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CLIENT'S COPY

DRAFT

TAX RETURN FILING INSTRUCTIONS

FORM 990

FOR THE YEAR ENDING

June 30, 2015

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	Not applicable
Make check payable to	Not applicable
Mail tax return and check (if applicable) to	Not applicable
Return must be mailed on or before	Not applicable
Special Instructions	This return has qualified for electronic filing. The return has been transmitted electronically to the IRS and no further action is required.

IRS e-file Signature Authorization for an Exempt Organization

Form **8879-EO**

For calendar year 2014, or fiscal year beginning JUL 1, 2014, and ending JUN 30, 2015

2014

Department of the Treasury
Internal Revenue Service

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

▶ **Information about Form 8879-EO and its instructions is at www.irs.gov/form8879e.**

Name of exempt organization

Employer identification number

UNION HOSPITAL OF CECIL COUNTY, INC.

52-0607945

Name and title of officer

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

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

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

1a Form 990 check here ▶ <input checked="" type="checkbox"/>	b Total revenue , if any (Form 990, Part VIII, column (A), line 12)	1b <u>165,062,877.</u>
2a Form 990-EZ check here ▶ <input type="checkbox"/>	b Total revenue , if any (Form 990-EZ, line 9)	2b _____
3a Form 1120-POL check here ▶ <input type="checkbox"/>	b Total tax (Form 1120-POL, line 22)	3b _____
4a Form 990-PF check here ▶ <input type="checkbox"/>	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b _____
5a Form 8868 check here ▶ <input type="checkbox"/>	b Balance Due (Form 8868, Part I, line 3c or Part II, line 8c)	5b _____

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2014 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

I authorize 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 2014 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 2014 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

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

Part III Certification and Authentication

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

24298358001

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2014 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**

Form **990**

Return of Organization Exempt From Income Tax
Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

OMB No. 1545-0047

2014

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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.

A For the 2014 calendar year, or tax year beginning JUL 1, 2014 and ending JUN 30, 2015

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	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: KENNETH S. LEWIS, MD, JD SAME AS C ABOVE	D Employer identification number 52-0607945 E Telephone number (410) 398-4000 G Gross receipts \$ 170,592,693. H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) H(c) Group exemption number ▶
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		
J Website: ▶ WWW.UHCC.COM		
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		
L Year of formation: 1903		M State of legal domicile: MD

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: PROVIDE HEALTHCARE SERVICES TO THE RESIDENTS OF CECIL COUNTY, MD, AND THE SURROUNDING AREA. 2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets. 3 Number of voting members of the governing body (Part VI, line 1a) 3 14 4 Number of independent voting members of the governing body (Part VI, line 1b) 4 12 5 Total number of individuals employed in calendar year 2014 (Part V, line 2a) 5 1307 6 Total number of volunteers (estimate if necessary) 6 295 7a Total unrelated business revenue from Part VIII, column (C), line 12 7a 1,879,768. b Net unrelated business taxable income from Form 990-T, line 34 7b -344,190.	
Revenue	8 Contributions and grants (Part VIII, line 1h) 591,508. 2,360,946. 9 Program service revenue (Part VIII, line 2g) 155,558,982. 156,204,081. 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) 1,857,214. 2,534,753. 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) 3,252,842. 3,963,097. 12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) 161,260,546. 165,062,877.	Prior Year Current Year
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3) 2,350,032. 1,790,991. 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) 78,793,256. 80,458,877. 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) 77,067,739. 77,180,025. 18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) 158,211,027. 159,429,893. 19 Revenue less expenses. Subtract line 18 from line 12 3,049,519. 5,632,984.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16) 198,798,630. 193,142,014. 21 Total liabilities (Part X, line 26) 101,119,793. 92,744,500. 22 Net assets or fund balances. Subtract line 21 from line 20 97,678,837. 100,397,514.	Beginning of Current Year End of Year

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 LAURIE R. BEYER, CPA, SENIOR VP/CFO Type or print name and title	Date
Paid Preparer Use Only	Print/Type preparer's name JULIUS C. GREEN, CPA, JD	Preparer's signature Date Check if self-employed <input type="checkbox"/> PTIN P00350393
	Firm's name ▶ BAKER TILLY VIRCHOW KRAUSE, LLP Firm's address ▶ 1650 MARKET STREET, SUITE 4500 PHILADELPHIA, PA 19103	Firm's EIN ▶ 39-0859910 Phone no. (215) 972-0701

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

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response 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 [X] No

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code:) (Expenses \$ 155,637,526. including grants of \$ 1,790,991.) (Revenue \$ 156,204,081.) 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 155,637,526.

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	1 X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors?</i>	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? <i>If "Yes," complete Schedule C, Part I</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? <i>If "Yes," complete Schedule C, Part II</i>	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? <i>If "Yes," complete Schedule C, Part III</i>	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? <i>If "Yes," complete Schedule D, Part I</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? <i>If "Yes," complete Schedule D, Part II</i>	7	X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>	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? <i>If "Yes," complete Schedule D, Part IV</i>	9	X
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i>	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? <i>If "Yes," complete Schedule D, Part VI</i>	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? <i>If "Yes," complete Schedule D, Part VII</i>	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? <i>If "Yes," complete Schedule D, Part VIII</i>	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? <i>If "Yes," complete Schedule D, Part IX</i>	11d	X
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	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)? <i>If "Yes," complete Schedule D, Part X</i>	11f X	
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>	12a X	
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	12b X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>	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? <i>If "Yes," complete Schedule F, Parts I and IV</i>	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? <i>If "Yes," complete Schedule F, Parts II and IV</i>	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? <i>If "Yes," complete Schedule F, Parts III and IV</i>	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? <i>If "Yes," complete Schedule G, Part I</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? <i>If "Yes," complete Schedule G, Part II</i>	18	X
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>	19	X
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	20a X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b X	

Part IV Checklist of Required Schedules (continued)

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

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Input box for Schedule O

Main table with columns for question number, description, and Yes/No checkboxes. Includes rows 1a-14b with various tax-related questions and numerical inputs like 224, 0, 1307.

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

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.		
1b	Enter the number of voting members included in line 1a, above, who are independent		
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?		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?		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		X
6	Did the organization have members or stockholders?	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?	X	
7b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
8a	The governing body?	X	
8b	Each committee with authority to act on behalf of the governing body?	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		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?		X
10b	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?		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	X	
11b	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	X	
12b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	X	
12c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	X	
13	Did the organization have a written whistleblower policy?	X	
14	Did the organization have a written document retention and destruction policy?	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?		
15a	The organization's CEO, Executive Director, or top management official	X	
15b	Other officers or key employees of the organization	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?		X
16b	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?		

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 CHAIRMAN	0.50 0.50	X		X				0.	0.	0.
(2) RAYMOND HAMM VICE CHAIRMAN/TREASURER	0.50 0.50	X		X				0.	0.	0.
(3) RONALD GRAYBEAL SECRETARY	0.50 0.50	X		X				0.	0.	0.
(4) KELLY ALBANESE DIRECTOR	0.50 0.50	X						0.	0.	0.
(5) ALFONSO BASILE, MD DIRECTOR/PHYSICIAN	40.00 0.50	X					376,055.	0.	24,902.	
(6) MARY BOLT, PH.D. DIRECTOR	0.50 0.50	X					0.	0.	0.	
(7) RON CULLIS DIRECTOR	0.50 0.50	X					0.	0.	0.	
(8) DAVID FERGUSON DIRECTOR	0.50 0.50	X					0.	0.	0.	
(9) STEPHANIE GARRITY DIRECTOR	0.50 0.50	X					0.	0.	0.	
(10) MARTHA HOSFORD, MD DIRECTOR	0.50 0.50	X					0.	0.	0.	
(11) KENNETH S. LEWIS, MD, JD PRESIDENT/CEO	30.00 10.00	X		X			0.	919,879.	152,713.	
(12) TARI MOORE DIRECTOR (RES 6/1/15)	0.50 0.50	X					0.	0.	0.	
(13) HENRY PASSI DIRECTOR	0.50 0.50	X					0.	0.	0.	
(14) CARL ROBERTS DIRECTOR	0.50 0.50	X					0.	0.	0.	
(15) SHEELMOHAN SACHDEV, MD DIRECTOR	0.50 0.50	X					0.	0.	0.	
(16) LAURIE R. BEYER, CPA SENIOR VP/CFO	28.00 12.00			X			0.	603,883.	91,237.	
(17) CYDNEY TEAL VP MEDICAL AFFAIRS	39.90 0.10				X		0.	369,908.	25,878.	

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below 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) DAVID GIPSON SENIOR VP/COO	28.60 11.40				X			0.	649,279.	89,430.
(19) KHADIJATU BOSTON SENIOR VP/CNO	39.90 0.10				X			0.	230,794.	4,793.
(20) TERRANCE LOVELL VP HUMAN RESOURCES	40.00				X			202,811.	0.	60,967.
(21) IRFAN M HISAMUDDIN PHYSICIAN	40.00					X		563,169.	0.	20,525.
(22) ROGER WU PHYSICIAN	40.00					X		432,064.	0.	18,031.
(23) JUSTIN SAUSVILLE PHYSICIAN	40.00					X		426,510.	0.	24,050.
(24) BERNARD J HYNES PHYSICIAN	40.00					X		414,148.	0.	20,079.
(25) JOHN HEBEKA PHYSICIAN	40.00					X		367,630.	0.	23,944.
1b Sub-total								2,782,387.	2,773,743.	556,549.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								2,782,387.	2,773,743.	556,549.

