

EXTENDED TO MAY 17, 2021

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Form 990 (Rev. January 2020) Department of the Treasury Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations) Do not enter social security numbers on this form as it may be made public. Go to www.irs.gov/Form990 for instructions and the latest information.

2019 Open to Public Inspection

A For the 2019 calendar year, or tax year beginning JUL 1, 2019 and ending JUN 30, 2020

B Check if applicable: C Name of organization ATLANTIC GENERAL HOSPITAL D Employer identification number 52-1656507 E Telephone number 410-641-1100 F Name and address of principal officer: MICHAEL FRANKLIN 9733 HEALTHWAY DR, BERLIN, MD 21811 G Gross receipts \$ 139,965,652. H(a) Is this a group return for subordinates? Yes No H(b) Are all subordinates included? Yes No I Tax-exempt status: 501(c)(3) J Website: WWW.ATLANTICGENERAL.ORG K Form of organization: Corporation L Year of formation: 1989 M State of legal domicile: MD

Part I Summary

Table with 3 columns: Line number, Description, and Amount. Rows include: 1. Mission statement: TO CREATE A COORDINATED CARE DELIVERY SYSTEM... 2. Discontinued operations box. 3-7. Governance metrics. 8-12. Revenue (Total: 135,409,639). 13-19. Expenses (Total: 134,938,000). 20-22. Net Assets or Fund Balances (Total: 52,838,358).

Part II Signature Block

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

Sign Here: Signature of officer: CHERYL NOTTINGHAM, VP FINANCE Date: 10/14/2021. Preparer: AMY BIBBY Date: 05/12/21 PTIN: P00445891. Firm: DIXON HUGHES GOODMAN LLP, 1410 SPRING HILL ROAD, SUITE 500, TYSONS, VA 22102-3056. Phone: (703) 970-0400.

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: TO CREATE A COORDINATED CARE DELIVERY SYSTEM THAT WILL PROVIDE ACCESS TO QUALITY CARE, PERSONALIZED SERVICE, AND EDUCATION TO IMPROVE INDIVIDUAL AND COMMUNITY HEALTH. WE ACCOMPLISH OUR MISSION THROUGH OUR SET OF VALUES, WHICH ARE HONORED IN ALL OUR INTERACTIONS.

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

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? Yes 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 \$ 105,618,010. including grants of \$) (Revenue \$ 132,967,624.) ATLANTIC GENERAL HOSPITAL IS A NON PROFIT HEALTHCARE PROVIDER FOCUSING ON INPATIENT AND OUTPATIENT SERVICES FOR OUR LOCAL COMMUNITY. WE ALSO OPERATE MULTIPLE PHYSICIAN OFFICES THROUGHOUT THE REGION THAT PROVIDES FAMILY, INTERNAL AND SPECIALTY MEDICINE TO OUR LOCAL RESIDENTS. WE HAD THE FOLLOWING KEY STATISTICS DURING THE 2019 TAX YEAR: ADMISSIONS: 2,658, PATIENT DAYS: 10,103, ED VISITS: 31,606, SURGERIES: 5,954, OTHER OUTPATIENT VISITS: 44,412, TOTAL VISITS TO OUR PHYSICIAN PRACTICES WERE 107,398.

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

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

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

4e Total program service expenses 105,618,010.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

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

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

Table with columns for question number, question text, and Yes/No columns. Includes questions 2a through 16 regarding employee counts, tax returns, unrelated business income, foreign accounts, prohibited transactions, and charitable contributions.

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

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

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain on Schedule O.		
	19		
b	Enter the number of voting members included on line 1a, above, who are independent		
	18		
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, 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
b	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 on Schedule O		X

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

		Yes	No
10a	Did the organization have local chapters, branches, or affiliates?		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
12a	Did the organization have a written conflict of interest policy? If "No," go to line 13	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	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 If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).	X	
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
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?		

Section C. Disclosure

- 17** List the states with which a copy of this Form 990 is required to be filed **▶MD**
- 18** Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
 Own website Another's website Upon request Other (explain on Schedule O)
- 19** Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records **▶**
CHERYL NOTTINGHAM - 410-641-9095
9733 HEALTHWAY DRIVE, BERLIN, MD 21811

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

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

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below 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) GREGORY SHOCKLEY CHAIRMAN	2.00	X		X			0.	0.	0.	
(2) WILLIAM ESHAM III VICE CHAIRMAN	2.00	X		X			0.	0.	0.	
(3) DOUG COOK TREASURER	2.00	X		X			0.	0.	0.	
(4) CHARLOTTE CATHELL SECRETARY	2.00	X		X			0.	0.	0.	
(5) DR. JON ANDES DIRECTOR	2.00	X					0.	0.	0.	
(6) J. RYAN BERGEY III DIRECTOR	2.00	X					0.	0.	0.	
(7) COREY CARPENTER, MD VICE CHIEF OF STAFF, EX-OFFICIO	2.00	X					0.	0.	0.	
(8) AARON FINNEY DIRECTOR (START APRIL 2020)	2.00	X					0.	0.	0.	
(9) TODD FERRANTE FOUNDATION BOARD CHAIRMAN	2.00	X					0.	0.	0.	
(10) JEFFREY GREENWOOD, MD DIRECTOR	2.00	X					0.	0.	0.	
(11) MICHAEL GUERRIERI DIRECTOR	2.00	X					0.	0.	0.	
(12) HARRIET L JOHNSON DIRECTOR	2.00	X					0.	0.	0.	
(13) JAY KNERR DIRECTOR	2.00	X					0.	0.	0.	
(14) TOM MEARS DIRECTOR	2.00	X					0.	0.	0.	
(15) LOIS SIRMAN DIRECTOR	2.00	X					0.	0.	0.	
(16) DALE SMACK DIRECTOR	2.00	X					0.	0.	0.	
(17) PHILLIP SPINUZZA VICE CHIEF OF STAFF, EX-OFFICIO	2.00	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 line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) CHRIS WOODLEY DIRECTOR	2.00	X						0.	0.	0.
(19) EDWIN CASTANEDA, MD DIRECTOR (THROUGH OCT 19)	2.00	X						0.	0.	0.
(20) ROBERT THOMPSON DIRECTOR (THROUGH OCT 19)	2.00	X						0.	0.	0.
(21) MICHAEL FRANKLIN PRESIDENT & CEO, EX-OFFICIO	40.00	X		X				459,307.	0.	28,602.
(22) CHERYL NOTTINGHAM CFO	40.00			X				226,836.	0.	19,409.
(23) TIMOTHY R. WHETSTONE VP PROFESSIONAL SERVICES	40.00			X				169,976.	0.	14,970.
(24) COLLEEN WAREING VP PATIENT CARE	40.00				X			169,206.	0.	20,240.
(25) RABINDRA PAUL PHYSICIAN	40.00					X		1,094,668.	0.	28,602.
(26) JAMES P. CHERRY PHYSICIAN	40.00					X		584,997.	0.	28,602.
1b Subtotal								2,704,990.	0.	140,425.
c Total from continuation sheets to Part VII, Section A								2,420,560.	0.	76,440.
d Total (add lines 1b and 1c)								5,125,550.	0.	216,865.

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 **90**

	Yes	No
3 Did the organization list any former officer, director, 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
WHITING TURNER 300 EAST JOPPA ROAD, BALTIMORE, MD 21286	CONSTRUCTION	1,849,681.
ALLSCRIPTS 24630 NETWORK PLACE, CHICAGO, IL 60673	IT SERVICES	1,733,388.
INTERMED GROUP, INC. 13301 US HIGHWAY 441, ALACHUA, FL 32615	MEDICAL SERVICE	1,044,725.
PENINSULA REGIONAL MED. CTR., 100 EAST CARROLL STREET, SALISBURY, MD 21801	MEDICAL SERVICE	896,277.
GENESIS REHABILITATION SERVICE, 101 E. STATE STREET, KENNETT SQUARE, PA 19348	MEDICAL SERVICE	595,842.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization **25**

SEE PART VII, SECTION A CONTINUATION SHEETS

Part VIII Statement of Revenue

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

			(A)	(B)	(C)	(D)	
			Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c	178,305.				
	d Related organizations	1d					
	e Government grants (contributions)	1e	295,000.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	4,907,391.				
	g Noncash contributions included in lines 1a-1f	1g	\$ 100.				
	h Total. Add lines 1a-1f			5,380,696.			
Program Service Revenue	2 a NET PATIENT REVENUE	Business Code 621110	116,773,643.	116,773,643.			
	b CARES ACT PROVIDER RELIEF FUNDS	621110	9,897,273.	9,897,273.			
	c PHARMACY	621110	4,323,950.	4,077,285.	246,665.		
	d OTHER OPERATING	621110	1,590,353.	1,565,530.	24,823.		
	e						
	f All other program service revenue						
	g Total. Add lines 2a-2f			132,585,219.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		484,370.			484,370.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real	356,540.				
		(ii) Personal					
		6b Less: rental expenses	29,042.				
	6c Rental income or (loss)	327,498.					
	d Net rental income or (loss)		327,498.			327,498.	
	7 a Gross amount from sales of assets other than inventory	(i) Securities	240,700.				
		(ii) Other	50,376.				
		7b Less: cost or other basis and sales expenses	0.	4,334,992.			
	7c Gain or (loss)	240,700.	-4,284,616.				
	d Net gain or (loss)		-4,043,916.			-4,043,916.	
8 a Gross income from fundraising events (not including \$ 178,305. of contributions reported on line 1c). See Part IV, line 18		27,162.					
	8b Less: direct expenses	38,647.					
	c Net income or (loss) from fundraising events		-11,485.			-11,485.	
9 a Gross income from gaming activities. See Part IV, line 19							
	9b Less: direct expenses						
	c Net income or (loss) from gaming activities						
10 a Gross sales of inventory, less returns and allowances		186,696.					
	10b Less: cost of goods sold	153,332.					
	c Net income or (loss) from sales of inventory		33,364.			33,364.	
Miscellaneous Revenue	11 a MISCELLANEOUS	Business Code 621110	457,817.	457,817.			
	b CAFETERIA	621110	196,076.	196,076.			
	c						
	d All other revenue						
	e Total. Add lines 11a-11d			653,893.			
12 Total revenue. See instructions			135,409,639.	132,967,624.	271,488.	-3,210,169.	

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 ...				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	1,108,546.		1,108,546.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	58,614,864.	50,586,512.	7,773,180.	255,172.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	930,000.		930,000.	
9 Other employee benefits	7,132,026.	2,708,827.	4,422,601.	598.
10 Payroll taxes	3,766,268.	3,130,651.	616,193.	19,424.
11 Fees for services (nonemployees):				
a Management				
b Legal	184,561.	90,035.	94,526.	
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch. O.)	4,017,287.	3,750,750.	266,365.	172.
12 Advertising and promotion	704,671.	700,271.	1,333.	3,067.
13 Office expenses	34,974,928.	33,793,856.	749,642.	431,430.
14 Information technology	2,430,357.	9,817.	2,420,540.	
15 Royalties				
16 Occupancy	956,590.	914,558.	41,777.	255.
17 Travel	87,854.	71,487.	20,403.	-4,036.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials ...				
19 Conferences, conventions, and meetings	85,591.	36,667.	44,359.	4,565.
20 Interest	1,535,809.	417,436.		1,118,373.
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	7,181,681.	2,004,878.	718.	5,176,085.
23 Insurance	2,017,089.	640,366.	24,362.	1,352,361.
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a PURCHASED SERVICES & PR	3,218,095.	2,051,272.	1,162,575.	4,248.
b REPAIRS & MAINTENANCE	3,095,818.	2,502,690.	568,592.	24,536.
c OUTSIDE LAB SERVICES	1,287,601.	1,287,601.		
d DUES	396,272.	77,469.	33,671.	285,132.
e All other expenses	1,212,092.	842,867.	280,213.	89,012.
25 Total functional expenses. Add lines 1 through 24e	134,938,000.	105,618,010.	20,559,596.	8,760,394.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				
Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing		1	
	2 Savings and temporary cash investments	7,784,202.	2	34,779,417.
	3 Pledges and grants receivable, net	3,508,673.	3	6,786,569.
	4 Accounts receivable, net	11,155,724.	4	11,152,597.
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	2,491,024.	8	2,670,835.
	9 Prepaid expenses and deferred charges	2,322,096.	9	2,511,984.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 148,406,182.		
	b Less: accumulated depreciation	10b 82,461,865.	64,159,377.	10c 65,944,317.
	11 Investments - publicly traded securities	13,244,676.	11	13,526,110.
	12 Investments - other securities. See Part IV, line 11	7,696.	12	7,696.
	13 Investments - program-related. See Part IV, line 11		13	
	14 Intangible assets	2,223,207.	14	2,012,006.
	15 Other assets. See Part IV, line 11	5,956,784.	15	6,397,045.
16 Total assets. Add lines 1 through 15 (must equal line 33)	112,853,459.	16	145,788,576.	
Liabilities	17 Accounts payable and accrued expenses	13,651,743.	17	13,730,209.
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities	34,138,392.	20	36,114,172.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		22	
	23 Secured mortgages and notes payable to unrelated third parties	1,800,813.	23	1,481,443.
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	10,828,390.	25	41,624,394.
	26 Total liabilities. Add lines 17 through 25	60,419,338.	26	92,950,218.
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.			
	27 Net assets without donor restrictions	48,479,963.	27	45,682,984.
	28 Net assets with donor restrictions	3,954,158.	28	7,155,374.
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building, or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
	32 Total net assets or fund balances	52,434,121.	32	52,838,358.
	33 Total liabilities and net assets/fund balances	112,853,459.	33	145,788,576.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	135,409,639.
2	Total expenses (must equal Part IX, column (A), line 25)	2	134,938,000.
3	Revenue less expenses. Subtract line 2 from line 1	3	471,639.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	52,434,121.
5	Net unrealized gains (losses) on investments	5	53,311.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	14.
9	Other changes in net assets or fund balances (explain on Schedule O)	9	-120,727.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	52,838,358.

Part XII Financial Statements and Reporting

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

- 1 Accounting method used to prepare the Form 990: Cash 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 on Schedule O.
- 3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the 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 on Schedule O and describe any steps taken to undergo such audits

	Yes	No
2a		X
2b	X	
2c	X	
3a		X
3b		

Form 990 (2019)

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2018 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2019. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 33 1/3% support test - 2018. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2019. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2018. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2019 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2018 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2019 (line 10c, column (f), divided by line 13, column (f))	17	%
18 Investment income percentage from 2018 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2019. 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 - 2018. 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

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

	Yes	No
1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
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? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
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? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		

Section E. Type III Functionally Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2 Activities Test. Answer (a) and (b) below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
3 Parent of Supported Organizations. Answer (a) and (b) below.		
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		

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	Adjusted Net Income (subtract lines 5, 6, and 7 from line 4)	8	

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

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1.	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3.	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions.	
7 Total annual distributions. Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	
9 Distributable amount for 2019 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-2019	(iii) Distributable Amount for 2019
1 Distributable amount for 2019 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required- explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2019			
a From 2014			
b From 2015			
c From 2016			
d From 2017			
e From 2018			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2019 distributable amount			
i Carryover from 2014 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2019 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2019, 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 2019. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI . See instructions.			
7 Excess distributions carryover to 2020. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2015			
b Excess from 2016			
c Excess from 2017			
d Excess from 2018			
e Excess from 2019			

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.)

Multiple horizontal lines for supplemental information.

Schedule B

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

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2019

Name of the organization

ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

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).

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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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	<u>AGH AUXILIARY</u> <u>9733 HEALTHWAY DRIVE</u> <u>BERLIN, MD 21811</u>	\$ <u>30,100.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	<u>AGH JUNIOR AUXILIARY GROUP</u> <u>9733 HEALTHWAY DRIVE</u> <u>BERLIN, MD 21811</u>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	<u>BULL ON THE BEACH RESTAURANTS</u> <u>12507 SUNSET AVENUE, #8</u> <u>OCEAN CITY, MD 21842</u>	\$ <u>23,919.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	<u>CHRISTINE W. GLICK</u> <u>10706 PINEY ISLAND DRIVE</u> <u>BISHOPVILLE, MD 21813-1452</u>	\$ <u>6,350.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	<u>COMMUNITY FOUNDATION OF THE EASTERN SHORE</u> <u>1324 BELMONT AVENUE, SUITE 401</u> <u>SALISBURY, MD 21804</u>	\$ <u>104,940.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	<u>EMERGENCY SERVICE ASSOCIATES, P.A.</u> <u>100 E. CARROLL STREET</u> <u>SALISBURY, MD 21801</u>	\$ <u>6,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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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	HAL GLICK SERVICE AWARD GALA 11036 WORCESTER HIGHWAY BERLIN, MD 21811	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	HARVEY L. BERGER 11734 INDIAN RIDGE ROAD RESTON, VA 20191	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	JACK BURBAGE FOUNDATION, INC. 9919 STEPHEN DECATUR HIGHWAY UNIT 1 OCEAN CITY, MD 21842	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10	JOAN W. JENKINS FOUNDATION, INC. PO BOX 572 OCEAN CITY, MD 21843	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11	JOHN W. FAGER 11831 BACK CREEK ROAD BISHOPVILLE, MD 21813	\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12	MARYLAND HOSPITAL ASSOCIATION 6820 DEERPATH ROAD ELKRIDGE, MD 21705	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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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	<u>THE CAROUSEL GROUP</u> <u>11700 COASTAL HIGHWAY</u> <u>OCEAN CITY, MD 21842</u>	\$ <u>12,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14	<u>TOWN OF BERLIN</u> <u>10 WILLIAM STREET</u> <u>BERLIN, MD 21811</u>	\$ <u>20,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15	<u>WORCESTER COUNTY COMMISSIONERS</u> <u>PO BOX 248</u> <u>SNOW HILL, MD 21863-0248</u>	\$ <u>175,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16	<u>BETTY S. BUSH</u> <u>9416 LAKE VIEW DRIVE</u> <u>BERLIN, MD 21811</u>	\$ <u>11,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17	<u>ESHAM FAMILY LIMITED PARTNERSHIP</u> <u>PO BOX 77</u> <u>BERLIN, MD 21811</u>	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18	<u>ESTATE OF ROSE M. WAINWRIGHT</u> <u>PO BOX 600</u> <u>OCEAN CITY, MD 21843</u>	\$ <u>18,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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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	MICHAEL A. FRANKLIN 11418 NEWPORT BAY DRIVE BERLIN, MD 21811-9642	\$ 6,350.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
20	WILLIAM A. GIBBS 1558 TEAL DRIVE OCEAN CITY, MD 21842-0419	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
21	HUMPHREYS FOUNDATION, INC. 9748 STEPHEN DECATUR HWY STE 103 OCEAN CITY, MD 21842	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
22	JOE M. SHAW 10264 BENT CREEK CT OCEAN CITY, MD 21842	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
23	LOIS A. SIRMAN 9559 OCEAN VIEW LN OCEAN CITY, MD 21842	\$ 5,300.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
24	G. MARVIN STEEN 627 B OCEAN PARKWAY OCEAN PINES, MD 21811	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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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	SUNSET GRILLE, LLC 12933 SUNSET AVENUE OCEAN CITY, MD 21842	\$ 5,650.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
26	BRUCE C. LEINER 421 BERING RD OCEAN CITY, MD 21842	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
27	CHANTILLY CRUSHED STONE, INC. BOX 220112 CHANTILLY, VA 20153	\$ 800,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
28	CHARLES M. PARKER 6 DOMI DR CAPE MAY, NJ 08210	\$ 35,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
29	O. PALMER GILLIS 3501 S. CANAL STREET OCEAN CITY, MD 21842	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
30	LEE W. KLEPPER 101 PINE FOREST DRIVE OCEAN PINES, MD 21811	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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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	KATHLEEN MARSHALL 12111 PIMLICO LANE BERLIN, MD 21811	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
32	MYERS FAMILY FOUNDATION 11726 WINDING CREEK DRIVE BERLIN, MD 21811	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
33	OLD PRO GOLF, INC. 6801 COASTAL HIGHWAY OCEAN CITY, MD 21842	\$ 5,100.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
34	ROYAL PLUS ELECTRIC, INC. 9939 JERRY MACK ROAD, SUITE 400 OCEAN CITY, MD 21842	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
35	MACKY STANSELL 11708 GUM POINT ROAD BERLIN, MD 21811	\$ 33,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
36	TAYLOR BANK PO BOX 5 BERLIN, MD 21811	\$ 44,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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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	<u>THE INTERMED GROUP</u> <u>13301 NW US HWY 441</u> <u>ALACHUA, FL 32615</u>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
38	<u>TOWN OF OCEAN CITY</u> <u>PO BOX 158</u> <u>OCEAN CITY, MD 21843</u>	\$ <u>100,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
39	<u>PAMELA F. ADKINS</u> <u>37792 CEDAR ROAD</u> <u>SELBYVILLE, DE 19975</u>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
40	<u>DEELEY INSURANCE GROUP</u> <u>7171 BENT PINE RD</u> <u>WILLARDS, MD 21874</u>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
41	<u>ESTATE OF KATHLEEN M. PARKER</u> <u>101 PINE STREET</u> <u>BERLIN, MD 21811</u>	\$ <u>17,217.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
42	<u>EUGENE B. CASEY FOUNDATION</u> <u>16803 CRABBS BRANCH WAY</u> <u>ROCKVILLE, MD 20855</u>	\$ <u>11,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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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	<u>GEORGE A. PURNELL</u> <u>1546 TEAL DRIVE</u> <u>OCEAN CITY, MD 21842</u>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
44	<u>JAMES SULLIVAN</u> <u>10002 COASTAL HIGHWAY, UNIT 601</u> <u>OCEAN CITY, MD 21842</u>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
45	<u>LESLIE C. KOPP INC.</u> <u>PO BOX 1578</u> <u>BETHANY BEACH, DE 19930</u>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
46	<u>MILES RIVER INVESTMENTS</u> <u>PO BOX 1697</u> <u>SALISBURY, MD 21802</u>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
47	<u>PATRICIA ILCZUK (LAVANCEAU) SHAFFER</u> <u>8617 OTTER CREEK RD</u> <u>LAUREL, MD 20724</u>	\$ <u>10,325.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
48	<u>PENINSULA PATHOLOGY ASSOCIATES, PA</u> <u>PO BOX 3483</u> <u>SALISBURY, MD 21802</u>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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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	<u>PENINSULA RADIOLOGY ASSOCIATES, P.A.</u> <u>918 EASTERN SHORE DR</u> <u>SALISBURY, MD 21804</u>	\$ <u>15,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
50	<u>ROBERT P. HAMMOND</u> <u>11070 CATHELL ROAD, UNIT 4</u> <u>BERLIN, MD 21811</u>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
51	<u>ROYAL PLUS INC.</u> <u>201 BELT ST</u> <u>SNOW HILL, MD 21863</u>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
52	<u>SHENANIGAN'S IRISH PUB AND GRILLE</u> <u>PO BOX 631</u> <u>OCEAN CITY, MD 21842</u>	\$ <u>6,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
53	<u>TEMPLE BAT YAM</u> <u>11036 WORCESTER HWY</u> <u>BERLIN, MD 21811</u>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
54	<u>TROND'S POOL CONSTRUCTION, LLC</u> <u>PO BOX 1371</u> <u>BERLIN, MD 21811</u>	\$ <u>5,400.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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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
55	WILDE CHARITABLE FOUNDATION, INC. PO BOX 540 OCEAN CITY, MD 21843-0540	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
56	NORA ROBERTS FOUNDATION 100 CAMPUS DR STE 350 FLORHAM PARK, NJ 07932	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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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
33	GIFT CERTIFICATES _____ _____ _____	\$ 100.	06/30/20
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

