

# Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Form **990**

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

2016

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](http://www.irs.gov/form990).

Open to Public Inspection

**A** For the 2016 calendar year, or tax year beginning 07/01, 2016, and ending 06/30, 2017

<b>B</b> Check if applicable:  <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C</b> Name of organization THE UNION MEMORIAL HOSPITAL Doing Business As <u>MEDSTAR UNION MEMORIAL HOSPITAL</u>		<b>D</b> Employer identification number 52-0591685
	Number and street (or P.O. box if mail is not delivered to street address) Room/suite 201 EAST UNIVERSITY PARKWAY		<b>E</b> Telephone number (410) 772-6721
	City or town, state or province, country, and ZIP or foreign postal code BALTIMORE, MD 21218		<b>G</b> Gross receipts \$ <u>463,029,985.</u>
	<b>F</b> Name and address of principal officer: <u>BRADLEY CHAMBERS</u> 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218		<b>H(a)</b> Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>H(b)</b> Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)
<b>I</b> Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			
<b>J</b> Website: ▶ <u>WWW.UNIONMEMORIAL.ORG</u>			
<b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			
		<b>L</b> Year of formation: <u>1854</u>	<b>M</b> State of legal domicile: <u>MD</u>

**Part I Summary**

<b>Activities &amp; Governance</b>	1	Briefly describe the organization's mission or most significant activities: <u>TO BE A COMPREHENSIVE HOSPITAL WITH REGIONAL SPECIALTY SERVICES OF DISTINCTION AND QUALITY COMMUNITY SERVICES, ALL ENHANCED BY CLINICAL EDUCATION &amp; RESEARCH.</u>		
	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)	<b>3</b>	24.
	4	Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	15.
	5	Total number of individuals employed in calendar year 2016 (Part V, line 2a)	<b>5</b>	2,595.
	6	Total number of volunteers (estimate if necessary)	<b>6</b>	130.
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	462,691.
7b	Net unrelated business taxable income from Form 990-T, line 34	<b>7b</b>	-91,742.	
<b>Revenue</b>	8	Contributions and grants (Part VIII, line 1h)	<b>Prior Year</b>	<b>Current Year</b>
	9	Program service revenue (Part VIII, line 2g)	2,582,734.	3,607,904.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	437,142,505.	456,497,307.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	987,920.	1,531,149.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	4,045,348.	1,393,625.
<b>Expenses</b>	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	444,758,507.	463,029,985.
	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)	0.	0.
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	201,507,246.	223,380,418.
	16b	Total fundraising expenses (Part IX, column (D), line 25)	6,663.	0.
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	0.	0.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	234,758,224.	224,404,364.
<b>Net Assets or Fund Balances</b>	19	Revenue less expenses. Subtract line 18 from line 12	436,265,470.	447,784,782.
	20	Total assets (Part X, line 16)	8,493,037.	15,245,203.
	21	Total liabilities (Part X, line 26)	0.	0.
	22	Net assets or fund balances. Subtract line 21 from line 20	202,424,790.	200,739,664.
			<b>Beginning of Current Year</b>	<b>End of Year</b>
			59,269,627.	57,006,308.
			143,155,163.	143,733,356.

COPY FOR PUBLIC INSPECTION

**Part II Signature Block**

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

<b>Sign Here</b>	Signature of officer	Date <u>5/10/18</u>
	Type or print name and title JOEL BRYAN VP/TREASURER	

<b>Paid Preparer Use Only</b>	Print/Type preparer's name JG WHITE	Preparer's signature	Date 05/09/2018	Check <input type="checkbox"/> if self-employed	PTIN P01498698	
	Firm's name ▶ KPMG LLP			Firm's EIN ▶ 13-5565207		
	Firm's address ▶ 1676 INTERNATIONAL DRIVE, MCLEAN, VA 22102			Phone no. 703-286-8000		

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2016)

# Application for Automatic Extension of Time To File an Exempt Organization Return

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

**Electronic filing (e-file).** You can electronically file Form 8868 to request a 6-month automatic extension of time to file any of the forms listed below with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, for which an extension request 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](http://www.irs.gov/efile), click on Charities & Non-Profits, and click on e-file for Charities and Non-Profits.

### Automatic 6-Month Extension of Time. Only submit original (no copies needed).

All corporations required to file an income tax return other than Form 990-T (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, see instructions

<b>Type or print</b>  File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.  THE UNION MEMORIAL HOSPITAL	Employer identification number (EIN) or  52-0591685
	Number, street, and room or suite no. If a P.O. box, see instructions. 201 EAST UNIVERSITY PARKWAY	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. BALTIMORE, MD 21218	

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-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

JOEL BRYAN

• The books are in the care of ▶ 10980 GRANTCHESTER WAY COLUMBIA MD 21044

Telephone No. ▶ 410 772-6721 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 6-month extension of time until 05/15, 2018, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

▶  calendar year 20\_\_ or  
▶  tax year beginning 07/01, 2016, and ending 06/30, 2017.

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 <b>Balance due.</b> 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.

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:

ATTACHMENT 1

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

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

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

4a (Code: ) (Expenses \$ 341,222,049. including grants of \$ ) (Revenue \$ 453,066,975. )

ATTACHMENT 2

4b (Code: ) (Expenses \$ 17,141,419. including grants of \$ ) (Revenue \$ 146,650. )

MEDSTAR UNION MEMORIAL PROVIDED \$17.1M IN HEALTH PROFESSIONS EDUCATION IN FISCAL YEAR 2017. THIS CATEGORY INCLUDES TRAINING IN GRADUATE MEDICAL EDUCATION, EDUCATION FOR PHYSICIANS, MEDICAL STUDENTS, NURSES, AND OTHER HEALTH PROFESSIONS.

4c (Code: ) (Expenses \$ 6,152,041. including grants of \$ ) (Revenue \$ 2,903,100. )

MEDSTAR UNION MEMORIAL PROVIDED \$6.1M IN SUBSIDIZED (MISSION DRIVEN) HEALTH SERVICES IN FISCAL YEAR 2017. THESE CRITICAL SERVICES, WHICH ARE DRIVEN BY COMMUNITY NEEDS, OPERATE AT A LOSS. THEY ADDRESS PRIORITIES PRIMARILY THROUGH DISEASE PREVENTION AND IMPROVEMENT OF HEALTH STATUS. SERVICES PROVIDED INCLUDE HOSPITALISTS, AND WOMEN'S AND CHILDREN'S SERVICES.

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

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

4e Total program service expenses 364,515,509.

Part IV Checklist of Required Schedules

Table with 3 columns: Question, Yes, No. Rows 1-19 detailing various organizational requirements and their status.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include questions 20a through 38 regarding organizational operations, financial statements, grants, compensation, tax-exempt bonds, and controlled entities.

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

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

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year (24); 1b Enter the number of voting members included in line 1a, above, who are independent (15); 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: a The governing body? (X); b 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.)

Table with 3 columns: Question, Yes, No. Rows include: 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? a The organization's CEO, Executive Director, or top management official (X); b 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? (X).

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 [X] 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: JOEL BRYAN 10980 GRANTCHESTER WAY COLUMBIA, MD 21044 410-772-6721

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) PETER J. SLOANE, M.D. DIRECTOR	20.00 20.00	X					50,045.	0.	4,324.	
(2) MICHAEL FIOCCO, M.D. DIRECTOR	40.00 0.	X					727,293.	0.	14,989.	
(3) CYNTHIA WEBB, M.D. DIRECTOR	1.00 39.00	X					0.	498,107.	32,738.	
(4) P. JUSTIN TORTOLANI, M.D. DIRECTOR	40.00 0.	X					1,042,737.	0.	23,100.	
(5) CHRISTOPHER D. KEARNEY, M.D. DIRECTOR	40.00 0.	X					154,396.	146,768.	12,649.	
(6) DAVID NASRALLAH, M.D. DIRECTOR	40.00 0.	X					363,002.	0.	40,406.	
(7) MICHAEL RANDOLPH, M.D. DIRECTOR	1.00 0.	X					0.	0.	0.	
(8) KENNETH A. SAMET DIRECTOR	1.00 39.00	X					0.	7,675,042.	76,815.	
(9) BRADLEY S. CHAMBERS PRESIDENT/DIRECTOR	20.00 20.00	X		X			559,724.	559,725.	42,754.	
(10) DAVID NORRIS WILLIS DIRECTOR	1.00 0.	X					0.	0.	0.	
(11) EBEN D. FINNEY, III DIRECTOR	1.00 0.	X					0.	0.	0.	
(12) DERRICK A. ADAMS DIRECTOR	1.00 0.	X					0.	0.	0.	
(13) EILEEN AUEN DIRECTOR	1.00 0.	X					0.	0.	0.	
(14) NATHAN J. BIEL DIRECTOR	1.00 0.	X					0.	0.	0.	



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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
( 15) SAVAS J. KARAS CHAIR	1.00 0.	X						0.	0.	0.
( 16) NANCY PERRY DIRECTOR	1.00 0.	X						0.	0.	0.
( 17) JOHN A. WOLF DIRECTOR	1.00 0.	X						0.	0.	0.
( 18) CHRISTOPHER G. WUNDER DIRECTOR	1.00 0.	X						0.	0.	0.
( 19) WILLIAM F. RIENHOFF, IV DIRECTOR	1.00 0.	X						0.	0.	0.
( 20) PETER R. FENWICK DIRECTOR	1.00 0.	X						0.	0.	0.
( 21) DAWN M. MOTOVIDLAK VICE CHAIR	1.00 0.	X						0.	0.	0.
( 22) JAMES R. PAQUETTE DIRECTOR	1.00 0.	X						0.	0.	0.
( 23) CHRISTOPHER P. GIBSON DIRECTOR (AS OF 11/2016)	1.00 0.	X						0.	0.	0.
( 24) JEFFREY R. ELKIN DIRECTOR (AS OF 11/2016)	1.00 0.	X						0.	0.	0.
( 25) DEANA STOUT CHIEF FINANCIAL OFFICER	20.00 20.00			X				207,095.	207,095.	38,987.
<b>1b Sub-total</b>								2,897,197.	8,879,642.	247,775.
<b>c Total from continuation sheets to Part VII, Section A</b>								7,087,504.	504,096.	233,613.
<b>d Total (add lines 1b and 1c)</b>								9,984,701.	9,383,738.	481,388.

**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 **270**

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 3		

**2** Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **40**

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
( 26) STEPHEN KOENIGSBERG VICE PRESIDENT	20.00 20.00				X		124,086.	124,086.	22,342.	
( 27) SHARON BOTTCHEER VICE PRESIDENT	20.00 20.00				X		172,915.	172,915.	15,647.	
( 28) FRANK EBERT, M.D. PHYSICIAN	40.00 0.					X	1,305,950.	0.	21,766.	
( 29) HENRY BOUCHER, M.D. PHYSICIAN	40.00 0.					X	1,117,584.	0.	23,784.	
( 30) ANAND MURTHI, M.D. MEDICAL DIRECTOR	40.00 0.					X	1,110,136.	0.	23,003.	
( 31) JOHN WANG CHIEF OF CARDIAC CATH LAB	40.00 0.					X	995,417.	0.	23,049.	
( 32) RICHARD LEVINE PHYSICIAN	40.00 0.					X	966,519.	0.	23,071.	
( 33) JOSEPH SMITH FORMER OFFICER	40.00 0.						164,996.	0.	0.	
( 34) STUART BELL FORMER OFFICER	40.00 0.						693,343.	0.	22,360.	
( 35) CHERYL LUNNEN FORMER KEY EMPLOYEE	40.00 0.					X	229,463.	0.	19,604.	
<b>1b Sub-total</b>										
<b>c Total from continuation sheets to Part VII, Section A</b>										
<b>d Total (add lines 1b and 1c)</b>										

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 **270**

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **0**

Part VIII Statement of Revenue

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

Table with columns (A) Total revenue, (B) Related or exempt function revenue, (C) Unrelated business revenue, (D) Revenue excluded from tax under sections 512-514. Rows include Contributions, Gifts, Grants and Other Similar Amounts; Program Service Revenue; and Other Revenue.

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]

Table with 5 columns: (A) Total expenses, (B) Program service expenses, (C) Management and general expenses, (D) Fundraising expenses. Rows include categories like Grants, Compensation, Salaries, Advertising, Office expenses, etc.