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 **110**

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
WHITING-TURNER CONTRACTING CO. P.O. BOX 17596, BALTIMORE, MD 21297	CONTRACTOR	4,837,457.
UNION RADIOLOGISTS, LLC 106 BOW STREET, ELKTON, MD 21921	RADIOLOGISTS	3,100,000.
PHILIPS MEDICAL SYSTEMS P.O. BOX 100355, ATLANTA, GA 30384	EQUIPMENT SERVICE	1,024,071.
INSIGHT INVESTMENTS 611 ANTON BLVD., COSTA MESA, CA 92626	LEASING MANAGEMENT SERVICE	921,240.
DIVERSIFIED CLINICAL SERVICES, INC 4500 SALISBURY ROAD, JACKSONVILLE, FL 32216	MEDICAL MANAGEMENT COMPANY	807,627.

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 **90**

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	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d	293,176.				
	e Government grants (contributions)	1e	2,000,000.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	67,770.				
	g Noncash contributions included in lines 1a-1f: \$						
	h Total. Add lines 1a-1f		2,360,946.				
	Program Service Revenue	2 a NET PATIENT SERVICE REVENUE	Business Code 621990	154,746,973.	154,746,973.		
b OTHER OPERATING REVENUE		621990	888,053.	888,053.			
c ADULT DAY CARE		623990	526,092.	526,092.			
d LIFELINE		900099	42,963.	42,963.			
e							
f All other program service revenue							
g Total. Add lines 2a-2f			156,204,081.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		1,310,660.			1,310,660.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real	47,011.				
		(ii) Personal					
		b Less: rental expenses		21,812.			
		c Rental income or (loss)		25,199.			
	d Net rental income or (loss)		25,199.			25,199.	
	7 a Gross amount from sales of assets other than inventory	(i) Securities	6,708,428.				
		(ii) Other		23,669.			
		b Less: cost or other basis and sales expenses		5,479,617.			
		c Gain or (loss)		1,228,811.			
	d Net gain or (loss)		1,224,093.			1,224,093.	
	8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a					
		b Less: direct expenses	b				
c Net income or (loss) from fundraising events							
9 a Gross income from gaming activities. See Part IV, line 19	a						
	b Less: direct expenses	b					
	c Net income or (loss) from gaming activities						
10 a Gross sales of inventory, less returns and allowances	a						
	b Less: cost of goods sold	b					
	c Net income or (loss) from sales of inventory						
Miscellaneous Revenue		Business Code					
11 a LABORATORY REVENUE		621500	1,870,225.		1,870,225.		
	b MEANINGFUL USE REVENUE		910,052.			910,052.	
	c CAFETERIA/FOOD SERVICE		810,826.			810,826.	
	d All other revenue		346,795.		9,543.	337,252.	
	e Total. Add lines 11a-11d		3,937,898.				
12 Total revenue. See instructions.		165,062,877.	156,204,081.	1,879,768.	4,618,082.		

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	1,790,991.	1,790,991.		
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	309,091.		309,091.	
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	67,661,012.	66,611,882.	1,049,130.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	535,543.	514,348.	21,195.	
9 Other employee benefits	7,327,523.	7,302,831.	24,692.	
10 Payroll taxes	4,625,708.	4,555,547.	70,161.	
11 Fees for services (non-employees):				
a Management	2,253,624.	1,126,812.	1,126,812.	
b Legal	294,046.		294,046.	
c Accounting	96,911.		96,911.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	45,877.		45,877.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	20,531,251.	20,086,799.	444,452.	
12 Advertising and promotion	533,249.	533,249.		
13 Office expenses	2,129,723.	2,067,838.	61,885.	
14 Information technology	255,858.	255,858.		
15 Royalties				
16 Occupancy	2,933,146.	2,933,146.		
17 Travel	238,982.	191,148.	47,834.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	48,934.	19,296.	29,638.	
20 Interest	2,346,084.	2,346,084.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	10,866,890.	10,866,890.		
23 Insurance	2,967,215.	2,967,215.		
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	19,423,346.	19,423,346.		
b BAD DEBTS	6,631,024.	6,631,024.		
c REPAIRS & MAINTENANCE	2,824,631.	2,824,631.		
d DIETARY	1,081,521.	1,081,521.		
e All other expenses	1,677,713.	1,507,070.	170,643.	
25 Total functional expenses. Add lines 1 through 24e	159,429,893.	155,637,526.	3,792,367.	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)		(B)
		Beginning of year		End of year
Assets	1 Cash - non-interest-bearing	4,791,231.	1	7,622,571.
	2 Savings and temporary cash investments	2,877,238.	2	2,225,164.
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	17,964,783.	4	13,294,247.
	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	1,936,385.	8	1,974,105.
	9 Prepaid expenses and deferred charges	2,604,779.	9	2,893,481.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 206,209,473.		
	b Less: accumulated depreciation	10b 111,641,438.		
	11 Investments - publicly traded securities	94,969,498.	10c	94,568,035.
	12 Investments - other securities. See Part IV, line 11	59,367,528.	11	56,528,098.
	13 Investments - program-related. See Part IV, line 11	5,565,010.	12	6,030,772.
	14 Intangible assets		13	
	15 Other assets. See Part IV, line 11	8,722,178.	14	8,005,541.
16 Total assets. Add lines 1 through 15 (must equal line 34)	198,798,630.	15	193,142,014.	
17 Accounts payable and accrued expenses	15,237,765.	16	12,681,544.	
18 Grants payable		17		
19 Deferred revenue		18		
20 Tax-exempt bond liabilities	72,012,044.	19	66,398,857.	
21 Escrow or custodial account liability. Complete Part IV of Schedule D		20		
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		21		
23 Secured mortgages and notes payable to unrelated third parties		22		
24 Unsecured notes and loans payable to unrelated third parties		23		
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	13,869,984.	24	13,664,099.	
26 Total liabilities. Add lines 17 through 25	101,119,793.	25	92,744,500.	
27 Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.		26		
28 Unrestricted net assets	96,434,672.	27	98,057,789.	
29 Temporarily restricted net assets	1,244,165.	28	2,339,725.	
30 Permanently restricted net assets		29		
31 Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.				
32 Capital stock or trust principal, or current funds		30		
33 Paid-in or capital surplus, or land, building, or equipment fund		31		
34 Retained earnings, endowment, accumulated income, or other funds		32		
35 Total net assets or fund balances	97,678,837.	33	100,397,514.	
36 Total liabilities and net assets/fund balances	198,798,630.	34	193,142,014.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	165,062,877.
2	Total expenses (must equal Part IX, column (A), line 25)	2	159,429,893.
3	Revenue less expenses. Subtract line 2 from line 1	3	5,632,984.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	97,678,837.
5	Net unrealized gains (losses) on investments	5	-2,517,187.
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	-397,120.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	100,397,514.

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: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other		
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?		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:			
<input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	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:			
<input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input checked="" type="checkbox"/> 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?	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?		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		

Form 990 (2014)

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

2014

Open to Public Inspection

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

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

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

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E.)
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8 A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9 An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)
- 10 An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 11 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**. Check the box 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 or IRC section (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see Instructions)	(vi) Amount of other support (see Instructions)
			Yes	No		
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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2014 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2013 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2014. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 33 1/3% support test - 2013. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2014. 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		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2013. 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		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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 2014 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2013 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2013 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2014. 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 - 2013. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

Part IV Supporting Organizations

(Complete only if you checked a box on line 11 of 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? <i>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.</i>		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>		
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2) (B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below.</i>		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
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)? <i>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.</i>		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>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).</i>		
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?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations; (b) individuals that are part of the charitable class benefited by one or more of its supported organizations; or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
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))? <i>If "Yes," provide detail in Part VI.</i>		
b Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
c Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
10a Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer (b) below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

Part IV Supporting Organizations (continued)

	Yes	No
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?		
b A family member of a person described in (a) above?		
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 .		

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.		
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.		

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).		

Section D. 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, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
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).		
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.		

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 year (see instructions):		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
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.	Yes	No
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.		
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 .		
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.		

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	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).		

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 2014 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-2014	(iii) Distributable Amount for 2014
1 Distributable amount for 2014 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2014 (reasonable cause required-see instructions)			
3 Excess distributions carryover, if any, to 2014:			
a			
b			
c			
d			
e From 2013			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2014 distributable amount			
i Carryover from 2009 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2014 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2014 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2014, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions).			
6 Remaining underdistributions for 2014. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7 Excess distributions carryover to 2015. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a			
b			
c			
d Excess from 2013			
e Excess from 2014			

Schedule A (Form 990 or 990-EZ) 2014

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

2014

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

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).

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2014)

Name of organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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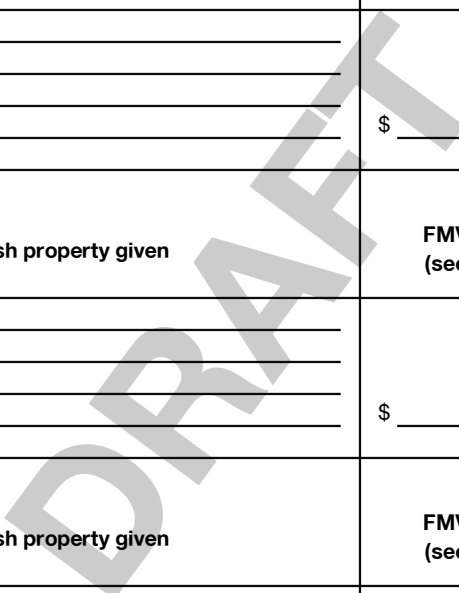
Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	MARYLAND HOSPITAL ASSOCIATION 6820 DEERPATH RD. ELKRIDGE, MD 21075	\$ 35,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	UNION HOSPITAL OF CECIL COUNTY FOUNDATION, INC. 106 BOW STREET ELKTON, MD 21921	\$ 293,176.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	MARYLAND COMPTROLLERS OFFICE - CAPITAL GRANTS UNIT ROOM 215, LLG TREASURY BLDG., 80 CALVERT STREET ANNAPOLIS, MD 21404	\$ 2,000,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

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



Name of organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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Part III Exclusively religious, charitable, etc., 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" to 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

2014
Open to Public Inspection

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

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

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

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).
 Preservation of land for public use (e.g., recreation or education) Preservation of 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?

