (See instructions)	16	11,135,283. 00
	17	Other Expenses and Disbursements SEE STATEMENT 5	17	71,226,337. 00
	18	**Total** expenses and disbursements. Add line 9 through line 17. Enter here and on Side 1, Part I, line 9	18	164,213,727. 00

Schedule L **Balance Sheets**

Assets	Beginning of taxable year (a)	Beginning of taxable year (b)	End of taxable year (c)	End of taxable year (d)
1 Cash		9,847,735.		3,939,028.
2 Net accounts receivable		13,294,247.		15,088,409.
3 Net notes receivable				
4 Inventories		1,974,105.		2,065,581.
5 Federal and state government obligations				
6 Investments in other bonds				
7 Investments in stock				
8 Mortgage loans				
9 Other investments STMT 6		62,558,870.		59,490,573.
10 a Depreciable assets	204,988,168.		209,375,444.	
b Less accumulated depreciation	(111,641,438.)	93,346,730.	(117,036,933.)	92,338,511.
11 Land		1,221,305.		1,221,305.
12 Other assets STMT 7		10,899,022.		14,204,593.
13 **Total assets**		193,142,014.		188,348,000.
Liabilities and net worth				
14 Accounts payable		12,681,544.		9,482,516.
15 Contributions, gifts, or grants payable				
16 Bonds and notes payable STMT 8		66,398,857.		64,045,962.
17 Mortgages payable				
18 Other liabilities STMT 9		13,664,099.		16,387,527.
19 Capital stock or principal fund				
20 Paid-in or capital surplus. Attach reconciliation				
21 Retained earnings or income fund		100,397,514.		98,431,995.
22 **Total liabilities and net worth**		193,142,014.		188,348,000.

Schedule M-1 **Reconciliation of income per books with income per return**

Do not complete this schedule if the amount on Schedule L, line 13, column (d), is less than $50,000.

1 Net income per books	1,895,610.	7 Income recorded on books this year not included in this return.	
2 Federal income tax		8 Deductions in this return not charged against book income this year	
3 Excess of capital losses over capital gains		9 Total. Add line 7 and line 8	
4 Income not recorded on books this year		10 Net income per return. Subtract line 9 from line 6	1,895,610.
5 Expenses recorded on books this year not deducted in this return			
6 Total. Add line 1 through line 5	1,895,610.		

FORM 199 CASH CONTRIBUTIONS INCLUDED ON PART I, LINE 3 STATEMENT 1

CONTRIBUTOR'S NAME	CONTRIBUTOR'S ADDRESS	DATE OF GIFT	AMOUNT
MARYLAND HEALTH CARE COMMISSION	4160 PATTERSON AVE BALTIMORE, MD 21215		10,067.
UNION HOSPITAL OF CECIL COUNTY FOUNDATION, INC.	106 BOW STREET ELKTON, MD 21921		246,480.
TOTAL INCLUDED ON LINE 3			256,547.

FORM 199 GROSS AMOUNT FROM SALE OF ASSETS STATEMENT 2

DESCRIPTION	DATE ACQUIRED	DATE SOLD	METHOD ACQUIRED	COST OR OTHER BASIS	DEPREC.	EXPENSE OF SALE	GROSS SALES PRICE
			PURCHASED	14,183,049.	0.	0.	14,774,426.

DESCRIPTION	DATE ACQUIRED	DATE SOLD	METHOD ACQUIRED	COST OR OTHER BASIS	DEPREC.	EXPENSE OF SALE	GROSS SALES PRICE
			PURCHASED	6,206,658.	6,194,261.	0.	47,179.
TOTAL TO FORM 199, PAGE 2, LN 6				20,389,707.	6,194,261.	0.	14,821,605.