Name of organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
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Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this info. once.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

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

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

OMB No. 1545-0047

2019
Open to Public Inspection

Name of the organization ATLANTIC GENERAL HOSPITAL **Employer identification number** 52-1656507

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

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

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).
 Preservation of land for public use (for example, recreation or education) Preservation of a historically important land area
 Protection of natural habitat Preservation of a certified historic structure
 Preservation of open space

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

	Held at the End of the Tax Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

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

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

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

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

(i) Revenue included on Form 990, Part VIII, line 1

(ii) Assets included in Form 990, Part X

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

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

b Assets included in Form 990, Part X

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule D (Form 990) 2019

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

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

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

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	5,813,047.	5,638,785.	5,180,221.	5,007,236.	5,306,622.
b Contributions			404,325.	279,635.	
c Net investment earnings, gains, and losses	-10,220.	372,458.	88,495.	-74,567.	-63,878.
d Grants or scholarships					
e Other expenditures for facilities and programs	209,845.	164,495.			204,117.
f Administrative expenses	32,020.	33,701.	34,256.	32,083.	31,391.
g End of year balance	5,560,962.	5,813,047.	5,638,785.	5,180,221.	5,007,236.

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment 68.00 %
 - b Permanent endowment 32.00 %
 - c Term endowment .00 %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|-----|----|
| (i) Unrelated organizations | | X |
| (ii) Related organizations | | X |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? <input type="checkbox"/> | 3b | |
- 4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		5,841,074.		5,841,074.
b Buildings		53,656,416.	21,586,996.	32,069,420.
c Leasehold improvements				
d Equipment		84,729,706.	60,874,869.	23,854,837.
e Other		4,178,986.		4,178,986.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				65,944,317.

Part VII Investments - Other Securities.

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

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

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

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

Part X Other Liabilities.

Complete if the organization answered "Yes" 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 THIRD PARTIES	27,051,288.
(3) CAPITAL LEASE	1,381,171.
(4) INSURANCE UNPAID LOSS	5,199,621.
(5) INSURANCE IBNR FOR CAPTIVE	1,500,000.
(6) SWAP CONTRACT	6,492,314.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	41,624,394.

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

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

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

1	Total revenue, gains, and other support per audited financial statements		1	135,371,265.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
a	Net unrealized gains (losses) on investments	2a	53,311.	
b	Donated services and use of facilities	2b		
c	Recoveries of prior year grants	2c		
d	Other (Describe in Part XIII.)	2d	29,042.	
e	Add lines 2a through 2d	2e		82,353.
3	Subtract line 2e from line 1		3	135,288,912.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:			
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a		
b	Other (Describe in Part XIII.)	4b	120,727.	
c	Add lines 4a and 4b	4c		120,727.
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)		5	135,409,639.

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

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

1	Total expenses and losses per audited financial statements		1	134,967,042.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:			
a	Donated services and use of facilities	2a		
b	Prior year adjustments	2b		
c	Other losses	2c		
d	Other (Describe in Part XIII.)	2d	29,042.	
e	Add lines 2a through 2d	2e		29,042.
3	Subtract line 2e from line 1		3	134,938,000.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:			
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a		
b	Other (Describe in Part XIII.)	4b		
c	Add lines 4a and 4b	4c		0.
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)		5	134,938,000.

Part XIII Supplemental Information.

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

PART V, LINE 4:

THE COMMUNITY FOUNDATION OF THE EASTERN SHORE HOLDS, AND ACCOUNTS FOR IN ITS FINANCIAL STATEMENTS, A PERMANENT ENDOWMENT FUND (THE "FUND") ESTABLISHED IN THE HOSPITAL'S NAME. THE HOSPITAL IS THE SOLE BENEFICIARY OF THE FUND AND IS ENTITLED TO INVESTMENT INCOME EARNED BY THE FUND. THE 2019 TAX YEAR ENDING BALANCE FOR THE FUND WAS \$1,798,032.

PART X, LINE 2:

THE CORPORATION IS EXEMPT FROM FEDERAL INCOME TAX UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE AS A PUBLIC CHARITY. FEDERAL TAX LAW REQUIRES THAT THE CORPORATION BE OPERATED IN A MANNER CONSISTENT WITH ITS INITIAL EXEMPTION APPLICATION IN ORDER TO MAINTAIN ITS EXEMPT STATUS. MANAGEMENT

Part XIII Supplemental Information (continued)

HAS ANALYZED THE OPERATIONS OF THE CORPORATION AND CONCLUDED THAT IT REMAINS IN COMPLIANCE WITH THE REQUIREMENTS FOR EXEMPTION.

THE STATE IN WHICH THE CORPORATION OPERATES ALSO PROVIDES GENERAL EXEMPTION FROM STATE INCOME TAXATION FOR ORGANIZATIONS THAT ARE EXEMPT FROM FEDERAL INCOME TAXATION. HOWEVER, THE CORPORATION IS SUBJECT TO BOTH FEDERAL AND STATE INCOME TAXATION AT CORPORATE TAX RATES ON ITS UNRELATED BUSINESS INCOME. EXEMPTION FROM OTHER STATE TAXES, SUCH AS REAL AND PERSONAL PROPERTY TAXES, IS SEPARATELY DETERMINED.

CURRENT ACCOUNTING STANDARDS DEFINE THE THRESHOLD FOR RECOGNIZING UNCERTAIN INCOME TAX RETURN POSITIONS IN THE FINANCIAL STATEMENTS AS "MORE LIKELY THAN NOT" THAT THE POSITION IS SUSTAINABLE, BASED ON TECHNICAL MERITS, AND ALSO PROVIDE GUIDANCE ON THE MEASUREMENT, CLASSIFICATION, AND DISCLOSURE OF TAX RETURN POSITIONS IN THE FINANCIAL STATEMENTS. MANAGEMENT BELIEVES THERE IS NO IMPACT ON THE CORPORATION'S ACCOMPANYING FINANCIAL STATEMENTS RELATED TO UNCERTAIN INCOME TAX PROVISIONS.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

RENTAL EXPENSES 29,042.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

RESTRICTED CONTRIBUTION 120,727.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

RENTAL EXPENSES 29,042.

Part II Fundraising Events. Complete if the organization answered "Yes" on Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events (add col. (a) through col. (c))	
		2019 ANNUAL FALL GOLF CL (event type)	2020 PENGUIN SWIM (event type)	1 (total number)		
Revenue	1	Gross receipts	110,840.	89,377.	5,250.	205,467.
	2	Less: Contributions	90,440.	87,865.		178,305.
	3	Gross income (line 1 minus line 2)	20,400.	1,512.	5,250.	27,162.
Direct Expenses	4	Cash prizes	695.			695.
	5	Noncash prizes	9,458.	9,823.		19,281.
	6	Rent/facility costs	8,246.			8,246.
	7	Food and beverages	4,484.			4,484.
	8	Entertainment				
	9	Other direct expenses	970.	4,971.		5,941.
	10	Direct expense summary. Add lines 4 through 9 in column (d)				38,647.
11	Net income summary. Subtract line 10 from line 3, column (d)				-11,485.	

Part III Gaming. Complete if the organization answered "Yes" on Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1	Gross revenue			
	2	Cash prizes			
Direct Expenses	3	Noncash prizes			
	4	Rent/facility costs			
	5	Other direct expenses			
6	Volunteer labor	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	
7	Direct expense summary. Add lines 2 through 5 in column (d)				
8	Net gaming income summary. Subtract line 7 from line 1, column (d)				

9 Enter the state(s) in which the organization conducts gaming activities: _____

a Is the organization licensed to conduct gaming activities in each of these states? Yes No

b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended, or terminated during the tax year? Yes No

b If "Yes," explain: _____

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

Name of the organization **ATLANTIC GENERAL HOSPITAL** Employer identification number **52-1656507**

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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

7 Financial Assistance and Certain Other Community Benefits at Cost

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			1253862.		1253862.	.93%
b Medicaid (from Worksheet 3, column a)			7353555.	11761993.	0.	.00%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			8607417.	11761993.	1253862.	.93%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			603,374.	610.	602,764.	.45%
f Health professions education (from Worksheet 5)			312,639.		312,639.	.23%
g Subsidized health services (from Worksheet 6)			190,663.		190,663.	.14%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			59,741.		59,741.	.04%
j Total. Other Benefits			1166417.	610.	1165807.	.86%
k Total. Add lines 7d and 7j			9773834.	11762603.	2419669.	1.79%

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 ATLANTIC GENERAL 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
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input 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>18</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		X
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C		X
7 Did the hospital facility make its CHNA report widely available to the public?	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.ATLANTICGENERAL.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>18</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a If "Yes," (list url): <u>WWW.ATLANTICGENERAL.ORG</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
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 ATLANTIC GENERAL HOSPITAL

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	X	
If "Yes," indicate the eligibility criteria explained in the FAP:		
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input type="checkbox"/> Insurance status		
f <input type="checkbox"/> Underinsurance status		
g <input type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	X	
15 Explained the method for applying for financial assistance?	X	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.ATLANTICGENERAL.ORG</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>WWW.ATLANTICGENERAL.ORG</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>WWW.ATLANTICGENERAL.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 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 Limited English Proficiency (LEP) populations		
j <input type="checkbox"/> Other (describe in Section C)		

Schedule H (Form 990) 2019

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group ATLANTIC GENERAL 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 type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
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 ATLANTIC GENERAL HOSPITAL

		Yes	No
22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a	<input type="checkbox"/> The hospital facility used 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 type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.		23	X
24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.		24	X

Schedule H (Form 990) 2019

Part V Facility Information *(continued)*

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

ATLANTIC GENERAL HOSPITAL:

PART V, SECTION B, LINE 3J: THIS 2019-2021 CHNA COMBINES POPULATION HEALTH STATISTICS, IN ADDITION TO FEEDBACK GATHERED FROM THE COMMUNITY IN THE FORM OF SURVEYS AND FOCUS GROUPS. AGH USES HEALTHY COMMUNITIES INSTITUTE TO PROVIDE HEALTH INDICATOR AND RANKING DATA TO SUPPLEMENT COMMUNITY DATA PROVIDED BY PARTNERS OF THE COLLABORATION. WHEN COMBINED, FINDINGS FROM THE DATA AND COMMUNITY FEEDBACK ARE PARTICULARLY USEFUL IN IDENTIFYING PRIORITY HEALTH NEEDS AND DEVELOPING ACTION PLANS TO MEET THOSE NEEDS.

THIS ASSESSMENT INCORPORATES DATA FROM BOTH QUANTITATIVE AND QUALITATIVE SOURCES. QUANTITATIVE DATA INPUT INCLUDES PRIMARY RESEARCH (SURVEYS) AND SECONDARY RESEARCH (VITAL STATISTICS AND OTHER EXISTING HEALTH-RELATED DATA); THESE QUANTITATIVE COMPONENTS ALLOW FOR COMPARISON TO BENCHMARK DATA AT THE STATE AND NATIONAL LEVELS. QUALITATIVE DATA INPUT INCLUDES INFORMATION GATHERED THROUGH ONGOING KEY COMMUNITY GROUPS.

SECONDARY DATA COLLECTION AGH PARTNERS WITH SURROUNDING HOSPITALS, HEALTH DEPARTMENTS AND STATE AGENCIES TO BRING TO TOGETHER A MULTITUDE OF INFORMATION. THIS COMMUNITY HEALTH NEEDS ASSESSMENT, A FOLLOW-UP TO A SIMILAR STUDY CONDUCTED IN 2012 AND 2015, IS A SYSTEMATIC, DATA-DRIVEN APPROACH TO DETERMINING THE HEALTH STATUS, BEHAVIORS AND NEEDS OF RESIDENTS IN THE PRIMARY SERVICE AREA OF ATLANTIC GENERAL HOSPITAL. SUBSEQUENTLY, THIS INFORMATION MAY BE USED TO INFORM DECISIONS AND GUIDE EFFORTS TO IMPROVE COMMUNITY HEALTH AND WELLNESS. THE INFORMATION AS WELL AS OTHER SURVEYS, RESEARCH AND COMMUNITY DATA ARE USED TO IDENTIFY ISSUES OF GREATEST CONCERN AND GUIDE RESOURCE ALLOCATION TO THOSE AREAS, THEREBY

Part V Facility Information (continued)

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

MAKING THE GREATEST POSSIBLE IMPACT ON COMMUNITY HEALTH STATUS. THE NEEDS ASSESSMENT IS A PRIMARY TOOL USED BY THE HOSPITAL TO DETERMINE ITS COMMUNITY BENEFIT PRIORITIES, WHICH OUTLINES HOW THE HOSPITAL WILL GIVE BACK TO THE COMMUNITY IN THE FORM OF HEALTH CARE AND OTHER COMMUNITY SERVICES TO ADDRESS UNMET COMMUNITY HEALTH NEEDS. THIS ASSESSMENT INCORPORATES COMPONENTS OF PRIMARY DATA COLLECTION AND SECONDARY DATA ANALYSIS THAT FOCUSES ON THE HEALTH AND SOCIAL NEEDS OF OUR SERVICE AREA. A SAMPLING OF RESOURCES UTILIZED TO COMPLETE THE ASSESSMENT IS LISTED BELOW. A COMPREHENSIVE LIST IS FOUND UNDER CHNA FY19-21 REFERENCES.

-COMMUNITY MEETINGS WITH PERSONS REPRESENTING THE BROAD INTERESTS OF THE COMMUNITY

-AGH COMMUNITY NEEDS SURVEY

-MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)

WWW.DHMH.MARYLAND.GOV/SHIP

-TRI-COUNTY HEALTH IMPROVEMENT PLAN (T-CHIP)

-HEALTHY PEOPLE 2020

-WORCESTER COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) LHIC LOCAL HEALTH IMPROVEMENT COALITION

HEALTH IMPROVEMENT COALITION

-MEDICAL STAFF DEVELOPMENT PLAN

-HEALTH FAIRS

-COMMUNITY EDUCATION EVENTS

-COUNTY HEALTH OUTCOMES & ROADMAPS

-WWW.DHSS.DELAWARE.GOV/DHSS/DPH/FLES/SHASHIP.PDF

-DELAWARE HEALTH AND SOCIAL SERVICES THROUGH THE DELAWARE HEALTH TRACKER

WWW.DELAWAREHEALTHTRACKER.COM

-BEEBE MEDICAL CENTER COMMUNITY HEALTH NEEDS ASSESSMENT

Part V Facility Information (continued)

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

-US CENSUS BUREAU

THE COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY WAS DISTRIBUTED BY COMMUNITY OUTREACH PERSONNEL AND THE ATLANTIC GENERAL HOSPITAL WEBSITE. STAKEHOLDER INTERVIEWS AND FOCUS GROUPS WERE CONDUCTED BY COMMUNITY OUTREACH PERSONNEL. COMMUNITY SURVEYS REPRESENT INFORMATION THAT IS SELF-REPORTED. RESULTS FROM THE PAPER SURVEYS AND ELECTRONIC VERSIONS ARE FOUND IN CHNA FY19-21.

ATLANTIC GENERAL HOSPITAL:

PART V, SECTION B, LINE 5: THE HOSPITAL FACILITY TOOK INTO ACCOUNT INPUT FROM REPRESENTATIVES OF THE COMMUNITY SERVED BY THE HOSPITAL FACILITY, INCLUDING THOSE WITH SPECIAL EXPERTISE IN PUBLIC HEALTH AND REPRESENTATIVES FROM UNDERSERVED, UNINSURED OR MINORITY GROUPS. IN PARTICULAR, INFORMATION WAS GATHERED FROM PARTICIPANTS IN OUR FREE CLINICS AND SCREENINGS, CHURCH GROUPS (VARIOUS CONGREGATIONS TO WHOM WE PROVIDE SERVICES AND THROUGH THOSE REPRESENTED IN OUR FAITH BASED PARTNERSHIP), LOCAL BUSINESSES AND THROUGH OUR COMMUNITY HEALTH FAIRS. THIS PRIMARY DATA WAS COLLECTED THROUGH THE USE OF PAPER QUESTIONNAIRES PROVIDED DIRECTLY TO THE PARTICIPANTS, AS WELL AS QUESTIONNAIRES THAT COULD BE ACCESSED ON THE HOSPITAL FACILITY'S WEBSITE.