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

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

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

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 in Form 990, Part VIII, line 1

(ii) Assets included in Form 990, Part X

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

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

b Assets included in Form 990, Part X

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

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

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

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

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

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

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

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

	Amount
c Beginning balance	1c
d Additions during the year	1d
e Distributions during the year	1e
f Ending balance	1f

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

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

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

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

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

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

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

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

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

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

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" to 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		80,126,043.	31,842,922.	48,283,121.
c Leasehold improvements		159,229.	75,748.	83,481.
d Equipment		121,564,983.	78,536,585.	43,028,398.
e Other		3,137,913.	1,186,183.	1,951,730.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				94,568,035.

Part VII Investments - Other Securities.

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

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

Part X Other Liabilities.

Complete if the organization answered "Yes" to 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	2,891,605.
(3) CAPITAL LEASE OBLIGATIONS	2,886,324.
(4) ESTIMATED MEDICAL MALPRACTICE	
(5) CLAIMS LIABILITY	7,764,109.
(6) DUE TO AFFILIATE	122,061.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	13,664,099.

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

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

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

1	Total revenue, gains, and other support per audited financial statements		1	155,566,432.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
a	Net unrealized gains (losses) on investments	2a	-2,517,187.	
b	Donated services and use of facilities	2b		
c	Recoveries of prior year grants	2c		
d	Other (Describe in Part XIII.)	2d	-6,979,258.	
e	Add lines 2a through 2d	2e		-9,496,445.
3	Subtract line 2e from line 1	3		165,062,877.
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		165,062,877.

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

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

1	Total expenses and losses per audited financial statements		1	152,847,755.
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	94,763.	
e	Add lines 2a through 2d	2e		94,763.
3	Subtract line 2e from line 1	3		152,752,992.
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	6,676,901.	
c	Add lines 4a and 4b	4c		6,676,901.
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)	5		159,429,893.

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 2015 AND 2014.

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 2012 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	386,848.
LOSS ON REFINANCING	-763,968.
PROVISION FOR BAD DEBTS NETTED AGAINST REVENUE ON FINANCIAL STATEMENTS	-6,631,024.
BANK FEES NETTED ON FINANCIAL STATEMENTS	-45,877.
NET ASSETS RELEASED	-20,000.
WRITE OFF OF PLEDGES NETTED AGAINST TRANSFER TO AFFILIATE ON FINANCIALS	94,763.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	-6,979,258.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

WRITE OFF OF PLEDGES NETTED AGAINST TRANSFER TO AFFILIATE ON FINANCIALS	94,763.
---	---------

PART XII, LINE 4B - OTHER ADJUSTMENTS:

PROVISION FOR BAD DEBTS NETTED AGAINST REVENUE ON FINANCIAL STATEMENTS	6,631,024.
BANK FEES NETTED ON FINANCIAL STATEMENTS	45,877.
TOTAL TO SCHEDULE D, PART XII, LINE 4B	6,676,901.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2014

Department of the Treasury
Internal Revenue Service

- ▶ **Complete if the organization answered "Yes" to 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.**

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	<input checked="" type="checkbox"/>	
b If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	<input checked="" type="checkbox"/>	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	<input checked="" type="checkbox"/>	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the 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"?	<input checked="" type="checkbox"/>	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<input checked="" type="checkbox"/>	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		<input checked="" type="checkbox"/>
6a Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization make it available to the public?	<input checked="" type="checkbox"/>	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			833,308.		833,308.	.55%
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			833,308.		833,308.	.55%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		9,390	286,805.	46,308.	240,497.	.16%
f Health professions education (from Worksheet 5)		1,023	729,887.		729,887.	.48%
g Subsidized health services (from Worksheet 6)		146	11,378,445.	6,435,052.	4,943,393.	3.24%
h Research (from Worksheet 7)		39,246	7,568.		7,568.	.00%
i Cash and in-kind contributions for community benefit (from Worksheet 8)			334,437.	154,823.	179,614.	.12%
j Total. Other Benefits		49,805	12,737,142.	6,636,183.	6,100,959.	4.00%
k Total. Add lines 7d and 7j		49,805	13,570,450.	6,636,183.	6,934,267.	4.55%

Part V Facility Information

Section A. Hospital Facilities

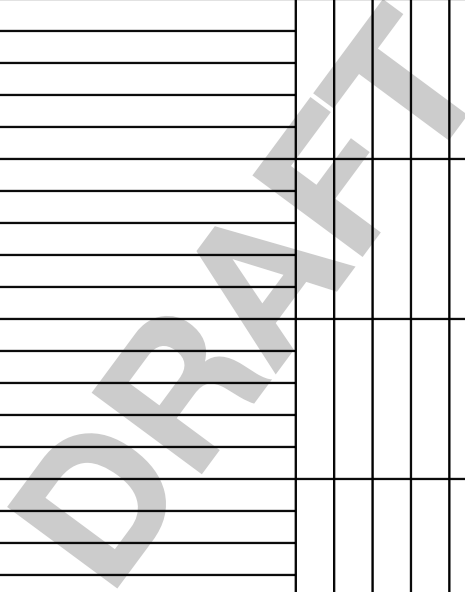
(list in order of size, from largest to smallest)

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)

1 UNION HOSPITAL OF CECIL COUNTY, INC.
106 BOW STREET
ELKTON, MD 21921
WWW.UHCC.COM
07-005

Table with columns: 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. Row 1 contains 'X' marks in the first three and seventh columns.



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?		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		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	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>12</u>		
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	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		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		X
7 Did the hospital facility make its CHNA report widely available to the public?	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.UHCC.COM</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> 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	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>12</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a If "Yes," (list url): <u>WWW.UHCC.COM</u>		
b If "No", is the hospital facility's most recently adopted implementation strategy attached to this return?		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)?		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
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 <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input checked="" type="checkbox"/> Residency		
h <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> 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 <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> 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 <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Actions that require a legal or judicial process		
d <input type="checkbox"/> Other similar actions (describe in Section C)		
e <input checked="" type="checkbox"/> 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?		X
If "Yes", check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Actions that require a legal or judicial process		
d <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> 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 <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions			
b <input type="checkbox"/> The hospital facility's policy was not in writing			
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d <input type="checkbox"/> 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 <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d <input checked="" type="checkbox"/> 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: CONDUCTING THE COMMUNITY HEALTH NEEDS

ASSESSMENT (CHNA) WAS A COLLABORATIVE EFFORT BETWEEN UNION HOSPITAL OF

CECIL COUNTY AND THE CECIL COUNTY HEALTH DEPARTMENT. UNION HOSPITAL'S

COMMUNITY BENEFITS COORDINATOR MET WITH CECIL COUNTY HEALTH DEPARTMENT'S

PUBLIC HEALTH OFFICER, DEPUTY PUBLIC HEALTH OFFICER, AND EPIDEMIOLOGIST TO

CONDUCT THE COMMUNITY HEALTH NEEDS ASSESSMENT. THIS TEAM FACILITATED A

SERIES OF MEETINGS WITH BOTH COMMUNITY LEADERS AND COMMUNITY RESIDENTS TO

GAIN FIRST-HAND KNOWLEDGE OF IMPORTANT HEALTH NEEDS IN CECIL COUNTY. THE

CHNA PROCESS BEGAN IN JANUARY 2012 (DURING THE 3RD QUARTER OF FISCAL YEAR

2012). SECONDARY DATA WAS ANALYZED AND USED IN CONJUNCTION WITH ALL

COMMUNITY MEETINGS AS PART OF THE SUPPORTING DATA PLATFORM. USE OF

SECONDARY DATA WAS ALSO INTEGRAL TO THE HEALTH NEEDS PRIORITIZATION

PROCESS CONDUCTED BY UNION HOSPITAL.

INPUT FROM COMMUNITY PARTNERS ENGAGED IN CECIL COUNTY'S LOCAL HEALTH

IMPROVEMENT COALITION MEETINGS WAS INCLUDED TO FURTHER VERIFY AND SUPPORT

CONDUCTION OF THE CHNA. THE COMMUNITY PARTNERS CONSULTED WERE AS FOLLOWS:

*AMERICAN CANCER SOCIETY

*CECIL COLLEGE

*CECIL COUNTY COMMISSIONERS

*CECIL COUNTY DEPARTMENT OF EMERGENCY SERVICES

*CECIL COUNTY DEPARTMENT OF JUVENILE SERVICES

*CECIL COUNTY DEPARTMENT OF SOCIAL SERVICES

*CECIL COUNTY HEALTH DEPARTMENT

*CECIL COUNTY LIQUOR BOARD

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.

*CECIL COUNTY LOCAL MANAGEMENT BOARD

*CECIL COUNTY PARKS AND RECREATIONAL SERVICES

*CECIL COUNTY PUBLIC SCHOOLS

*CECIL COUNTY SHERIFF'S OFFICE

*ELKTON HOUSING AUTHORITY

*JOHNS HOPKINS HEALTH CARE

*MARYLAND STATE DELEGATION

*MARYLAND STATE SENATE

*PRIVATE HEALTH CARE PROVIDERS

*PROJECT CROSSROAD

*UNION HOSPITAL EMPLOYED PROVIDERS, STAFF, AND EXECUTIVE MANAGEMENT

*UNIVERSITY OF MARYLAND STATEWIDE HEALTH NETWORK

*UPPER BAY COUNSELING AND SUPPORT SERVICES

*WEST CECIL HEALTH CENTER (FQHC)

*YMCA

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

FOUR FOCUS GROUPS WERE ALSO CONDUCTED WITH COMMUNITY RESIDENTS. THESE FOCUS GROUPS INCLUDED RESIDENTS FROM ELKTON, CHARLESTOWN, NORTH EAST, CHESAPEAKE CITY, CECILTON, PERRYVILLE, RISING SUN, AND PORT DEPOSIT. FOCUS GROUP PARTICIPANTS INCLUDED YOUNG ADULTS, SENIOR CITIZENS, MEMBERS FROM VARIOUS LOCAL COMMUNITY ORGANIZATIONS AND CHURCHES, HOMEMAKERS, SMALL

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.