FORM 199 OTHER INCOME STATEMENT 3

DESCRIPTION	AMOUNT
CAFETERIA/FOOD SERVICE	812,188.
PURCHASE DISCOUNTS	95,706.
MEANINGFUL USE REVENUE	558,187.
OTHER REVENUE	40,794.
LABORATORY REVENUE	1,893,827.
NET PATIENT SERVICE REVENUE	157,675,670.
OTHER OPERATING REVENUE	853,641.
ADULT DAY CARE	628,680.
TOTAL TO FORM 199, PART II, LINE 7	162,558,693.

FORM 199 COMPENSATION OF OFFICERS, DIRECTORS AND TRUSTEES STATEMENT 4

NAME AND ADDRESS	TITLE AND AVERAGE HRS WORKED/WK	COMPENSATION
MARTIN J. HEALY 106 BOW STREET ELKTON, MD 21921-5596	CHAIRMAN 0.50	0.
RAYMOND HAMM 106 BOW STREET ELKTON, MD 21921-5596	VICE CHAIRMAN/TREASURER 0.50	0.
RONALD GRAYBEAL 106 BOW STREET ELKTON, MD 21921-5596	SECRETARY 0.50	0.
KENNETH S. LEWIS, MD, JD 106 BOW STREET ELKTON, MD 21921-5596	PRESIDENT & CEO (UNTIL 12/ 30.00	0.
RICHARD C. SZUMEL, MD 106 BOW STREET ELKTON, MD 21921-5596	PRESIDENT & CEO (AS OF 1/1 30.00	0.
KELLY ALBANESE BEDDER 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
CHRISTY DRYER 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR (AS OF 3/2016) 0.50	0.
RYAN GERACIMOS, MD 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR (AS OF 7/2015) 0.50	0.
MARY BOLT, PH.D. 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
RONALD CULLIS 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
DAVID FERGUSON 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.

STEPHANIE GARRITY 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
MARTHA HOSFORD, MD 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR (UNTIL 5/2016) 0.50	0.
CARL ROBERTS 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
SHEELMOHAN SACHDEV, MD 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
DWIGHT THOMEY 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR (AS OF 2/2016) 0.50	0.
LAURIE R. BEYER, CPA 106 BOW STREET ELKTON, MD 21921-5596	SENIOR VP/CHIEF FINANCIAL 31.00	0.
CYDNEY TEAL 106 BOW STREET ELKTON, MD 21921-5596	VP MEDICAL AFFAIRS 39.00	0.
DAVID GIPSON 106 BOW STREET ELKTON, MD 21921-5596	SENIOR VP/CHIEF OPERATING 33.00	0.
KHADIJATU BOSTON 106 BOW STREET ELKTON, MD 21921-5596	SENIOR VP/CHIEF NURSING OF 39.00	0.
TERRANCE LOVELL 106 BOW STREET ELKTON, MD 21921-5596	VP HUMAN RESOURCES 40.00	0.
JUSTIN SAUSVILLE 106 BOW STREET ELKTON, MD 21921-5596	PHYSICIAN 40.00	0.
MICHAEL BASS 106 BOW STREET ELKTON, MD 21921-5596	PHYSICIAN 40.00	0.
ROGER WU 106 BOW STREET ELKTON, MD 21921-5596	PHYSICIAN 40.00	0.

OSCAR GALVIS 106 BOW STREET ELKTON, MD 21921-5596	PHYSICIAN 40.00	0.
EUGENIA GRAY 106 BOW STREET ELKTON, MD 21921-5596	PHYSICIAN 40.00	0.
TOTAL TO FORM 199, PART II, LINE 11		0.

FORM 199 OTHER EXPENSES STATEMENT 5

DESCRIPTION	AMOUNT
MEDICAL SUPPLIES	19,407,111.
BAD DEBTS	6,826,331.
REPAIRS & MAINTENANCE	2,750,959.
DIETARY	1,083,904.
RENTAL EXPENSES	14,287.
CONDO FEES	0.
PENSION PLAN CONTRIBUTIONS	743,583.
OTHER EMPLOYEE BENEFITS	6,967,130.
MANAGEMENT FEES	1,899,642.
LEGAL FEES	274,589.
ACCOUNTING FEES	109,467.
INVESTMENT MANAGEMENT FEES	53,877.
OTHER PROFESSIONAL FEES	23,890,061.
ADVERTISING AND PROMOTION	510,403.
OFFICE EXPENSES	866,383.
INFORMATION TECHNOLOGY	246,019.
TRAVEL	264,549.
CONFERENCES AND CONVENTIONS	49,314.
INSURANCE	2,966,353.
ALL OTHER EXPENSES	2,302,375.
TOTAL TO FORM 199, PART II, LINE 17	71,226,337.