WE ALSO CONSULTED WITH NUMEROUS AGENCIES IN THE COMMUNITY WHO ARE KNOWLEDGEABLE ABOUT HEALTH NEEDS OF THE COMMUNITY, INCLUDING:

WORCESTER COUNTY HEALTH DEPARTMENT

Part V Facility Information (continued)

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

WORCESTER COUNTY PREVENTION OFFICE

WORCESTER COUNTY MENTAL/BEHAVIOR HEALTH SERVICES

MAC, INC. (MAINTAINING ACTIVE CITIZENS-YOUR AREA AGENCY OF AGING)

CAREGIVERS RESOURCE CENTER

LOCAL PARKS AND RECREATION DEPARTMENTS

TRI-COUNTY DIABETES ALLIANCE

TRI-COUNTY COMMUNITY HEALTH BOARD

COASTAL HOSPICE

WORCESTER COUNTY BOARD OF EDUCATION

WORCESTER YOUTH AND FAMILY SERVICES

ATLANTIC GENERAL HOSPITAL:

PART V, SECTION B, LINE 6A: PART OF THE DATA USED IN OUR COMMUNITY HEALTH NEEDS ASSESSMENT STEMS FROM THE TRI-COUNTY NEEDS ASSESSMENT UNDERTAKEN IN CONJUNCTION WITH PENINSULA REGIONAL MEDICAL CENTER IN SALISBURY AND MCCREADY HOSPITAL IN CRISFIELD.

ATLANTIC GENERAL HOSPITAL:

PART V, SECTION B, LINE 11: DURING THE HOSPITAL FACILITY'S 2019 TAX YEAR, IT CONTINUED TO ADDRESS COMMUNITY HEALTH NEEDS IDENTIFIED IN ITS MOST RECENTLY CONDUCTED CHNA PURSUANT TO THE IMPLEMENTATION STRATEGY. BELOW IS A BRIEF DESCRIPTION OF SOME OF THE ACTIVITIES UNDERTAKEN TO MEET IDENTIFIED COMMUNITY HEALTH NEEDS:

INITIATIVE: ACCESS TO CARE

Part V Facility Information (continued)

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

1) REDUCE UNNECESSARY HEALTHCARE COSTS AND REDUCTION IN HOSPITAL

ADMISSIONS AND READMISSIONS DURING FY19

A) DESCRIPTION: THROUGH AGH'S INITIATIVE TO IMPROVE ACCESS TO CARE

REDUCTION IN UNNECESSARY HEALTHCARE COSTS WOULD BE AN IMPACT OF OBJECTIVES IMPROVING ACCESS TO CARE, EDUCATING THE COMMUNITY ON ED APPROPRIATE USE, CHRONIC ILLNESS SELF-MANAGEMENT, AND COLLABORATION EFFORTS WITH COMMUNITY ORGANIZATIONS WITH A SHARED VISION.

2) INCREASE IN AWARENESS AND SELF-MANAGEMENT OF CHRONIC DISEASE DURING FY19

A) DESCRIPTION: UTILIZE FAITH-BASED PARTNERSHIPS, TO PROVIDE ACCESS TO HIGH RISK POPULATIONS FOR EDUCATION ABOUT HEALTHY LIFESTYLES AND CHRONIC DISEASE MANAGEMENT

3) REDUCE HEALTH DISPARITIES DURING FY19

A) DESCRIPTION:

STRATEGY #1-PARTICIPATE ON AGH'S HEALTH EQUITY STEERING COMMITTEE TO PROMOTE HEALTH EQUITY AND REDUCE DISPARITIES.

STRATEGY #2-PROVIDE COMMUNITY HEALTH EVENTS TO TARGET MINORITY POPULATIONS BY INCREASING RELATIONSHIPS WITH FAITH-BASED PARTNERSHIPS, LOCAL BUSINESSES AND CULTURAL/ETHNIC COMMUNITY EVENTS.

STRATEGY #3-EDUCATE COMMUNITY ON FINANCIAL ASSISTANCE OPTIONS TO IMPROVE AFFORDABILITY OF CARE AND REDUCE DELAY IN CARE.

STRATEGY #4-PROMOTE PATIENT ENGAGEMENT THROUGH ADULT HEALTH LITERACY INITIATIVE.

STRATEGY #5-PILOT SCHOOL BASED TELEHEALTH PROGRAM.

Part V Facility Information (continued)

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

4) INCREASE COMMUNITY CAPACITY AND COLLABORATION FOR SHARED RESPONSIBILITY TO ADDRESS UNMET HEALTH NEEDS DURING FY19

A) DESCRIPTION: PARTNERING WITH COMMUNITY ORGANIZATIONS AND PARTICIPATION ON COMMITTEES THAT ADDRESS ACCESS TO CARE AND HEALTH DISPARITIES:

-PARTNER WITH HOMELESS SHELTERS AND FOOD PANTRIES TO PROMOTE WELLNESS

-REFER COMMUNITY TO LOCAL AGENCIES SUCH AS SHORE TRANSIT AND WORCESTER

COUNTY HEALTH DEPARTMENT FOR TRANSPORTATION ASSISTANCE

-PARTICIPATE ON TRI COUNTY HEALTH PLANNING COUNCIL

-PARTICIPATE ON WORCESTER COUNTY LHIC

-PARTICIPATE ON HOMELESSNESS COMMITTEE AND HOT

5) INCREASE NUMBER OF PRACTICING PRIMARY CARE PROVIDERS AND SPECIALISTS TO COMMUNITY DURING FY19

A) DESCRIPTION: PROVIDER RECRUITMENT

INITIATIVE: DECREASE THE INCIDENCE OF ADVANCED BREAST, LUNG, COLON, AND SKIN CANCER IN COMMUNITY

1) INCREASE AWARENESS AROUND IMPORTANCE OF PREVENTION AND EARLY DETECTION AND REDUCE HEALTH DISPARITIES

A) DESCRIPTION:

-IMPROVE PROPORTION OF MINORITIES RECEIVING WOMEN'S PREVENTATIVE HEALTH SERVICES

-IMPROVE PROPORTION OF MINORITIES PARTICIPATING IN COMMUNITY HEALTH SCREENINGS

2) INCREASE PROVIDER SERVICES IN COMMUNITY TO PROVIDE FOR CANCER RELATED TREATMENT

Part V Facility Information (continued)

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

A) DESCRIPTION: RECRUIT PROPER PROFESSIONALS IN COMMUNITY TO PROVIDE FOR
CANCER RELATED TREATMENT

3) IMPROVE ACCESS AND REFERRALS TO COMMUNITY RESOURCES RESULTING IN BETTER
OUTCOMES

A) DESCRIPTION: PARTNER WITH LOCAL HEALTH AGENCIES TO FACILITATE GRANT
APPLICATION TO FUND CANCER PROGRAMS

4) INCREASE SUPPORT TO PATIENTS AND CAREGIVERS

A) DESCRIPTION: PATIENTS AND CAREGIVERS NEED SUPPORT THROUGHOUT THE
CANCER TREATMENT PROCESS. PATIENTS EXPERIENCE THE PHYSICAL AND EMOTIONAL
STRESSORS UNDERGOING TREATMENT WHILE CAREGIVERS FULFILL A PROMINENT AND
UNIQUE ROLE SUPPORTING CANCER PATIENTS AND MULTITUDE OF SERVICES SUCH AS
HOME SUPPORT, MEDICAL TASKS SUPPORT, COMMUNICATION WITH HEALTHCARE
PROVIDERS AND PATIENT ADVOCATE. AGH COMMUNITY EDUCATION OPPORTUNITIES
PROVIDE SUPPORT AND PROMOTE AN INFORMED PATIENT AND CAREGIVER.

5) INCREASE PARTICIPATION IN COMMUNITY CANCER SCREENINGS ESPECIALLY
AT-RISK AND VULNERABLE POPULATIONS

A) DESCRIPTION:

-PROVIDE COMMUNITY HEALTH SCREENINGS :

-IMPROVE PROPORTION OF MINORITIES RECEIVING COLONOSCOPY SCREENINGS

-IMPROVE PROPORTION OF MINORITIES RECEIVING LDCT SCREENINGS

-INCREASE THE PROPORTION OF PERSONS WHO PARTICIPATE IN BEHAVIORS THAT
REDUCE THEIR EXPOSURE TO HARMFUL ULTRAVIOLET (UV) IRRADIATION AND AVOID
SUNBURN THROUGH MELANOMA EDUCATION AND SKIN CANCER SCREENINGS

Part V Facility Information (continued)

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

INITIATIVE 3 - DECREASE INCIDENCE OF DIABETES IN THE COMMUNITY

PRIMARY OBJECTIVE OF INITIATIVE: REDUCE UNNECESSARY HEALTHCARE COSTS AND DECREASE HOSPITAL ADMISSIONS AND READMISSIONS

A) DESCRIPTION: THROUGH AGH'S INITIATIVE TO IMPROVE ACCESS TO CARE REDUCTION IN UNNECESSARY HEALTHCARE COSTS WOULD BE AN IMPACT OF OBJECTIVES IMPROVING ACCESS TO CARE, EDUCATING THE COMMUNITY ON ED APPROPRIATE USE, DIABETES CHRONIC ILLNESS SELF-MANAGEMENT, DIABETES PREVENTION, AND COLLABORATION EFFORTS WITH COMMUNITY ORGANIZATIONS WITH A SHARED VISION.

2) INCREASE AWARENESS AROUND IMPORTANCE OF PREVENTION OF DIABETES AND EARLY DETECTION

A) DESCRIPTION: STRATEGY #1 -PROVIDE DIABETES SCREENINGS IN COMMUNITY VIA HEALTH FAIRS AND CLINICAL SCREENING EVENTS STRATEGY #2 - INCREASE PREVENTION BEHAVIORS IN PERSONS AT HIGH RISK FOR DIABETES WITH PREDIABETES THROUGH COMMUNITY EDUCATION OPPORTUNITIES AND SUPPORT GROUPS.

3) INCREASE PATIENT ENGAGEMENT IN SELF-MANAGEMENT OF CHRONIC CONDITIONS

A) DESCRIPTION: DESCRIPTION: AGH PARTNERS WITH MAC, LOCAL SENIOR CENTERS AND FAITH-BASED PARTNERSHIPS TO BRING STANFORD SELF-MANAGEMENT WORKSHOPS TO THE COMMUNITY TO INCREASE PATIENT ENGAGEMENT AND SELF-MANAGEMENT OF CHRONIC DISEASE.

4) INCREASE PROVIDER SERVICES IN COMMUNITY TO PROVIDE FOR DIABETES RELATED TREATMENT

Part V Facility Information (continued)

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

A) DESCRIPTION: STRATEGY #1 EXPLORE DIABETES EDUCATION OPPORTUNITIES VIA TELEHEALTH

5) INCREASE COMMUNITY CAPACITY AND COLLABORATION FOR SHARED RESPONSIBILITY TO ADDRESS UNMET HEALTH NEEDS

A) DESCRIPTION: PARTNER WITH LOCAL HEALTH AGENCIES TO FACILITATE GRANT APPLICATIONS TO FUND DIABETES PROGRAMS. DPP FOR ASSOCIATES.

THE HOSPITAL FACILITY WILL NOT ATTEMPT TO ADDRESS ALL OF THE IDENTIFIED NEEDS IN ITS COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). WHEN UNDERTAKING THE CHNA AND IMPLEMENTATION STRATEGY, THE HOSPITAL FACILITY WENT THROUGH A PRIORITIZATION PROCESS TO DETERMINE THOSE COMMUNITY HEALTH NEEDS THAT THE HOSPITAL FACILITY WOULD ATTEMPT TO ADDRESS. SOME OF THE FACTORS CONSIDERED WHEN PRIORITIZING THE NEEDS WERE THE SIZE AND SEVERITY OF THE NEED, THE HOSPITAL FACILITY'S ABILITY TO IMPACT THE NEED, THE AVAILABILITY OF OTHER RESOURCES AND STAKEHOLDERS IN THE COMMUNITY THAT ARE ALREADY ATTEMPTING TO MEET THE NEED, AND THE ABILITY FOR THE HOSPITAL TO EFFICIENTLY UTILIZE FINANCIAL RESOURCES TO EFFECT EACH NEED.

PURSUANT TO THE PRIORITIZATION PROCESS, THE HOSPITAL FACILITY DETERMINED THAT CERTAIN IDENTIFIED NEEDS WOULD NOT BE ADDRESSED BY THE HOSPITAL FACILITY, INCLUDING DENTAL HEALTH SERVICES, INJURY AND VIOLENCE, AND HIV STDS.

EACH OF THE HEALTH NEEDS LISTED IN THE HOSPITAL'S CHNA AS WELL AS WORCESTER COUNTY HEALTH DEPARTMENT'S COMMUNITY NEEDS ASSESSMENT IS IMPORTANT AND IS BEING ADDRESSED BY NUMEROUS PROGRAMS AND INITIATIVES

Part V Facility Information (continued)

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

OPERATED BY THE HOSPITAL AND/OR OTHER COMMUNITY PARTNERS OF THE HOSPITAL.

NEEDS NOT ADDRESSED AS A PRIORITY AREA IN THE IMPLEMENTATION PLAN ARE

BEING ADDRESSED IN THE COMMUNITY BY OTHER ORGANIZATIONS AND BY

ORGANIZATIONS BETTER SITUATED TO ADDRESS THE NEED.

NEEDS NOT ADDRESSED IN PLAN:

DENTAL/ORAL HEALTH

RATIONALE: NEED ADDRESSED BY WORCESTER COUNTY HEALTH DEPARTMENT'S DENTAL

SERVICES FOR PREGNANT WOMEN AND CHILDREN LESS THAN 21 YEARS OF AGE

-PRIORITY AREA WORCESTER CHIP

-NEED ADDRESSED BY LOWER SHORE DENTAL TASK FORCE & MISSION OF MERCY FOR

ADULT POPULATION

-NEED ADDRESSED BY AGH ED REFERRAL TO COMMUNITY RESOURCES

-NEED ADDRESSED BY CHESAPEAKE HEALTH SERVICES, A FEDERALLY FUNDED DENTAL

CLINIC FOR SOMERSET AND WICOMICO COUNTIES

INJURY & VIOLENCE

RATIONALE: NEED ADDRESSED BY WORCESTER COUNTY HEALTH DEPARTMENT PROGRAMS:

CHILD PASSENGER SAFETY SEATS (REFER TO WORC GOLD)

INJURY PREVENTION

HIGHWAY SAFETY PROGRAM

SAFE ROUTES TO SCHOOL

-NEED ADDRESSED BY WORCESTER COUNTY SHERIFF'S DEPARTMENT, STATE POLICE AND

MUNICIPAL LAW ENFORCEMENT AGENCIES

-NEED ADDRESSED BY AGH HEALTH LITERACY PROGRAM

HIV & STD (<2% EA)

Part V Facility Information *(continued)*

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

RATIONALE: NEED ADDRESSED BY WORCESTER COUNTY HEALTH DEPARTMENT

COMMUNICABLE DISEASE PROGRAMS

ATLANTIC GENERAL HOSPITAL:

PART V, SECTION B, LINE 18E: THE HOSPITAL FACILITY OR AN AUTHORIZED THIRD PARTY DID NOT UNDERTAKE ANY OF THE COLLECTION ACTIONS NOTED IN PART V, SECTION B, LINE 16 BEFORE MAKING REASONABLE EFFORTS TO DETERMINE ANY PATIENT'S ELIGIBILITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY. IN ORDER TO HELP DETERMINE PATIENTS' ELIGIBILITY UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL UNDERTAKES A NUMBER OF ACTIONS, INCLUDING NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY ON ADMISSION, NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY PRIOR TO DISCHARGE, NOTIFYING PATIENTS OF THE FINANCIAL ASSISTANCE POLICY IN COMMUNICATIONS WITH THE PATIENTS' BILLS, AND DOCUMENTING ITS DETERMINATION OF WHETHER PATIENTS WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY.

ATLANTIC GENERAL HOSPITAL:

PART V, SECTION B, LINE 20E: THE HOSPITAL FACILITY DOES NOT CHARGE ANY INDIVIDUALS THAT IT KNOWS ARE ELIGIBLE FOR FINANCIAL ASSISTANCE AN AMOUNT EQUAL TO THE GROSS CHARGE FOR ANY SERVICE. THE HOSPITAL USES THE CHARGE MASTER RATES FOR A SERVICE AS A STARTING POINT AGAINST WHICH THE DISCOUNTS MANDATED IN THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY ARE APPLIED TO DETERMINE THE AMOUNT ACTUALLY BILLED TO PATIENTS ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY. THE HOSPITAL FACILITY WILL NOT COLLECT

Part V Facility Information (continued)

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

PAYMENT FROM ANY PATIENT ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY IN EXCESS OF THE REDUCED AMOUNT THAT IS ACTUALLY BILLED TO SUCH FINANCIAL ASSISTANCE PATIENT. IN ADDITION, IF THE HOSPITAL CHARGED AN INDIVIDUAL THAT HAD NOT YET BEEN DETERMINED TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE AT THE TIME OF CHARGE AN AMOUNT EQUAL TO GROSS CHARGES, THEN UPON DETERMINING THE INDIVIDUAL WAS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL PROMPTLY CORRECTS THE BILL.

ATLANTIC GENERAL HOSPITAL:

PART V, SECTION B, LINE 23: THE HOSPITAL FACILITY DOES NOT CHARGE ANY INDIVIDUALS THAT IT KNOWS ARE ELIGIBLE FOR FINANCIAL ASSISTANCE AN AMOUNT EQUAL TO THE GROSS CHARGE FOR ANY SERVICE. THE HOSPITAL USES THE CHARGE MASTER RATES FOR A SERVICE AS A STARTING POINT AGAINST WHICH THE DISCOUNTS MANDATED IN THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY ARE APPLIED TO DETERMINE THE AMOUNT ACTUALLY BILLED TO PATIENTS ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY. THE HOSPITAL FACILITY WILL NOT COLLECT PAYMENT FROM ANY PATIENT ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY IN EXCESS OF THE REDUCED AMOUNT THAT IS ACTUALLY BILLED TO SUCH FINANCIAL ASSISTANCE PATIENT. IN ADDITION, IF THE HOSPITAL CHARGED AN INDIVIDUAL THAT HAD NOT YET BEEN DETERMINED TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE AT THE TIME OF CHARGE AN AMOUNT EQUAL TO GROSS CHARGES, THEN UPON DETERMINING THE INDIVIDUAL WAS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY, THE HOSPITAL PROMPTLY CORRECTS THE BILL.

Part V Facility Information *(continued)*

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

PART V, SECTION, LINE 22

MARYLAND WAIVER MEDICARE EXEMPT

PART V, SECTION B, LINE 4:

PART OF THE DATA USED IN OUR COMMUNITY HEALTH NEEDS ASSESSMENT STEMS FROM THE TRI-COUNTY NEEDS ASSESSMENT UNDERTAKEN IN CONJUNCTION WITH PENINSULA REGIONAL MEDICAL CENTER IN SALISBURY AND MCCREADY HOSPITAL IN CRISFIELD.