BUSINESS OWNERS, LIFE COACHES, RETIREES, AND COMMUNITY ORGANIZERS. THE FOCUS GROUPS WERE FACILITATED/MODERATED BY UNION HOSPITAL'S COMMUNITY BENEFITS COORDINATOR AND CECIL COUNTY HEALTH DEPARTMENT'S PUBLIC HEALTH OFFICER. THE HEALTH DEPARTMENT'S EPIDEMIOLOGIST PROVIDED TECHNICAL SUPPORT AND TRANSCRIPTION OF MEETING NOTES.

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

FOCUS GROUP	HEALTH NEEDS IDENTIFIED
ELKTON FOCUS GROUP	SUBSTANCE ABUSE
	MENTAL HEALTH CARE ACCESS
	HOMELESSNESS
	SMOKING
	NUTRITION
CHESAPEAKE CITY FOCUS GROUP	LUNG CANCER
	GERIATRIC CARE IMPROVEMENTS
	MEDICAL TRANSPORTATION ACCESS
	CANCER
	TOBACCO USE
	SUBSTANCE ABUSE

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.

OBESITY

MENTAL HEALTH CARE ACCESS

GENERAL ACCESS TO HEALTH CARE

FOR RESIDENTS THAT LIVE BELOW

THE C & D CANAL

PERRYVILLE FOCUS GROUP

CANCER

SMOKING

OBESITY

ACCESS TO HEALTHIER FOODS

MENTAL HEALTH CARE ACCESS

CHILD NEGLECT

SUBSTANCE ABUSE

RISING SUN FOCUS GROUP

MENTAL HEALTH CARE ACCESS

SUICIDE PREVENTION

CANCER

OBESITY

DIABETES

PRESCRIPTION DRUG ABUSE

HEALTH COMMUNICATION IMPROVEMENTS

ADDRESSING HEALTH DISPARITIES

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

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.

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

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

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

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.

- VALUE. SUBJECTIVE MEASURES THAT INDICATED IMPORTANCE.

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

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

UNION HOSPITAL IS CURRENTLY ADDRESSING THESE HEALTH PRIORITIES THROUGH THE COMMUNITY BENEFIT IMPLEMENTATION PLAN AS PART OF THE THREE FISCAL YEAR CYCLE OF THE CHNA.

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 11: UNION HOSPITAL'S INTERNAL COMMUNITY BENEFITS WORKGROUP WAS ESTABLISHED TO MONITOR THE PROGRESSION OF COMMUNITY BENEFITS PLANNING AND REPORTING ACTIVITIES. IT WAS ALSO ESTABLISHED TO SET THE FRAMEWORK FOR ACCOUNTABILITY AND TRANSPARENCY BOTH INTERNALLY AND EXTERNALLY TO THE HOSPITAL. THE WORKGROUP'S MAIN ROLE DURING THE CHNA WAS TO HELP PRIORITIZE HEALTH NEEDS IDENTIFIED FROM BOTH THE COMMUNITY AND THE ANALYSIS OF SECONDARY HEALTH DATA SOURCES.

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

1. RESPIRATORY HEALTH

THE CHNA IDENTIFIED THAT CECIL COUNTY COMMUNITY HEALTH PROBLEMS AND UNION

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.

HOSPITAL RE-ADMISSIONS WERE GREATEST AROUND RESPIRATORY HEALTH ISSUES. IN PARTICULAR, ISSUES LIKE COPD WERE EXACERBATED BY TOBACCO USE. CREATING A TOBACCO CESSATION PROGRAM WAS EXPLORED; HOWEVER, IT WAS DETERMINED THAT BECAUSE OF THE RESOURCES THAT THE CECIL COUNTY HEALTH DEPARTMENT HAD AND WITH SUPPORTS PROVIDED THROUGH THE CECIL COUNTY TOBACCO TASK FORCE, UNION HOSPITAL SHOULD FOCUS TOBACCO CESSATION EFFORTS ON INCREASING THE NUMBER OF CONTACTS AND CONNECTIONS MADE WITH THESE ESTABLISHED COMMUNITY PROGRAMS.

2. HEART DISEASE

THE CHNA IDENTIFIED HEART DISEASE AS THE SECOND MOST IMPORTANT HEALTH ISSUE IN CECIL COUNTY. CECIL COUNTY RESIDENTS ARE AT HIGH RISK FOR HEART DISEASE AND STROKE DUE TO HIGHER PREVALENCE OF DIABETES, HYPERTENSION, AND POOR NUTRITION. UNION HOSPITAL WILL CONTINUE TO PROVIDE OPPORTUNITIES TO EDUCATE AND CREATE AWARENESS AROUND THE RISK FACTORS ASSOCIATED WITH HEART DISEASE, INCLUDING CONTINUED ACCESS TO STROKE RISK ASSESSMENTS AT COMMUNITY EVENTS. IN FACT, DURING FY15 THE UNION HOSPITAL MULTI-SPECIALTY PRACTICES MADE IT THEIR GOAL TO REDUCE HYPERTENSION AMONG OUTPATIENTS. THE PRACTICES WORKED HAND-IN-HAND WITH THE CECIL COUNTY HEALTH DEPARTMENT TO COMPILE EDUCATIONAL MATERIALS FOR PATIENTS, AS WELL AS TRAINED ALL MEDICAL ASSISTANT STAFF IN THE APPROPRIATE WAY TO TAKE A MANUAL BLOOD PRESSURE, ACCORDING TO A COMMUNITY HEALTH POLICY THAT WAS ESTABLISHED IN FY14 THROUGH THE MILLION HEARTS GRANT FOR CECIL COUNTY.

3. OBESITY

IN CECIL COUNTY, OBESITY IMPACTS BOTH YOUTH AND ADULTS. SIMILAR TO HEART DISEASE AND TOBACCO USE, MAKING HEALTHY LIFESTYLE CHOICES, SUCH AS CHOOSING A HEALTHIER DIET OR GETTING MORE EXERCISE, HELPS REDUCE THE RISK

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.

FOR OBESITY. UNION HOSPITAL PARTNERED WITH SEVERAL COMMUNITY ORGANIZATIONS TO ASSESS AND IMPLEMENT ACTIVITIES THAT AIMED TO REDUCE THE PREVALENCE OF OBESITY IN CECIL COUNTY. IN FY15, UNION HOSPITAL PARTNERED WITH NEMOURS HEALTH AND PREVENTION SERVICES, CECIL COUNTY PUBLIC SCHOOLS, CECIL COUNTY HEALTH DEPARTMENT, AND THE YMCA OF CECIL COUNTY, INC. TO IMPLEMENT AN AFTER-SCHOOL PILOT PROGRAM CALLED "CATCH KIDS CLUB" (CKC) IN A TITLE 1 PUBLIC ELEMENTARY SCHOOL AND A PUBLIC MIDDLE SCHOOL IN ELKTON. CKC ENGAGES YOUTH IN STRUCTURED PHYSICAL ACTIVITIES WITH INTEGRATED NUTRITION EDUCATION.

THE CHNA REVEALED SEVERAL HEALTH NEEDS THAT WERE NOT SELECTED FOR PRIORITIZATION BY UNION HOSPITAL. THESE NEEDS ARE NOT BEING ADDRESSED DIRECTLY BY THE HOSPITAL BUT ARE BEING ADDRESSED BY OTHER ENTITIES IN THE COMMUNITY.

LOCAL HEALTH IMPROVEMENT COALITION HEALTH NEEDS: PRESCRIPTION DRUG ABUSE, SUBSTANCE ABUSE, MENTAL HEALTH ACCESS TO TREATMENT, CHILD NEGLECT THESE HEALTH NEEDS WERE NOT PRIORITIZED BECAUSE THE LOCAL HEALTH IMPROVEMENT COALITION WAS ABLE TO PRODUCE A COMMUNITY HEALTH ACTION PLAN TO ADDRESS THEM. MEMBER ORGANIZATIONS IN THE COALITION ARE CURRENTLY WORKING TOGETHER TO INCORPORATE STRATEGIES TO ADDRESS THESE HEALTH NEEDS, AS WELL AS ACHIEVE MEASURABLE OUTCOMES. UNION HOSPITAL IS REPRESENTED ON THE COALITION AND IS CURRENTLY WORKING IN PARTNERSHIP WITH SEVERAL COMMUNITY PARTNERS ON ALL OF THESE HEALTH NEEDS.

HOMELESSNESS

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

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.

THIS COALITION.

ACCESS TO CARE

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

ACCESS TO MEDICAL TRANSPORTATION

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

GERIATRIC CARE IMPROVEMENTS

GERIATRIC CARE IMPROVEMENTS REFLECT CONCERNS RELATED TO FALLS, ISOLATION, DEPRESSION, IMPROPER DIET AND POOR CHRONIC DISEASE MANAGEMENT.

INCIDENTALLY, THE CECIL COUNTY HEALTH DEPARTMENT AND SEVERAL LOCAL COMMUNITY ORGANIZATIONS HAVE PROGRAMS TAILORED TO ADDRESSING, DEPRESSION, ISOLATION, CHRONIC DISEASE MANAGEMENT AND FALLS PREVENTION. UNION HOSPITAL ALSO WORKS ON CHRONIC DISEASE MANAGEMENT AMONG THE ELDERLY AND FALLS PREVENTION.