FORM 199 OTHER INVESTMENTS STATEMENT 6

DESCRIPTION	BEG. OF YEAR	END OF YEAR
INTEREST IN NET ASSETS OF UNION HOSPITAL OF CECIL COUNTY FOUNDATION	5,803,366.	5,481,265.
PREMIER PURCHASING PARTNERS, LP	207,406.	313,313.
FREESTATE HEALTHCARE COMPANY	20,000.	20,000.
OTHER PUBLICLY TRADED SECURITIES	56,528,098.	53,675,995.
TOTAL TO FORM 199, SCHEDULE L, LINE 9	62,558,870.	59,490,573.

FORM 199 OTHER ASSETS STATEMENT 7

DESCRIPTION	BEG. OF YEAR	END OF YEAR
PREPAID EXPENSES AND DEFERRED CHARGES	2,893,481.	3,520,101.
OTHER ASSETS	600,923.	601,294.
LOAN ISSUANCE COSTS	651,295.	584,710.
INSURANCE CLAIMS RECEIVABLE	6,753,323.	9,473,438.
DUE FROM AFFILIATES	0.	25,050.
TOTAL TO FORM 199, SCHEDULE L, LINE 12	10,899,022.	14,204,593.

FORM 199 BONDS AND NOTES PAYABLE STATEMENT 8

DESCRIPTION	BEG. OF YEAR	END OF YEAR
TAX-EXEMPT BONDS LIABILITIES	66,398,857.	64,045,962.
TOTAL TO FORM 199, SCHEDULE L, LINE 16	66,398,857.	64,045,962.

FORM 199 OTHER LIABILITIES STATEMENT 9

DESCRIPTION	BEG. OF YEAR	END OF YEAR
THIRD PARTY ADVANCES	2,891,605.	3,637,293.
CAPITAL LEASE OBLIGATIONS	2,886,324.	2,266,010.
ESTIMATED MEDICAL MALPRACTICE CLAIMS LIABILITY	7,764,109.	10,484,224.
DUE TO AFFILIATE	122,061.	0.
TOTAL TO FORM 199, SCHEDULE L, LINE 18	13,664,099.	16,387,527.

FORM 199 FUND BALANCES STATEMENT 10

DESCRIPTION	BEG. OF YEAR	END OF YEAR
UNRESTRICTED ASSETS	98,057,789.	95,806,742.
TEMPORARILY RESTRICTED ASSETS	2,339,725.	2,625,253.
TOTAL TO FORM 199, SCHEDULE L, LINE 21	100,397,514.	98,431,995.

2015 TAX RETURN FILING INSTRUCTIONS

CALIFORNIA FORM 109

FOR THE YEAR ENDING

June 30, 2016

Prepared for	Union Hospital of Cecil County, Inc. 106 Bow Street Elkton, MD 21921-5596
Prepared by	Baker Tilly Virchow Krause, LLP 1650 Market Street, Suite 4500 Philadelphia, PA 19103
To be signed and dated by	The authorized individual(s).
Amount of tax	Total tax $ 0.00 Less: payments and credits $ 0.00 Plus: other amount $ 0.00 Plus: interest and penalties $ 0.00 No pmt required $
Overpayment	Credited to your estimated tax $ 0.00 Other amount $ 0.00 Refunded to you $ 0.00
Make check payable to	Not Applicable
Mail tax return and check (if applicable) to	Franchise Tax Board P.O. Box 942857 Sacramento, CA 94257-0500
Return must be mailed on or before	June 15, 2017
Special Instructions	

TAXABLE YEAR **2015**

California Exempt Organization Business Income Tax Return

528961 02-25-16

FORM **109**

Calendar Year 2015 or fiscal year beginning (mm/dd/yyyy) 07/01/2015 , and ending (mm/dd/yyyy) 06/30/2016 .