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing . . . . .	168,085.	<b>1</b>	4,115.
	<b>2</b> Savings and temporary cash investments . . . . .	0.	<b>2</b>	0.
	<b>3</b> Pledges and grants receivable, net . . . . .	968,283.	<b>3</b>	1,334,948.
	<b>4</b> Accounts receivable, net . . . . .	55,715,293.	<b>4</b>	50,931,985.
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L . . . . .	0.	<b>5</b>	0.
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L . . . . .	0.	<b>6</b>	0.
	<b>7</b> Notes and loans receivable, net . . . . .	8,392.	<b>7</b>	0.
	<b>8</b> Inventories for sale or use . . . . .	6,843,571.	<b>8</b>	7,329,863.
	<b>9</b> Prepaid expenses and deferred charges . . . . .	1,600,906.	<b>9</b>	1,002,987.
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D . . . . .	<b>10a</b> 352,723,157.		
	<b>b</b> Less: accumulated depreciation . . . . .	<b>10b</b> 279,355,251.		
		74,002,500.	<b>10c</b>	73,367,906.
	<b>11</b> Investments - publicly traded securities . . . . .	0.	<b>11</b>	0.
	<b>12</b> Investments - other securities. See Part IV, line 11 . . . . .	58,750,354.	<b>12</b>	66,224,412.
	<b>13</b> Investments - program-related. See Part IV, line 11 . . . . .	0.	<b>13</b>	0.
	<b>14</b> Intangible assets . . . . .	0.	<b>14</b>	0.
<b>15</b> Other assets. See Part IV, line 11 . . . . .	4,367,406.	<b>15</b>	543,448.	
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	202,424,790.	<b>16</b>	200,739,664.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	31,384,658.	<b>17</b>	27,641,411.
	<b>18</b> Grants payable . . . . .	1,287,087.	<b>18</b>	2,408,219.
	<b>19</b> Deferred revenue . . . . .	19,667.	<b>19</b>	2,518,111.
	<b>20</b> Tax-exempt bond liabilities . . . . .	0.	<b>20</b>	0.
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D . . . . .	0.	<b>21</b>	0.
	<b>22</b> Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L . . . . .	0.	<b>22</b>	0.
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	0.	<b>23</b>	0.
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .	0.	<b>24</b>	0.
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D . . . . .	26,578,215.	<b>25</b>	24,438,567.
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	59,269,627.	<b>26</b>	57,006,308.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here</b> <input checked="" type="checkbox"/> <b>and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets . . . . .	112,173,641.	<b>27</b>	109,639,777.
	<b>28</b> Temporarily restricted net assets . . . . .	4,619,267.	<b>28</b>	7,786,256.
	<b>29</b> Permanently restricted net assets . . . . .	26,362,255.	<b>29</b>	26,307,323.
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here</b> <input type="checkbox"/> <b>and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds . . . . .		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building, or equipment fund . . . . .		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds . . . . .		<b>32</b>	
	<b>33</b> Total net assets or fund balances . . . . .	143,155,163.	<b>33</b>	143,733,356.
	<b>34</b> Total liabilities and net assets/fund balances . . . . .	202,424,790.	<b>34</b>	200,739,664.

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	463,029,985.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	447,784,782.
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	15,245,203.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	143,155,163.
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	5,609,852.
<b>6</b>	Donated services and use of facilities	<b>6</b>	0.
<b>7</b>	Investment expenses	<b>7</b>	0.
<b>8</b>	Prior period adjustments	<b>8</b>	0.
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-20,276,862.
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	143,733,356.

**Part XII Financial Statements and Reporting**

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

- 1** Accounting method used to prepare the Form 990:  Cash  Accrual  Other \_\_\_\_\_  
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant? . . . . .  
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant? . . . . .  
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain 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? . . . . .
- 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.

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

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

**Public Charity Status and Public Support**

OMB No. 1545-0047

**2016**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

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

▶ Attach to Form 990 or Form 990-EZ.

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

Name of the organization <b>THE UNION MEMORIAL HOSPITAL</b>	Employer identification number <b>52-0591685</b>
--	---

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

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

- 1  A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2  A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E (Form 990 or 990-EZ).)
- 3  A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4  A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: \_\_\_\_\_
- 5  An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6  A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7  An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8  A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9  An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: \_\_\_\_\_
- 10  An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)
- 11  An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 12  An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**. Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
  - a  **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
  - b  **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
  - c  **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
  - d  **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
  - e  Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
  - f Enter the number of supported organizations. . . . .
  - g Provide the following information about the supported organization(s).

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

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule A (Form 990 or 990-EZ) 2016

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

Section A. Public Support

Table with 7 columns: (a) 2012, (b) 2013, (c) 2014, (d) 2015, (e) 2016, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2012, (b) 2013, (c) 2014, (d) 2015, (e) 2016, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10.

12 Gross receipts from related activities, etc. (see instructions) 12
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here

Section C. Computation of Public Support Percentage

14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f)) 14 %
15 Public support percentage from 2015 Schedule A, Part II, line 14 15 %
16a 33 1/3% support test - 2016. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization
b 33 1/3% support test - 2015. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization
17a 10%-facts-and-circumstances test - 2016. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization
b 10%-facts-and-circumstances test - 2015. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions



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

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

Section A. Public Support

Table with 7 columns: (a) 2012, (b) 2013, (c) 2014, (d) 2015, (e) 2016, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Gross receipts from admissions, merchandise sold or services performed; 3 Gross receipts from activities that are not an unrelated trade or business under section 513; 4 Tax revenues levied for the organization's benefit; 5 The value of services or facilities furnished by a governmental unit; 6 Total. Add lines 1 through 5; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 7c Add lines 7a and 7b; 8 Public support. (Subtract line 7c from line 6.)

Section B. Total Support

Table with 7 columns: (a) 2012, (b) 2013, (c) 2014, (d) 2015, (e) 2016, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 10b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975; 10c Add lines 10a and 10b; 11 Net income from unrelated business activities not included in line 10b; 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

Table with 3 columns: Description, Value, Percentage. Row 15: Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f)). Row 16: Public support percentage from 2015 Schedule A, Part III, line 15.

Section D. Computation of Investment Income Percentage

Table with 3 columns: Description, Value, Percentage. Row 17: Investment income percentage for 2016 (line 10c, column (f) divided by line 13, column (f)). Row 18: Investment income percentage from 2015 Schedule A, Part III, line 17.

19a 33 1/3% support tests - 2016. 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 - 2015. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization.

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

Table with 3 columns: Question, Yes, No. Rows include questions 1 through 10b regarding supported organizations, including their designation, IRS status, foreign support, and excess business holdings.

Part IV Supporting Organizations (continued)

Table with 3 columns: Question, Yes, No. Row 11: Has the organization accepted a gift or contribution from any of the following persons? Sub-rows 11a, 11b, 11c.

Section B. Type I Supporting Organizations

Table with 3 columns: Question, Yes, No. Row 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? Row 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?

Section C. Type II Supporting Organizations

Table with 3 columns: Question, Yes, No. Row 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)?

Section D. All Type III Supporting Organizations

Table with 3 columns: Question, Yes, No. Row 1: Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided? Row 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? Row 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?

Section E. Type III Functionally Integrated Supporting Organizations

Table with 3 columns: Question, Yes, No. Row 1: Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions). Sub-rows a, b, c. Row 2: Activities Test. Answer (a) and (b) below. Sub-rows a, b. Row 3: Parent of Supported Organizations. Answer (a) and (b) below. Sub-rows a, b.

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
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	<b>Adjusted Net Income</b> (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	<b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e <b>Discount</b> 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	<b>Minimum Asset Amount</b> (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	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	

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

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

Section D - Distributions		Current Year		
1	Amounts paid to supported organizations to accomplish exempt purposes			
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity			
3	Administrative expenses paid to accomplish exempt purposes of supported organizations			
4	Amounts paid to acquire exempt-use assets			
5	Qualified set-aside amounts (prior IRS approval required)			
6	Other distributions (describe in Part VI). See instructions.			
7	<b>Total annual distributions.</b> 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 2016 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-2016	(iii) Distributable Amount for 2016
1	Distributable amount for 2016 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2016 (reasonable cause required-explain in Part VI). See instructions.			
3	Excess distributions carryover, if any, to 2016:			
a				
b				
c	From 2013. . . . .			
d	From 2014. . . . .			
e	From 2015. . . . .			
f	<b>Total</b> of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2016 distributable amount			
i	Carryover from 2011 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2016 from Section D, line 7: \$			
a	Applied to underdistributions of prior years			
b	Applied to 2016 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2016, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI. See instructions.			
6	Remaining underdistributions for 2016. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI. See instructions.			
7	<b>Excess distributions carryover to 2017.</b> Add lines 3j and 4c.			
8	Breakdown of line 7:			
a				
b	Excess from 2013. . . .			
c	Excess from 2014. . . .			
d	Excess from 2015. . . .			
e	Excess from 2016. . . .			

---

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

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**Schedule of Contributors**

**2016**

▶ 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](http://www.irs.gov/form990).

Name of the organization THE UNION MEMORIAL HOSPITAL	Employer identification number 52-0591685
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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. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year . . . . . ▶ \$ \_\_\_\_\_

**Caution:** An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 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 doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

<b>Name of organization</b> THE UNION MEMORIAL HOSPITAL	<b>Employer identification number</b> 52-0591685
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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	_____ _____ _____	\$ 825,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	_____ _____ _____	\$ 178,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	_____ _____ _____	\$ 163,718.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	_____ _____ _____	\$ 105,190.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	_____ _____ _____	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	_____ _____ _____	\$ 37,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)



<b>Name of organization</b> THE UNION MEMORIAL HOSPITAL	<b>Employer identification number</b> 52-0591685
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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
7	_____ _____ _____	\$ 35,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	_____ _____ _____	\$ 32,333.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	_____ _____ _____	\$ 32,142.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10	_____ _____ _____	\$ 31,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11	_____ _____ _____	\$ 25,948.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12	_____ _____ _____	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

<b>Name of organization</b> THE UNION MEMORIAL HOSPITAL	<b>Employer identification number</b> 52-0591685
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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
13	_____ _____ _____	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14	_____ _____ _____	\$ 23,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15	_____ _____ _____	\$ 21,125.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16	_____ _____ _____	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17	_____ _____ _____	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18	_____ _____ _____	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

<b>Name of organization</b> THE UNION MEMORIAL HOSPITAL	<b>Employer identification number</b> 52-0591685
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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
19	_____ _____ _____	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
20	_____ _____ _____	\$ 12,530.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
21	_____ _____ _____	\$ 12,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
22	_____ _____ _____	\$ 11,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
23	_____ _____ _____	\$ 10,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
24	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

<b>Name of organization</b> THE UNION MEMORIAL HOSPITAL	<b>Employer identification number</b> 52-0591685
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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
25	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
26	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
27	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
28	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
29	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
30	_____ _____ _____	\$ 8,269.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

<b>Name of organization</b> THE UNION MEMORIAL HOSPITAL	<b>Employer identification number</b> 52-0591685
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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
31	_____ _____ _____	\$ 7,877.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
32	_____ _____ _____	\$ 7,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
33	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
34	_____ _____ _____	\$ 7,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
35	_____ _____ _____	\$ 6,075.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
36	_____ _____ _____	\$ 6,054.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

<b>Name of organization</b> THE UNION MEMORIAL HOSPITAL	<b>Employer identification number</b> 52-0591685
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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
37	_____ _____ _____	\$ 5,865.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
38	_____ _____ _____	\$ 5,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
39	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
40	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
41	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
42	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

<b>Name of organization</b> THE UNION MEMORIAL HOSPITAL	<b>Employer identification number</b> 52-0591685
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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
43	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
44	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
45	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
46	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
47	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
48	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

<b>Name of organization</b> THE UNION MEMORIAL HOSPITAL	<b>Employer identification number</b> 52-0591685
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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
49	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
50	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
51	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
52	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
53	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
54	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)



Name of organization **THE UNION MEMORIAL HOSPITAL**

Employer identification number  
52-0591685

**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
55	_____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
56	_____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
57	_____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
58	_____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
59	_____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
60	_____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

<b>Name of organization</b> THE UNION MEMORIAL HOSPITAL	<b>Employer identification number</b> 52-0591685
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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
61	_____ _____ _____	\$ 5,057.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
62	_____ _____ _____	\$ 5,054.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
63	_____ _____ _____	\$ 20,480.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" 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 <b>THE UNION MEMORIAL HOSPITAL</b>	Employer identification number <b>52-0591685</b>
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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
61	SECURITIES _____ _____ _____	\$ 5,057.	VAR
62	SECURITIES _____ _____ _____	\$ 5,054.	VAR
63	SECURITIES _____ _____ _____	\$ 20,480.	VAR
_____	_____ _____ _____ _____	\$ _____	_____
_____	_____ _____ _____ _____	\$ _____	_____
_____	_____ _____ _____ _____	\$ _____	_____

Name of organization **THE UNION MEMORIAL HOSPITAL**

Employer identification number

52-0591685

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

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____

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

(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)

Supplemental Financial Statements

OMB No. 1545-0047

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

2016

Attach to Form 990.