ADDRESSING DISPARITIES IN HEALTH CARE

HEALTH DISPARITIES HAVE BEEN IDENTIFIED WHERE APPLICABLE IN THE LOCAL

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.

HEALTH IMPROVEMENT COALITION'S COMMUNITY HEALTH ACTION PLAN. UNION

HOSPITAL ACTIVELY SEEKS TO REDUCE HEALTH DISPARITIES BOTH IN ITS DAILY

FUNCTIONING AND IN PARTNERSHIP WITH CECIL COUNTY'S LOCAL HEALTH

IMPROVEMENT COALITION.

UNION HOSPITAL OF CECIL COUNTY, INC.

PART V, LINE 16A, FAP WEBSITE:

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

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

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.

SERVICES COST REVIEW COMMISSION (HSCRC) SETS THE RATES FOR UNION HOSPITAL.

DRAFT

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 \$6,631,024.

PART II, COMMUNITY BUILDING ACTIVITIES:

ECONOMIC DEVELOPMENT (F2)

IN FISCAL YEAR 2015, UNION HOSPITAL SUPPORTED THE FOLLOWING ORGANIZATIONS IN CECIL COUNTY:

- 1. AMER-INDO ORGANIZATION. THIS NON-PROFIT ORGANIZATION SEEKS MUTUAL BUSINESS OPPORTUNITIES BETWEEN AMERICAN & INDONESIAN CULTURES. AS A SUPPORTER OF CULTURAL DIVERSITY, UNION HOSPITAL'S CEO MET WITH THIS ORGANIZATION TO LEARN MORE ABOUT THE BARRIERS AND NEEDS THAT INDONESIANS

Part VI Supplemental Information (Continuation)

IN CECIL COUNTY FACE (BY WAY OF BOARD MEETINGS).

2. 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 HOSPITAL'S WORKFORCE OF HEALTH PROFESSIONALS AND TO BRING MUCH NEEDED PRACTITIONERS TO THE AREA, ESPECIALLY WHERE THERE ARE TOO FEW PROVIDERS OR IDENTIFIED SERVICE GAPS (EXECUTIVE MANAGEMENT STAFF ATTENDED BOARD MEETINGS).

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

4. CECIL COUNTY SCHOOL EMPLOYEES FEDERAL CREDIT UNION BOARD. UNION HOSPITAL FINANCE STAFF SAT ON THE BOARD PROVIDING FINANCIAL GUIDANCE ACCORDING TO THE CREDIT UNION'S MISSION. THE CREDIT UNION'S BOARD PROMOTES FINANCIAL LITERACY AND EDUCATION FOR ITS MEMBERS AND FOR LOCAL ELEMENTARY SCHOOL STUDENTS.

COMMUNITY SUPPORT (F3)

IN FISCAL YEAR 2015, UNION HOSPITAL SUPPORTED THE FOLLOWING COMMUNITY INITIATIVES IN CECIL COUNTY:

1. CALVERT REGIONAL PARK. CALVERT REGIONAL PARK WAS DEVELOPED BY CECIL COUNTY PARKS & RECREATION TO FOSTER THE HEALTH AND WELLBEING OF COMMUNITIES IN CECIL COUNTY. UNION HOSPITAL SUPPORTED THE CALVERT REGIONAL PARK DURING ITS DEVELOPMENT BY PARTICIPATING IN PLANNING SESSIONS TO

Part VI Supplemental Information (Continuation)

PROMOTE COMMUNITY HEALTH AND WELLNESS THROUGH PHYSICAL ACTIVITY ELEMENTS TO BE INCLUDED IN THE PARK.

2. UNITED WAY OF CECIL COUNTY. UNION HOSPITAL EXECUTIVE MANAGEMENT STAFF, AS WELL AS THEIR ADMINISTRATIVE STAFF, WORKED CLOSELY WITH UNITED WAY OF CECIL COUNTY TO SUPPORT ITS COMMUNITY-BASED PROGRAMMING FOR UNDERSERVED YOUTH IN CECIL COUNTY (SPECIFICALLY THROUGH FUNDRAISING AND BOARD SUPPORT).

WORKFORCE DEVELOPMENT (F8)

IN FISCAL YEAR 2015, UNION HOSPITAL SUPPORTED THE FOLLOWING WORKFORCE DEVELOPMENT PROGRAMS/ENTITIES IN CECIL COUNTY:

1. HIGH SCHOOL WORK ENRICHMENT PROGRAM. UNION HOSPITAL FOOD SERVICES STAFF MENTORED 138 MENTALLY-CHALLENGED 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-RELATED WORK ASSIGNMENTS AND TRAINING, 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, WORKING INDIVIDUALLY AND AS PART OF A TEAM.

2. SUSQUEHANNA WORKFORCE BOARD IN CECIL COUNTY. SUSQUEHANNA WORKFORCE IS A NON-PROFIT ORGANIZATION THAT PLANS WORKFORCE DEVELOPMENT PROGRAMS AND SERVICES FOR INDIVIDUALS AND BUSINESSES IN CECIL COUNTY AND HARFORD COUNTY. UNION HOSPITAL EXECUTIVE MANAGEMENT STAFF SUPPORTS THE SUSQUEHANNA WORKFORCE BY ATTENDING BOARD MEETINGS.

3. WORKFORCE DEVELOPMENT WORKSHOPS. UNION HOSPITAL HUMAN RESOURCES STAFF PROVIDES CAREER COUNSELING WORKSHOPS FOR COMMUNITY MEMBERS ON HOW TO CONSTRUCT A RESUME, IMPROVE INTERVIEWING SKILLS, AND CONNECT WITH

Part VI Supplemental Information (Continuation)

WORKFORCE RESOURCES. IN FISCAL YEAR 2015 STAFF PROVIDED INTERVIEW AND RESUME BUILDING SUPPORT FOR PHLEBOTOMY STUDENTS AT CECIL COLLEGE.

4. PHYSICIAN RECRUITMENT. RECRUITMENT COSTS WERE REPORTED IN FISCAL YEAR 2015 FOR SPECIALTIES THAT BRIDGED ACCESS TO HEALTH CARE SERVICE GAPS IN CECIL COUNTY (SPECIFICALLY, ENT, ENDOCRINOLOGY, NEUROLOGY, AND OBSTETRICS/GYNECOLOGY).

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 DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE (WHICH

Part VI Supplemental Information (Continuation)

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 ORDER TO DETERMINE ELIGIBILITY FOR CHARITY CARE PER POLICY. WITHIN 2 BUSINESS DAYS FOLLOWING A PATIENT'S REQUEST FOR CHARITY CARE SERVICES THE

Part VI Supplemental Information (Continuation)

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:

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

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

PART VI, LINE 3:

UNION HOSPITAL OF CECIL COUNTY UTILIZES A COMMUNITY FINANCIAL ASSISTANCE

Part VI Supplemental Information (Continuation)

(CHARITY CARE) POLICY TO ENSURE THAT THE HOSPITAL'S STAFF FOLLOWS A CONSISTENT AND EQUITABLE PROCESS IN GRANTING CHARITY CARE/FINANCIAL ASSISTANCE TO APPROPRIATE PATIENTS, WHILE RESPECTING THE INDIVIDUAL'S DIGNITY. THE POLICY IS IN AGREEMENT WITH THE ESTABLISHED MARYLAND STATE FINANCIAL ASSISTANCE GUIDELINES REGARDING CHARITY CARE.

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

THE APPLICATION FOR FINANCIAL ASSISTANCE IS AVAILABLE TO ALL UNDERINSURED AND UNINSURED PATIENTS OF UNION HOSPITAL. APPLICATIONS AND SIGNAGE ARE LOCATED THROUGHOUT THE HOSPITAL, EMERGENCY ROOM, AND OUTPATIENT AREAS. THE FINANCIAL ASSISTANCE APPLICATION AND BROCHURE (IN ENGLISH AND SPANISH) ARE AVAILABLE ON THE HOSPITAL'S WEBSITE:

[HTTP://WWW.UHCC.COM/ABOUT/PATIENTS-VISITORS/ADMISSION/FINANCIAL-ASSISTANCE](http://www.uhcc.com/about/patients-visitors/admission/financial-assistance)
IN ADDITION, THE HOSPITAL PLACES AN ADVERTISEMENT TWICE A YEAR IN THE LOCAL NEWSPAPERS OUTLINING ITS FINANCIAL ASSISTANCE POLICY.

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

Part VI Supplemental Information (Continuation)

FROM THE HOSPITAL, EACH PATIENT RECEIVES A SUMMARY OF CHARGES WHICH INCLUDES NOTICE OF THE FINANCIAL ASSISTANCE PROGRAM AND A DESIGNATED CONTACT TELEPHONE NUMBER.

PART VI, LINE 4:

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

IN 2014, THE TOTAL POPULATION OF CECIL COUNTY WS 102,383 PERSONS. OF THE TOTAL COUNTY POPULATION, 49.8% WAS FEMALE (50.2% MALE). THE MEDIAN AGE WAS 39.5 YEARS. THE RACIAL MAKE-UP OF THE COUNTY WAS AS FOLLOWS:

- WHITE: 89.3%
- BLACK/AFRICAN AMERICAN: 6.8%
- AMERICAN INDIAN/ALASKAN NATIVE: 0.4%
- ASIAN: 1.6%
- NATIVE PACIFIC ISLANDER: 0.2%
- OTHER: 0.2%
- MULTI-RACIAL: 2.29%

NINETY-FIVE PERCENT OF CECIL COUNTY WAS NON-HISPANIC WITH 96% OF THE POPULATION SPEAKING ENGLISH AS A FIRST LANGUAGE. THE MEDIAN HOUSEHOLD INCOME WAS \$72,809. APPROXIMATELY 6.1% OF FAMILIES WITH CHILDREN LIVED BELOW THE POVERTY LEVEL.