Corporation/Organization name	California corporation number
UNION HOSPITAL OF CECIL COUNTY, INC.	
Additional information. See instructions.	FEIN 52-0607945
Street address (suite/room no.) 106 BOW STREET	PMB no.
City (If the corporation has a foreign address, see instructions.) ELKTON	State MD / ZIP code 21921-5596
Foreign country name / Foreign province/state/county / Foreign postal code	

A First Return Filed? ☐ Yes ☒ No

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

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

D Final Return? ● ☐ Dissolved ☐ Surrendered (Withdrawn) ☐ Merged/Reorganized
Enter date (mm/dd/yyyy) ●

E Amended Return ● ☐ Yes ☒ No

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

G Nature of trade or business SEE STATEMENT 11

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

I Is this organization claiming any former; 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

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

K Unrelated Business Activity (UBA) Code ● 621500

L Is this a Hospital? ● ☒ Yes ☐ No
If "Yes," attach federal Schedule H (Form 990)

Taxable Corporation	1	Unrelated business taxable income from Side 2, Part II, line 30 ●	1	-35,991.	00
	2	Mult. In 1 by the avg. apport. pctg _____ % from the Sch. R, Apport. Formula Wksht, Part A, In 2 or Part B, In 5. See instr. ●	2		00
	3	Enter the lesser amt from In 1 or In 2. If the unrelated bus. activity is wholly in CA and Sch. R was not compltd, enter the amt from In 1 ●	3	-35,991.	00
Taxable Trust	4	Unrelated business taxable income from Side 2, Part II, line 30 ●	4		00
Tax Computation	5	Unrelated business taxable income from line 3 or line 4 ●	5	-35,991.	00
	6	Pierce's disease, EZ, LARZ, LAMBRA, or TTA NOL carryover deduction ●	6		00
	7	Net Operating Loss deduction. See General Information N ●	7		00
	8	Add line 6 and line 7 ●	8		00
	9	Net unrelated business taxable income. Subtract line 8 from line 5 ●	9	-35,991.	00
	10	Tax 8.84 % x line 9. See General Information J ●	10		00
	11	**a** New employment credit, amount generated. ● **a)** _____ **11 b)** Amount claimed ●	11b		00
		c Tax credits from Schedule B. See instructions ●	11c		00
		d Total Credits. Add line 11b and 11c ●	11d		00
Total Tax	12	Balance. Subtract line 11d from line 10. If line 11d is greater than line 10, enter -0- ●	12		00
	13	Alternative minimum tax. See General Information O ●	13		00
	14	Total tax. Add line 12 and line 13 ●	14	0.	00
Payments	15	Overpayment from a prior year allowed as a credit ●	15	00	
	16	2015 estimated tax payments. See instructions ●	16	00	
	17	Withholding (Form 592-B and/or 593.) See instructions ●	17	00	
	18	Amount paid with extension (form FTB 3539) ●	18	00	
	19	Total payments and credits. Add line 15 through line 18 ●	19		00
Use Tax/ Tax Due/ Overpayment	20	**Use tax.** See instructions ●	20		00
	21	Payments balance. If line 19 is more than line 20, subtract line 20 from line 19 ●	21		00
	22	**Use tax balance.** If line 20 is more than line 19, subtract line 19 from line 20 ●	22		00
	23	Tax due. Subtract line 21 from line 14. Pay entire amount with return. See instructions ●	23		00
	24	Overpayment. Subtract line 14 from line 21. See instructions ●	24		00
	25	Enter amount of line 24 to be applied to 2016 estimated tax ●	25		00