PART V, SECTION B, LINE 7:

THE HOSPITAL FACILITY WILL NOT ATTEMPT TO ADDRESS ALL OF THE IDENTIFIED NEEDS IN ITS COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). WHEN UNDERTAKING THE CHNA AND IMPLEMENTATION STRATEGY, THE HOSPITAL FACILITY WENT THROUGH A PRIORITIZATION PROCESS TO DETERMINE THOSE COMMUNITY HEALTH NEEDS THAT THE HOSPITAL FACILITY WOULD ATTEMPT TO ADDRESS. SOME OF THE FACTORS CONSIDERED WHEN PRIORITIZING THE NEEDS WERE THE SIZE AND SEVERITY OF THE NEED, THE HOSPITAL FACILITY'S ABILITY TO IMPACT THE NEED, THE AVAILABILITY OF OTHER RESOURCES AND STAKEHOLDERS IN THE COMMUNITY THAT ARE ALREADY ATTEMPTING TO MEET THE NEED, AND THE ABILITY FOR THE HOSPITAL TO EFFICIENTLY UTILIZE FINANCIAL RESOURCES TO EFFECT EACH NEED.

KEY FINDINGS FROM ALL RESOURCES WERE USED AS A FRAMEWORK TO DEVELOP COMMUNITY BENEFIT PRIORITIES. THESE ARE CLOSELY ALIGNED WITH LOCAL, STATE, AND NATIONAL PRIORITY AREAS. THE PROCESS FOR DETERMINING THE

Part V Facility Information (continued)

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

PRIORITIES OF THE COMMUNITY OUTREACH PROGRAMS INVOLVES MANY PEOPLE INSIDE AND OUTSIDE THE ORGANIZATION. THE HOSPITAL'S STRATEGIC INITIATIVES ARE DETERMINED BY THE HOSPITAL BOARD OF TRUSTEES, THE MEDICAL STA AND THE LEADERSHIP OF THE HOSPITAL. EACH YEAR THOSE LONG TERM INITIATIVES ARE EVALUATED AND UPDATED WITH ENVIRONMENTAL INFORMATION, SUCH AS THE MOST RECENT COMMUNITY HEALTH NEEDS ASSESSMENT. IN ADDITION TO INPUT FROM THOSE GROUPS THERE ARE TWO COMMITTEES THAT HAVE A PART IN SETTING OUR PRIORITIES; THEY ARE THE COMMUNITY BENEFITS COMMITTEE AND THE HEALTHY HAPPENINGS ADVISORY BOARD. THE HEALTHY HAPPENINGS BOARD IS MADE UP OF HOSPITAL AND COMMUNITY MEMBERS WHO HAVE A HEALTH CONNECTION IN THE COMMUNITY. THROUGH THIS BOARD WE ARE ABLE TO KEEP OUR PULSE ON THE NEEDS OF THE COMMUNITY. EACH DEPARTMENT IN THE HOSPITAL HAS AN APPOINTEE WHO SITS ON THE COMMUNITY BENEFITS COMMITTEE. THE PURPOSE OF THIS COMMITTEE IS TO OVERSEE THE COMMUNITY OUTREACH OF THE HOSPITAL AND COMPLY WITH THE GOVERNMENT REGULATIONS REGARDING REPORTING COMMUNITY BENEFITS. BECAUSE THE COMMITTEE IS MADE OF ALL DEPARTMENTS THE VIEWS ARE VARIED. ANNUAL EVALUATIONS OF EACH INITIATIVE'S SUCCESS ARE FOUND IN THE HSCRC COMMUNITY BENEFIT REPORT SENT TO THE STATE OF MARYLAND. OUR HOSPITAL LEADERS ARE INVOLVED ON MANY COMMUNITY BOARDS AND COMMUNITY ENTITIES (BOTH FOR PROFIT AND NOT-FOR-PROFIT). THROUGH THESE BOARDS WE ARE ABLE TO KEEP ABREAST OF THE UNDERSERVED, LOW INCOME AND/OR MINORITY NEEDS IN THE COMMUNITY. WE ARE INVOLVED IN THE HEALTH DEPARTMENTS THROUGHOUT OUR SERVICE AREA IN MARYLAND AND DELAWARE AND COORDINATE SERVICES WITH THEM TO DECREASE DUPLICATION OF SERVICES AND KNOW WHAT SERVICES ARE NEEDED TO FILL THE GAPS. OBVIOUSLY WORKING WITH THE TARGET AREAS OF THE STATE IMPROVEMENT INITIATIVES INFLUENCES THE PRIORITIES WE SET. OUR POPULATION HEALTH

Part V Facility Information (continued)

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

OUTREACH PROVIDERS ARE OUT IN THE COMMUNITY AND ARE ABLE TO OBSERVE
COMMUNITY NEEDS. THROUGH OUR PATIENT CENTERED MEDICAL HOME, CARE
COORDINATION MODELS AND POPULATION HEALTH DEPARTMENT, WE ARE ABLE TO
HAVE ANOTHER RESOURCE IN THE COMMUNITY THAT WE CAN USE FOR ASSISTING US
IN SETTING PRIORITIES. THE 2019-2021 COMMUNITY BENEFIT PRIORITIES ARE
BASED ON THE CRITERIA OF:

- SIZE AND SEVERITY OF THE PROBLEM DETERMINED BY WHAT PERCENTAGE OF THE
POPULATION IS AFFECTED BY RISKS
- HEALTH SYSTEM'S ABILITY TO IMPACT THE NEED
- AVAILABILITY OF RESOURCES

THEY WERE GRADED AS HIGH (3), MODERATE (2) AND LOW (1) TO RANK THE
PRIORITY, BASED ON SELF-REPORTED SURVEY DATA AND PRIORITIZED AS ABOVE.

PURSUANT TO THE PRIORITIZATION PROCESS, THE HOSPITAL FACILITY
DETERMINED THAT CERTAIN IDENTIFIED NEEDS WOULD NOT BE ADDRESSED BY THE
HOSPITAL FACILITY, INCLUDING DENTAL HEALTH SERVICES; INJURY AND
VIOLENCE; M AND HIV STDs.

EACH OF THE HEALTH NEEDS LISTED IN THE HOSPITAL'S CHNA AS WELL AS
WORCESTER COUNTY HEALTH DEPARTMENT'S COMMUNITY NEEDS ASSESSMENT IS
IMPORTANT AND IS BEING ADDRESSED BY NUMEROUS PROGRAMS AND INITIATIVES
OPERATED BY THE HOSPITAL AND/OR OTHER COMMUNITY PARTNERS OF THE
HOSPITAL. NEEDS NOT ADDRESSED AS A PRIORITY AREA IN THE IMPLEMENTATION
PLAN ARE BEING ADDRESSED IN THE COMMUNITY BY OTHER ORGANIZATIONS AND BY
ORGANIZATIONS BETTER SITUATED TO ADDRESS THE NEED.

NEEDS NOT ADDRESSED IN PLAN:

- DENTAL/ORAL HEALTH

Part V Facility Information (continued)

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

RATIONALE: -NEED ADDRESSED BY WORCESTER COUNTY HEALTH DEPARTMENT'S

DENTAL SERVICES FOR PREGNANT WOMEN AND CHILDREN LESS THAN 21 YEARS OF AGE

-PRIORITY AREA WORCESTER CHIP

-NEED ADDRESSED BY LOWER SHORE DENTAL TASK FORCE & MISSION OF MERCY FOR ADULT POPULATION

-NEED ADDRESSED BY AGH ED REFERRAL TO COMMUNITY RESOURCES

-NEED ADDRESSED BY CHESAPEAKE HEALTH SERVICES, A FEDERALLY FUNDED DENTAL CLINIC FOR SOMERSET AND WICOMICO COUNTIES

INJURY & VIOLENCE

RATIONALE: -NEED ADDRESSED BY WORCESTER COUNTY HEALTH DEPARTMENT

PROGRAMS:

CHILD PASSENGER SAFETY SEATS (REFER TO WORC GOLD)

INJURY PREVENTION

HIGHWAY SAFETY PROGRAM

SAFE ROUTES TO SCHOOL

-NEED ADDRESSED BY WORCESTER COUNTY SHERIFF'S DEPARTMENT, STATE POLICE AND MUNICIPAL LAW ENFORCEMENT AGENCIES

-NEED ADDRESSED BY AGH HEALTH LITERACY PROGRAM

HIV & STD (<2% EA)

RATIONALE: -NEED ADDRESSED BY WORCESTER COUNTY HEALTH DEPARTMENT

COMMUNICABLE DISEASE PROGRAMS

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? 25

Name and address	Type of Facility (describe)
1 ATLANTIC HEALTH CENTER 9714 HEALTHWAY DR BERLIN, MD 21811	MEDICAL OFFICE
2 AGHS NEUROLOGY 314 FRANKLIN AVENUE, SUITE 104 BERLIN, MD 21811	MEDICAL OFFICE
3 AGHS SURGICAL ASSOCIATES AGH BARIATRI 10231 OLD OCEAN CITY BLVD, SUITE 207 BERLIN, MD 21811	MEDICAL OFFICE
4 ATLANTIC UROLOGY 10231 OLD OCEAN CITY BLVD, SUITE 206 BERLIN, MD 21811	MEDICAL OFFICE
5 ATLANTIC GENERAL INTERNAL MEDICINE 10324 OLD OCEAN CITY BLVD BERLIN, MD 21811	MEDICAL OFFICE
6 ATLANTIC GENERAL PRIMARY CARE & PULM 10344 OLD OCEAN CITY BLVD, SUITE B BERLIN, MD 21811	MEDICAL OFFICE
7 ATLANTIC GENERAL WOMEN'S HEALTH WEST 12308 OCEAN GATEWAY, UNIT 8 OCEAN CITY, MD 21842	MEDICAL OFFICE
8 REGIONAL CANCER CENTER 9707 HEALTHWAY DR BERLIN, MD 21811	MEDICAL OFFICE
9 ATLANTIC GENERAL PRIMARY CARE & ENDOC 11107 RACETRACK ROAD BERLIN, MD 21811	MEDICAL OFFICE
10 ATLANTIC GENERAL SPECIALTY CARE OCEAN 96 ATLANTIC AVENUE, UNIT #103 OCEAN VIEW, DE 19970	MEDICAL OFFICE

Schedule H (Form 990) 2019

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? 25

Name and address	Type of Facility (describe)
11 ATLANTIC GENERAL PRIMARY & SPECIALTY 500 MARKET STREET EXCHANGE POCOMOKE, MD 21851	MEDICAL OFFICE
12 ATLANTIC GENERAL WOMEN'S HEALTH SELBY 38394 DUPONT BOULEVARD, UNIT H SELBYVILLE, DE 19975	MEDICAL OFFICE
13 ATLANTIC GENERAL PRIMARY & SPECIALTY 37464 LION DRIVE UNIT 2 SELBYVILLE, DE 19975	MEDICAL OFFICE
14 TOWNSEND MEDICAL CENTER 1001 PHILADELPHIA AVENUE OCEAN CITY, MD 21842	MEDICAL OFFICE
15 ATLANTIC GENERAL PRIMARY CARE & PEDIA 12308 OCEAN GATEWAY, UNIT 1 OCEAN CITY, MD 21842	MEDICAL OFFICE
16 ATLANTIC GENERAL PEDIATRICS 12308 OCEAN GATEWAY, UNIT 3 OCEAN CITY, MD 21842	MEDICAL OFFICE
17 ATLANTIC ENDOSCOPY CENTER 10231 OLD OCEAN CITY BLVD, SUITE 304 BERLIN, MD 21811	MEDICAL OFFICE
18 WOUND CARE CENTER 10231 OLD OCEAN CITY BLVD, SUITE 104 BERLIN, MD 21811	MEDICAL OFFICE
19 ATLANTIC GENERAL PRIMARY CARE OCEAN V 96 ATLANTIC AVENUE, UNIT 101 OCEAN VIEW, DE 19970	MEDICAL OFFICE
20 ATLANTIC GENERAL IMAGING WEST OCEAN C 12308 OCEAN GATEWAY, UNIT 5 OCEAN CITY, MD 21842	MEDICAL OFFICE

Schedule H (Form 990) 2019

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? 25

Name and address	Type of Facility (describe)
21 ATLANTIC GENERAL GASTROENTEROLOGY 314 FRANKLIN AVE BERLIN, MD 21811	MEDICAL OFFICE
22 ATLANTIC GENERAL PRIMARY CARE SELBYVI 15 N WILLIAMS STREET SELBYVILLE, DE 19975	MEDICAL OFFICE
23 ATLANTIC GENERAL RHEUMATOLOGY 10231 OLD OCEAN CITY BLVD BERLIN, MD 21811	MEDICAL OFFICE
24 ATLANTIC GENERAL ORTHOPEDICS 314 FRANKLIN AVE, STE 201 BERLIN, MD 21811	MEDICAL OFFICE
25 ATLANTIC GENERAL UROLOGY 10231 OLD OCEAN CITY BLVD, SUITE 210 BERLIN, MD 21811	MEDICAL OFFICE

Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 3C:

IN ADDITION TO QUALIFYING FOR FINANCIAL ASSISTANCE BECAUSE THE PATIENT'S FAMILY INCOME FALLS BELOW THE FEDERAL POVERTY GUIDELINES THRESHOLDS (FREE CARE FOR FAMILY INCOME LESS THAN 200% OF THE FEDERAL POVERTY GUIDELINES, AND DISCOUNTED CARE FOR FAMILY INCOME LESS THAN 300% OF THE FEDERAL POVERTY GUIDELINES), A PATIENT MAY QUALIFY FOR FINANCIAL ASSISTANCE IF THAT PATIENT INCURS A FINANCIAL HARDSHIP AND HAS FAMILY INCOME UNDER 500% OF THE FEDERAL POVERTY GUIDELINES. A FINANCIAL HARDSHIP MEANS MEDICAL DEBT INCURRED BY A FAMILY OVER A TWELVE MONTH PERIOD THAT EXCEEDS 25% OF THE FAMILY'S INCOME. ONLY INCOME AND FAMILY SIZE WILL BE CONSIDERED IN APPROVING APPLICATIONS FOR FINANCIAL ASSISTANCE, UNLESS THE AMOUNT OWED IS GREATER THAN \$20,000, THE PATIENT'S TAX RETURN SHOWS A SIGNIFICANT AMOUNT OF INTEREST INCOME, OR THE PATIENT INDICATES THAT THE PATIENT HAS BEEN LIVING OFF OF THEIR SAVINGS ACCOUNT. IF ONE OF THE SCENARIOS LISTED ABOVE IS APPLICABLE, THEN THE ORGANIZATION MAY CONSIDER THE PATIENT'S LIQUID ASSETS, INCLUDING THE PATIENT'S CHECKING AND SAVINGS ACCOUNTS, STOCKS, BONDS, CD'S, MONEY MARKET OR ANY OTHER ACCOUNTS FOR THE PAST THREE MONTHS. HOWEVER, THE FOLLOWING ASSETS ARE ALWAYS EXCLUDED: THE FIRST \$10,000 OF

Part VI Supplemental Information (Continuation)

MONETARY ASSETS, UP TO \$150,000 IN A PRIMARY RESIDENCE, AND CERTAIN RETIREMENT BENEFITS, SUCH AS 401K PLANS WHERE THE IRS HAS GRANTED PREFERENTIAL TAX TREATMENT. IF THE PATIENT IS ALREADY ENROLLED IN A MEANS-TESTED PROGRAM, THE PATIENT IS DEEMED ELIGIBLE FOR FREE CARE ON A PRESUMPTIVE BASIS, WITHOUT REQUIRING ANY OF THE FINANCIAL DOCUMENTS REQUIRED ON A FULL APPLICATION.

SCHEDULE H, PART I, LINE 5

IT IS THE ORGANIZATION'S POLICY TO PROVIDE FINANCIAL ASSISTANCE TO ANY INDIVIDUAL THAT QUALIFIES UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY, REGARDLESS OF THE AMOUNT OF CHARITY CARE BUDGETED FOR BY THE ORGANIZATION DURING THE YEAR.

SCHEDULE H, PART I, LINE 6

THE ORGANIZATION FILES A COMMUNITY BENEFIT REPORT WITH THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION ANNUALLY. THE COMMUNITY BENEFIT REPORT IS AVAILABLE TO THE PUBLIC.

SCHEDULE H, PART I, LINE 7A, 7B AND 7F

MARYLAND HOSPITAL ASSOCIATION UNIFIED MARYLAND HOSPITAL RESPONSES SCHEDULE H PART I LINE 7A, 7B AND 7F 7A. CHARITY CARE AT COST AND 7F. HEALTH PROFESSIONS EDUCATION ARE EXPLAINED IN THE FOLLOWING: 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

Part VI Supplemental Information (Continuation)

EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO
 BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. 7B.
 UNREIMBURSED MEDICAID IS EXPLAINED IN THE FOLLOWING: 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 DIRECTED 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. DURING
 THE 2020 TAX YEAR, THE MEDICAID PROVIDER ASSESSMENT WAS \$ 364,838.

PART I, LINE 3C:

IN ADDITION TO QUALIFYING FOR FINANCIAL ASSISTANCE BECAUSE THE
 PATIENT'S FAMILY INCOME FALLS BELOW THE FEDERAL POVERTY GUIDELINES
 THRESHOLDS (FREE CARE FOR FAMILY INCOME LESS THAN 200% OF THE FEDERAL
 POVERTY GUIDELINES, AND DISCOUNTED CARE FOR FAMILY INCOME LESS THAN
 300% OF THE FEDERAL POVERTY GUIDELINES), A PATIENT MAY QUALIFY FOR
 FINANCIAL ASSISTANCE IF THAT PATIENT INCURS A FINANCIAL HARDSHIP AND
 HAS FAMILY INCOME UNDER 500% OF THE FEDERAL POVERTY GUIDELINES. A
 FINANCIAL HARDSHIP MEANS MEDICAL DEBT INCURRED BY A FAMILY OVER A
 TWELVE MONTH PERIOD THAT EXCEEDS 25% OF THE FAMILY'S INCOME. ONLY

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

INCOME AND FAMILY SIZE WILL BE CONSIDERED IN APPROVING APPLICATIONS FOR FINANCIAL ASSISTANCE, UNLESS THE AMOUNT OWED IS GREATER THAN \$20,000, THE PATIENT'S TAX RETURN SHOWS A SIGNIFICANT AMOUNT OF INTEREST INCOME, OR THE PATIENT INDICATES THAT THE PATIENT HAS BEEN LIVING OFF OF THEIR SAVINGS ACCOUNT. IF ONE OF THE SCENARIOS LISTED ABOVE IS APPLICABLE, THEN THE ORGANIZATION MAY CONSIDER THE PATIENT'S LIQUID ASSETS, INCLUDING THE PATIENT'S CHECKING AND SAVINGS ACCOUNTS, STOCKS, BONDS, CD'S, MONEY MARKET OR ANY OTHER ACCOUNTS FOR THE PAST THREE MONTHS. HOWEVER, THE FOLLOWING ASSETS ARE ALWAYS EXCLUDED: THE FIRST \$10,000 OF MONETARY ASSETS, UP TO \$150,000 IN A PRIMARY RESIDENCE, AND CERTAIN RETIREMENT BENEFITS, SUCH AS 401K PLANS WHERE THE IRS HAS GRANTED PREFERENTIAL TAX TREATMENT. IF THE PATIENT IS ALREADY ENROLLED IN A MEANS-TESTED PROGRAM, THE PATIENT IS DEEMED ELIGIBLE FOR FREE CARE ON A PRESUMPTIVE BASIS, WITHOUT REQUIRING ANY OF THE FINANCIAL DOCUMENTS REQUIRED ON A FULL APPLICATION.