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Name of the organization: THE UNION MEMORIAL HOSPITAL; Employer identification number: 52-0591685

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

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

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows 1-4 for values, 5-6 for Yes/No questions.

Part II Conservation Easements.

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

Form with multiple sections: Purpose(s) of conservation easements, Table for lines 2a-2d, and questions 3-9 regarding monitoring and reporting.

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

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

Form with questions 1a-1b regarding reporting of art and historical treasures, and 2 regarding financial gain reporting.

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

Schedule D (Form 990) 2016

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

- 3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):
a Public exhibition
b Scholarly research
c Preservation for future generations
d Loan or exchange programs
e Other
4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

Part IV Escrow and Custodial Arrangements.

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

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?
b If "Yes," explain the arrangement in Part XIII and complete the following table:
Table with columns: Amount, 1c Beginning balance, 1d Additions during the year, 1e Distributions during the year, 1f Ending balance
2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?
b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

Part V Endowment Funds.

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

- Table with columns: (a) Current year, (b) Prior year, (c) Two years back, (d) Three years back, (e) Four years back
1a Beginning of year balance
b Contributions
c Net investment earnings, gains, and losses
d Grants or scholarships
e Other expenditures for facilities and programs
f Administrative expenses
g End of year balance
2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
a Board designated or quasi-endowment %
b Permanent endowment %
c Temporarily restricted endowment %
The percentages on lines 2a, 2b, and 2c should equal 100%.
3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
(i) unrelated organizations
(ii) related organizations
b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?
4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

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

Table with 5 columns: Description of property, (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows include Land, Buildings, Leasehold improvements, Equipment, Other, and a Total row.

**Part VII Investments - Other Securities.**

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives . . . . .		
(2) Closely-held equity interests . . . . .		
(3) Other _____		
(A) RESTRICTED INVESTMENT FUNDS	33,076,785.	FMV
(B) GREATER CHES SURGERY CTR	188,039.	FMV
(C) BOARD DESIGNATED	32,959,588.	FMV
(D)		
(E)		
(F)		
(G)		
(H)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 12.) ►	66,224,412.	

**Part VIII Investments - Program Related.**

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

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

**Part IX Other Assets.**

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

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

**Part X Other Liabilities.**

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ADVANCES FROM 3RD PARTY PAYORS	11,361,084.
(3) GBR LIABILITY	507,170.
(4) CREDIT BALANCE PATIENT A/R	2,441,096.
(5) STOCK OPTION PLAN	426,041.
(6) WORKERS COMPENSATION	2,337,044.
(7) INTERCOMPANY PAYABLES	1,415,466.
(8) UCC POOL LIABILITY	516,680.
(9) OTHER LIABILITIES	5,433,986.
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ►	24,438,567.

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 XIII Supplemental Information** (continued)

FIN 48 FOOTNOTE

SCHEDULE D, PART X

INCOME TAXES ARE ACCOUNTED FOR UNDER THE ASSET AND LIABILITY METHOD. DEFERRED TAX ASSETS AND LIABILITIES ARE RECOGNIZED FOR THE FUTURE TAX CONSEQUENCES ATTRIBUTABLE TO DIFFERENCES BETWEEN THE FINANCIAL STATEMENT CARRYING AMOUNTS OF EXISTING ASSETS AND LIABILITIES AND THEIR RESPECTIVE TAX BASES AND OPERATING LOSS AND TAX CREDIT CARRYFORWARDS. DEFERRED TAX ASSETS AND LIABILITIES ARE MEASURED USING ENACTED TAX RATES EXPECTED TO APPLY TO TAXABLE INCOME IN THE YEARS IN WHICH THOSE TEMPORARY DIFFERENCES ARE EXPECTED TO BE RECOVERED OR SETTLED. THE EFFECT ON DEFERRED TAX ASSETS AND LIABILITIES OF A CHANGE IN TAX RATES IS RECOGNIZED IN THE PERIOD THAT INCLUDES THE ENACTMENT DATE. ANY CHANGES TO THE VALUATION ALLOWANCE ON THE DEFERRED TAX ASSET ARE REFLECTED IN THE YEAR OF CHANGE. THE CORPORATION ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH THE FASB ACCOUNTING STANDARDS CODIFICATION (ASC) TOPIC 740, INCOME TAXES. THERE WAS NO LIABILITY RECORDED FOR UNCERTAIN TAX POSITIONS AS OF JUNE 30, 2017.

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2016**

**Open to Public Inspection**

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.

▶ Attach to Form 990.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

THE UNION MEMORIAL HOSPITAL

Employer identification number

52-0591685

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

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

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

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			4,398,013.		4,398,013.	.98
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .						
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
<b>d</b> Total Financial Assistance and Means-Tested Government Programs . . . . .			4,398,013.		4,398,013.	.98
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) . . . . .			1,445,889.	290,866.	1,155,023.	.25
<b>f</b> Health professions education (from Worksheet 5) . . . . .			17,141,419.	146,650.	16,994,769.	3.75
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .			6,152,041.	2,903,100.	3,248,941.	.73
<b>h</b> Research (from Worksheet 7) . . . . .			1,905,252.		1,905,252.	.43
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			68,989.		68,989.	.02
<b>j</b> Total. Other Benefits . . . . .			26,713,590.	3,340,616.	23,372,974.	5.18
<b>k</b> Total. Add lines 7d and 7j. . . . .			31,111,603.	3,340,616.	27,770,987.	6.16

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support			184,871.		184,871.	.04
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy			26,386.		26,386.	.01
8 Workforce development			4,016.		4,016.	
9 Other						
10 Total			215,273.		215,273.	.05

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

**Section A. Bad Debt Expense**

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

**Section B. Medicare**

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

**Section C. Collection Practices**

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

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

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

**Part V Facility Information**

**Section A. Hospital Facilities**

(list in order of size, from largest to smallest - see instructions)  
 How many hospital facilities did the organization operate during the tax year? 1

Name, address, 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 MEMORIAL HOSPITAL  
 201 EAST UNIVERSITY PARKWAY  
 BALTIMORE MD 21218

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

**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 MEMORIAL HOSPITAL

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

		Yes	No
<b>Community Health Needs Assessment</b>			
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 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	X	
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 checked="" 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"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>14</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
6b	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? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply):	X	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.MEDSTARUNIONMEMORIAL.ORG</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>14</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . .	X	
a	If "Yes," (list url): <u>WWW.MEDSTARUNIONMEMORIAL.ORG</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 MEMORIAL HOSPITAL

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>400.0000</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" 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)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	X	
<b>15</b>	Explained the method for applying for financial assistance? . . . . . 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):	X	
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)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.MEDSTARUNIONMEMORIAL.ORG</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>WWW.MEDSTARUNIONMEMORIAL.ORG</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>WWW.MEDSTARUNIONMEMORIAL.ORG</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 checked="" 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 checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" 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"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information (continued)**

**Billing and Collections**

Name of hospital facility or letter of facility reporting group UNION MEMORIAL HOSPITAL

		Yes	No
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 nonpayment? . . . . .	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"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
f	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
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"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<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"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
d	<input checked="" type="checkbox"/> Made presumptive eligibility determinations		
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? . . . . .	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)		

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

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

Name of hospital facility or letter of facility reporting group UNION MEMORIAL HOSPITAL

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



**Part V Facility Information** (continued)

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

CHNA INPUT

PART V, SECTION B, LINE 5

HOSPITAL LEAD

ROLE DESCRIPTION

THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) HOSPITAL LEAD SERVES AS THE COORDINATOR OF ALL ASPECTS OF THE COMMUNITY HEALTH ASSESSMENT PROCESS. HE/SHE HELPS ESTABLISH AND COORDINATE THE ACTIVITIES OF THE ADVISORY TASK FORCE. THE LEAD ALSO HELPS PRODUCE THE HOSPITAL'S COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY. HE/SHE WORKS COLLABORATIVELY WITH REPRESENTATIVES FROM THE CORPORATE COMMUNITY HEALTH DEPARTMENT AND GEORGETOWN UNIVERSITY. THE LEAD ALSO WORKS CLOSELY WITH THE WRITER. HE/SHE REVIEWS ALL NARRATIVES PRIOR TO PUBLICATION.

NAME OF HOSPITAL LEAD: JAMES BLOOM

EXECUTIVE SPONSOR

ROLE DESCRIPTION

THE EXECUTIVE SPONSOR SERVES AS THE CONDUIT BETWEEN THE ADVISORY TASK FORCE AND THE SENIOR MANAGEMENT TEAM. THE SPONSOR IS AN ACTIVE PARTICIPANT OF THE ADVISORY TASK FORCE AND HE/SHE COMMUNICATES THE HOSPITAL'S CLINICAL STRENGTHS AND PROGRAM PRIORITIES TO DIVERSE AUDIENCES.

**Part V Facility Information** (continued)

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

NAME OF EXECUTIVE SPONSOR: STUART BELL, M.D.

ADVISORY TASK FORCE

ROLE DESCRIPTION

THE ADVISORY TASK FORCE (ATF) REVIEWS PRIMARY/SECONDARY DATA AND LOCAL/STATE/FEDERAL COMMUNITY HEALTH GOALS. BASED ON FINDINGS, THE ATF PROVIDES INPUT INTO THE HOSPITAL'S THREE-YEAR IMPLEMENTATION STRATEGY.

AS AMBASSADORS FOR THE CHNA PROCESS, THE ATF MEMBERS SUPPORT EFFORTS TO OPTIMIZE COMMUNITY PARTICIPATION.

NOTE:

THE ATF SHOULD BE A COMBINATION OF COMMUNITY REPRESENTATIVES AND STAFF. COMMUNITY REPRESENTATIVES SHOULD MAKEUP AT LEAST 50% OF TOTAL PARTICIPANTS.

NAME	TITLE/AFFILIATION WITH HOSPITAL	NAME OF ORGANIZATION
JAMES BLOOM	FINANCIAL ANALYST	MEDSTAR UNION MEMORIAL HOSPITAL
BRAD CHAMBERS	PRESIDENT & SVP MSH	MEDSTAR UNION MEMORIAL HOSPITAL

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

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

SAVAS KARAS	BOARD MEMBER	MEDSTAR UNION MEMORIAL HOSPITAL
DERRICK ADAMS	BOARD MEMBER	MEDSTAR UNION MEMORIAL HOSPITAL
SARAH FAWCETT	REGIONAL VP OF PHILANTHROPY	MEDSTAR UNION MEMORIAL HOSPITAL, GUILFORD RESIDENT
LEE		
GLENDIA	EXECUTIVE DIRECTOR	SHEPHERD'S CLINIC & JOY WELLNESS CENTER
SKULETICH		
LISA GHINGER	EXECUTIVE DIRECTOR	HAMPDEN FAMILY CENTER
ALICE ANN	COMMUNITY LEADER	GUILFORD RESIDENT
FINNERTY		
NICHOLE BATTLE	CHIEF EXECUTIVE OFFICER	GOVANS ECUMENICAL DEVELOPMENT CORPORATION

IMPLEMENTATION STRATEGIES

PART V, SECTION B, LINE 8

THE IMPLEMENTATION STRATEGIES SERVE AS A ROADMAP FOR HOW COMMUNITY BENEFIT RESOURCES WILL BE ALLOCATED AND DEPLOYED. MEDSTAR'S HOSPITAL WILL BE ABLE TO MEASURE OUR CONTRIBUTION TO IMPROVING THE HEALTH OF UNDERSERVED AND VULNERABLE POPULATIONS IN THE REGIONS WE SERVE. THREE-YEAR IMPLEMENTATION STRATEGIES WITH MEASURABLE OBJECTIVES WERE DEVELOPED FOR EACH HOSPITAL'S COMMUNITY BENEFIT SERVICE AREA - A SPECIFIC COMMUNITY OR TARGET POPULATION OF FOCUS. PRIORITIES WERE BASED ON COMMUNITY NEED AS DETERMINED BY QUANTITATIVE DATA AND COMMUNITY INPUT, AS

**Part V Facility Information** (continued)

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

WELL AS ON HOSPITAL EXPERTISE, RESOURCES, STRENGTHS OF EXISTING PROGRAMMING AND PARTNERSHIPS, AND ALIGNMENT WITH NATIONAL, STATE, AND LOCAL HEALTH GOALS. THE MEDSTAR HEALTH CORPORATE COMMUNITY HEALTH DEPARTMENT WILL PROVIDE SYSTEM-WIDE COORDINATION AND OVERSIGHT OF COMMUNITY BENEFIT PROGRAMMING.