Refund or Amount Due	**26** Refund. If line 25 is less than line 24, then subtract line 25 from line 24		**26**	00
	a Fill in the account information to have the refund directly deposited. Routing number	**26a**		
	b Type: Checking ☐ Savings ☐ **c** Account Number	**26c**		
	27 Penalties and interest. See General Information M		**27**	00
	28 ☐ Check if estimate penalty computed using Exception B or C and attach form FTB 5806.			
	29 Total amount due. Add line 22, line 23, line 25, and line 27, then subtract line 24		**29**	00

Unrelated Business Taxable Income

Part I Unrelated Trade or Business Income

1	**a** Gross receipts or gross sales 2,036,970. **b** Less returns and allowances 143,143. **c** Balance		**1c**	1,893,827. 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**	1,893,827. 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 12		**5**	270. 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**	1,894,097. 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**	562,912. 00
16	Repairs			**16**	35,715. 00
17	Bad debts			**17**	25,820. 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**	64,949. 00		
	b Less: depreciation claimed on Schedule A	**21b**	00	**21**	64,949. 00
22	Depletion			**22**	00
23	**a** Contributions to deferred compensation plans			**23a**	00
	b Employee benefit programs			**23b**	95,598. 00
24	Other deductions SEE STATEMENT 13			**24**	1,145,094. 00
25	Total deductions. Add line 14 through line 24			**25**	1,930,088. 00
26	Unrelated business taxable income before allowable excess advertising costs. Subtract line 25 from line 13			**26**	-35,991. 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**	-35,991. 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**	-35,991. 00

Sign Here

To learn about your privacy rights, how we may use your information, and the consequences for not providing the requested information, go to ftb.ca.gov and search for privacy notice. To request this notice by mail, call 800.852.5711.

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.

Signature of officer ▶	Title	Date	Telephone
	SR. VP/CHIEF FINAN		

Paid Preparer's Use Only

Preparer's signature ▶	Date	Check if self-employed ▶ ☐	PTIN
			P00350393

Firm's name (or yours, if self-employed) and address ▶ BAKER TILLY VIRCHOW KRAUSE, LLP
1650 MARKET STREET, SUITE 4500
PHILADELPHIA, PA 19103

FEIN 39-0859910

Telephone (215) 972-0701

May the FTB discuss this return with the preparer shown above? See instructions ☒ Yes ☐ 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 Employment Credit on Schedule B.

1 Enter credit name _____ code • _____ •	1	00	
2 Enter credit name _____ code • _____ •	2	00	
3 Enter credit name _____ code • _____ •	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 Employment 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.

Part A. Standard Method - Single-Sales Factor Formula. Complete this part only if the corporation uses the single-sales factor formula.

	(a) Total within and outside California	(b) Total within California	(c) Percent within California [(b) ÷ (a)] x 100
1 **Total Sales**	•	•	
2 **Apportionment percentage.** Divide total sales column (b) by total sales column (a) and multiply the result by 100. Enter the result here and on Form 109, Side 1, line 2.			•

Part B. Three Factor Formula. Complete this part only if the corporation uses the three-factor formula.

	(a) Total within and outside California	(b) Total within California	(c) Percent within California [(b) ÷ (a)] x 100
1 **Property factor:**	•	•	•
2 **Payroll factor:** Wages and other compensation of employees	•	•	•
3 **Sales factor:** Gross sales and/or receipts less returns and allowances	•	•	•
4 **Total percentage:** Add the percentages in column (c)			
5 **Average apportionment percentage:** Divide the factor on line 4 by 3 and enter the result here and on Form 109, Side 1, line 2. See instructions for exceptions			

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 .....