Part VI Supplemental Information (Continuation)

DATA FROM THE 2014 AMERICAN COMMUNITY SURVEY, 1-YEAR ESTIMATES SHOWED THAT 7.7% OF THE POPULATION IN CECIL COUNTY WAS UNINSURED. MCO ENROLLMENT DATA FROM THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE SHOWED THAT AS OF JUNE 30, 2014, 32.6% OF CECIL COUNTY RESIDENTS WERE ENROLLED IN MEDICAID.

PART VI, LINE 5:

EACH FISCAL YEAR, UNION HOSPITAL SERVES THE CECIL COUNTY COMMUNITY BY PROVIDING ACTIVITIES, PROGRAMS, AND INITIATIVES THAT AIM TO IMPROVE COMMUNITY HEALTH, 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 2015:

COMMUNITY HEALTH EDUCATION

- O A VARIETY OF HEALTH EDUCATION TOPICS HELD IN THE COMMUNITY
- O FREE BASIC LIFE SUPPORT (BLS) INSTRUCTION IN THE COMMUNITY
- O EXPLORER POST AT UNION HOSPITAL FOR HIGH SCHOOL STUDENTS SEEKING EXPOSURE TO MEDICAL OR HEALTH SCIENCE EXPERIENCES
- O SUPPORT GROUPS TO SUPPORT VARIOUS HEALTH NEEDS
- O HEALTH FAIRS
- O HEALTH LITERACY CAMPAIGN DEVELOPMENT
- O FACILITATING THE CECIL COUNTY MILLION HEARTS GRANT ACTIVITIES IN THE COMMUNITY THROUGH THE CECIL COUNTY HEALTH DEPARTMENT AND UNION HOSPITAL STAFF AND EMPLOYED PROVIDERS

COMMUNITY-BASED CLINICAL SERVICES

- O WORKING WITH COMMUNITY PARTNERS TO DEVELOP AN INDEPENDENT CRISIS CENTER IN ELKTON, MD TO ENHANCE ACCESS TO BEHAVIORAL HEALTH SUPPORTS IN THE

Part VI Supplemental Information (Continuation)

COMMUNITY

FREE SCREENINGS FOR CANCERS, STROKE, DIABETES, AND HEARING LOSS

FREE SPORTS PHYSICALS FOR COUNTY PUBLIC AND PRIVATE HIGH SCHOOL STUDENTS
(ONE-TIME CLINIC HELD ANNUALLY IN JUNE)

HEALTH CARE SUPPORT SERVICES

FREE, SUPPORTIVE CARE COORDINATION SERVICES FOR VULNERABLE POPULATIONS
OUTSIDE THE HOSPITAL VISIT (FACILITATED THROUGH A HOSPITAL SOCIAL WORKER)

FREE CONSULTATIONS FOR BREAST-FEEDING MOMS IN THE COMMUNITY (FACILITATED
THROUGH A HOSPITAL FAMILY EDUCATOR)

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

LIFELINE INSTALLATIONS

SUPPORTED ACCESS TO HEALTH INSURANCE (IN PARTNERSHIP WITH THE COUNTY
CERTIFIED MARYLAND HEALTH CONNECTION NAVIGATORS)

SUPPORTED THE PEER RECOVERY ADVOCATE PROGRAM PARTNERSHIP BETWEEN THE
ALCOHOL AND DRUG RECOVERY CENTER AT CECIL COUNTY HEALTH DEPARTMENT AND
UNION HOSPITAL'S EMERGENCY DEPARTMENT AND PSYCH UNIT/CRISIS

TRANSPORTATION DONATIONS FOR ELIGIBLE PATIENTS AND THEIR FAMILIES

DEVELOPING/IMPLEMENTING 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)

SOCIAL AND ENVIRONMENTAL IMPROVEMENTS

HOSPITAL STAFF VOLUNTEERS TO PARTICIPATE WITH THE FOLLOWING
OUTDOOR/LABOR-INTENSIVE INITIATIVES TO ENHANCE QUALITY OF LIFE IN CECIL
COUNTY:

- CHRISTMAS IN APRIL

Part VI Supplemental Information (Continuation)

- ADOPT-A-HIGHWAY

O HOSPITAL STAFF VOLUNTEERS TO MENTOR AT-RISK YOUTH

O UNION HOSPITAL SUPPORTS ITS PARTNER IN EDUCATION, GILPIN MANOR ELEMENTARY SCHOOL, THROUGH DONATIONS, MENTOR SUPPORT, AND COMMUNITY HEALTH EDUCATION OPPORTUNITIES FOR FAMILIES

O HOSPITAL STAFF PROVIDES LEADERSHIP DEVELOPMENT THROUGH THE CECIL LEADERSHIP INSTITUTE, A LOCAL, NON-PROFIT, LEADERSHIP ORGANIZATION

O HOSPITAL STAFF SERVES ON THE FOLLOWING COMMUNITY BOARDS THAT SEEK TO IMPROVE THE SOCIAL DETERMINANTS OF HEALTH:

- CECIL HUMAN SERVICES AGENCY

- FAMILY SERVICES ASSOCIATION

- INTERAGENCY COUNCIL ON HOMELESSNESS

HEALTH PROFESSIONS EDUCATION

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

MISSION DRIVEN HEALTH SERVICES

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

- A FREE OSTOMY CLINIC

- EMPLOYED PHYSICIAN PRACTICE SUBSIDIES

- ACCESS TO PEDIATRIC HOSPITALISTS

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

- FREE HOSPICE SUPPORT

CLINICAL RESEARCH

O UNION HOSPITAL MAINTAINS A CANCER REGISTRY THROUGH THE CANCER PROGRAM

Part VI Supplemental Information (Continuation)

THAT IS AVAILABLE TO HEALTH SERVICE PROVIDERS AND RESEARCHERS.

FINANCIAL/IN-KIND CONTRIBUTIONS

O UNION HOSPITAL PROVIDED DONATIONS OF TIME (STAFF VOLUNTEER HOURS) AND MONEY (EQUIPMENT/SUPPLIES DONATIONS) FOR THE LOCAL COMMUNITY. EXAMPLES INCLUDE:

- PROVISION OF FREE AMBULANCE TRANSPORTS AND FREE SUPPLIES FOR AMBULANCE STOCK-UPS

- BLOOD DONATIONS AND BLOOD DRIVES

- 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 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

- PROVIDING FREE NOTARY SERVICES FOR THE COMMUNITY

- VOLUNTEERING WITH LOCAL ORGANIZATIONS TO PROVIDE A DIRECT IMPACT ON COMMUNITY HEALTH

FUNDRAISING FOR COMMUNITY BENEFIT PROGRAMMING

O COMMUNITY BENEFITS IS WORKING WITH THE UNIVERSITY OF MARYLAND SCHOOL OF DENTISTRY'S PERRYVILLE CLINIC ON A GRANT TO ENHANCE ACCESS TO DENTAL CARE SERVICES IN CECIL COUNTY WHILE REDUCING OVERUTILIZATION OF UNION HOSPITAL'S EMERGENCY DEPARTMENT FOR DENTAL CARE.

FOUNDATION FUNDED COMMUNITY BENEFIT

O THE UNION HOSPITAL FOUNDATION PROVIDES FUNDING FOR THE COMMUNITY ASSISTED MEDICATIONS PROGRAM (CAMP) WHICH PROVIDES REDUCED-COST

Part VI Supplemental Information (Continuation)

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. IS THE PARENT ENTITY.

AFFINITY HEALTH ALLIANCE, INC.'S PURPOSE IS TO SUPPORT THE UNION HOSPITAL OF CECIL COUNTY IN PROVIDING HEALTH CARE AND HEALTH CARE RELATED SERVICES THROUGH THE EFFECTIVE MANAGEMENT OF ALL AFFILIATED CORPORATIONS.

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

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

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

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

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

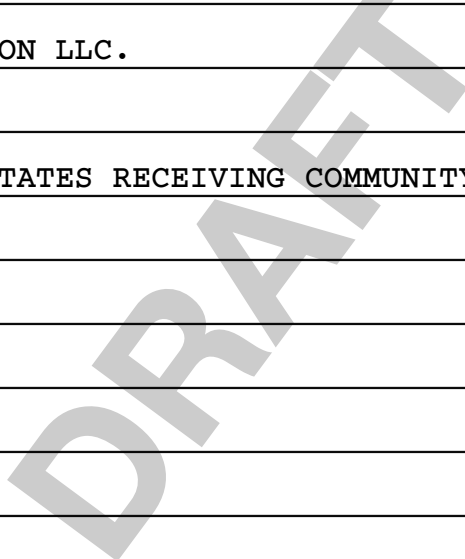
Part VI Supplemental Information (Continuation)

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. IT'S 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" to 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

2014

Open to Public
Inspection

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

Part I General Information on Grants and Assistance

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

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

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNION HOSPITAL OF CECIL COUNTY HEALTH SERVICES, INC. - 106 BOW STREET - ELKTON, MD 21921	52-1794553	501(C)(3)	890,537.	0.			CHARITABLE ACTIVITIES
TRIANGLE HEALTH ALLIANCE, INC. (WHOLLY OWNED SUB OF UHCC VENTURES, INC.) - 106 BOW STREET - ELKTON, MD 21921	01-0789341		647,886.	0.			CAPITAL CONTRIBUTION
OPEN MRI & IMAGING CENTER, LLC. (WHOLLY OWNED SUB OF UHCC VENTURES, INC.) - 106 BOW STREET - ELKTON, MD 21921	20-2119977		252,568.	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.**

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

Schedule I (Form 990) (2014)

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

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

Part IV Supplemental Information. 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)**

Compensation Information

OMB No. 1545-0047

2014

Open to Public Inspection

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.