PART III, LINE 4:

TEXT FROM THE ORGANIZATION'S AFS FOOTNOTE:

NET PATIENT SERVICE REVENUE AND PATIENT ACCOUNTS RECEIVABLE

NET PATIENT SERVICE REVENUE IS REPORTED AT ESTIMATED NET REALIZABLE AMOUNTS FROM PATIENTS, THIRD PARTY PAYORS, AND OTHERS FOR SERVICES RENDERED. PATIENT ACCOUNTS RECEIVABLE INCLUDE HOSPITAL AND PHYSICIAN CHARGES FOR ACCOUNTS DUE FROM MEDICARE, MARYLAND MEDICAL ASSISTANCE (MEDICAID), CAREFIRST, COMMERCIAL AND MANAGED CARE INSURERS, AND SELF-PAYING PATIENTS. DEDUCTED FROM PATIENT ACCOUNTS RECEIVABLE ARE

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

ESTIMATES OF IMPLICIT PRICE CONCESSIONS FOR THE EXCESS OF CHARGES OVER THE PAYMENTS ON PATIENT ACCOUNTS TO BE RECEIVED FROM THIRD PARTY PAYORS AND UNCOLLECTIBLE AMOUNTS RELATED TO SELF-PAYING PATIENTS. THESE ESTIMATES ARE CALCULATED BY MANAGEMENT BASED ON HISTORICAL COLLECTION EXPERIENCE AND ANALYSIS OF FINANCIAL CLASS AND AGE OF GROUPS OF ACCOUNTS RECEIVABLE.

THE BAD DEBT EXPENSE REPORTED ON LINE 2 WAS THE AMOUNT OF GROSS PATIENT CHARGES UNCOLLECTED FROM PATIENTS THAT DID NOT QUALIFY FOR FINANCIAL ASSISTANCE. WE BELIEVE THAT A MATERIALLY SIGNIFICANT PERCENTAGE OF OUR BAD DEBT EXPENSE WOULD BE CLASSIFIED AS "CHARITY CARE" HAD THE PATIENT CREATING THE BAD DEBT EXPENSE FILED FOR FINANCIAL ASSISTANCE. HOWEVER, WE DO NOT CURRENTLY POSSESS THE CAPACITY FOR DETERMINING HOW MANY OF OUR PATIENTS WOULD HAVE BEEN ELIGIBLE FOR CHARITY CARE HAD THEY COMPLETED THE FINANCIAL ASSISTANCE APPLICATION. ANY ESTIMATE ON OUR PART WOULD BE PURELY "SPECULATIVE" AND WE COULD NOT SUPPORT IT THROUGH EMPIRICAL DATA, THEREFORE, WE HAVE CHOSEN TO LEAVE THIS NUMBER BLANK. WE HAVE NOT NOTED THE NUMBER AS BEING ZERO, SINCE WE KNOW SOME OF THE BAD DEBT EXPENSE WOULD QUALIFY AS CHARITY CARE, BUT WE HAVE LEFT THIS ANSWER BLANK BECAUSE WE FEEL AN ACCURATE ESTIMATE IS UNOBTAINABLE.

PART III, LINE 8:

WE USED THE MEDICARE COST REPORT TO DETERMINE MEDICARE ALLOWABLE COSTS COMPARED TO MEDICARE TOTAL REVENUE.

PART III, LINE 9B:

THE CURRENT FINANCIAL ASSISTANCE APPLICATION PROCESS ALLOWS FOR PATIENTS TO APPLY FOR, AND RECEIVE, FINANCIAL ASSISTANCE, AT ANY POINT, POST DISCHARGE. WHEN A PATIENT IS SUBSEQUENTLY FOUND ELIGIBLE FOR FINANCIAL

Part VI Supplemental Information (Continuation)

ASSISTANCE POST DISCHARGE, THE ORGANIZATION WILL APPLY THE APPLICABLE FINANCIAL ASSISTANCE DISCOUNT TO ALL OUTSTANDING BALANCES ON THE PATIENT'S ACCOUNT AND IMMEDIATELY CEASE TO ATTEMPT TO COLLECT ANY AMOUNTS IN EXCESS OF ANY FINANCIAL ASSISTANCE DISCOUNTED AMOUNT STILL DUE. THE HOSPITAL WILL PROVIDE A REFUND FOR AMOUNTS PAID BY A PATIENT THAT WAS SUBSEQUENTLY FOUND TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE ON THE DATE OF SERVICE WHICH AMOUNTS WERE IN EXCESS OF THE AMOUNT DUE AFTER THE APPLICATION OF THE APPLICABLE FINANCIAL ASSISTANCE DISCOUNT, SO LONG AS THE APPLICATION FOR FINANCIAL ASSISTANCE WAS SUBMITTED BY THE PATIENT WITHIN TWO YEARS OF THE DATE OF SERVICE.

PART VI, LINE 2:

THE ORGANIZATION ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITY IT SERVES THROUGH MANY DIFFERENT ACTIVITIES, STUDIES AND COLLABORATIONS WITH LOCAL GOVERNMENT AND NON-GOVERNMENT ORGANIZATIONS. THE HOSPITAL IS CURRENTLY WORKING UNDER THE STRATEGIC INITIATIVES WHICH WERE DEVELOPED FOR PLANNING THROUGH 2020. EACH YEAR, WITHIN THIS FRAMEWORK THE HOSPITAL MAKES PLANS FOR THE UPCOMING YEAR USING THE SWOT/GAP ANALYSIS MODEL. USING THIS MODEL THE LEADERSHIP TEAM MEETS WITH THE MEDICAL STAFF TO LOOK AT STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS TO PLAN FOR THE COMING FISCAL YEAR. THIS INFORMATION THEN GOES TO THE BOARD TO, ALONG WITH SENIOR LEADERSHIP, FINALIZE THE STRATEGIC INITIATIVES FOR THE COMING YEAR. USING THIS INFORMATION THE COMMUNITY BENEFITS COMMITTEE AND THE HEALTHY HAPPENINGS (VISIONS) ADVISORY COMMITTEE DETERMINE THE GOALS FOR THE COMING YEAR. THE DOCUMENTS USED BY THE HOSPITAL TO DETERMINE COMMUNITY NEEDS ARE: THE HEALTH ASSESSMENT PUBLICATION FROM THE HEALTH DEPARTMENT, LOCAL AGENCIES AND HOSPITALS, WORCESTER COUNTY LOCAL HEALTH PLAN, FY2020 LOCAL HEALTH IMPROVEMENT COALITIONS, MARYLAND SHIP, FY2020 TRI-COUNTY HEALTH PLANNING

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

BOARD, STATE OF MARYLAND CANCER REGISTRY LATEST CENSUS UPDATE FEEDBACK FROM AREA PHYSICIANS AND COMMUNITY MEMBERS QUESTIONNAIRES AND EVALUATIONS FROM OUR COMMUNITY EVENTS NCR PICKER PATIENT EVALUATIONS AND FEEDBACK HOSPITAL PERCEPTION SURVEY 2019 IN ADDITION, INFORMATION REGARDING COMMUNITY HEALTH NEEDS IS OBTAINED AS A RESULT OF THE ORGANIZATION'S LEADERSHIP MEMBERS SITTING ON THE BOARDS OF MANY COMMUNITY ORGANIZATIONS, INCLUDING: LHIC, TCHIP, SART, SAFE, PLAY IT SAFE COMMITTEE, OCEAN CITY DRUG AND ALCOHOL ABUSE PREVENTION COMMITTEE, MHA ADVISORY BOARD, FAITH BASED COALITION, UNITED WAY, BLOOD BANK OF DELMARVA, LHIC, CHAMBERS OF COMMERCE OF TOWNS THROUGHOUT THE REGION, MANY HEALTH DEPARTMENT COUNCILS, MHA COMMITTEES, STATE HEALTH DEPARTMENT BOARDS, WE ALSO HAVE A HEALTHY HAPPENINGS (VISIONS) ADVISORY COMMITTEE COMPRISED OF COMMUNITY PROVIDERS OF HEALTH RELATED SERVICES INCLUDING TRADITIONAL AS WELL AS INTEGRATIVE HEALTH SERVICES. THROUGH THIS COMMITTEE WE CAN KEEP OUR FINGER ON THE PULSE OF THE AREA IN WHICH WE SERVE. THIS COMMITTEE GIVES US GREAT FEEDBACK ON SERVICES AND PROGRAMS THAT ARE NEEDED THOSE THAT ARE WORKING AND THOSE THAT AREN'T. IT IS THROUGH THIS COMMITTEE THAT PUTS ON A MAJOR HEALTH CONFERENCE EACH YEAR, WHICH PROVIDES HEALTH EDUCATION AS WELL AS SCREENINGS. WE MET WITH GREAT SUCCESS COMMUNITY HEALTH FAIRS. AND ACCORDING TO THE EVALUATIONS, WERE ABLE TO PROVIDE SERVICES TO PEOPLE WHO OTHERWISE WOULD NOT HAVE GOTTEN THEM. THE ORGANIZATION'S AUXILIARY VOLUNTEERS ARE ANOTHER GREAT RESOURCE FOR DETERMINING COMMUNITY HEALTH NEEDS. THE ORGANIZATION HAS OVER 400 AUXILIANS. THEY ARE ACTIVE ON MANY COMMITTEES WITHIN THE HOSPITAL AND ALSO REPRESENT THE HOSPITAL ON DIFFERENT COMMUNITY BOARDS. IN ADDITION, THE ORGANIZATION WORKS VERY CLOSELY WITH ITS LOCAL HEALTH DEPARTMENT TO PLAN SERVICES TO MEET COMMUNITY NEEDS AND DECREASE THE DUPLICATION OF SERVICES IN THE COMMUNITY. MEMBERS OF THE HOSPITAL STAFF SIT ON MANY COMMITTEES, COMMUNITY BOARDS,

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

COMMUNITY COALITIONS, AND BOARDS OF THE LOCAL HEALTH DEPARTMENT.

PART VI, LINE 3:

WE INFORM INDIVIDUALS IN THE COMMUNITY ABOUT THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY IN A NUMBER OF WAYS. FIRST, THERE IS SIGNAGE THROUGHOUT THE HOSPITAL, AS WELL AS BROCHURES IN ALL WAITING AREAS, EXPLAINING THAT THE ORGANIZATION PROVIDES FINANCIAL ASSISTANCE. IN ADDITION, ARTICLES ARE PUBLISHED IN NEWSLETTERS THAT ARE DISTRIBUTED TO THE HOMES OF ALL RESIDENTS IN THE COMMUNITY NOTING THE EXISTENCE OF THE ORGANIZATION'S FINANCIAL ASSISTANCE PROGRAM. HOSPITAL STAFF IS EDUCATED TO ANSWER QUESTIONS RELATED TO APPLYING FOR FINANCIAL ASSISTANCE, AND HOSPITAL SUPPORT SERVICES HELPS PATIENTS APPLY FOR MEDICAL ASSISTANCE (SUCH AS MEDICAID). FURTHERMORE, HOSPITAL FINANCIAL COUNSELORS HELP GUIDE PATIENTS TO FINANCIAL AID SERVICES THEY MAY QUALIFY FOR. ALL INPATIENTS ARE PROVIDED WITH A FINANCIAL ASSISTANCE APPLICATION IN THEIR DISCHARGE PACKAGE. IN ADDITION, DURING THE REGISTRATION PROCESS, IF THE PATIENT DOES NOT HAVE INSURANCE THE REGISTRAR OR FINANCIAL COUNSELOR WILL ASK IF THEY ARE INTERESTED IN APPLYING FOR FINANCIAL ASSISTANCE AND HELP WITH FILLING OUT THE APPLICATION. ANY PATIENT WHO SEEKS FINANCIAL OR MEDICAL ASSISTANCE WILL READILY FIND INFORMATION AND HOSPITAL STAFF TO HELP WITH THE PROCESS.

PART VI, LINE 4:

ATLANTIC GENERAL IS LOCATED IN WORCESTER COUNTY, WHICH IS THE EASTERNMOST COUNTY LOCATED IN THE U.S. STATE OF MARYLAND. WORCESTER COUNTY COMPRISES ATLANTIC GENERAL'S PRIMARY SERVICE AREA. WORCESTER COUNTY CONTAINS THE ENTIRE LENGTH OF THE STATE'S ATLANTIC COAST LINE. IT IS HOME TO THE POPULAR VACATION RESORT AREA OF OCEAN CITY. THE COUNTY IS APPROXIMATELY 60 MILES LONG. ACCORDING TO THE U.S. CENSUS BUREAU, THE COUNTY HAS A TOTAL

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

AREA OF 695 SQUARE MILES OF WHICH, 473 SQUARE MILES OF IT IS LAND AND 221 SQUARE MILES OF IT IS WATER. ATLANTIC GENERAL IS LOCATED IN A NON-URBAN AREA OF WORCESTER COUNTY, 10 MILES FROM THE ATLANTIC OCEAN. THE 2010 CENSUS SHOWED A POPULATION OF THE COUNTY OF 51,769 (2016 UPDATE). A 0.61% GROWTH IN POPULATION 2010 - 2016. THE LARGEST CONCENTRATION OF THE POPULATION IS IN THE NORTHERN PART OF THE COUNTY, WHICH IS WHERE THE OCEAN CITY RESORT AREA IS LOCATED, AS WELL AS THE BERLIN/OCEAN PINES AREA. THE AREA IS A MECCA FOR RETIREES WHO LIVE HERE FULL TIME OR DIVIDE THEIR TIME BETWEEN MARYLAND AND FLORIDA. ETHNICITY IS AS FOLLOWS: WHITE 42,024, BLACK/AF AMER 7,159, AM IND/AK NATIVE 143, ASIAN 729, NATIVE HI/PI 13, SOME OTHER RACE 699, 2+ RACES 1,002

MEDIAN HOUSEHOLD INCOME OF RESIDENTS OF WORCESTER COUNTY \$60,834. THE PERCENTAGE OF RESIDENTS BELOW THE POVERTY LEVEL IS 7.31%. THE AVERAGE AGE OF THE RESIDENTS IS BROKEN DOWN AS FOLLOWS:

2016 MALE POPULATION BY AGE 25,146

2016 POP, MALE: AGE <18 4,591 (18.26%)

2016 POP, MALE: AGE 18+ 20,555 (81.74%)

2016 POP, MALE: AGE 65+ 6,211 (24.70%)

2016 MEDIAN AGE MALE 47.9

2016 FEMALE POPULATION BY AGE 26,623

2016 POP, FEMALE: AGE <18 4,497 (16.89%)

2016 POP, FEMALE: AGE 18+ 22,126 (83.11%)

2016 POP, FEMALE: AGE 65+ 7,328 (27.53%)

2016 MEDIAN AGE FEMALE 50.3

FY20 50.83% OF THE PATIENTS CARED FOR AT THE HOSPITAL ARE MEDICARE PATIENTS. THE REMAINING PAYOR MIX IS THE FOLLOWING: MEDICAID 12.28%, COMMERCIAL 10.50%, BLUE CROSS 13.71%, MCO 3.78%, SELF PAY 3.48%, DONOR

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

0.25%, WORKERS COMPT 0.89%, AND OTHER GOVERNMENT PROGRAMS 4.26%. IN THE WORCESTER COUNTY VITAL STATS 2014, THE AGE-ADJUSTED MORTALITY RATE IS 599/100,000. ACCORDING TO THE WORCESTER COUNTY HEALTH DEPARTMENT 2017 COMMUNITY HEALTH IMPROVEMENT PLAN, PRIORITY AREAS IN THE COUNTY INCLUDE; #1 PROMOTE HEALTHY LIFESTYLES AND PREVENT CHRONIC DISEASE #2 PROMOTE SAFE SCHOOL ENVIRONMENTS AND HEALTHY BEHAVIORS #3 ACCESS TO HEALTH CARE #4 STRENGTHEN BEHAVIORAL HEALTH SERVICES. DURING THE SUMMER MONTHS, THE ORGANIZATION PROVIDES A SIGNIFICANT AMOUNT OF HEALTH CARE SERVICES (PREDOMINANTLY EMERGENCY CARE) TO TOURISTS VISITING THE OCEAN RESORT OF OCEAN CITY, MD. THIS IS RELATED TO THE FACT THAT THE POPULATION OF OCEAN CITY INCREASES BY ABOUT 200,000 EACH YEAR DURING THE TOURIST SEASON.

PART VI, LINE 5:

THE ORGANIZATION'S GOVERNING BODY IS COMPOSED PRIMARILY OF INDEPENDENT MEMBERS FROM THE ORGANIZATION'S COMMUNITY. IN ADDITION, THE ORGANIZATION'S MEDICAL STAFF IS OPEN TO ALL QUALIFIED PHYSICIANS IN THE COMMUNITY. ALL FINANCIAL SURPLUSES EARNED BY THE ORGANIZATION ARE USED TO ENHANCE THE ORGANIZATION'S PATIENT SERVICES, INCLUDING THROUGH THE UNDERTAKING OF VARIOUS COMMUNITY BENEFIT ACTIVITIES. THE ORGANIZATION UNDERTAKES NUMEROUS ACTIVITIES TO PROMOTE THE HEALTH OF ITS COMMUNITY. IN PARTICULAR, THE ORGANIZATION HAS IDENTIFIED A COMMUNITY NEED FOR ACCESS TO ADDITIONAL PHYSICIANS LOCATED IN THE COMMUNITY. IN ORDER TO MEET THIS IDENTIFIED COMMUNITY NEED, THE ORGANIZATION HAS DIRECTLY EMPLOYED NUMEROUS PHYSICIANS AT A SUBSTANTIAL COST TO THE ORGANIZATION. DURING FY2020, THE PHYSICIAN PRACTICES INCURRED A LOSS OF \$14,080,157.

IN ADDITION, THE ORGANIZATION UNDERTAKES COMMUNITY BUILDING ACTIVITIES TO PROMOTE THE PROGRAMS THE ORGANIZATION OFFERS AND ASSURE THEY ARE REACHING

Part VI Supplemental Information (Continuation)

THE TARGETED AUDIENCE. EXAMPLES OF THESE SPECIFIC ACTIVITIES WOULD BE THE SMALL NEIGHBORHOOD-TYPE HEALTH FAIRS IN WHICH WE ARE INVOLVED, AT WHICH EVENTS YOUNG PEOPLE ARE TARGETED AND NEEDS THAT ARE FILLED THROUGH OUR SPEAKERS BUREAU.

OTHER INVOLVEMENT IN COMMUNITY BUILDING ACTIVITIES INCLUDE: OUR PARTICIPATION IN THE LOCAL SCHOOL MENTORING PROGRAMS IN WHICH OUR STAFF IS VERY ACTIVE. WE HAVE STUDENTS FROM OUR LOCAL HIGH SCHOOL WHO DO A SHADOWING PROGRAM THROUGHOUT ALL DEPARTMENTS OF OUR HOSPITAL. THIS HELPS THEM IN MAKING A CAREER CHOICE THROUGH EXPOSURE TO DIFFERENT JOBS IN THE HEALTH CARE ARENA.

WE HAVE STAFF WHO REPRESENT THE HOSPITAL ON MANY CIVIC BOARDS SUCH AS ALL THE LOCAL AREA CHAMBERS, VARIOUS CIVIC GROUPS, AND THE LOCAL COUNTY SCHOOL BOARD. WE ALSO PARTICIPATE IN THE ACS RELAY FOR LIFE, KOMEN RACE, AND OUT OF THE DARKNESS.