HOSPITAL ADVISORY TASK FORCES CONVENE AT LEAST ANNUALLY TO MONITOR PROGRESS OF STRATEGY EXECUTION AND TO PROVIDE ONGOING RECOMMENDATIONS RELATED TO OUTCOMES ACHIEVEMENT, PROGRAM DEVELOPMENT, PARTNERSHIP APPROACHES, AND OVERALL IMPLEMENTATION IMPROVEMENT.

FOR SIGNIFICANT NEEDS IDENTIFIED IN THE CHNA THAT THE HOSPITAL HAS NOT PRIORITIZED AS FOCUS AREAS THROUGH ITS IMPLEMENTATION STRATEGY, THESE NEEDS WILL BE ADDRESSED BY COLLABORATING WITH OTHER LEADING ORGANIZATIONS, AND BY TAKING A SUPPORTER ROLE ON IDENTIFIED NEEDS THAT ARE BEYOND THE SCOPE OF THE HOSPITAL'S STRENGTHS.

**Part V Facility Information** (continued)

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

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

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

**Part VI Supplemental Information**

Provide the following information.

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

CHARITY CARE AT COST

PART I, LINE 7A

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

UNREIMBURSED MEDICAID

PART I, LINE 7B

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC), DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S

**Part VI Supplemental Information**

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UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. COMMUNITY BENEFIT EXPENSES ARE EQUAL TO MEDICAID REVENUES IN MARYLAND, AS SUCH, THE NET EFFECT IS ZERO. THE EXCEPTION TO THIS IS THE IMPACT ON THE HOSPITAL OF ITS SHARE OF THE MEDICAID ASSESSMENT. IN RECENT YEARS, THE STATE OF MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING HOSPITALS THROUGH THE RATE-SETTING SYSTEM.

BAD DEBT

PART III, LINES 2 & 4

MEDSTAR HEALTH AND ITS AFFILIATED ORGANIZATIONS REPORT BAD DEBT EXPENSE IN ACCORDANCE WITH ASU 2011-07, WHICH REQUIRES CERTAIN HEALTHCARE ENTITIES TO CHANGE THE PRESENTATION OF THEIR STATEMENT OF OPERATIONS BY RECLASSIFYING THE PROVISION FOR BAD DEBTS ASSOCIATED WITH PATIENT SERVICE REVENUE FROM AN OPERATING EXPENSE TO A DEDUCTION FROM PATIENT SERVICE REVENUE (NET OF CONTRACTUAL ALLOWANCES AND DISCOUNTS). HOWEVER, MEDSTAR AND ITS AFFILIATED ENTITIES DO NOT MAKE A DETERMINATION AS TO WHETHER

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SELF PAY AMOUNTS ARE COLLECTIBLE IN DETERMINING REVENUE RECOGNITION.

RESERVE MODELS, WHICH HAVE BEEN DEVELOPED BASED ON HISTORICAL COLLECTION RESULTS AND WHICH ARE ADJUSTED PERIODICALLY BASED ON ACTUAL COLLECTIONS EXPERIENCE, ARE USED TO ESTIMATE UNCOLLECTIBLE AMOUNTS ACROSS ALL PAYORS INCLUDING SELF PAY. BAD DEBT DETERMINATIONS ARE MADE ONLY AFTER SUFFICIENT EVIDENCE IS OBTAINED TO SUPPORT THAT AN AMOUNT IS NOT COLLECTIBLE.

MEDICARE

PART III, LINE 8

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. AS SUCH,



**Part VI** Supplemental Information

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THE NET EFFECT FOR MEDICARE EXPENSES AND REVENUES IN MARYLAND IS ZERO.

PART III, LINE 9B

IF IT IS DETERMINED THAT A PATIENT MAY POTENTIALLY QUALIFY FOR A CHARITABLE/FINANCIAL PROGRAM, A HOLD IS PLACED ON THE ACCOUNT TO PREVENT IT FROM BEING REPORTED AS BAD DEBT UNTIL PROGRAM APPROVALS HAVE BEEN OBTAINED. IF IT IS APPROVED, THE ACCOUNT IS DOCUMENTED AND THE NECESSARY ADJUSTMENTS ARE MADE TO CLOSE THE ACCOUNT.

NEEDS ASSESSMENT

PART VI, LINE 2

IN FY15, MEDSTAR UNION MEMORIAL HOSPITAL CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN ACCORDANCE WITH THE GUIDELINES ESTABLISHED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE INTERNAL REVENUE SERVICE.

THE HOSPITAL'S CHNA WAS LED BY NINE ADVISORY TASK FORCE (ATF) MEMBERS, WHICH WAS COMPRISED OF A DIVERSE GROUP OF INDIVIDUALS, INCLUDING HOSPITAL

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LEADERSHIP, CLINICAL EDUCATORS AND BOARD MEMBERS. THE ATF REVIEWED  
 QUANTITATIVE AND QUALITATIVE COMMUNITY HEALTH DATA, AS WELL AS LOCAL,  
 REGIONAL AND NATIONAL HEALTH GOALS.

BASED ON THEIR FINDINGS, ATF MEMBERS DESIGNED A SURVEY TO IDENTIFY TRENDS  
 IN HOW PARTICIPANTS PERCEIVED THE SEVERITY OF KEY HEALTH ISSUES IN THE  
 FOLLOWING CATEGORIES: WELLNESS AND PREVENTION, ACCESS TO CARE, QUALITY OF  
 LIFE, AND ENVIRONMENT. COMMUNITY MEMBERS RESPONDED TO THE SURVEY BY  
 ATTENDING A COMMUNITY INPUT SESSION OR COMPLETING IT ONLINE OR VIA  
 HARDCOPY.

BASED ON THE ATF'S RECOMMENDATION, THE HOSPITAL IDENTIFIED NORTH CENTRAL  
 BALTIMORE CITY ZIP CODES 21211, 21213 AND 21218 AS ITS COMMUNITY BENEFIT  
 SERVICE AREA (CBSA) - A GEOGRAPHY WITH A HIGH DENSITY OF LOW-INCOME OR  
 VULNERABLE RESIDENTS WITHIN CLOSE PROXIMITY OF THE HOSPITAL. HEALTH  
 PRIORITIES FOR THE CBSA INCLUDE CHRONIC DISEASE (HEART DISEASE/STROKE,  
 DIABETES, AND OBESITY), AND ACCESS TO CARE.

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THE HOSPITAL'S FY15 CHNA AND THREE-YEAR IMPLEMENTATION STRATEGIES WERE  
 ENDORSED BY MEDSTAR UNION MEMORIAL'S BOARD OF DIRECTORS AND APPROVED BY  
 THE MEDSTAR HEALTH BOARD OF DIRECTORS. THE DOCUMENT WAS PUBLISHED ON THE  
 HOSPITAL'S WEBSITE ON JUNE 30, 2015.

AS A PROUD MEMBER OF MEDSTAR HEALTH, REPRESENTATIVES FROM MEDSTAR UNION  
 MEMORIAL ROUTINELY PARTICIPATE IN THE MEDSTAR HEALTH COMMUNITY BENEFIT  
 WORKGROUP. THE WORKGROUP IS COMPRISED OF COMMUNITY HEALTH PROFESSIONALS  
 WHO REPRESENT ALL TEN MEDSTAR HOSPITALS. THE TEAM ANALYZES LOCAL AND  
 REGIONAL COMMUNITY HEALTH DATA, ESTABLISHES SYSTEM-WIDE COMMUNITY HEALTH  
 PROGRAMMING PERFORMANCE AND EVALUATION MEASURES, AND SHARES BEST  
 PRACTICES.

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

AS ONE OF THE REGION'S LEADING NOT-FOR-PROFIT HEALTHCARE SYSTEMS, MEDSTAR  
 HEALTH IS COMMITTED TO ENSURING THAT UNINSURED PATIENTS WITHIN THE  
 COMMUNITIES WE SERVE WHO LACK FINANCIAL RESOURCES HAVE ACCESS TO

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NECESSARY HOSPITAL SERVICES. MEDSTAR HEALTH AND ITS HEALTHCARE FACILITIES

WILL:

\* TREAT ALL PATIENTS EQUITABLY, WITH DIGNITY, WITH RESPECT AND WITH COMPASSION.

\* SERVE THE EMERGENCY HEALTH CARE NEEDS OF EVERYONE WHO PRESENTS AT OUR FACILITIES REGARDLESS OF A PATIENT'S ABILITY TO PAY FOR CARE.

\* ASSIST THOSE PATIENTS WHO ARE ADMITTED THROUGH OUR ADMISSIONS PROCESS FOR NON-URGENT, MEDICALLY NECESSARY CARE WHO CANNOT PAY FOR PART OF ALL OF THE CARE THEY RECEIVE.

\* BALANCE NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH BROADER FISCAL RESPONSIBILITIES IN ORDER TO KEEP ITS HOSPITALS' DOORS OPEN FOR ALL WHO MAY NEED CARE IN THE COMMUNITY.

IN MEETING ITS COMMITMENTS, MEDSTAR HEALTH'S FACILITIES WORK WITH THEIR UNINSURED PATIENTS TO GAIN AN UNDERSTANDING OF EACH PATIENT'S FINANCIAL RESOURCES PRIOR TO ADMISSION (FOR SCHEDULED SERVICES) OR PRIOR TO BILLING (FOR EMERGENCY SERVICES). BASED ON THIS INFORMATION AND PATIENT

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ELIGIBILITY, MEDSTAR HEALTH'S FACILITIES ASSISTS UNINSURED PATIENTS WHO RESIDE WITHIN THE COMMUNITIES WE SERVE IN ONE OR MORE OF THE FOLLOWING WAYS:

- \* ASSIST WITH ENROLLMENT IN PUBLICLY-FUNDED ENTITLEMENT PROGRAMS (E.G., MEDICAID).
- \* ASSIST WITH CONSIDERATION OF FUNDING THAT MAY BE AVAILABLE FROM OTHER CHARITABLE ORGANIZATIONS.
- \* PROVIDE CHARITY CARE AND FINANCIAL ASSISTANCE ACCORDING TO APPLICABLE GUIDELINES.
- \* PROVIDE FINANCIAL ASSISTANCE FOR PAYMENT OF FACILITY CHARGES USING A SLIDING SCALE BASED ON PATIENT FAMILY INCOME AND FINANCIAL RESOURCES.
- \* OFFER PERIODIC PAYMENT PLANS TO ASSIST PATIENTS WITH FINANCING THEIR HEALTHCARE SERVICES.

EACH FACILITY POSTS THE POLICY, INCLUDING A DESCRIPTION OF THE APPLICABLE COMMUNITIES IT SERVES, IN EACH MAJOR PATIENT REGISTRATION AREA AND IN ANY OTHER AREAS REQUIRED BY APPLICABLE REGULATIONS, COMMUNICATES THE

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INFORMATION TO PATIENTS AS REQUIRED BY THIS POLICY AND APPLICABLE

REGULATIONS AND MAKES A COPY OF THE POLICY AVAILABLE TO ALL PATIENTS.

ADDITIONALLY, THE MARYLAND PATIENT INFORMATION SHEET/MEDSTAR'S PATIENT

INFORMATION SHEET IS PROVIDED TO INPATIENTS ON ADMISSION AND AT TIME OF

FINAL ACCOUNT BILLING.

MEDSTAR HEALTH BELIEVES THAT ITS PATIENTS HAVE PERSONAL RESPONSIBILITIES

RELATED TO THE FINANCIAL ASPECTS OF THEIR HEALTHCARE NEEDS. THE CHARITY

CARE, FINANCIAL ASSISTANCE, AND PERIODIC PAYMENT PLANS AVAILABLE UNDER

THIS POLICY ARE NOT BE AVAILABLE TO THOSE PATIENTS WHO FAIL TO FULFILL

THEIR RESPONSIBILITIES. FOR PURPOSES OF THIS POLICY, PATIENT

RESPONSIBILITIES INCLUDE:

\* COMPLETING FINANCIAL DISCLOSURE FORMS NECESSARY TO EVALUATE THEIR  
 ELIGIBILITY FOR PUBLICLY-FUNDED HEALTHCARE PROGRAMS, CHARITY CARE  
 PROGRAMS, AND OTHER FORMS OF FINANCIAL ASSISTANCE. THESE DISCLOSURE FORMS  
 MUST BE COMPLETED ACCURATELY, TRUTHFULLY, AND TIMELY TO ALLOW MEDSTAR  
 HEALTH'S FACILITIES TO PROPERLY COUNSEL PATIENTS CONCERNING THE

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AVAILABILITY OF FINANCIAL ASSISTANCE.