Department of the Treasury
Internal Revenue Service

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Part I Questions Regarding Compensation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	Yes	No
1b	X	
2	X	
4a		X
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7	X	
8		X
9		

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

Schedule J (Form 990) 2014

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) ALFONSO BASILE, MD DIRECTOR/PHYSICIAN	(i)	341,620.	30,684.	3,751.	3,507.	21,395.	400,957.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) KENNETH S. LEWIS, MD, JD PRESIDENT/CEO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	563,890.	0.	355,989.	128,919.	23,794.	1,072,592.	0.
(3) LAURIE R. BEYER, CPA SENIOR VP/CFO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	280,246.	68,153.	255,484.	66,899.	24,338.	695,120.	228,867.
(4) CYDNEY TEAL VP MEDICAL AFFAIRS	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	293,487.	52,950.	23,471.	3,900.	21,978.	395,786.	0.
(5) DAVID GIPSON SENIOR VP/COO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	284,231.	70,324.	294,724.	67,675.	21,755.	738,709.	231,484.
(6) KHADIJATU BOSTON SENIOR VP/CNO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	183,315.	32,813.	14,666.	3,244.	1,549.	235,587.	0.
(7) TERRANCE LOVELL VP HUMAN RESOURCES	(i)	157,652.	31,532.	13,627.	42,176.	18,791.	263,778.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) IRFAN M HISAMUDDIN PHYSICIAN	(i)	486,119.	76,489.	561.	0.	20,525.	583,694.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) ROGER WU PHYSICIAN	(i)	413,578.	18,037.	449.	3,900.	14,131.	450,095.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) JUSTIN SAUSVILLE PHYSICIAN	(i)	386,747.	18,545.	21,218.	3,865.	20,185.	450,560.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) BERNARD J HYNES PHYSICIAN	(i)	384,778.	28,809.	561.	0.	20,079.	434,227.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) JOHN HEBEKA PHYSICIAN	(i)	356,890.	9,450.	1,290.	3,900.	20,044.	391,574.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(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) MEDICAL LICENSE RENEWAL
- E) FINGERPRINTING/CRIMINAL INVESTIGATION FOR DELAWARE PHYSICIAN LICENSE
- F) BJ'S MEMBERSHIP
- G) CASH

ALL BENEFITS HAVE BEEN INCLUDED IN TAXABLE WAGES.

PART I, LINE 4B:

THE FOLLOWING PEOPLE PARTICIPATE IN A SUPPLEMENTAL, NON-QUALIFIED RETIREMENT PLAN UNDER SECTION 457(F) OF THE INTERNAL REVENUE CODE:

DR. KENNETH LEWIS, PRESIDENT & CEO

LAURIE BEYER, SENIOR VP/CFO

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.

DAVID GIPSON, SENIOR VP/COO

TERRENCE LOVELL, VP HUMAN RESOURCES

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)

12/31/2011 - \$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)

12/31/2011 - \$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)

LAURIE BEYER RECEIVED PAYMENTS FROM THE 457(F) PLAN OF \$236,635

DAVID GIPSON RECEIVED PAYMENTS FROM THE 457(F) PLAN OF \$270,649

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.

Supplemental Information on Tax-Exempt Bonds

ENTITY 1

OMB No. 1545-0047

▶ 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.

2014
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	60,000.		938,596.		1,554,858.					
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

Supplemental Information on Tax-Exempt Bonds

ENTITY 2

OMB No. 1545-0047

▶ 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.

2014
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	2,649,490.		779,379.						
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						
	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				
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

2014

Open to Public
Inspection

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

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

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

PROGRAMS TO SUPPORT THE COMMUNITY WILL BE CONSIDERED WHERE THE NEED

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

INCLUDE COMMUNITY EDUCATION, SPECIAL PROGRAMS FOR THE ELDERLY, SPECIAL

PROGRAMS FOR THE PHYSICALLY/MENTALLY CHALLENGED, MEDICALLY UNDERSERVED

AND A VARIETY OF BROAD COMMUNITY SUPPORT ACTIVITIES.

UNION HOSPITAL OF CECIL COUNTY SERVICED 5,470 ADMISSIONS PROVIDING

21,867 PATIENT DAYS TO INPATIENTS IN FISCAL YEAR 2015 OF WHICH:

1) PATIENTS COVERED UNDER THE MEDICARE PROGRAM WERE 2,645 ADMISSIONS
AND 11,931 PATIENT DAYS

2) PATIENTS COVERED UNDER THE MEDICAID PROGRAM WERE 204 ADMISSIONS AND
972 PATIENT DAYS

3) PATIENTS COVERED UNDER THE MEDICAID HMO PROGRAM WERE 1,332
ADMISSIONS AND 4,680 PATIENT DAYS

4) PATIENTS COVERED UNDER THE MEDICARE HMO PROGRAM WERE 104 ADMISSIONS
AND 394 PATIENT DAYS

CHARITY CARE IS ALSO PROVIDED THROUGH MANY REDUCED PRICE SERVICES AND

FREE PROGRAMS OFFERED THROUGHOUT THE YEAR BASED UPON ACTIVITIES AND

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

FIDE COMMUNITY NEED. THESE INCLUDE:

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

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

Schedule O (Form 990 or 990-EZ) (2014)

432211
08-27-14

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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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 \$11,595,126 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:

THE COMPENSATION COMMITTEE OF THE ORGANIZATION'S BOARD OF DIRECTORS IS

432212
08-27-14

Schedule O (Form 990 or 990-EZ) (2014)

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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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	5,614,216.
MANAGEMENT AND GENERAL EXPENSES	444,452.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	6,058,668.

PHYSICIAN SERVICES AND FEES:

PROGRAM SERVICE EXPENSES	11,199,666.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	11,199,666.

PURCHASED SERVICES:

432212
08-27-14

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

PROGRAM SERVICE EXPENSES	1,637,135.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,637,135.

AGENCY EMPLOYEES:

PROGRAM SERVICE EXPENSES	1,228,972.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,228,972.

TRANSCRIPTION:

PROGRAM SERVICE EXPENSES	245,617.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	245,617.

RECORD FILE STORAGE:

PROGRAM SERVICE EXPENSES	158,996.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	158,996.

OTHER FEES:

PROGRAM SERVICE EXPENSES	2,197.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	2,197.

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A 20,531,251.

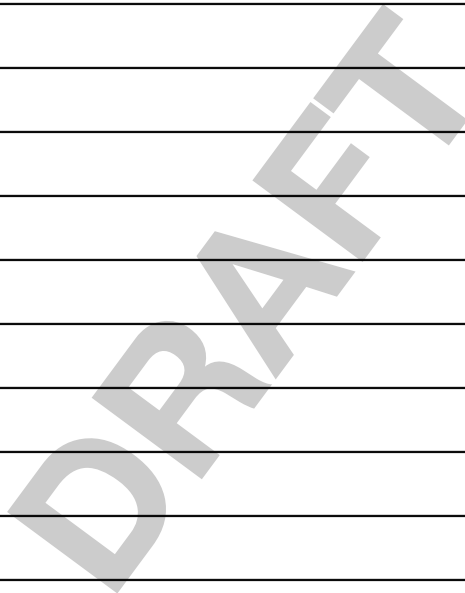
FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

CHANGE IN INTEREST IN NET ASSETS OF SUBSIDIARIES 386,848.

NET ASSETS RELEASED FROM RESTRICTION -20,000.

LOSS ON REFINANCING -763,968.

TOTAL TO FORM 990, PART XI, LINE 9 -397,120.



**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

2014

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	No
UNION HOSPITAL OF CECIL COUNTY FOUNDATION, INC. - 52-1794552, 106 BOW STREET, ELKTON, MD 21921	FUNDRAISING & SUPPORT	MARYLAND	501(C)(3)	LINE 11C, III-FI	AFFINITY HEALTH ALLIANCE, INC.		X
UNION HOSPITAL OF CECIL COUNTY HEALTH SERVICES, INC. - 52-1794553, 106 BOW STREET, ELKTON, MD 21921	HEALTHCARE PROPERTY MANAGEMENT	MARYLAND	501(C)(3)	LINE 9	AFFINITY HEALTH ALLIANCE, INC.		X
CECIL COUNTY BREEDERS FAIR, INC. - 51-6018180, 106 BOW STREET, ELKTON, MD 21921	FUNDRAISING & SUPPORT	MARYLAND	501(C)(4)		UNION HOSPITAL OF CECIL COUNTY FOUNDATION, INC.		X
AFFINITY HEALTH ALLIANCE, INC. - 52-1794697 106 BOW STREET ELKTON, MD 21921	MANAGEMENT & SUPPORT	MARYLAND	501(C)(3)	LINE 11C, III-FI	N/A		X

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

Schedule R (Form 990) 2014

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
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.

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

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

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

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

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

June 30, 2015

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 16, 2016
Special Instructions	The return should be signed and dated.

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

For calendar year 2014 or other tax year beginning JUL 1, 2014, and ending JUN 30, 2015.

2014

▶ 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).