Schedule H Advertising Income and Excess Advertising Costs

Part I Income from Periodicals Reported on a Consolidated Basis

1 Name of periodical	2 Gross advertising income	3 Direct advertising costs	4 Advertising income or excess advertising costs. If column 2 is greater than column 3, complete columns 5, 6, and 7. If column 3 is greater than column 2, enter the excess in Part III, column B(b). Do not complete columns 5, 6, and 7.	5 Circulation income	6 Readership costs	7 If column 5 is greater than column 6, enter the income shown in column 4, in Part III, column A(b). If column 6 is greater than column 5, subtract the sum of column 6 and column 3 from the sum of column 5 and column 2. Enter amount in Part III, column A(b). If the amount is less than zero, enter -0-.
Totals						

Part II Income from Periodicals Reported on a Separate Basis

Part III Column A - Net Advertising Income

(a) Enter "consolidated periodical" and/or names of non-consolidated periodicals	(b) Enter total amount from Part I, column 4 or 7, and amount listed in Part II, column 4 or 7
Enter total here and on Side 2, Part I, line 11	

Part III Column B - Excess Advertising Costs

(a) Enter "consolidated periodical" and/or names of non-consolidated periodicals	(b) Enter total amount from Part I, column 4, and amounts listed in Part II, column 4
Enter total here and on Side 2, Part II, line 27	

Schedule I Compensation of Officers, Directors, and Trustees

1 Name of Officer	2 SSN or ITIN	3 Title	4 Percent of time devoted to business	5 Compensation attributable to unrelated business	6 Expense account allowances
			%		
			%		
			%		
			%		
			%		
Total. Enter here and on Side 2, Part II, line 14					

Schedule J Depreciation (Corporations and Associations only. Trusts use form FTB 3885F.)

1 Group and guideline class or description of property	2 Date acquired (mm/dd/yyyy)	3 Cost or other basis	4 Depreciation allowed or allowable in prior years	5 Method of computing depreciation	6 Life or rate	7 Depreciation for this year
1 Total additional first-year depreciation (do not include in items below)						
2 Other depreciation:						
Buildings						
Furniture and fixtures						
Transportation equipment						
Machinery and other equipment						
Other (specify)						
3 Other depreciation						
4 Total						
5 Amount of depreciation claimed elsewhere on return						
6 Balance. Subtract line 5 from line 4. Enter here and on Side 2, Part II, line 21a						

FORM 109 NATURE OF TRADE OR BUSINESS STATEMENT 11

LABORATORY SERVICES TO NON-PATIENTS
INCOME FROM PARTNERSHIPS

TO FORM 109, PAGE 1

FORM 109 INCOME OR (LOSS) FROM PARTNERSHIPS, LIMITED LIABILITY COMPANIES OR S CORPORATIONS STATEMENT 12

DESCRIPTION	AMOUNT
PREMIER HEALTHCARE ALLIANCE LP (EIN: 33-0387407)	270.
TOTAL TO FORM 109, PAGE 2, LINE 5	270.

FORM 109 OTHER DEDUCTIONS STATEMENT 13

DESCRIPTION	AMOUNT
SUPPLIES	416,600.
PURCHASED SERVICES	232,445.
UTILITIES	972.
MINOR EQUIPMENT	1,847.
ACCREDITATION FEES	6,627.
EQUIPMENT RENTAL	8,537.
MISCELLANEOUS EXPENSE	16,197.
OVERHEAD ALLOCATION	461,759.
VEHICLE COSTS	83.
TRAVEL & CONFERENCE	27.
TOTAL TO FORM 109, PAGE 2, LINE 24	1,145,094.

TAX RETURN FILING INSTRUCTIONS

CALIFORNIA FORM RRF-1

FOR THE YEAR ENDING

June 30, 2016

Prepared for	Union Hospital of Cecil County, Inc. 106 Bow Street Elkton, MD 21921-5596
Prepared by	Baker Tilly Virchow Krause, LLP 1650 Market Street, Suite 4500 Philadelphia, PA 19103
Amount due or refund	Balance due of $300.00
Make check payable to	Attorney General Registry of Charitable Trusts
Mail tax return and check (if applicable) to	Registry of Charitable Trusts P.O. Box 903447 Sacramento, CA 94203-4470
Return must be mailed on or before	Please mail as soon as possible.
Special Instructions	The report should be signed and dated by the authorized individual(s).