- \* WORKING WITH THE FACILITY'S FINANCIAL COUNSELORS AND OTHER FINANCIAL SERVICES STAFF TO ENSURE THERE IS A COMPLETE UNDERSTANDING OF THE PATIENT'S FINANCIAL SITUATION AND CONSTRAINTS.
  - \* COMPLETING APPROPRIATE APPLICATIONS FOR PUBLICLY-FUNDED HEALTHCARE PROGRAMS. THIS RESPONSIBILITY INCLUDES RESPONDING IN A TIMELY FASHION TO REQUESTS FOR DOCUMENTATION TO SUPPORT ELIGIBILITY.
  - \* MAKING APPLICABLE PAYMENTS FOR SERVICES IN A TIMELY FASHION, INCLUDING ANY PAYMENTS MADE PURSUANT TO DEFERRED AND PERIODIC PAYMENT SCHEDULES.
  - \* PROVIDING UPDATED FINANCIAL INFORMATION TO THE FACILITY'S FINANCIAL COUNSELORS ON A TIMELY BASIS AS THE PATIENT'S CIRCUMSTANCES MAY CHANGE.
  - \* IT IS THE RESPONSIBILITY OF THE PATIENT TO INFORM THE MEDSTAR HOSPITAL OF THEIR EXISTING ELIGIBILITY UNDER A MEDICAL HARDSHIP DURING THE 12-MONTH PERIOD.
- UNINSURED PATIENTS OF MEDSTAR HEALTH'S FACILITIES MAY BE ELIGIBLE FOR CHARITY CARE OR SLIDING-SCALE FINANCIAL ASSISTANCE UNDER THIS POLICY. THE

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FINANCIAL COUNSELORS AND FINANCIAL SERVICES STAFF WILL DETERMINE  
 ELIGIBILITY FOR CHARITY CARE AND SLIDING-SCALE FINANCIAL ASSISTANCE BASED  
 ON REVIEW OF INCOME FOR THE PATIENT AND THEIR FAMILY (HOUSEHOLD), OTHER  
 FINANCIAL RESOURCES AVAILABLE TO THE PATIENT'S FAMILY, FAMILY SIZE, AND  
 THE EXTENT OF THE MEDICAL COSTS TO BE INCURRED BY THE PATIENT.

## COMMUNITY INFORMATION

PART VI, LINE 4

## GEOGRAPHIC:

MEDSTAR UNION MEMORIAL HOSPITAL'S CBSA INCLUDES ADULTS WHO RESIDE IN  
 BALTIMORE CITY ZIP CODES 21211, 21213 AND 21218. THE AREA WAS SELECTED  
 DUE TO ITS CLOSE PROXIMITY TO THE HOSPITAL, COUPLED WITH A HIGH DENSITY  
 OF LOW-INCOME RESIDENTS.

## DEMOGRAPHICS:

MEDSTAR UNION MEMORIAL HOSPITAL IS LOCATED IN ZIP CODE 21218 WITH 21211  
 TO THE WEST AND 21213 TO THE EAST; THUS, THE HOSPITAL IS DIRECTLY  
 SURROUNDED BY THE CBSA. THESE THREE ZIP CODES ACCOUNT FOR 40.8% OF THE



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ADMISSIONS TO THE HOSPITAL. NEIGHBORHOODS WITHIN THE CBSA INCLUDE MEDFIELD/HAMPDEN/WOODBERRY/REMLINGTON, GREATER CHARLES VILLAGE/BARCLAY, WAVERLIES, MIDWAY/COLDSTREAM, AND BELAIR-EDISON. ACCORDING TO THE UNITED STATES CENSUS BUREAU, THERE ARE 99,880 RESIDENTS CURRENTLY LIVING WITHIN THE CBSA, 15% OF THE ENTIRE POPULATION OF BALTIMORE CITY. IT IS A RELATIVELY DIVERSE POPULATION, WITH 64% BLACK/AFRICAN AMERICAN, 29% WHITE, 3.8% ASIAN, AND 0.6% OTHER. APPROXIMATELY 2% OF RESIDENTS ARE OF HISPANIC ORIGIN. THE VAST MAJORITY OF THE POPULATION (81%) IS OVER THE AGE OF 18. AVERAGE MEDIAN HOUSEHOLD INCOME ACROSS THE CBSA IS \$43,256 PER YEAR, JUST SLIGHTLY ABOVE THE CITY MEDIAN.

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

AS A COMMUNITY PARTNER, MEDSTAR UNION MEMORIAL ENGAGES IN A NUMBER OF COMMUNITY BENEFIT ACTIVITIES TO IMPROVE AND PROMOTE THE HEALTH AND WELL-BEING OF THE COMMUNITY. PRIORITY AREAS OF FOCUS, AS DETERMINED BY THE COMMUNITY HEALTH NEEDS ASSESSMENT, ARE CHRONIC DISEASE, SPECIFICALLY TARGETING HEART DISEASE/STROKE, DIABETES, AND OBESITY; AND ACCESS TO

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- 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.

CARE. IN FY17, MEDSTAR UNION MEMORIAL PROVIDED SUPPORT FOR THE SHEPHERD'S CLINIC & JOY WELLNESS CENTER, A SEPARATE COMMUNITY-BASED NOT-FOR-PROFIT HEALTH CARE PROVIDER FOR UNINSURED BALTIMORE CITY RESIDENTS. THE SHEPHERD'S CLINIC MEETS A VITAL NEED, PROVIDING PRIMARY HEALTH CARE TO WORKING ADULTS AND THE UNEMPLOYED WHO ARE UNINSURED. THE SHEPHERD'S CLINIC SERVES RESIDENTS SOLELY FROM ZIP CODES IN THE HOSPITAL'S COMMUNITY BENEFIT SERVICE AREA. THE HOSPITAL SUPPORTS PROGRAMMING AT SHEPHERD'S CLINIC WHICH INCLUDES EDUCATION ON HEART DISEASE, DIABETES, SMOKING CESSATION, AND CPR TRAINING. NUTRITIONAL CLASSES AND FOOD DEMONSTRATIONS ARE ALSO USED TO ADDRESS OBESITY ISSUES WITHIN THE COMMUNITY.

ADDITIONALLY, AN ASSORTMENT OF SUBSIDIZED HEALTH SERVICES ARE PROVIDED. THESE SERVICES OPERATE AT A NEGATIVE MARGIN BUT ARE NEEDED FOR THE COMMUNITY. EXAMPLES INCLUDE RENAL SERVICES, PSYCHIATRY AND PEDIATRIC CARE. SERVICES ARE AVAILABLE 24 HOURS PER DAY, 7 DAYS PER WEEK.

**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.

## AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR UNION MEMORIAL IS ABLE TO EXPAND ITS CAPACITY TO MEET THE NEEDS OF THE COMMUNITY BY PARTNERING WITH OTHER MEDSTAR HOSPITALS AND ASSOCIATED ENTITIES. MEDSTAR HEALTH RESOURCES ASSIST THE HOSPITAL IN COMMUNITY HEALTH PLANNING TO MEET THE NEEDS OF THE UNINSURED AND OTHER VULNERABLE POPULATIONS. THROUGH ITS COMMUNITY HEALTH FUNCTION, MEDSTAR HEALTH PROVIDES MEDSTAR UNION MEMORIAL WITH TECHNICAL SUPPORT TO ENHANCE COMMUNITY HEALTH PROGRAMMING AND EVALUATION. MEDSTAR'S CORPORATE PHILANTHROPY DEPARTMENT IDENTIFIES AND SEEKS PUBLIC AND PRIVATE FUNDING SOURCES TO ENSURE THE AVAILABILITY OF HIGH QUALITY HEALTH SERVICES, REGARDLESS OF ABILITY TO PAY.

## STATE FILING OF COMMUNITY BENEFIT REPORT

PART VI, LINE 7

THE COMMUNITY BENEFIT REPORT FOR MEDSTAR UNION MEMORIAL HOSPITAL IS ONLY FILED IN THE STATE OF MARYLAND.

**SCHEDULE J  
(Form 990)**

**Compensation Information**

OMB No. 1545-0047

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](http://www.irs.gov/form990).

**2016**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization

THE UNION MEMORIAL HOSPITAL

Employer identification number

52-0591685

**Part I Questions Regarding Compensation**

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

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

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

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

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

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee              | <input checked="" type="checkbox"/> Written employment contract                     |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study                    |
| <input checked="" 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 on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

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

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

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

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

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

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

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

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

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

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

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

Schedule J (Form 990) 2016

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
<b>1</b> MICHAEL FIOCCO, M.D. DIRECTOR	(i)	702,293.	25,000.	0.	14,989.	742,282.	0.
	(ii)	0.	0.	0.	0.	0.	0.
<b>2</b> CYNTHIA WEBB, M.D. DIRECTOR	(i)	498,107.	0.	0.	15,143.	530,845.	0.
	(ii)	992,993.	49,744.	0.	7,950.	1,065,837.	0.
<b>3</b> P. JUSTIN TORTOLANI, M. DIRECTOR	(i)	0.	0.	0.	0.	0.	0.
	(ii)	154,396.	0.	0.	752.	167,045.	0.
<b>4</b> CHRISTOPHER D. KEARNEY, DIRECTOR	(i)	146,768.	0.	0.	0.	146,768.	0.
	(ii)	363,002.	0.	0.	25,628.	403,408.	0.
<b>5</b> DAVID NASRALLAH, M.D. DIRECTOR	(i)	0.	0.	0.	0.	0.	0.
	(ii)	1,305,950.	0.	0.	6,809.	1,327,716.	0.
<b>6</b> FRANK EBERT, M.D. PHYSICIAN	(i)	0.	0.	0.	0.	0.	0.
	(ii)	962,553.	155,031.	0.	8,651.	1,141,368.	0.
<b>7</b> HENRY BOUCHER, M.D. PHYSICIAN	(i)	0.	0.	0.	0.	0.	0.
	(ii)	1,019,762.	90,374.	0.	7,950.	1,133,139.	0.
<b>8</b> ANAND MURTHI, M.D. MEDICAL DIRECTOR	(i)	0.	0.	0.	0.	0.	0.
	(ii)	101,977.	22,109.	0.	5,379.	135,257.	0.
<b>9</b> STEPHEN KOENIGSBERG VICE PRESIDENT	(i)	101,977.	22,109.	0.	5,378.	135,257.	0.
	(ii)	137,436.	35,479.	0.	7,382.	180,738.	0.
<b>10</b> SHARON BOTTCHE VICE PRESIDENT	(i)	137,436.	35,479.	0.	441.	180,738.	0.
	(ii)	0.	0.	0.	442.	180,739.	0.
<b>11</b> KENNETH A. SAMET DIRECTOR	(i)	1,739,872.	3,775,374.	2,159,796.	47,768.	7,751,857.	0.
	(ii)	290,742.	268,982.	0.	9,626.	581,101.	0.
<b>12</b> BRADLEY S. CHAMBERS PRESIDENT/DIRECTOR	(i)	290,743.	268,982.	0.	11,751.	581,102.	0.
	(ii)	6,018.	0.	158,978.	0.	164,996.	0.
<b>13</b> JOSEPH SMITH FORMER OFFICER	(i)	0.	0.	0.	0.	0.	0.
	(ii)	413,892.	279,451.	0.	14,410.	715,703.	0.
<b>14</b> STUART BELL FORMER OFFICER	(i)	0.	0.	0.	0.	0.	0.
	(ii)	197,089.	32,374.	0.	6,656.	249,067.	0.
<b>15</b> CHERYL LUNNEN FORMER KEY EMPLOYEE	(i)	0.	0.	0.	0.	0.	0.
	(ii)	139,773.	67,322.	0.	7,413.	226,588.	0.
<b>16</b> DEANA STOUT CHIEF FINANCIAL OFFICER	(i)	139,773.	67,322.	0.	12,080.	226,588.	0.
	(ii)	139,773.	67,322.	0.	12,080.	226,589.	0.