WE PROVIDE EMS TRAINING FOR THE LOCAL FIRE COMPANIES, MOST OF WHOM ARE VOLUNTEER STAFFED. WE OFFER AN EXCHANGE PROGRAM OF EQUIPMENT WHICH HELPS THEM WITH TRANSPORTS TO THE EMERGENCY DEPARTMENT.

AGH WORKS WITH THE LOCAL FAITH BASED COMMUNITIES BY PROVIDING EDUCATION AND SERVICES TO THEIR CONGREGATIONS. WE HAVE A FAITH BASED MEDICAL HOME GROUP WHICH MEETS WITH CLERGY AND LAY HEALTH AMBASSADORS FROM THEIR HOUSES OF WORSHIP TO FUNNEL THE MESSAGE OF HEALTH AND WELLNESS TO THEIR PEOPLE.

ALSO, PART OF OUR COMMUNITY BUILDING PROGRAM INCLUDES OUR PARTICIPATION IN DISASTER PREPAREDNESS. BECAUSE WE ARE GEOGRAPHICALLY LOCATED IN AN AREA OF

Part VI Supplemental Information (Continuation)

EXTREME POTENTIAL DISASTER, ONLY 6 MILES FROM THE ATLANTIC OCEAN, WE WOULD BE THE SOURCE OF CARE AND PROTECTION FOR MANY IN THE AREA SHOULD A MAJOR HURRICANE HIT OUR AREA OF COASTLINE. PART OF THE HOSPITAL'S PROVISION FOR THE COMMUNITY IN SUCH A DISASTER WOULD BE TO PROVIDE CLEAN DRINKING WATER FOR THEM; THROUGH THE WATER PURIFICATION SYSTEM WHICH WE PREVIOUSLY PURCHASED AND INSTALLED WE HAVE THE ABILITY TO PROVIDE CLEAN WATER FOR NOT JUST OUR PATIENTS AND STAFF BUT FOR THE COMMUNITY AT LARGE.

WE ALSO WORK CLOSELY WITH OUR LOCAL PUBLIC AND PRIVATE SCHOOLS TO OFFER EDUCATION PROGRAMMING. EACH YEAR WE HOST STUDENTS FOR OUR HOSPITAL TOURS. THIS SERVES TO INTRODUCE THEM TO THE SERVICES OF THE HOSPITAL IN HOPES THAT THEIR TRIP FOR SERVICES WILL NOT BE AS FRIGHTENING. MANY OF OUR ASSOCIATES SERVE ON VARIOUS BOARDS OF THE SCHOOL SYSTEM OFFERING OUR EXPERTISE. THROUGH OUR SPEAKER'S BUREAU WE SEND SPEAKERS INTO MANY CLASSROOMS FOR INSTRUCTION. THE INTEGRATED HEALTH LITERACY PROGRAM (IHLP) SERVES APPROXIMATELY 3,500 STUDENTS ACROSS WORCESTER COUNTY. CURRENTLY, THE PROGRAM IS IMPLEMENTED IN GRADES ONE THROUGH EIGHT COUNTY-WIDE. STUDENTS ARE TAUGHT FOUR HEALTH LESSONS THAT ARE INTEGRATED INTO THEIR CORE AREA (MATHEMATICS, SCIENCE, READING LANGUAGE ARTS, AND SOCIAL STUDIES) CURRICULUM. ALL LESSONS IN THE PROGRAM ARE TAUGHT BY CORE AREA CLASSROOM TEACHERS. THE IHLP TEAM EXPANDED THE PROGRAM TO INCLUDE A HIGH SCHOOL SENIOR HEALTH SURVEY. THE SURVEY WILL PROVIDE A BENCHMARK SINCE THOSE STUDENT SURVEYED HAD NOT PARTICIPATED IN THE IHLP. THE SURVEY WILL ENABLE THE IHLP TEAM TO EVALUATE THE IHLP LESSON HEALTH CONCEPTS RETAINED BY STUDENTS AS THEY GRADUATE. THE GOAL OF THE PROGRAM IS TO GRADUATE A HEALTH LITERATE ADULT.

SOME ADDITIONAL SERVICES WHICH THE HOSPITAL PROVIDES FOR FREE TO THE

Part VI Supplemental Information (Continuation)

COMMUNITY, WHICH PROMOTE HEALTH INCLUDE:

1. LIVING WELL PROGRAM - THIS CHRONIC DISEASE SELF MANAGEMENT PROGRAM FROM STANFORD UNIVERSITY TEACHES PEOPLE HOW TO LIVE A BETTER LIFE IN THE MIDST OF THE LIMITATIONS CAUSED BY THEIR CHRONIC CONDITIONS.

2. HYPERTENSION CLINICS - BLOOD PRESSURE SCREENINGS IN LOCAL PHARMACIES MONTHLY AS WELL AS AT MANY OTHER MEETINGS AND CONVENTIONS IN THE AREA. THESE HELP RESIDENTS MONITOR THEIR BLOOD PRESSURE AND RELIEVE SOME OVERCROWDING IN PHYSICIAN OFFICES. THIS ALLOWS US THE OPPORTUNITY TO PROVIDE ONE-ON-ONE TEACHING TO INDIVIDUALS.

3. HEALTHFAIRS -THE HOSPITAL IS INVOLVED IN SEVERAL LARGE AND SMALL HEALTHFAIR EVENTS IN VARIOUS LOCATIONS THROUGHOUT THE YEAR. ONE SUCH EVENT IS A PARTNERSHIP WITH AARP/TOWN OF OCEAN CITY TO OFFER A FAIR WITH MANY SCREENINGS AND HEALTH INFORMATION. WE ALSO SPONSOR AN EDUCATIONAL AND SCREENING CONFERENCES THROUGHOUT THE YEAR LED BY THE HEALTHY HAPPENINGS COMMITTEE. THIS IS HELD IN VARIOUS LOCATIONS WITHIN OUR SERVICE AREA WHICH ALLOWS US TO PROVIDE FREE SERVICES TO THOSE WHO MIGHT NOT OTHERWISE BE ABLE TO ACCESS HEALTH CARE. WE ALSO PARTNER WITH MANY CHURCHES AND COMMUNITY GROUPS TO OFFER SMALL HEALTH FAIRS.

4. WE PROVIDE EDUCATION IN WRITTEN FORM THROUGH LOCAL PUBLICATIONS (NEWSPAPERS AND MAGAZINES) AND OUR OWN ON CALL QUARTERLY PUBLICATION. MANY OF OUR PHYSICIANS PROVIDE ARTICLES FOR THESE.

5. WE ALSO HAVE A SPEAKER'S BUREAU WHICH PROVIDES EDUCATIONAL PRESENTATIONS FOR AREA CIVIC GROUPS, BUSINESSES, CHURCHES, SCHOOLS AND

Part VI Supplemental Information (Continuation)

CONVENTIONS WHICH ARE HELD IN OUR RESORT AREA.

6. WE PROVIDE EDUCATION FOR THE LOCAL SCHOOLS THROUGH OUR HOSPITAL TOUR PROGRAM AND IHLP. THESE PROGRAMS ALLOW US TO SPREAD THE HEALTH MESSAGE AGAINST CHILDHOOD OBESITY TO THE YOUNGER GENERATION. INCLUDING A YOUTH SPEAKERS BUREAU FOR SCHOOL AGE AND ADOLESCENT HEALTH TOPICS.

7. BEING IN A BEACH RESORT COMMUNITY THERE ARE MANY SPORTING EVENTS WHICH OCCUR LOCALLY. WE PARTICIPATE IN MANY OF THESE BY PROVIDING FIRST AID ON SITE FOR THOSE IN ATTENDANCE AND THOSE PARTICIPATING IN THE ACTIVITY.

PART VI, LINE 6:

IN ADDITION TO OPERATING AN ACUTE CARE HOSPITAL THAT PROVIDES A 24 HOUR ER, ATLANTIC GENERAL HOSPITAL EMPLOYS A NETWORK OF PRIMARY CARE AND SPECIALIST PHYSICIANS THAT PROVIDE NEEDED HEALTH CARE SERVICES THROUGHOUT ATLANTIC GENERAL'S COMMUNITY, INCLUDING SERVING SOME OF THE HOSPITAL'S MORE RURAL AREAS. BECAUSE OF THE RURAL NATURE OF THE COMMUNITIES THE HOSPITAL SERVES, TRANSPORTATION FOR HEALTHCARE CAN BE CHALLENGING. BY LOCATING THESE EMPLOYED PHYSICIANS' OFFICES THROUGHOUT THE HOSPITAL'S SERVICE REGION, THE HOSPITAL IS ABLE TO HELP IMPROVE ACCESS TO PHYSICIANS' SERVICES FOR MEMBERS OF THE COMMUNITY.

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

MD

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
 ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
 ▶ Attach to Form 990.
 ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization

ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

Part I Questions Regarding Compensation

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

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

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

Schedule J (Form 990) 2019

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) MICHAEL FRANKLIN PRESIDENT & CEO, EX-OFFICIO	(i)	440,807.	0.	18,500.	7,000.	21,602.	487,909.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) CHERYL NOTTINGHAM CFO	(i)	208,078.	0.	18,758.	5,828.	13,581.	246,245.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) TIMOTHY R. WHETSTINE VP PROFESSIONAL SERVICES	(i)	169,718.	0.	258.	0.	14,970.	184,946.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) COLLEEN WAREING VP PATIENT CARE	(i)	150,310.	0.	18,896.	4,442.	15,798.	189,446.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) RABINDRA PAUL PHYSICIAN	(i)	1,076,032.	0.	18,636.	7,000.	21,602.	1,123,270.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) JAMES P. CHERRY PHYSICIAN	(i)	566,359.	0.	18,638.	7,000.	21,602.	613,599.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) MICHAEL S. HOOKER PHYSICIAN	(i)	663,482.	0.	136.	7,000.	21,602.	692,220.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) JONATHAN D BELL PHYSICIAN	(i)	558,489.	0.	258.	3,438.	15,798.	577,983.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) ALAE ZARIF, MD PHYSICIAN	(i)	1,197,937.	0.	258.	7,000.	21,602.	1,226,797.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Supplemental Information on Tax-Exempt Bonds

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**
▶ **Attach to Form 990.** ▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Name of the organization **ATLANTIC GENERAL HOSPITAL** Employer identification number **52-1656507**

Part I Bond Issues											
(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A MHHEFA SERIES A		NONE	09/01/17	7,501,000.			X		X		X
B MHHEFA SERIES B		NONE	09/01/17	20013000.			X		X		X
C MAYOR AND COUNCIL OF BERLIN, MD		NONE	09/01/17	10000000.			X		X		X
D											

Part II Proceeds										
	A		B		C		D			
1 Amount of bonds retired	713,000.									
2 Amount of bonds legally defeased										
3 Total proceeds of issue	7,501,000.		20,013,000.		10,000,000.					
4 Gross proceeds in reserve funds										
5 Capitalized interest from proceeds										
6 Proceeds in refunding escrows										
7 Issuance costs from proceeds			402,264.		127,253.					
8 Credit enhancement from proceeds										
9 Working capital expenditures from proceeds										
10 Capital expenditures from proceeds			5,340,103.		8,500,563.					
11 Other spent proceeds										
12 Other unspent proceeds										
13 Year of substantial completion										
	Yes	No	Yes	No	Yes	No	Yes	No		
14 Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?		X		X		X				
15 Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X		X		X				
16 Has the final allocation of proceeds been made?	X		X		X					
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X					

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

Part IV Arbitrage								
	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?	X		X		X			
b Exception to rebate?		X		X		X		
c No rebate due?		X		X		X		
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X		X		X		

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2019

Open to Public
Inspection

Name of the organization

ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

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

PERSONALIZED SERVICE, AND EDUCATION TO IMPROVE INDIVIDUAL AND COMMUNITY
HEALTH. WE ACCOMPLISH OUR MISSION THROUGH OUR SET OF VALUES, WHICH ARE
HONORED IN ALL OUR INTERACTIONS.

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

THE DIRECTOR OF FINANCE COMPILES THE NECESSARY INFORMATION FROM THE
ORGANIZATION'S ACCOUNTING RECORDS, INFORMATION RECEIVED FROM THE
FOUNDATION, AND INFORMATION RECEIVED FROM THE PATIENT BILLING OFFICE. THE
COMPILED INFORMATION IS THEN SENT TO THE ORGANIZATION'S OUTSIDE TAX
ACCOUNTANTS TO HELP PREPARE THE FORM 990. A DRAFT OF THE FORM 990 IS THEN
REVIEWED BY THE DIRECTOR OF FINANCE, THE CFO, AND THE CEO OF THE
ORGANIZATION AND ANY COMMENTS ARE REFLECTED IN A FURTHER REVISED DRAFT.
PRIOR TO FILING THE FORM 990, THE LATEST VERSION OF THE FORM 990 IS MADE
AVAILABLE TO ALL MEMBERS OF THE BOARD FOR THEIR REVIEW AND COMMENTS.

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

IT IS THE POLICY OF ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM THAT MEMBERS OF
THE BOARD OF DIRECTORS, THE HOSPITAL PRESIDENT, AND THE SENIOR LEADERSHIP
STAFF WILL BE REQUIRED TO SIGN AN ANNUAL CONFLICT OF INTEREST STATEMENT AND
TO ADHERE TO THE CONFLICT OF INTEREST POLICY. THIS WILL BE SIGNED ANNUALLY
IN OCTOBER. ALL CANDIDATES FOR BOARD MEMBERSHIP MUST BE ADVISED OF THIS
POLICY PRIOR TO THEIR ELECTION TO THE BOARD.

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

THE ORGANIZATION UTILIZES A COMPENSATION COMMITTEE, A WRITTEN EMPLOYMENT

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

Schedule O (Form 990 or 990-EZ) (2019)

Name of the organization ATLANTIC GENERAL HOSPITAL	Employer identification number 52-1656507
--	---

**CONTRACT, A COMPENSTION SURVEY OR STUDY AND AN APPROVAL BY THE BOARD OR
COMPENSATION COMMITTEE.**

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

**FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:
NET ASSETS RELEASED FROM RESTRICTION -120,727.**

**FORM 990, PART XII, LINE 2C:
THE PROCESS HAS NOT CHANGED FROM THE PRIOR YEAR.**

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

2019

For calendar year 2019 or other tax year beginning JUL 1, 2019, and ending JUN 30, 2020

▶ Go to www.irs.gov/Form990T for instructions and the latest information.

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

Department of the Treasury
Internal Revenue Service

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

<p>A <input type="checkbox"/> Check box if address changed</p> <p>B Exempt under section <input checked="" type="checkbox"/> 501(c)(3)) <input type="checkbox"/> 408(e) <input type="checkbox"/> 220(e) <input type="checkbox"/> 408A <input type="checkbox"/> 530(a) <input type="checkbox"/> 529(a)</p>	Print or Type	<p>Name of organization (<input type="checkbox"/> Check box if name changed and see instructions.) ATLANTIC GENERAL HOSPITAL</p> <p>Number, street, and room or suite no. If a P.O. box, see instructions. 9733 HEALTHWAY DRIVE</p> <p>City or town, state or province, country, and ZIP or foreign postal code BERLIN, MD 21811</p>	<p>D Employer identification number (Employees' trust, see instructions.) 52-1656507</p> <p>E Unrelated business activity code (See instructions.) 446110</p>
--	---------------------	---	---

<p>C Book value of all assets at end of year 145,788,576.</p>	<p>F Group exemption number (See instructions.) ▶</p>	<p>G Check organization type ▶ <input checked="" type="checkbox"/> 501(c) corporation <input type="checkbox"/> 501(c) trust <input type="checkbox"/> 401(a) trust <input type="checkbox"/> Other trust</p>
--	--	---

H Enter the number of the organization's unrelated trades or businesses. ▶ 2 Describe the only (or first) unrelated trade or business here ▶ PHARMACY. If only one, complete Parts I-V. If more than one, describe the first in the blank space at the end of the previous sentence, complete Parts I and II, complete a Schedule M for each additional trade or business, then complete Parts III-V.

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

J The books are in care of ▶ CHERYL NOTTINGHAM Telephone number ▶ 410-641-9095

Part I Unrelated Trade or Business Income	(A) Income	(B) Expenses	(C) Net
1a Gross receipts or sales <u>248,523.</u>			
b Less returns and allowances <u>1,859.</u> c Balance ▶	1c <u>246,664.</u>		
2 Cost of goods sold (Schedule A, line 7)	2 <u>220,353.</u>		
3 Gross profit. Subtract line 2 from line 1c	3 <u>26,311.</u>		<u>26,311.</u>
4a Capital gain net income (attach Schedule D)	4a		
b Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b		
c Capital loss deduction for trusts	4c		
5 Income (loss) from a partnership or an S corporation (attach statement)	5		
6 Rent income (Schedule C)	6		
7 Unrelated debt-financed income (Schedule E)	7		
8 Interest, annuities, royalties, and rents from a controlled organization (Schedule F)	8		
9 Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9		
10 Exploited exempt activity income (Schedule I)	10		
11 Advertising income (Schedule J)	11		
12 Other income (See instructions; attach schedule)	12		
13 Total. Combine lines 3 through 12	13 <u>26,311.</u>		<u>26,311.</u>

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.) (Deductions must be directly connected with the unrelated business income.)			
14 Compensation of officers, directors, and trustees (Schedule K)	14		
15 Salaries and wages	15		<u>38.</u>
16 Repairs and maintenance	16		<u>63.</u>
17 Bad debts	17		
18 Interest (attach schedule) (see instructions)	18		
19 Taxes and licenses	19		<u>214.</u>
20 Depreciation (attach Form 4562)	20		
21 Less depreciation claimed on Schedule A and elsewhere on return	21a		
22 Depletion	22		
23 Contributions to deferred compensation plans	23		
24 Employee benefit programs	24		<u>533.</u>
25 Excess exempt expenses (Schedule I)	25		
26 Excess readership costs (Schedule J)	26		
27 Other deductions (attach schedule)	27	<u>SEE STATEMENT 1</u>	<u>89,056.</u>
28 Total deductions. Add lines 14 through 27	28		<u>89,904.</u>
29 Unrelated business taxable income before net operating loss deduction. Subtract line 28 from line 13	29		<u>-63,593.</u>
30 Deduction for net operating loss arising in tax years beginning on or after January 1, 2018 (see instructions)	30	<u>SEE STATEMENT 2</u>	<u>0.</u>
31 Unrelated business taxable income. Subtract line 30 from line 29	31		<u>-63,593.</u>

Part III Total Unrelated Business Taxable Income

32	Total of unrelated business taxable income computed from all unrelated trades or businesses (see instructions)	32	0.
33	Amounts paid for disallowed fringes	33	
34	Charitable contributions (see instructions for limitation rules)	34	0.
35	Total unrelated business taxable income before pre-2018 NOLs and specific deduction. Subtract line 34 from the sum of lines 32 and 33	35	
36	Deduction for net operating loss arising in tax years beginning before January 1, 2018 (see instructions) STMT 3	36	0.
37	Total of unrelated business taxable income before specific deduction. Subtract line 36 from line 35	37	
38	Specific deduction (Generally \$1,000, but see line 38 instructions for exceptions)	38	1,000.
39	Unrelated business taxable income. Subtract line 38 from line 37. If line 38 is greater than line 37, enter the smaller of zero or line 37	39	0.

Part IV Tax Computation

40	Organizations Taxable as Corporations. Multiply line 39 by 21% (0.21)	40	0.
41	Trusts Taxable at Trust Rates. See instructions for tax computation. Income tax on the amount on line 39 from: <input type="checkbox"/> Tax rate schedule or <input type="checkbox"/> Schedule D (Form 1041)	41	
42	Proxy tax. See instructions	42	
43	Alternative minimum tax (trusts only)	43	
44	Tax on Noncompliant Facility Income. See instructions	44	
45	Total. Add lines 42, 43, and 44 to line 40 or 41, whichever applies	45	0.