MAIL TO:
Registry of Charitable Trusts
P.O. Box 903447
Sacramento, CA 94203-4470
Telephone: (916) 445-2021

WEB SITE ADDRESS:
http://ag.ca.gov/charities/

ANNUAL REGISTRATION RENEWAL FEE REPORT TO ATTORNEY GENERAL OF CALIFORNIA

Sections 12586 and 12587, California Government Code
11 Cal. Code Regs. sections 301-307, 311 and 312

Failure to submit this report annually no later than four months and fifteen days after the end of the organization's accounting period may result in the loss of tax exemption and the assessment of a minimum tax of $800, plus interest, and/or fines or filing penalties as defined in Government Code section 12586.1. IRS extensions will be honored.

State Charity Registration Number: **CT** _____

UNION HOSPITAL OF CECIL COUNTY, INC.
Name of Organization

106 BOW STREET
Address (Number and Street)

ELKTON, MD 21921-5596
City or Town, State and ZIP Code

Check if:

☐ Change of address

☐ Amended report

Corporate or Organization No. _____

Federal Employer I.D. No. 52-0607945

ANNUAL REGISTRATION RENEWAL FEE SCHEDULE (11 Cal. Code Regs. sections 301-307, 311 and 312)
Make Check Payable to Attorney General's Registry of Charitable Trusts

Gross Annual Revenue	Fee	Gross Annual Revenue	Fee	Gross Annual Revenue	Fee
Less than $25,000	0	Between $100,001 and $250,000	$50	Between $1,000,001 and $10 million	$150
Between $25,000 and $100,000	$25	Between $250,001 and $1 million	$75	Between $10,000,001 and $50 million	$225
				Greater than $50 million	$300

PART A - ACTIVITIES

For your most recent full accounting period (beginning 07/01/2015 **ending** 06/30/2016 **) list:**
Gross annual revenue $ 166,095,050. **Total assets $** 188,348,000.

PART B - STATEMENTS REGARDING ORGANIZATION DURING THE PERIOD OF THIS REPORT

Note: If you answer "yes" to any of the questions below, you must attach a separate sheet providing an explanation and details for each "yes" response. Please review RRF-1 instructions for information required.

		Yes	No
1.	During this reporting period, were there any contracts, loans, leases or other financial transactions between the organization and any officer, director or trustee thereof either directly or with an entity in which any such officer, director or trustee had any financial interest?		X
2.	During this reporting period, was there any theft, embezzlement, diversion or misuse of the organization's charitable property or funds?		X
3.	During this reporting period, did non-program expenditures exceed 50% of gross revenues?		X
4.	During this reporting period, were any organization funds used to pay any penalty, fine or judgment? If you filed a Form 4720 with the Internal Revenue Service, attach a copy.		X
5.	During this reporting period, were the services of a commercial fundraiser or fundraising counsel for charitable purposes used? If "yes," provide an attachment listing the name, address, and telephone number of the service provider.		X
6.	During this reporting period, did the organization receive any governmental funding? If so, provide an attachment listing the name of the agency, mailing address, contact person, and telephone number.		X
7.	During this reporting period, did the organization hold a raffle for charitable purposes? If "yes," provide an attachment indicating the number of raffles and the date(s) they occurred.		X
8.	Does the organization conduct a vehicle donation program? If "yes," provide an attachment indicating whether the program is operated by the charity or whether the organization contracts with a commercial fundraiser for charitable purposes.		X
9.	Did your organization have prepared an audited financial statement in accordance with generally accepted accounting principles for this reporting period?	X	

Organization's area code and telephone number (410) 398-4000

Organization's e-mail address _____

I declare under penalty of perjury that I have examined this report, including accompanying documents, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of authorized officer	Printed Name	Title	Date
	LAURIE R. BEYER, CPA	SR. VP/CHIEF FINANCIAL OF	