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JOHN WANG CHIEF OF CARDIAC CATH LAB	(i)	900,417.	95,000.	7,950.	15,099.	1,018,466.	0.
	(ii)	0.	0.	0.	0.	0.	0.
2 RICHARD LEVINE PHYSICIAN	(i)	966,519.	0.	7,950.	15,121.	989,590.	0.
	(ii)	0.	0.	0.	0.	0.	0.
3	(i)						
	(ii)						
4	(i)						
	(ii)						
5	(i)						
	(ii)						
6	(i)						
	(ii)						
7	(i)						
	(ii)						
8	(i)						
	(ii)						
9	(i)						
	(ii)						
10	(i)						
	(ii)						
11	(i)						
	(ii)						
12	(i)						
	(ii)						
13	(i)						
	(ii)						
14	(i)						
	(ii)						
15	(i)						
	(ii)						
16	(i)						
	(ii)						

**Part III Supplemental Information**

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

SOCIAL CLUB DUES

SCHEDULE J, PART I, LINE 1

THE ORGANIZATION PAID SOCIAL CLUB DUES FOR ONE OF ITS OFFICERS DURING

THIS YEAR. PARTICIPATION IN THESE ACTIVITIES BY THE OFFICER WAS FOR

BUSINESS PURPOSES, AND HELPED THE ORGANIZATION FURTHER ITS EXEMPT

PURPOSES. THE AMOUNT OF DUES PAID WAS INCLUDED IN THE OFFICER'S W-2.

SEVERANCE PAYMENTS

SCHEDULE J, PART I, LINE 4A

JOSEPH SMITH'S (RETIRED) OTHER REPORTABLE COMPENSATION IN PART II, COLUMN

(B) (III) INCLUDES \$158,978 REPRESENTING SEVERANCE PAYMENTS RECEIVED BY

MR. SMITH.

SUPPLEMENTAL RETIREMENT PLAN

SCHEDULE J, PART III

MR. SAMET'S COMPENSATION IN PART II, COLUMN (B) INCLUDES \$3,752,690,

REPRESENTING BENEFITS RECEIVED FROM EXECUTIVE RETIREMENT PLANS THAT ARE

COMPRISED OF TARGET BENEFITS DETERMINED ANNUALLY BASED ON COMPENSATION

AND YEARS OF SERVICE AND LONG-TERM RETENTION ARRANGEMENTS.

**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.

BRADLEY CHAMBERS' COMPENSATION IS FOR SERVICES PROVIDED AS PRESIDENT TO BOTH MEDSTAR GOOD SAMARITAN HOSPITAL AND MEDSTAR UNION MEMORIAL HOSPITAL.

DEANA STOUT'S COMPENSATION IS FOR SERVICES PROVIDED AS CFO TO BOTH MEDSTAR GOOD SAMARITAN HOSPITAL AND MEDSTAR UNION MEMORIAL HOSPITAL.

STEPHEN KOENIGSBURG'S COMPENSATION IS FOR SERVICES PROVIDED AS A KEY EMPLOYEE TO BOTH MEDSTAR GOOD SAMARITAN HOSPITAL AND MEDSTAR UNION MEMORIAL HOSPITAL.

SHARON BOTTCHEER'S COMPENSATION IS FOR SERVICES PROVIDED AS A KEY EMPLOYEE TO BOTH MEDSTAR GOOD SAMARITAN HOSPITAL AND MEDSTAR UNION MEMORIAL HOSPITAL

PETER MONGE'S COMPENSATION IS FOR PHYSICIAN SERVICES PROVIDED TO BOTH MEDSTAR GOOD SAMARITAN HOSPITAL AND MEDSTAR UNION MEMORIAL HOSPITAL.



**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.

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

**Transactions With Interested Persons**

OMB No. 1545-0047

**2016**

**Open To Public Inspection**

Department of the Treasury  
Internal Revenue Service

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.

▶ Attach to Form 990 or Form 990-EZ.

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

Name of the organization

THE UNION MEMORIAL HOSPITAL

Employer identification number

52-0591685

**Part I Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).  
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 . . . . . ▶ \$ \_\_\_\_\_

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization. . . . . ▶ \$ \_\_\_\_\_

**Part II Loans to and/or From Interested Persons.**  
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
			(1)									
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												
<b>Total</b> . . . . . ▶						\$						

**Part III Grants or Assistance Benefiting Interested Persons.**  
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				

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

Schedule L (Form 990 or 990-EZ) 2016

**Part IV Business Transactions Involving Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) MORRISON HEALTHCARE FOOD SERVICES	SEE PART V	3,898,881.	FOOD SERVICES		X
(2) ACME PAPER & SUPPLY CO.	SEE PART V	480,223.	MANUFACTURING SERVICES		X
(3) CINTAS	SEE PART V	396,126.	UNIFORM SERVICES		X
(4) UP-TO-DATE LAUNDRY, INC.	SEE PART V	878,251.	LAUNDRY SERVICES		X
(5) WEBB/MASON	SEE PART V	265,486.	MARKETING STRATEGY SERVICES		X
(6) EXACTECH	SEE PART V	186,159.	MEDICAL DEVICE SERVICES		X
(7) K2M, INC.	SEE PART V	103,505.	MEDICAL SERVICES		X
(8) SMITH & NEPHEW	SEE PART V	748,569.	MEDICAL EQUIPMENT SERVICES		X
(9)					
(10)					

**Part V Supplemental Information**

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

BUSINESS TRANSACTION INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

MORRISON HEALTHCARE FOOD SERVICES IS A SUBSTANTIAL CONTRIBUTOR THAT ALSO PROVIDED FOOD SERVICES TO THE HOSPITAL.

ACME PAPER & SUPPLY CO., INC. IS A SUBSTANTIAL CONTRIBUTOR THAT ALSO PROVIDED MANUFACTURING SERVICES TO THE HOSPITAL.

CINTAS IS A SUBSTANTIAL CONTRIBUTOR THAT ALSO PROVIDED UNIFORM SERVICES TO THE HOSPITAL.

UP-TO-DATE LAUNDRY, INC. IS A SUBSTANTIAL CONTRIBUTOR THAT ALSO PROVIDED LAUNDRY SERVICES TO THE HOSPITAL.

WEBB/MASON IS A SUBSTANTIAL CONTRIBUTOR THAT ALSO PROVIDED MARKETING STRATEGIES SERVICES TO THE HOSPITAL.

EXACTECH IS A SUBSTANTIAL CONTRIBUTOR THAT ALSO PROVIDED MEDICAL DEVICE SERVICES TO THE HOSPITAL.

**Part IV Business Transactions Involving Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

**Part V Supplemental Information**

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

K2M, INC. IS A SUBSTANTIAL CONTRIBUTOR THAT ALSO PROVIDED MEDICAL SERVICES TO THE HOSPITAL.

SMITH & NEPHEW IS A SUBSTANTIAL CONTRIBUTOR THAT ALSO PROVIDED MEDICAL EQUIPMENT SERVICES TO THE HOSPITAL.

PER THE CONFLICT OF INTEREST POLICY, ALL TRANSACTIONS BETWEEN THE HOSPITAL AND OUTSIDE VENDORS SHOULD BE AT ARMS-LENGTH FOR FAIR MARKET VALUE.

**SCHEDULE M  
(Form 990)**

**Noncash Contributions**

OMB No. 1545-0047

**2016**

**Open To Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

- ▶ Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
- ▶ Attach to Form 990.
- ▶ Information about Schedule M (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Name of the organization

THE UNION MEMORIAL HOSPITAL

Employer identification number

52-0591685

**Part I Types of Property**

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art . . . . .				
2 Art - Historical treasures . . . . .				
3 Art - Fractional interests . . . . .				
4 Books and publications . . . . .				
5 Clothing and household goods . . . . .				
6 Cars and other vehicles . . . . .				
7 Boats and planes . . . . .				
8 Intellectual property . . . . .				
9 Securities - Publicly traded . . . . .	X	5.	33,288.	FMV
10 Securities - Closely held stock . . . . .				
11 Securities - Partnership, LLC, or trust interests . . . . .				
12 Securities - Miscellaneous . . . . .				
13 Qualified conservation contribution - Historic structures . . . . .				
14 Qualified conservation contribution - Other . . . . .				
15 Real estate - Residential . . . . .				
16 Real estate - Commercial . . . . .				
17 Real estate - Other . . . . .				
18 Collectibles . . . . .				
19 Food inventory . . . . .				
20 Drugs and medical supplies . . . . .				
21 Taxidermy . . . . .				
22 Historical artifacts . . . . .				
23 Scientific specimens . . . . .				
24 Archeological artifacts . . . . .				
25 Other ▶ ( _____ )				
26 Other ▶ ( _____ )				
27 Other ▶ ( _____ )				
28 Other ▶ ( _____ )				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement . . . . . **29**

	Yes	No
30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period? . . . . .		X
b If "Yes," describe the arrangement in Part II.		
31 Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions? . . . . .	X	
32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? . . . . .		X
b If "Yes," describe in Part II.		
33 If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.		

---

**Part II** **Supplemental Information.** Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

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

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

**2016**

**Open to Public  
Inspection**

Employer identification number

THE UNION MEMORIAL HOSPITAL

52-0591685

ORGANIZATION MEMBERS

PART VI, LINE 6

THE ORGANIZATION IS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC.,  
A TAX-EXEMPT MARYLAND NON-STOCK CORPORATION. MEDSTAR HEALTH, INC., OR ONE  
OF ITS AFFILIATES AND SUBSIDIARIES, IS THE SOLE MEMBER OF THE  
ORGANIZATION.

DESCRIPTION OF MEMBERS

PART VI, LINE 7A

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT  
MARYLAND NON-STOCK CORPORATION, THE ORGANIZATION MAY RECOMMEND PERSON(S)  
FOR MEMBERSHIP ON THE ORGANIZATION'S GOVERNING BODY. ANY SUCH  
RECOMMENDATION BY THE ORGANIZATION IS SUBJECT TO APPROVAL BY THE  
GOVERNANCE COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR HEALTH, INC.  
THE BOARD OF MEDSTAR HEALTH, INC. HAS DELEGATED CERTAIN APPROVAL  
AUTHORITY TO THE GOVERNANCE COMMITTEE AND THE PRESIDENT & CEO OF MEDSTAR  
HEALTH, INC.

DECISIONS OF GOVERNING BODY

PART VII, LINE 7B

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT  
MARYLAND NON-STOCK CORPORATION, THE BYLAWS OF THE ORGANIZATION ARE  
SUBJECT TO CERTAIN RESERVED POWERS, WHICH PROVIDE THAT THE SOLE MEMBER OF  
THE ORGANIZATION MUST APPROVE CERTAIN DECISIONS, INCLUDING BUT NOT

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LIMITED TO MATTERS CONCERNING THE SALE OR PURCHASE OF REAL OR PERSONAL PROPERTY, CAPITAL BUDGETS, STRATEGIC PLANNING, INVESTMENTS, AND CORPORATE GOVERNANCE.

PROCESS FOR REVIEWING FORM 990

PART VI, LINE 11B

THE PROCESS FOR REVIEWING THE FORM 990 INCLUDED EDUCATION AND TRANSPARENCY. SENIOR FINANCIAL EXECUTIVES, WORKING WITH INDEPENDENT OUTSIDE EXPERTS, THOROUGHLY REVIEWED FORM 990 AND ACCOMPANYING INSTRUCTIONS. IN ADDITION, SENIOR EXECUTIVES REVIEWED THE RELEVANT SECTIONS OF THE FORM 990 WITH THE FOLLOWING COMMITTEES OF THE ORGANIZATION'S GOVERNING BODY: FINANCE, AUDIT, GOVERNANCE, STRATEGIC PLANNING, AND EXECUTIVE COMPENSATION. FOLLOWING THESE MEETINGS, THE GOVERNING BODY WAS PROVIDED A COPY OF THE FORM 990 IN ITS FINAL FORM AND GIVEN AN OPPORTUNITY TO PROVIDE ANY INPUT OR COMMENTS RELATING TO THE FORM 990 PRIOR TO ITS FILING.

CONFLICT OF INTEREST POLICY

PART VI, LINE 12C

APPOINTMENT OF BOARDS OF DIRECTORS MEDSTAR HEALTH (AND ITS SUBSIDIARIES) REQUIRE ALL NOMINATED DIRECTORS, PRIOR TO THEIR APPOINTMENT OR ELECTION, TO DISCLOSE THE EXISTENCE OF (OR POTENTIAL EXISTENCE OF) ANY TRANSACTION WITH MEDSTAR THAT WOULD RESULT IN A CONFLICT OF INTEREST. SUCH DISCLOSURES (IF ANY) ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE RESOLVED.



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## ANNUAL DISCLOSURES - ALL OFFICERS, DIRECTORS, AND SENIOR MANAGERS

ALL OFFICERS, DIRECTORS AND SENIOR MANAGERS ARE REQUIRED, NOT LESS THAN ANNUALLY, TO COMPLETE A SURVEY OF QUESTIONS CONCERNING ANY TRANSACTIONS OR RELATIONSHIPS WHICH WOULD OR COULD REPRESENT A CONFLICT OF INTEREST. SUCH DISCLOSURES (IF ANY) ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE RESOLVED.