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

Department of the Treasury
Internal Revenue Service

<p>A <input type="checkbox"/> Check box if address changed</p> <p>B Exempt under section <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 408(e) <input type="checkbox"/> 220(e) <input type="checkbox"/> 408A <input type="checkbox"/> 530(a) <input type="checkbox"/> 529(a)</p> <p>C Book value of all assets at end of year <u>193,142,014.</u></p>	<p>Print or Type</p>	<p>Name of organization (<input type="checkbox"/> Check box if name changed and see instructions.) UNION HOSPITAL OF CECIL COUNTY, INC.</p> <p>Number, street, and room or suite no. If a P.O. box, see instructions. 106 BOW STREET</p> <p>City or town, state or province, country, and ZIP or foreign postal code ELKTON, MD 21921-5596</p> <p>F Group exemption number (See instructions.)</p> <p>G Check organization type <input checked="" type="checkbox"/> 501(c) corporation <input type="checkbox"/> 501(c) trust <input type="checkbox"/> 401(a) trust <input type="checkbox"/> Other trust</p>	<p>D Employer identification number (Employees' trust, see instructions.) 52-0607945</p> <p>E Unrelated business activity codes (See instructions.) 621500 541900</p>
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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 <u>1,973,285.</u>			
b Less returns and allowances <u>103,060.</u> c Balance ▶	1c <u>1,870,225.</u>		
2 Cost of goods sold (Schedule A, line 7)	2		
3 Gross profit. Subtract line 2 from line 1c	3 <u>1,870,225.</u>		<u>1,870,225.</u>
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 <u>10,311.</u>	STMT 2	<u>10,311.</u>
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 <u>1,880,536.</u>		<u>1,880,536.</u>

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		<u>567,549.</u>
16 Repairs and maintenance	16		<u>32,926.</u>
17 Bad debts	17		<u>21,014.</u>
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	<u>61,761.</u>	
22 Less depreciation claimed on Schedule A and elsewhere on return	22a		<u>61,761.</u>
23 Depletion	23		
24 Contributions to deferred compensation plans	24		
25 Employee benefit programs	25		<u>104,978.</u>
26 Excess exempt expenses (Schedule I)	26		
27 Excess readership costs (Schedule J)	27		
28 Other deductions (attach schedule)	28	SEE STATEMENT 3	<u>1,436,498.</u>
29 Total deductions. Add lines 14 through 28	29		<u>2,224,726.</u>
30 Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13	30		<u>-344,190.</u>
31 Net operating loss deduction (limited to the amount on line 30)	31	SEE STATEMENT 4	
32 Unrelated business taxable income before specific deduction. Subtract line 31 from line 30	32		<u>-344,190.</u>
33 Specific deduction (Generally \$1,000, but see line 33 instructions for exceptions)	33		<u>1,000.</u>
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		<u>-344,190.</u>

Part III Tax Computation

Table with 3 columns: Description, Line Number, Amount. Includes rows for Organizations Taxable as Corporations (35), Trusts Taxable at Trust Rates (36), Proxy tax (37), Alternative minimum tax (38), and Total (39).

Part IV Tax and Payments

Table with 3 columns: Description, Line Number, Amount. Includes rows for Foreign tax credit (40a-40e), Other taxes (42), Total tax (43), Payments (44a-44g), Total payments (45), Estimated tax penalty (46), Tax due (47), Overpayment (48), and Refunded (49).

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

Table with 3 columns: Question, Yes, No. Includes questions about foreign accounts, foreign trusts, and tax-exempt interest.

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

Table with 3 columns: Description, Line Number, Amount. Includes rows for Inventory at beginning/end of year, Purchases, Cost of labor, Additional section 263A costs, and Total.

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

Sign Here section containing signature of officer (JULIUS C. GREEN), title (SENIOR VP/CFO), and Paid Preparer Use Only section with firm name (BAKER TILLY VIRCHOW KRAUSE, LLP) and address (PHILADELPHIA, PA 19103).

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.	Total	0.
(c) Total income. Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A)		(b) Total deductions. Enter here and on page 1, Part I, line 6, column (B) ...	
		0.	

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

1. Description of debt-financed property		2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property	
			(a) Straight line depreciation (attach 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)		%		
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)				
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-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
Totals		0.		0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income

(see instructions)

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

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

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

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

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

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

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

FORM 990-T	DESCRIPTION OF ORGANIZATION'S PRIMARY UNRELATED BUSINESS ACTIVITY	STATEMENT	1
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LABORATORY SERVICES TO NON-PATIENTS
INCOME FROM PARTNERSHIPS

TO FORM 990-T, PAGE 1

FORM 990-T	INCOME (LOSS) FROM PARTNERSHIPS AND S CORPORATIONS	STATEMENT	2
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DESCRIPTION	AMOUNT
PREMIER PURCHASING PARTNERS LP (EIN: 33-0387407)	4,928.
SECONDARY OPPORTUNITIES FUND II (EIN: 99-0383162)	5,383.
TOTAL TO FORM 990-T, PAGE 1, LINE 5	10,311.

FORM 990-T	OTHER DEDUCTIONS	STATEMENT	3
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DESCRIPTION	AMOUNT
SUPPLIES	408,306.
PURCHASED SERVICES	209,019.
UTILITIES	2,134.
MINOR EQUIPMENT	1,908.
ACCREDITATION FEES	9,434.
EQUIPMENT RENTAL	18,444.
MISCELLANEOUS EXPENSE	14,748.
OVERHEAD ALLOCATION	772,357.
VEHICLE COSTS	124.
TRAVEL & CONFERENCE	24.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	1,436,498.

FORM 990-T

NET OPERATING LOSS DEDUCTION

STATEMENT 4

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.
NOL CARRYOVER AVAILABLE THIS YEAR			5,655,737.	5,655,737.

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

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

► For more information about Form 5471, see www.irs.gov/form5471.
Information furnished for the foreign corporation's annual accounting period (tax year required by section 898) (see instructions) beginning **JAN 1**, 2014, and ending **DEC 31**, 2014

Attachment
Sequence No. **121**

Name of person filing this return UNION HOSPITAL OF CECIL COUNTY, INC. <small>Number, street, and room or suite no. (or P.O. box number if mail is not delivered to street address)</small> 106 BOW STREET City or town, state, and ZIP code ELKTON, MD 21921-5596 Filer's tax year beginning JUL 1 , 2014, and ending JUN 30 , 2015	A Identifying number 52-0607945 B Category of filer (See instructions. Check applicable box(es): 1 (repealed) 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input checked="" type="checkbox"/> C Enter the total percentage of the foreign corporation's voting stock you owned at the end of its annual accounting period 20.00 %
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D Person(s) on whose behalf this information return is filed:

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

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

1a Name and address of foreign corporation FREESTATE HEALTHCARE INSURANCE COMPANY, LTD P.O. BOX 10233 GRAND CAYMAN 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
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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: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">(i) Taxable income or (loss)</td> <td style="width:50%;">(ii) U.S. income tax paid (after all credits)</td> </tr> <tr> <td> </td> <td> </td> </tr> </table>	(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)		
(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)				

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

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

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

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

Schedule F Balance Sheet

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

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

Schedule G Other Information

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

Schedule H Current Earnings and Profits

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

1 Current year net income or (loss) per foreign books of account	1		
2 Net adjustments made to line 1 to determine current earnings and profits according to U.S. financial and tax accounting standards (see instructions):			
	Net Additions	Net Subtractions	
a Capital gains or losses	30,888.		
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 3,618,948.	4,759,307.	
3 Total net additions	3,649,836.		
4 Total net subtractions		4,759,307.	
5a Current earnings and profits (line 1 plus line 3 minus line 4)			5a -1,109,471.
b DASTM gain or (loss) for foreign corporations that use DASTM			5b
c Combine lines 5a and 5b			5c -1,109,471.
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 -1,109,471.
Enter exchange rate used for line 5d ▶ 1.000000			

Schedule I Summary of Shareholder's Income From Foreign Corporation

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

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

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

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

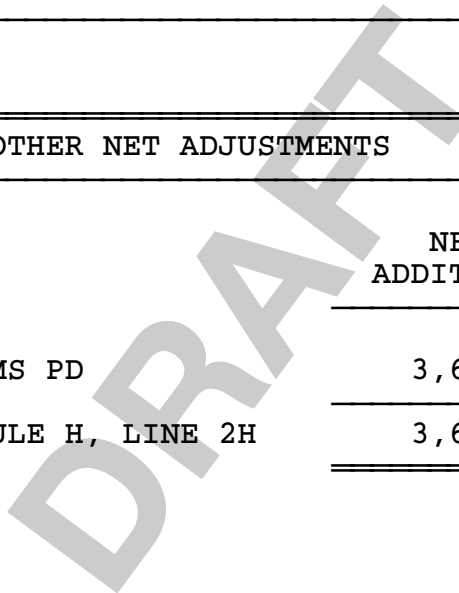
AMOUNT	DESCRIPTION
	N/A

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		4,759,307.
REL. PARTY LOSS RESERVE/CLAIMS PD	3,618,948.	
TOTAL TO 5471, PAGE 4, SCHEDULE H, LINE 2H	3,618,948.	4,759,307.



**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	-8,795,103.					-8,795,103.
2a Current year E&P						
b Current year deficit in E&P	1,109,471.					
3 Total current and accumulated E&P not previously taxed (line 1 plus line 2a or line 1 minus line 2b)	-9,904,574.					
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)	-9,904,574.					
7 Balance at end of year. (Enter amount from line 6a or line 6b, whichever is applicable.)	-9,904,574.					-9,904,574.

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

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

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

Enter the Return code for the return that this application is for (file a separate application for each return) 01

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.

DERON G. BROWN, DIRECTOR OF FINANCE

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

4 I request an additional 3-month extension of time until **MAY 15, 2016**.

5 For calendar year _____, or other tax year beginning **JUL 1, 2014**, and ending **JUN 30, 2015**.

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

Application for Extension of Time To File an Exempt Organization Return

Department of the Treasury
Internal Revenue Service

▶ **File a separate application for each return.**
▶ **Information about Form 8868 and its instructions is at www.irs.gov/form8868.**

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

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

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

DERON G. BROWN, DIRECTOR OF FINANCE

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

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until **MAY 15, 2016**, 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, 2014**, and ending **JUN 30, 2015**.

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.