Part V Tax and Payments

46a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	46a	
b	Other credits (see instructions)	46b	
c	General business credit. Attach Form 3800	46c	
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	46d	
e	Total credits. Add lines 46a through 46d	46e	
47	Subtract line 46e from line 45	47	0.
48	Other taxes. Check if from: <input type="checkbox"/> Form 4255 <input type="checkbox"/> Form 8611 <input type="checkbox"/> Form 8697 <input type="checkbox"/> Form 8866 <input type="checkbox"/> Other (attach schedule)	48	
49	Total tax. Add lines 47 and 48 (see instructions)	49	0.
50	2019 net 965 tax liability paid from Form 965-A or Form 965-B, Part II, column (k), line 3	50	0.
51a	Payments: A 2018 overpayment credited to 2019	51a	
b	2019 estimated tax payments	51b	
c	Tax deposited with Form 8868	51c	
d	Foreign organizations: Tax paid or withheld at source (see instructions)	51d	
e	Backup withholding (see instructions)	51e	
f	Credit for small employer health insurance premiums (attach Form 8941)	51f	
g	Other credits, adjustments, and payments: <input type="checkbox"/> Form 2439 <input type="checkbox"/> Form 4136 <input type="checkbox"/> Other Total	51g	
52	Total payments. Add lines 51a through 51g	52	
53	Estimated tax penalty (see instructions). Check if Form 2220 is attached <input type="checkbox"/>	53	
54	Tax due. If line 52 is less than the total of lines 49, 50, and 53, enter amount owed	54	
55	Overpayment. If line 52 is larger than the total of lines 49, 50, and 53, enter amount overpaid	55	
56	Enter the amount of line 55 you want: Credited to 2020 estimated tax <input type="checkbox"/> Refunded <input type="checkbox"/>	56	

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

57	At any time during the 2019 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If "Yes," the organization may have to file FinCEN Form 114, Report of Foreign Bank and Financial Accounts. If "Yes," enter the name of the foreign country here	Yes	No
58	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If "Yes," see instructions for other forms the organization may have to file.		X
59	Enter the amount of tax-exempt interest received or accrued during the tax year \$		

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

Sign Here
 Signature of officer: _____ Date: _____
 Title: **VP FINANCE**

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

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
AMY BIBBY	AMY BIBBY	05/12/21		P00445891
Firm's name	Firm's address		Firm's EIN	Phone no.
DIXON HUGHES GOODMAN LLP	1410 SPRING HILL ROAD, SUITE 500 TYSONS, VA 22102-3056		56-0747981	(703) 970-0400

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

1	Inventory at beginning of year	1	0.	6	Inventory at end of year	6	0.
2	Purchases	2	220,353.	7	Cost of goods sold. Subtract line 6 from line 5. Enter here and in Part I, line 2	7	220,353.
3	Cost of labor	3		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
4a	Additional section 263A costs (attach schedule)	4a					
b	Other costs (attach schedule)	4b					
5	Total. Add lines 1 through 4b	5	220,353.				X

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

(see instructions)

1. Description of property

(1)	
(2)	
(3)	
(4)	

2. Rent received or accrued

(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
(1)		
(2)		
(3)		
(4)		
Total	0.	Total 0.

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

(b) **Total deductions.** Enter here and on page 1, Part I, line 6, column (B) ...

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

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

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

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

Nonexempt Controlled Organizations

7. Taxable income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)				
(2)				
(3)				
(4)				
			Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).
Totals			0.	0.

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

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
		Enter here and on page 1, Part I, line 9, column (A).		Enter here and on page 1, Part I, line 9, column (B).
Totals		0.		0.

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

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
		Enter here and on page 1, Part I, line 10, col. (A).	Enter here and on page 1, Part I, line 10, col. (B).			Enter here and on page 1, Part II, line 25.
Totals		0.	0.			0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

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

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

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I	0.	0.				0.
Totals, Part II (lines 1-5)	Enter here and on page 1, Part I, line 11, col. (A). 0.	Enter here and on page 1, Part I, line 11, col. (B). 0.				Enter here and on page 1, Part II, line 26. 0.

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

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

Form 990-T (2019)

FORM 990-T

OTHER DEDUCTIONS

STATEMENT 1

DESCRIPTION	AMOUNT
PURCHASED SERVICES	2,733.
OFFICE EXPENSES	2,139.
SUPPLIES	671.
CONTRACT SERVICE	80,482.
ADVERTISING	22.
CONSULTATION FEES	2,393.
BOOKS AND SUBSCRIPTIONS	616.
TOTAL TO FORM 990-T, PAGE 1, LINE 27	89,056.

FORM 990-T

NET OPERATING LOSS DEDUCTION

STATEMENT 2

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
06/30/19	100,161.	0.	100,161.	100,161.
NOL CARRYOVER AVAILABLE THIS YEAR			100,161.	100,161.

FORM 990-T

NET OPERATING LOSS DEDUCTION

STATEMENT 3

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
06/30/05	308,028.	239,281.	68,747.	68,747.
06/30/06	232,633.	0.	232,633.	232,633.
06/30/07	343,156.	0.	343,156.	343,156.
06/30/08	366,549.	0.	366,549.	366,549.
06/30/09	390,246.	0.	390,246.	390,246.
06/30/10	71,125.	0.	71,125.	71,125.
06/30/18	22,864.	0.	22,864.	22,864.
NOL CARRYOVER AVAILABLE THIS YEAR			1,495,320.	1,495,320.

**SCHEDULE M
(Form 990-T)**

**Unrelated Business Taxable Income from an
Unrelated Trade or Business**

ENTITY 1

OMB No. 1545-0047

2019

For calendar year 2019 or other tax year beginning JUL 1, 2019, and ending JUN 30, 2020.

▶ Go to www.irs.gov/Form990T for instructions and the latest information.

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

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

Department of the Treasury
Internal Revenue Service

Name of the organization **ATLANTIC GENERAL HOSPITAL** Employer identification number **52-1656507**

Unrelated Business Activity Code (see instructions) ▶ **561000**

Describe the unrelated trade or business ▶ **PHYSICIAN BILLING SERVICES**

Part I Unrelated Trade or Business Income		(A) Income	(B) Expenses	(C) Net
1 a Gross receipts or sales	<u>24,823.</u>			
b Less returns and allowances				
c Balance ▶		1c 24,823.		
2 Cost of goods sold (Schedule A, line 7)		2		
3 Gross profit. Subtract line 2 from line 1c		3 24,823.		24,823.
4 a Capital gain net income (attach Schedule D)		4a		
b Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)		4b		
c Capital loss deduction for trusts		4c		
5 Income (loss) from a partnership or an S corporation (attach statement)		5		
6 Rent income (Schedule C)		6		
7 Unrelated debt-financed income (Schedule E)		7		
8 Interest, annuities, royalties, and rents from a controlled organization (Schedule F)		8		
9 Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)		9		
10 Exploited exempt activity income (Schedule I)		10		
11 Advertising income (Schedule J)		11		
12 Other income (See instructions; attach schedule)		12		
13 Total. Combine lines 3 through 12		13 24,823.		24,823.

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.) (Deductions must be directly connected with the unrelated business income.)

14 Compensation of officers, directors, and trustees (Schedule K)		14		
15 Salaries and wages		15		25,537.
16 Repairs and maintenance		16		2,523.
17 Bad debts		17		
18 Interest (attach schedule) (see instructions)		18		
19 Taxes and licenses		19		1,952.
20 Depreciation (attach Form 4562)	20 23.			
21 Less depreciation claimed on Schedule A and elsewhere on return	21a			21b 23.
22 Depletion		22		
23 Contributions to deferred compensation plans		23		
24 Employee benefit programs		24		2,794.
25 Excess exempt expenses (Schedule I)		25		
26 Excess readership costs (Schedule J)		26		
27 Other deductions (attach schedule)	SEE STATEMENT 4	27		13,005.
28 Total deductions. Add lines 14 through 27		28		45,834.
29 Unrelated business taxable income before net operating loss deduction. Subtract line 28 from line 13		29		-21,011.
30 Deduction for net operating loss arising in tax years beginning on or after January 1, 2018 (see instructions)		30		0.
31 Unrelated business taxable income. Subtract line 30 from line 29		31		-21,011.

LHA For Paperwork Reduction Act Notice, see instructions.

Schedule M (Form 990-T) 2019

FORM 990-T (M)

OTHER DEDUCTIONS

STATEMENT 4

DESCRIPTION

AMOUNT

OFFICE EXPENSE
PURCHASED SERVICES
OCCUPANCY
CONFERENCES

1,570.
11,266.
163.
6.

TOTAL TO SCHEDULE M, PART II, LINE 27

13,005.

ATLANTIC GENERAL HOSPITAL

52-1656507

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

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

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

(see instructions)

1. Description of property

(1)	
(2)	
(3)	
(4)	

2. Rent received or accrued

(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
(1)		
(2)		
(3)		
(4)		
Total	0.	Total 0.

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

(b) **Total deductions.** Enter here and on page 1, Part I, line 6, column (B) ... 0.

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

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

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

(Rev. December 2019)
Department of the Treasury
Internal Revenue Service

▶ Go to www.irs.gov/Form5471 for instructions and the latest information.

Information furnished for the foreign corporation's annual accounting period (tax year required by section 898) (see instructions) beginning **JAN 1, 2019**, and ending **DEC 31, 2019**

Attachment
Sequence No. **121**

Name of person filing this return ATLANTIC GENERAL HOSPITAL <small>Number, street, and room or suite no. (or P.O. box number if mail is not delivered to street address)</small> 9733 HEALTHWAY DRIVE City or town, state, and ZIP code BERLIN, MD 21811	A Identifying number 52-1656507 B Category of filer (See instructions. Check applicable box(es): 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input checked="" type="checkbox"/> C Enter the total percentage of the foreign corporation's voting stock you owned at the end of its annual accounting period 20.00 %
Filer's tax year beginning JUL 1, 2019 , and ending JUN 30, 2020	

D Check box if this is a final Form 5471 for the foreign corporation

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

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

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

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

1a Name and address of foreign corporation FREESTATE HEALTHCARE INSURANCE COMPANY, LTD. P.O. BOX 10233 GRAND CAYMAN KY1-1002 CAYMAN ISLANDS	b(1) Employer identification number, if any 98-0464065 b(2) Reference ID number (see instructions) c Country under whose laws incorporated CAYMAN ISLANDS
---	--

d Date of incorporation	e Principal place of business	f Principal business activity code number	g Principal business activity	h Functional currency
12/14/04	CAYMAN ISLANDS	525100	OTHER INSURANCE FUND	UNITED STATES, DOLLAR

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

a Name, address, and identifying number of branch office or agent (if any) in the United States	b If a U.S. income tax return was filed, enter: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">(i) Taxable income or (loss)</td> <td style="width:50%;">(ii) U.S. income tax paid (after all credits)</td> </tr> <tr> <td> </td> <td> </td> </tr> </table>	(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)		
(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)				

c Name and address of foreign corporation's statutory or resident agent in country of incorporation ARTEX RISK SOLUTIONS (CAYMAN) LIMIT P.O. BOX 10233 GRAND CAYMAN KY1-1002 CAYMAN ISLANDS	d Name and address (including corporate department, if applicable) of person (or persons) with custody of the books and records of the foreign corporation, and the location of such books and records, if different SAME AS 2C
---	--

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

Schedule C Income Statement

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

		Functional Currency	U.S. Dollars
Income	1a Gross receipts or sales	1a	
	b Returns and allowances	1b	
	c Subtract line 1b from line 1a	1c	
	2 Cost of goods sold	2	
	3 Gross profit (subtract line 2 from line 1c)	3	
	4 Dividends	4	
	5 Interest	5	
	6a Gross rents	6a	
	b Gross royalties and license fees	6b	
	7 Net gain or (loss) on sale of capital assets	7	
8a Foreign currency transaction gain or loss - unrealized		8a	
	b Foreign currency transaction gain or loss - realized	8b	
	9 Other income (attach statement)	9	
	10 Total income (add lines 3 through 9)	10	
Deductions	11 Compensation not deducted elsewhere	11	
	12a Rents	12a	
	b Royalties and license fees	12b	
	13 Interest	13	
	14 Depreciation not deducted elsewhere	14	
	15 Depletion	15	
	16 Taxes (exclude income tax expense (benefit))	16	
	17 Other deductions (attach statement - exclude income tax expense (benefit))	17	
18 Total deductions (add lines 11 through 17)	18		
Net Income	19 Net income or (loss) before unusual or infrequently occurring items, and income tax expense (benefit) (subtract line 18 from line 10)	19	
	20 Unusual or infrequently occurring items	20	
	21a Income tax expense (benefit) - current	21a	
	b Income tax expense (benefit) - deferred	21b	
22 Current year net income or (loss) per books (combine lines 19 through 21b)	22		
Other Comprehensive Income	23a Foreign currency translation adjustments	23a	
	b Other	23b	
	c Income tax expense (benefit) related to other comprehensive income	23c	
	24 Other comprehensive income (loss), net of tax (line 23a plus line 23b less line 23c)	24	

Schedule F Balance Sheet

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

Assets	(a) Beginning of annual accounting period	(b) End of annual accounting period
1 Cash	1	
2a Trade notes and accounts receivable	2a	
b Less allowance for bad debts	2b () ()	
3 Derivatives	3	
4 Inventories	4	
5 Other current assets (attach statement)	5	
6 Loans to shareholders and other related persons	6	
7 Investment in subsidiaries (attach statement)	7	
8 Other investments (attach statement)	8	
9a Buildings and other depreciable assets	9a	
b Less accumulated depreciation	9b () ()	
10a Depletable assets	10a	
b Less accumulated depletion	10b () ()	
11 Land (net of any amortization)	11	
12 Intangible assets:		
a Goodwill	12a	
b Organization costs	12b	
c Patents, trademarks, and other intangible assets	12c	
d Less accumulated amortization for lines 12a, 12b, and 12c	12d () ()	
13 Other assets (attach statement)	13	
14 Total assets	14	
Liabilities and Shareholders' Equity		
15 Accounts payable	15	
16 Other current liabilities (attach statement)	16	
17 Derivatives	17	
18 Loans from shareholders and other related persons	18	
19 Other liabilities (attach statement)	19	
20 Capital stock:		
a Preferred stock	20a	
b Common stock	20b	
21 Paid-in or capital surplus (attach reconciliation)	21	
22 Retained earnings	22	
23 Less cost of treasury stock	23 () ()	
24 Total liabilities and shareholders' equity	24	

Schedule G Other Information

	Yes	No
1 During the tax year, did the foreign corporation own at least a 10% interest, directly or indirectly, in any foreign partnership? If "Yes," see the instructions for required statement.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2 During the tax year, did the foreign corporation own an interest in any trust?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3 During the tax year, did the foreign corporation own any foreign entities that were disregarded as separate from their owner under Regulations sections 301.7701-2 and 301.7701-3 or did the foreign corporation own any foreign branches (see instructions)? If "Yes," you are generally required to attach Form 8858 for each entity or branch (see instructions).	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4a During the tax year, did the filer pay or accrue any base erosion payment under section 59A(d) to the foreign corporation or did the filer have a base erosion tax benefit under section 59A(c)(2) with respect to a base erosion payment made or accrued to the foreign corporation (see instructions)? If "Yes," complete lines 4b and 4c.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b Enter the total amount of the base erosion payments	▶ \$	
c Enter the total amount of the base erosion tax benefit	▶ \$	
5a During the tax year, did the foreign corporation pay or accrue any interest or royalty for which the deduction is not allowed under section 267A? If "Yes," complete line 5b.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b Enter the total amount of the disallowed deductions (see instructions)	▶ \$	

Schedule G Other Information (continued)

		Yes	No
6a	Is the filer of this Form 5471 claiming a foreign-derived intangible income deduction (under section 250) with respect to any amounts listed on Schedule M? If "Yes," complete lines 6b, 6c, and 6d.		X
b	Enter the amount of gross income derived from sales, leases, exchanges, or other dispositions (but not licenses) from transactions with the foreign corporation that the filer included in its computation of foreign-derived deduction eligible income (FDDEI) (see instructions) ▶ \$ _____		
c	Enter the amount of gross income derived from a license of property to the foreign corporation that the filer included in its computation of FDDEI (see instructions) ▶ \$ _____		
d	Enter the amount of gross income derived from services provided to the foreign corporation that the filer included in its computation of FDDEI (see instructions) ▶ \$ _____		
7	During the tax year, was the foreign corporation a participant in any cost sharing arrangement?		X
8	During the course of the tax year, did the foreign corporation become a participant in any cost sharing arrangement?		X
9	If the answer to question 7 is "Yes," was the foreign corporation a participant in a cost sharing arrangement that was in effect before January 5, 2009?		X
10	If the answer to question 7 is "Yes," did a U.S. taxpayer make any platform contributions as defined under Regulations section 1.482-7(c) to that cost sharing arrangement during the taxable year?		X
11	If the answer to question 10 is "Yes," enter the present value of the platform contributions in U.S. dollars ▶ \$ _____		
12	If the answer to question 10 is "Yes," check the box for the method under Regulations section 1.482-7(g) used to determine the price of the platform contribution transaction(s): <input type="checkbox"/> Comparable uncontrolled transaction method <input type="checkbox"/> Income method <input type="checkbox"/> Acquisition price method <input type="checkbox"/> Market capitalization method <input type="checkbox"/> Residual profit split method <input type="checkbox"/> Unspecified methods		
13	From April 25, 2014, to December 31, 2017, did the foreign corporation purchase stock or securities of a shareholder of the foreign corporation for use in a triangular reorganization (within the meaning of Regulations section 1.358-6(b)(2))?		X
14a	Did the foreign corporation receive any intangible property in a prior year or the current tax year for which the U.S. transferor is required to report a section 367(d) annual income inclusion for the taxable year?		X
	If "Yes," go to line 14b.		
b	Enter the amount of the earnings and profits reduction pursuant to section 367(d)(2)(B) for the taxable year ▶ \$ _____		
15	During the tax year, was the foreign corporation an expatriated foreign subsidiary under Regulations section 1.7874-12(a)(9)?		X
	If "Yes," see instructions and attach statement.		
16	During the tax year, did the foreign corporation participate in any reportable transaction as defined in Regulations section 1.6011-4?		X
	If "Yes," attach Form(s) 8886 if required by Regulations section 1.6011-4(c)(3)(i)(G).		
17	During the tax year, did the foreign corporation pay or accrue any foreign tax that was disqualified for credit under section 901(m)?		X
18	During the tax year, did the foreign corporation pay or accrue foreign taxes to which section 909 applies, or treat foreign taxes that were previously suspended under section 909 as no longer suspended?		X
19	Did you answer "Yes" to any of the questions in the instructions for line 19? STMT 5	X	
	If "Yes," enter the corresponding code(s) from the instructions and attach statement (see instructions) ▶ _____		
20	Does the foreign corporation have interest expense disallowed under section 163(j) (see instructions)?		X
	If "Yes," enter the amount ▶ \$ _____		
21	Does the foreign corporation have previously disallowed interest expense under section 163(j) carried forward to the current tax year (see instructions)?		X
	If "Yes," enter the amount ▶ \$ _____		

CODE	DESCRIPTION	AMOUNT
DED	DEDUCTIONS TAKEN INTO ACCOUNT	106,025.
EP	EXCESS SUBPART F INCOME OVER EARNINGS AND PROFITS	943,759.