## EXECUTIVE COMPENSATION PROCESS

PART VI, LINE 15

THE EXECUTIVE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR HEALTH, INC. (THE "COMMITTEE") HAS OVERSIGHT OVER THE EXECUTIVE COMPENSATION PROGRAM (THE "PROGRAM") OF MEDSTAR HEALTH, INC. AND ITS AFFILIATES. TOTAL COMPENSATION FOR THE TOP MANAGEMENT OFFICIALS, OFFICERS AND KEY EMPLOYEES OF MEDSTAR HEALTH, INC. AND ITS AFFILIATES ARE REVIEWED AND APPROVED BY THE COMMITTEE WITH ASSISTANCE AND GUIDANCE FROM AN INDEPENDENT THIRD PARTY ADVISOR. THE MEMBERS OF THE COMMITTEE ARE INDEPENDENT FROM ALL OF THE PARTICIPANTS IN THE PROGRAM.

THE MAIN OBJECTIVE OF THE PROGRAM IS TO PROVIDE MARKET COMPETITIVE TOTAL COMPENSATION THAT IS INTERNALLY EQUITABLE AND HAS A STRONG PAY-FOR-PERFORMANCE LINKAGE. PERFORMANCE IS EVALUATED AT THE SYSTEM, OPERATING UNIT, AND INDIVIDUAL LEVELS. THE OVERALL TOTAL COMPENSATION PHILOSOPHY IS MANAGED AT THE 75TH PERCENTILE OF THE COMPETITIVE MARKET FOR COMPARABLE SIZE (NET REVENUE) AND TYPE ("TAX-EXEMPT HEALTHCARE

Name of the organization THE UNION MEMORIAL HOSPITAL	Employer identification number 52-0591685
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ORGANIZATIONS"). WHERE APPROPRIATE, ADDITIONAL INDUSTRY DATA IS CONSIDERED (GENERAL BUSINESS AND/OR TAXABLE HEALTHCARE) FOR SELECTED POSITIONS THAT CAN BE RECRUITED FROM OR POTENTIALLY LOST TO THESE INDUSTRIES (E.G., INFORMATION TECHNOLOGY, FINANCE, ETC.).

THE COMMITTEE HAS ENGAGED ERNST & YOUNG LLP ("E&Y") TO SERVE AS AN ADVISOR ON THE REASONABLENESS AND COMPETITIVENESS OF THE PROGRAM. IN DETERMINING REASONABLENESS AND COMPETITIVENESS, E&Y REVIEWS MARKET PRACTICES AND TRENDS, AND MAKES RECOMMENDATIONS RELATED TO THE PROGRAM. E&Y UTILIZES INFORMATION FROM CUSTOM SURVEYS, NATIONAL COMPENSATION SURVEYS, PROPRIETARY DATABASES, AND CLIENT EXPERIENCES TO DETERMINE ITS FINAL RECOMMENDATIONS. E&Y PRESENTS THEIR FINDINGS AND RECOMMENDATIONS TO THE COMMITTEE. THE COMMITTEE MAKES THE FINAL DECISIONS ON ALL OF THE COMPENSATION DETERMINATIONS OF THE PROGRAM. ALL DECISIONS MADE BY THE COMMITTEE ARE CONTEMPORANEOUSLY DOCUMENTED.

#### FINANCIAL STATEMENTS AVAILABILITY

PART VI, LINE 19

MEDSTAR HEALTH POSTS ITS ANNUAL FINANCIAL AUDIT AND QUARTERLY FINANCIAL REPORTS TO THE ELECTRONIC MUNICIPAL MARKET ACCESS (EMMA) SYSTEM. THE ORGANIZATION ALSO E-MAILS ITS ANNUAL AND QUARTERLY DISCLOSURES TO HOLDERS OF THE COMPANY'S PUBLICLY TRADED DEBT. THE COMPANY'S GOVERNANCE DOCUMENTS AND CONFLICTS OF INTEREST POLICIES ARE AVAILABLE UPON REQUEST THROUGH ITS CORPORATE (OR AS APPLICABLE ENTITY) PUBLIC INFORMATION OFFICES.

#### FINANCIAL STATEMENTS AND REPORTING

PART XII, LINE 2C

Name of the organization THE UNION MEMORIAL HOSPITAL	Employer identification number 52-0591685
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THE UNION MEMORIAL HOSPITAL IS PART OF THE MEDSTAR HEALTH, INC. AUDIT AND SUBJECT TO OVERSIGHT BY THE AUDIT COMMITTEE OF THE MEDSTAR BOARD.

OTHER CHANGES IN NET ASSETS

PART XI, LINE 9

EQUITY TRANSFERS - NET ASSETS..... \$(20,276,862)

ATTACHMENT 1

FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

AS A PROUD MEMBER OF MEDSTAR HEALTH, MEDSTAR UNION MEMORIAL HOSPITAL'S (MEDSTAR UNION MEMORIAL) MISSION IS TO BE A COMPREHENSIVE HOSPITAL WITH REGIONAL SPECIALTY SERVICES OF DISTINCTION AND QUALITY COMMUNITY SERVICES, ALL ENHANCED BY CLINICAL EDUCATION AND RESEARCH. MEDSTAR UNION MEMORIAL IS AN ACUTE CARE HOSPITAL LOCATED IN THE NORTH-CENTRAL SECTION OF BALTIMORE CITY, MARYLAND. IN FISCAL YEAR 2017, MEDSTAR UNION MEMORIAL HAD 14,611 INPATIENT ADMISSIONS AND OBSERVATIONS, 395,016 OUTPATIENT VISITS, AND 57,150 EMERGENCY VISITS.

ATTACHMENT 2

FORM 990, PART III - PROGRAM SERVICE, LINE 4A

MEDSTAR UNION MEMORIAL HOSPITAL'S LARGEST PROGRAM IS ACCESS TO AND THE PROVISION OF ACUTE HOSPITAL SERVICES TO THE COMMUNITIES OF NORTHERN BALTIMORE CITY, MARYLAND AND THE SURROUNDING AREAS. IN ADDITION TO THE PROGRAM SERVICE EXPENSES LISTED ABOVE, MEDSTAR UNION MEMORIAL INCURRED \$102.6M OF MANAGEMENT AND GENERAL EXPENSES IN PROVIDING SERVICES TO ITS COMMUNITIES. MEDSTAR UNION MEMORIAL OFFERS CLINICAL SERVICES IN GENERAL MEDICINE AND SURGERY, AND

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ATTACHMENT 2 (CONT'D)

SPECIALTY SERVICES IN CARDIAC CARE, HAND SURGERY, ORTHOPAEDICS, SPORTS MEDICINE, VASCULAR SURGERY, AND REHABILITATION. IT IS KNOWN FOR THE CURTIS NATIONAL HAND CENTER, MEDSTAR HEART & VASCULAR INSTITUTE, MEDSTAR ORTHOPAEDICS, AND THE DEVELOPMENT OF THE FIRST HOSPITAL-BASED SPORTS MEDICINE PROGRAM IN THE COUNTRY. IN ADDITION, THE HOSPITAL IS RECOGNIZED AS AN ADVANCED PRIMARY STROKE CENTER AND EARNED CERTIFICATION IN JOINT REPLACEMENT OF THE HIP AND KNEE AS WELL AS SPINE SURGERY BY THE JOINT COMMISSION. THE AMERICAN HEART ASSOCIATION AND AMERICAN STROKE ASSOCIATION RECOGNIZED MEDSTAR UNION MEMORIAL FOR ACHIEVING 85% OR HIGHER COMPLIANCE WITH ALL GET WITH THE GUIDELINES - STROKE ACHIEVEMENT MEASURES AND 75% OR HIGHER WITH FIVE OR MORE GET WITH THE GUIDELINES -STROKE QUALITY MEASURES FOR 12 CONSECUTIVE MONTHS. MEDSTAR UNION MEMORIAL WAS RECOGNIZED BY PRACTICE GREENHEALTH ENVIRONMENTAL EXCELLENCE FOR ITS ONGOING COMMITMENT TO IMPROVING ITS ENVIRONMENTAL PERFORMANCE AND PRIDE IN REALIZING A TOP STANDARD OF EXCELLENCE IN SUSTAINABILITY. IN 2015, MEDSTAR UNION MEMORIAL WAS RECOGNIZED BY U.S. NEWS & WORLD REPORT AS ONE OF THE BEST HOSPITALS IN THE BALTIMORE REGION FOR HEART BYPASS, KNEE REPLACEMENT AND ORTHOPAEDICS.

ATTACHMENT 3990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
PARKWAY ANESTHESIOLOGISTS 201 E UNIVERSITY PARKWAY	PHYSICIAN SERVICES	12,516,000.

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ATTACHMENT 3 (CONT'D)

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

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
BALTIMORE, MD 21218		
CROTHALL SVCS GROUP 13028 COLLECTIONS CENTER DRIVE CHICAGO, IL 60693	ENVIRONMENTAL SVCS	4,377,655.
GREATER CHESAPEAKE ORTHO ASSOC 201 E UNIVERSITY PARKWAY BALTIMORE, MD 21218	MEDICAL SERVICES	3,946,554.
MORRISON MANAGEMENT SPECIALIST 4721 MORRISON DRIVE MOBILE, AL 36609	FOOD SERVICES	3,846,802.
AMN HEALTHCARE INC 12400 HIGH BLUFF DRIVE SAN DIEGO, CA 92130	STAFFING SERVICES	2,802,900.

**SCHEDULE R  
(Form 990)**

**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](http://www.irs.gov/form990).

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) MEDSTAR HEALTH ANESTHESIA SERVICES D LLC 20-5909921 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218	HEALTH SVCS	MS	5,210,618.	-187,661.	N/A
(2) BALTIMORE/WASHINGTON PATHOLOGY GROUP LLC 52-2242146 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218	HEALTH SVCS	MD	0.	0.	N/A
(3) UNION MEMORIAL IMAGING, LLC 27-2549579 201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218	HEALTH SVCS	MD	893,912.	0.	N/A
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) CHURCH HOME CORPORATION 23-7374724 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL FUND	MD	501 (C) (3)	PF	N/A		X
(2) FRANKLIN SQUARE HOSPITAL CENTER, INC. 52-0608007 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237	HOSPITAL	MD	501 (C) (3)	3	N/A		X
(3) HARBOR HOSPITAL, INC. 52-0491660 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225	HOSPITAL	MD	501 (C) (3)	3	N/A		X
(4) MEDSTAR HEALTH, INC. 52-2087445 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SVCS	MD	501 (C) (3)	12C III	N/A		X
(5) MONTGOMERY GENERAL HOSPITAL 52-0646893 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	HOSPITAL	MD	501 (C) (3)	3	N/A		X
(6) THE GOOD SAMARITAN HOSPITAL OF MARYLAND, 52-0591607 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	HOSPITAL	MD	501 (C) (3)	3	N/A		X
(7) MEDSTAR HEALTH RESEARCH INSTITUTE 52-6056274 108 IRVING STREET NW WASHINGTON, DC 20010	HOSPITAL	DC	501 (C) (3)	4	N/A		X

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

Schedule R (Form 990) 2016

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

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

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

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

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

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	THE MEDSTAR-GEORGETOWN MEDICAL CENTER, I HOSPITAL ADMIN, 1 MAIN BLDG WASHINGTON, DC 20007 52-2218584	HOSPITAL	DC	501(C)(3)	3	N/A	X	
(2)	WASHINGTON HOSPITAL CENTER CORPORATION 110 IRVING STREET NW WASHINGTON, DC 20010 52-1272129	HOSPITAL	DC	501(C)(3)	3	N/A	X	
(3)	HH MEDSTAR HEALTH, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044 52-1542230	MEDICAL SVCS	MD	501(C)(3)	12C III	N/A	X	
(4)	MEDSTAR AMBULATORY SERVICES, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044 52-1132992	ADMIN SVCS	MD	501(C)(3)	12C III	N/A	X	
(5)	BAY LIFE SERVICES, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044 52-1496539	MENTAL HEALTH	MD	501(C)(3)	10	N/A	X	
(6)	MEDSTAR SURGERY CENTER, INC. 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1061679	MEDICAL SVCS	MD	501(C)(3)	10	N/A	X	
(7)	CHURCH HOME AND HOSPITAL OF THE CITY OF 10980 GRANTCHESTER WAY COLUMBIA, MD 21044 52-0591600	MEDICAL FUND	MD	501(C)(3)	12A I	N/A	X	

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Schedule R (Form 990) 2016

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

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

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

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

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	FRANKLIN SQUARE HOSPITAL CENTER FOUNDATI 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237	FOUNDATION	MD	501 (C) (3)	7	N/A	X	
(2)	GOOD SAMARITAN HOSPITAL FOUNDATION, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	FOUNDATION	MD	501 (C) (3)	12A I	N/A	X	
(3)	GOOD SAMARITAN NURSING CENTER, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	MEDICAL SVCS	MD	501 (C) (3)	10	N/A	X	
(4)	GS HOUSING, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ELDER HOUSING	MD	501 (C) (3)	10	N/A	X	
(5)	GS PROPERTIES, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ADMIN SVCS	MD	501 (C) (3)	12A I	N/A	X	
(6)	HARBOR HOSPITAL FOUNDATION, INC. 3001 SOUTH HANOVER STREET BALTIMORE, MD 21225	FOUNDATION	MD	501 (C) (3)	12A I	N/A	X	
(7)	MEDSTAR HEALTH INFUSION, INC. 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705	MEDICAL SVCS	MD	501 (C) (3)	10	N/A	X	

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

Schedule R (Form 990) 2016



**SCHEDULE R  
(Form 990)**

**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.

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Name of the organization

THE UNION MEMORIAL HOSPITAL

Employer identification number

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

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

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

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	MEDSTAR HEALTH VISITING NURSES ASSOCIATI 4061 POWDERMILL ROAD CALVERTON, MD 20705 53-0196597	MEDICAL SVCS	MD	501(C)(3)	10	N/A	X	
(2)	MEDSTAR VNA HEALTHCARE 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705 52-1458516	MEDICAL SVCS	MD	501(C)(3)	10	N/A	X	
(3)	MGH COMMUNITY HEALTH, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1372467	MEDICAL SVCS	MD	501(C)(3)	10	N/A	X	
(4)	MGH HEALTH FOUNDATION, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1129959	FOUNDATION	MD	501(C)(3)	7	N/A	X	
(5)	MGH HEALTH SERVICES, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-1366812	FOUNDATION	MD	501(C)(3)	12B II	N/A	X	
(6)	MGH WOMEN'S BOARD 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832 52-6039600	FOUNDATION	MD	501(C)(3)	12C III	N/A	X	
(7)	NATIONAL REHABILITATION HOSPITAL 102 IRVING STREET NW WASHINGTON, DC 20010 52-1369749	HOSPITAL	DC	501(C)(3)	3	N/A	X	

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**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.  
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(1)	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	NRH REGIONAL REHAB AT OLNEY, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SVCS	MD	501 (C) (3)	3	N/A		X
(2)	SUBURBAN / NRH MEDICAL REHABILITATION, I 102 IRVING STREET NW WASHINGTON, DC 20010	MEDICAL SVCS	DC	501 (C) (3)	3	N/A		X
(3)	THE THOMAS O'NEIL CATHOLIC HEALTH CARE F 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	FOUNDATION	MD	501 (C) (3)	12D IIII	N/A		X
(4)	YNA, INC. 4061 POWDERMILL ROAD, SUITE 21 CALVERTON, MD 20705	ADMIN SVCS	MD	501 (C) (3)	12A I	N/A		X
(5)	WHC FOUNDATION, INC. 110 IRVING STREET NW WASHINGTON, DC 20010	FOUNDATION	DC	501 (C) (3)	7	N/A		X
(6)	WOODBORNE WOODS, INC. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239	ELDER HOUSING	MD	501 (C) (3)	10	N/A		X
(7)	HOSPICE OF ST. MARY'S, INC. PO BOX 527 LEONARDTOWN, MD 20650	SUPPORT ORG	MD	501 (C) (3)	12A I	N/A		X

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

Schedule R (Form 990) 2016

**SCHEDULE R  
(Form 990)**

**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](http://www.irs.gov/form990).

Department of the Treasury  
Internal Revenue Service

Name of the organization

THE UNION MEMORIAL HOSPITAL

Employer identification number

52-0591685

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) ST. MARY'S HOSPITAL OF ST. MARY'S COUNTY 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650	HOSPITAL	MD	501(C)(3)	3	N/A		X
(2) ST. MARY'S HOSPITAL FOUNDATION, INC. PO BOX 527 LEONARDTOWN, MD 20650	SUPPORT ORG	MD	501(C)(3)	12A I	N/A		X
(3) MEDSTAR SOUTHERN MD HOSPITAL CENTER 7503 SURRATTS ROAD CLINTON, MD 20735	HOSPITAL	MD	501(C)(3)	3	N/A		X
(4) MEDSTAR HEALTH INC AND AFFILIATES MASTER 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	RET. TRUST	MD	501(A)	N/A	N/A		X
(5)							
(6)							
(7)							

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

**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	
(1) MEDSTAR SHAH MSO 46-2700536 10980 GRANTCHESTER WAY COLUMBI	MGMT SVCS	MD	N/A	N/A								
(2) 22590 SHADY COURT, LLC 22590 SHADY COURT CALIFORNIA,	REAL ESTATE	MD	N/A	N/A								
(3) 24035 THREE NOTCH ROAD, LLC 24035 THREE NOTCH ROAD, LLC HO	REAL ESTATE	MD	N/A	N/A								
(4) 37767 MARKET DRIVE, LLC 37767 MARKET DRIVE, LLC CHARLO	REAL ESTATE	MD	N/A	N/A								
(5) 26840 POINT LOOKOUT ROAD, LLC 26840 POINT LOOKOUT ROAD, LLC	REAL ESTATE	MD	N/A	N/A								
(6) GREATER CHESAPEAKE SURGERY CEN 1212 YORK ROAD, STE B100 LUTHE	SURGERY CENTER	MD	N/A	N/A								
(7) MONTGOMERY COMMUNITY MAGNETIC 4110 ASPEN HILL ROAD, SUITE 20	MRI SCREENING	MD	N/A	N/A								

**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
(1) MEDSTAR PHARMACIES, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	DRUG SALES	MD	N/A	C CORP					
(2) EXTENCARE, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SERVICES	MD	N/A	C CORP					
(3) HELIX RESOURCES MANAGEMENT, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	ADMIN SERVICE	MD	N/A	C CORP					
(4) HELIXCARE MEDICAL GROUP, LLC 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SERVICES	MD	N/A	C CORP					
(5) HELIXCARE PROPERTIES, LLC 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SERVICES	MD	N/A	C CORP					
(6) PARKWAY VENTURES, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	HOLDING COMPANY	MD	N/A	C CORP					
(7) PHYSICIANS ADMINISTRATIVE SERVICES, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	BILLING SERVICES	MD	N/A	C CORP					

**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	
(1) PHYSIOTHERAPY ASSOCIATES NRH R 4714 GETTYSBURG ROAD MECHANICS FRANKLIN SQUARE MEDICAL CENTER	PHYSIOTHERAPY	PA	N/A	N/A								
(2) FRANKLIN SQUARE MEDICAL CENTER 101 EAST STATE STREET KENNETT	NURSING HOME	PA	N/A	N/A								
(3) PHYSICIAN IMAGING OF WASHINGTON 840 CRESCENT CENTRE DR., STE 20	RADIOLOGY SVCS	TN	N/A	N/A								
(4) FRANKLIN IMAGING, LLC 52-15886 7253 AMBASSADOR RD., BALTIMORE,	IMAGING	MD	N/A	N/A								
(5)												
(6)												
(7)												

**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
(1) MEDSTAR FAMILY CHOICE, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MANAGED CARE	MD	N/A	C CORP					
(2) MEDSTAR ENTERPRISES, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	ADMIN SERVICES	MD	N/A	C CORP					
(3) SITEL, INC. 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	EDUCATIONAL SVCS	MD	N/A	C CORP					
(4) STAR BILLING, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	BILLING SERVICES	MD	N/A	C CORP					
(5) WASHINGTON RISK NETWORK MANAGEMENT, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SERVICES	MD	N/A	C CORP					
(6) WASHINGTON HOSPITAL CENTER PHYSICIAN HOS 100 IRVING STREET NW WASHINGTON, DC 20010	MEDICAL SERVICES	MD	N/A	C CORP					
(7) MEDSTAR PHYSICIAN PARTNERS, INC. 4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SERVICES	MD	N/A	C CORP					

**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	
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

**Part IV Identification of Related Organizations Taxable as a Corporation or Trust.** Complete if the organization answered "Yes" 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
(1) FRANKLIN SQUARE DRIVE LAND CONDO ASSOCIA 10980 GRANTCHESTER WAY COLUMBIA, MD 21044	CONDO OWNER ASSOC	MD	N/A	C CORP					
(2) MGH DIVERSIFIED SERVICES, INC. 18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SERVICES	MD	N/A	C CORP					
(3) ST. MARY'S HEALTH ALLIANCE, INC. 25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650	MEDICAL SERVICES	MD	N/A	C CORP					
(4) GREENSPRING FINANCIAL INSURANCE LIMITED 23 LIME TREE BAY AVENUE, PO BOX 1051, GRAND CAYMAN CJ KY1	INSURANCE	MD	N/A	C CORP					
(5) ST MARY'S CONDO ASSN 25500 POINT LOOKOUT RD LEONARDTOWN, MD 20650	CONDOMINIUMS	MD	N/A	C CORP					
(6) MEDSTAR HEALTH MASTER RETIREMENT TRUST 102 SOUTH CHURCH ST., GRAND CAYMAN, CJ KY1-1002	INVESTMENTS	CJ	N/A	C CORP					
(7) MEDSTAR HEALTH, INC. - INVESTMENT FUND I 102 SOUTH CHURCH ST., GRAND CAYMAN, CJ KY1-1002	INVESTMENTS	CJ	N/A	C CORP					

**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?

- a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity. . . . .
- b Gift, grant, or capital contribution to related organization(s) . . . . .
- c Gift, grant, or capital contribution from related organization(s) . . . . .
- d Loans or loan guarantees to or for related organization(s) . . . . .
- e Loans or loan guarantees by related organization(s) . . . . .
- f Dividends from related organization(s) . . . . .
- g Sale of assets to related organization(s) . . . . .
- h Purchase of assets from related organization(s) . . . . .
- i Exchange of assets with related organization(s) . . . . .
- j Lease of facilities, equipment, or other assets to related organization(s) . . . . .
- k Lease of facilities, equipment, or other assets from related organization(s) . . . . .
- l Performance of services or membership or fundraising solicitations for related organization(s) . . . . .
- m Performance of services or membership or fundraising solicitations by related organization(s) . . . . .
- n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .
- o Sharing of paid employees with related organization(s) . . . . .
- p Reimbursement paid to related organization(s) for expenses. . . . .
- q Reimbursement paid by related organization(s) for expenses . . . . .
- r Other transfer of cash or property to related organization(s) . . . . .
- s Other transfer of cash or property from related organization(s) . . . . .

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	Yes	No
(1) CHURCH HOME&HOSPITAL OF THE CITY OF BALTIMORE	P	322,001.	FMV		X
(2) HH MEDSTAR HEALTH, INC.	Q	64,489.	FMV		X
(3) MEDSTAR HEALTH RESEARCH INSTITUTE	Q	4,394,231.	FMV		X
(4) WASHINGTON HOSPITAL CENTER CORPORATION	Q	1,177,975.	FMV		X
(5)					
(6)					

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

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

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



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

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

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Cumulative e-File History 2016

Federal

<b>Tax Return</b> 32068H	<b>Return Type</b> 990
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**Taxpayer**  
The Union Memorial Hospital

**Submitted Date**            2018-05-11 09:21:42

**Acknowledgement Date**   2018-05-11 09:58:23

**Status**                        Accepted

**Submission ID**                54028020181315000015

# IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2016, or fiscal year beginning 07/01, 2016, and ending 06/30, 20 17

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

▶ Information about Form 8879-EO and its instructions is at [www.irs.gov/form8879eo](http://www.irs.gov/form8879eo).

# 2016

Department of the Treasury  
Internal Revenue Service

Name of exempt organization

THE UNION MEMORIAL HOSPITAL

Employer identification number

52-0591685

Name and title of officer

JOEL BRYAN, VICE PRESIDENT/TREASUER

### 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>463029985.</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, line 3c) . . . . .	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 2016 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 KPMG LLP

ERO firm name

to enter my PIN

21218

as my signature

Enter five numbers, but do not enter all zeros

on the organization's tax year 2016 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 2016 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶

Date ▶ 5/10/18

### 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.

54028022102

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2016 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 ▶ 5/9/2018

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

For Paperwork Reduction Act Notice, see back of form.

Form **8879-EO** (2016)