Schedule I Summary of Shareholder's Income From Foreign Corporation

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

Name of U.S. shareholder ▶	Identifying number ▶	
1a Section 964(e)(4) Subpart F dividend income from the sale of stock of a lower-tier foreign corporation (see instructions)		1a
b Section 245A(e)(2) Subpart F income from hybrid dividends of tiered corporations (see instructions)		1b
c Section 954(c) Subpart F Foreign Personal Holding Company Income (enter result from Worksheet A)		1c
d Section 954(d) Subpart F Foreign Base Company Sales Income (enter result from Worksheet A)		1d
e Section 954(e) Subpart F Foreign Base Company Services Income (enter result from Worksheet A)		1e
f Other subpart F income (see instructions)		1f
2 Earnings invested in U.S. property (enter the result from Worksheet B in the instructions)		2
3 Section 245A eligible dividends (see instructions)		3
4 Factoring income		4
See instructions for reporting amounts on lines 1, 2, and 4 on your income tax return.		
5 Dividends received (translated at spot rate on payment date under section 989(b)(1))		5
6 Exchange gain or (loss) on a distribution of previously taxed earnings and profits		6

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

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

**SCHEDULE E
(Form 5471)**

(Rev. December 2019)
Department of the Treasury
Internal Revenue Service

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

▶ **Attach to Form 5471.**

OMB No. 1545-0123

▶ **Go to www.irs.gov/Form5471 for instructions and the latest information.**

Name of person filing Form 5471 ATLANTIC GENERAL HOSPITAL		Identifying number 52-1656507
Name of foreign corporation FREESTATE HEALTHCARE INSURANCE COMPANY, LTD.	EIN (if any) 98-0464065	Reference ID number (see instructions) GEN
a Separate Category (Enter code - see instructions.) b If code 901j is entered on line a, enter the country code for the sanctioned country (see instructions)		

Part I Taxes for Which a Foreign Tax Credit Is Allowed

	(a) Name of Payor Entity	(b) EIN or Reference ID Number of Payor Entity	(c) Country or U.S. Possession to Which Tax Is Paid (Enter code-see instructions. Use a separate line for each.)	(d) Foreign Tax Year of Foreign Corporation to Which Tax Relates (Year/Month/Day)	(e) U.S. Tax Year of Foreign Corporation to Which Tax Relates (Year/Month/Day)
1					
2					
3					
4					
5					
6					
7					
	(f) Income Subject to Tax in the Foreign Jurisdiction (see instructions)	(g) Tax Paid or Accrued (in local currency in which the tax is payable)	(h) Conversion Rate to U.S. Dollars	(i) In U.S. Dollars (divide column (g) by column (h))	(j) In Functional Currency of Foreign Corporation
1					
2					
3					
4					
5					
6					
7					
8	Total (combine lines 1 through 7 of column (i)). Report amount on Schedule E-1, line 4				
9	Total (combine lines 1 through 7 of column (j)). See instructions for Schedule H, line 2g				

Part II Election

For tax years beginning after December 31, 2004, has an election been made under section 986(a)(1)(D) to translate taxes using the exchange rate on the date of payment?

Yes No If "Yes," state date of election ▶

Part III Taxes for Which a Foreign Tax Credit Is Disallowed (Enter in functional currency of foreign corporation.)

	(a) Name of Payor Entity	(b) EIN or Reference ID Number of Payor Entity	(c) Section 901(j)	(d) Section 901(k) and (l)	(e) Section 901(m)	(f) U.S. Taxes	(g) Other	(h) Total
1								
2								
3	In functional currency (combine lines 1 and 2)							
4	In U.S. dollars (translated at the average exchange rate, as defined in section 989(b)(3) and related regulations (see instructions))							

Schedule E-1 Taxes Paid, Accrued, or Deemed Paid on Accumulated Earnings and Profits (E&P) of Foreign Corporation

IMPORTANT: Enter amounts in U.S. dollars unless otherwise noted (see instructions).		Taxes related to:			
		(a) Post-2017 E&P Not Previously Taxed (post-2017 section 959(c)(3) balance)	(b) Post-1986 Undistributed Earnings (post-1986 and pre-2018 section 959(c)(3) balance)	(c) Pre-1987 E&P Not Previously Taxed (pre-1987 section 959(c)(3) balance) (in functional currency)	(d) Hovering Deficit and Suspended Taxes
1a	Balance at beginning of year (as reported in prior year Schedule E-1)				
b	Beginning balance adjustments (attach statement)				
c	Adjusted beginning balance (combine lines 1a and 1b)				
2	Adjustment for redetermination of prior year U.S. tax liability				
3a	Taxes unsuspended under anti-splitter rules				
b	Taxes suspended under anti-splitter rules				
4	Taxes reported on Schedule E, Part I, line 8, column (i)				
5a	Taxes carried over in nonrecognition transactions				
b	Taxes reclassified as related to hovering deficit after nonrecognition transaction				
6	Other adjustments (attach statement)				
7	Taxes paid or accrued on accumulated E&P (combine lines 1c through 6)				
8	Taxes deemed paid with respect to inclusions under section 951(a)(1) (see instructions)				
9	Taxes deemed paid with respect to inclusions under section 951A (see instructions)				
10	Taxes deemed paid with respect to actual distributions				
11	Taxes on amounts reclassified to section 959(c)(1) E&P from section 959(c)(2) E&P				
12	Other (attach statement)				
13	Taxes related to hovering deficit offset of undistributed post-transaction E&P				
14	Balance at beginning of next year (combine lines 7 through 13)				

(e) Taxes related to previously taxed E&P (see instructions)

	(i) Section 965(a) Inclusion (section 959(c)(1)(A))	(ii) Section 965(b)(4)(A) (section 959(c)(1)(A))	(iii) Earnings Invested in U.S. Property (section 959(c)(1)(A))	(iv) Section 951A Inclusion (section 959(c)(1)(A))	(v) Section 245A(e)(2) Inclusion (section 959(c)(1)(A))	(vi) Section 959(e) (section 959(c)(1)(A))	(vii) Section 964(e)(4) Inclusion (section 959(c)(1)(A))	(viii) Section 951(a)(1)(A) Inclusion (section 959(c)(1)(A))
1a								
b								
c								
2								
3a								
b								
4								
5a								
b								
6								
7								
8								
9								
10								
11								
12								
13								
14								

Schedule E-1 Taxes Paid, Accrued, or Deemed Paid on Accumulated Earnings and Profits (E&P) of Foreign Corporation *(continued)*

(e) Taxes related to previously taxed E&P (see instructions)

	(ix) Earnings Invested Excess Passive Assets (section 959(c)(1)(B))	(x) Section 965(a) Inclusion (section 959(c)(2))	(xi) Section 965(b)(4)(A) (section 959(c)(2))	(xii) Section 951A Inclusion (section 959(c)(2))	(xiii) Section 245A(e)(2) Inclusion (section 959(c)(2))	(xiv) Section 959(e) (section 959(c)(2))	(xv) Section 964(e)(4) Inclusion (section 959(c)(2))	(xvi) Section 951(a)(1)(A) Inclusion (section 959(c)(2))
1a								
b								
c								
2								
3a								
b								
4								
5a								
b								
6								
7								
8								
9								
10								
11								
12								
13								
14								

**SCHEDULE H
(Form 5471)**

(December 2018)
Department of the Treasury
Internal Revenue Service

Current Earnings and Profits

▶ Attach to Form 5471.

OMB No. 1545-0123

▶ Go to www.irs.gov/Form5471 for instructions and the latest information.

Name of person filing Form 5471
ATLANTIC GENERAL HOSPITAL

Identifying number
52-1656507

Name of foreign corporation
FREESTATE HEALTHCARE INSURANCE CO

EIN (if any)
98-0464065

Reference ID number (see instr.)

a Separate Category (Enter code-see instructions.) ▶ **GEN**

b If code 901j is entered on line a, enter the country code for the sanctioned country (see instructions) ▶

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

1	Current year net income or (loss) per foreign books of account		1	0.
2	Net adjustments made to line 1 to determine current earnings and profits according to U.S. financial and tax accounting standards (see instructions):			
		Net Additions	Net Subtractions	
a	Capital gains or losses	2a	3,399,833.	
b	Depreciation and amortization	2b		
c	Depletion	2c		
d	Investment or incentive allowance	2d		
e	Charges to statutory reserves	2e		
f	Inventory adjustments	2f		
g	Income taxes (see Schedule E, Part I, line 9, column (j))	2g		
h	Foreign currency gains or losses	2h		
i	Other (attach statement) SEE STATEMENT 6	2i	7,769,688.	4,679,354.
3	Total net additions	3	7,769,688.	
4	Total net subtractions	4	8,079,187.	
5a	Current earnings and profits (line 1 plus line 3 minus line 4)	5a		-309,499.
b	DASTM gain or (loss) for foreign corporations that use DASTM (see instructions)	5b		
c	Combine lines 5a and 5b	5c		-309,499.
d	Current earnings and profits in U.S. dollars (line 5c translated at the average exchange rate, as defined in section 989(b)(3) and the related regulations (see instructions))	5d		-309,499.
	Enter exchange rate used for line 5d ▶		1.000000	

LHA For Paperwork Reduction Act Notice, see instructions.

Schedule H (Form 5471) (12-2018)

FORM 5471

OTHER NET ADJUSTMENTS

STATEMENT 6

<u>DESCRIPTION</u>	<u>NET ADDITIONS</u>	<u>NET SUBTRACTIONS</u>
RELATED PARTY PREMIUMS	0.	4,679,354.
RELATED PTY LOSS RESERVES & CLAIM	7,769,688.	0.
TOTAL TO 5471, SCHEDULE H, LINE 2I	<u>7,769,688.</u>	<u>4,679,354.</u>

**SCHEDULE I-1
(Form 5471)**

(Rev. December 2019)

Department of the Treasury
Internal Revenue Service

Information for Global Intangible Low-Taxed Income

▶ **Attach to Form 5471.**

OMB No. 1545-0704

▶ **Go to www.irs.gov/Form5471 for instructions and the latest information.**

Name of person filing Form 5471
ATLANTIC GENERAL HOSPITAL Identifying number
52-1656507

Name of foreign corporation
FREESTATE HEALTHCARE INSURANCE COMP EIN (if any)
98-0464065 Reference ID number (see instr.)

Separate Category (Enter code - see instructions) ▶ **GEN**

		Functional Currency	Conversion Rate	U.S. Dollars
1	Gross income	1 4679354.		
2	Exclusions			
a	Effectively connected income	2a		
b	Subpart F income	2b 4679354.		
c	High-tax exception income per section 954(b)(4)	2c		
d	Related party dividends	2d		
e	Foreign oil and gas extraction income	2e		
3	Total exclusions (total of lines 2a-2e)	3 4679354.		
4	Gross income less total exclusions (line 1 minus line 3)	4 0.		
5	Deductions properly allocable to amount on line 4	5		
6	Tested income (loss) (line 4 minus line 5)	6 0.	1.000000	
7	Tested foreign income taxes	7	1.000000	
8	Qualified business asset investment (QBAI)	8	1.000000	
9a	Interest expense included on line 5	9a		
b	Qualified interest expense	9b		
c	Tested loss QBAI amount	9c		
d	Tested interest expense (line 9a minus the sum of line 9b and line 9c). If zero or less, enter -0-	9d	1.000000	
10a	Interest income included in line 4	10a		
b	Qualified interest income	10b		
c	Tested interest income (line 10a minus line 10b). If zero or less, enter -0-	10c	1.000000	

LHA For Paperwork Reduction Act Notice, see instructions.

Schedule I-1 (Form 5471) (Rev. 12-2019)

**SCHEDULE J
(Form 5471)**

(Rev. December 2019)
Department of the Treasury
Internal Revenue Service

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

▶ Attach to Form 5471.

OMB No. 1545-0123

▶ Go to www.irs.gov/Form5471 for instructions and the latest information.

Name of person filing Form 5471

Identifying number

ATLANTIC GENERAL HOSPITAL

52-1656507

Name of foreign corporation

EIN (if any)

Reference ID number

FREESTATE HEALTHCARE INSURANCE COMPANY, LTD.

98-0464065

a Separate Category (Enter code - see instructions.) ▶ **GEN**
b If code 901j is entered on line a, enter the country code for the sanctioned country (see instructions) ▶

Part I Accumulated E&P of Controlled Foreign Corporation

Check the box if person filing return does not have all U.S. shareholders' information to complete amount for columns (e)(i), (e)(ii), (e)(iv), and (e)(x) through (e)(xii) (see instructions).

Important: Enter amounts in functional currency.

	(a) Post-2017 E&P Not Previously Taxed (post-2017 section 959(c)(3) balance)	(b) Post-1986 Undistributed Earnings (post-1986 and pre-2018 section 959(c)(3) balance)	(c) Pre-1987 E&P Not Previously Taxed (pre-1987 section 959(c)(3) balance)	(d) Hovering Deficit and Deduction for Suspended Taxes	(e) Previously Taxed E&P (see instructions)	
					(i) Section 965(a) Inclusion (section 959(c)(1)(A))	(ii) Section 965(b)(4)(A) (section 959(c)(1)(A))
1a Balance at beginning of year (as reported on prior year Schedule J)	- 150 .	-12877111 .				
b Beginning balance adjustments (attach statement)						
c Adjusted beginning balance (combine lines 1a and 1b)	- 150 .	-12877111 .				
2a Reduction for taxes unsuspending under anti-splitter rules						
b Disallowed deduction for taxes suspended under anti-splitter rules						
3 Current year E&P (or deficit in E&P)	- 309 , 499 .					
4 E&P attributable to distributions of previously taxed E&P from lower-tier foreign corporation						
5a E&P carried over in nonrecognition transaction						
b Reclassify deficit in E&P as hovering deficit after nonrecognition transaction						
6 Other adjustments (attach statement)						
7 Total current and accumulated E&P (combine lines 1c through 6)	- 309 , 649 .	-12877111 .				
8 Amounts reclassified to section 959(c)(2) E&P from section 959(c)(3) E&P						
9 Actual distributions						
10 Amounts reclassified to section 959(c)(1) E&P from section 959(c)(2) E&P						
11 Amounts included as earnings invested in U.S. property and reclassified to section 959(c)(1) E&P (see instructions)						
12 Other adjustments (attach statement)						
13 Hovering deficit offset of undistributed posttransaction E&P (see instructions)						
14 Balance at beginning of next year (combine lines 7 through 13)	- 309 , 649 .	-12877111 .				

Part I Accumulated E&P of Controlled Foreign Corporation *(continued)*

	(e) Previously Taxed E&P (see instructions)							(x) Section 965(a) Inclusion (section 959(c)(2))
	(iii) Earnings Invested in U.S. Property (section 959(c)(1)(A))	(iv) Section 951A Inclusion (section 959(c)(1)(A))	(v) Section 245A(e)(2) Inclusion (section 959(c)(1)(A))	(vi) Section 959(e) (section 959(c)(1)(A))	(vii) Section 964(e)(4) Inclusion (section 959(c)(1)(A))	(viii) Section 951(a)(1)(A) Inclusion (section 959(c)(1)(A))	(ix) Earnings Invested in Excess Passive Assets (section 959(c)(1)(B))	
1a								
b								
c								
2a								
b								
3								
4								
5a								
b								
6								
7								
8								
9								
10								
11								
12								
13								
14								

	(e) Previously Taxed E&P (see instructions)						(f) Total Section 964(a) E&P (combine columns (a), (b), (c), and (e)(i) through (e)(xvi))
	(xi) Section 965(b)(4)(A) (section 959(c)(2))	(xii) Section 951A Inclusion (section 959(c)(2))	(xiii) Section 245A(e)(2) Inclusion (section 959(c)(2))	(xiv) Section 959(e) (section 959(c)(2))	(xv) Section 964(e)(4) Inclusion (section 959(c)(2))	(xvi) Section 951(a)(1)(A) Inclusion (section 959(c)(2))	
1a							-12,877,261.
b							
c							-12,877,261.
2a							
b							
3							-309,499.
4							
5a							
b							
6							
7							-13,186,760.
8							
9							
10							
11							
12							
13							
14							-13,186,760.

Part II Nonpreviously Taxed E&P Subject to Recapture as Subpart F Income (section 952(c)(2))

Important: Enter amounts in functional currency.

1	Balance at beginning of year	▶	1	
2	Additions (amounts subject to future recapture)	▶	2	
3	Subtractions (amounts recaptured in current year)	▶	3	
4	Balance at end of year (combine lines 1 through 3)	▶	4	

Schedule J (Form 5471) (Rev. 12-2019)

**SCHEDULE P
(Form 5471)**

(Rev. December 2019)

Department of the Treasury
Internal Revenue Service

**Previously Taxed Earnings and Profits of U.S. Shareholder
of Certain Foreign Corporations**

▶ **Attach to Form 5471.**

▶ **Go to www.irs.gov/Form5471 for instructions and the latest information.**

OMB No. 1545-0123

Name of U.S. shareholder ATLANTIC GENERAL HOSPITAL		Identifying number 52-1656507
Name of foreign corporation FREESTATE HEALTHCARE INSURANCE COMPANY, LTD.	EIN (if any) 98-0464065	Reference ID number (see instructions)

- a** Separate Category (Enter code - see instructions.) ▶ **GEN**
- b** If code 901j is entered on line a, enter the country code for the sanctioned country (see instructions) ▶

Part I Previously Taxed E&P in Functional Currency (see instructions)

	(a) Section 965(a) Inclusion (section 959(c)(1)(A))	(b) Section 965(b)(4)(A) (section 959(c)(1)(A))	(c) Earnings Invested in U.S. Property (section 959(c)(1)(A))	(d) Section 951A Inclusion (section 959(c)(1)(A))	(e) Section 245A(e)(2) Inclusion (section 959(c)(1)(A))	(f) Section 959(e) (section 959(c)(1)(A))	(g) Section 964(e)(4) Inclusion (section 959(c)(1)(A))
1a Balance at beginning of year (see instructions)							
b Beginning balance adjustments (attach statement)							
c Adjusted beginning balance (combine lines 1a and 1b)							
2 Reduction for taxes unsuspended under anti-splitter rules							
3 Previously taxed E&P attributable to distributions of previously taxed E&P from lower-tier foreign corporation							
4 Previously taxed E&P carried over in nonrecognition transaction							
5 Other adjustments (attach statement)							
6 Total previously taxed E&P (combine lines 1c through 5)							
7 Amounts reclassified to section 959(c)(2) E&P from section 959(c)(3) E&P							
8 Actual distributions of previously taxed E&P ...							
9 Amounts reclassified to section 959(c)(1) E&P from section 959(c)(2) E&P							
10 Amounts included as earnings invested in U.S. property and reclassified to section 959(c)(1) E&P (see instructions) ...							
11 Other adjustments (attach statement) ...							
12 Balance at beginning of next year (combine lines 6 through 11)							

LHA For Paperwork Reduction Act Notice, see instructions.

Schedule P (Form 5471) (Rev. 12-2019)

Part I **Previously Taxed E&P in Functional Currency** (see instructions) *(continued)*

	(h) Section 951(a)(1)(A) Inclusion (section 959(c)(1)(A))	(i) Earnings Invested in Excess Passive Assets (section 959(c)(1)(B))	(j) Section 965(a) Inclusion (section 959(c)(2))	(k) Section 965(b)(4)(A) (section 959(c)(2))	(l) Section 951A Inclusion (section 959(c)(2))	(m) Section 245A(e)(2) Inclusion (section 959(c)(2))	(n) Section 959(e) (section 959(c)(2))	(o) Section 964(e)(4) Inclusion (section 959(c)(2))	(p) Section 951(a)(1)(A) Inclusion (section 959(c)(2))	(q) Total
1a										
b										
c										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

Part II Previously Taxed E&P in U.S. Dollars

	(a) Section 965(a) Inclusion (section 959(c)(1)(A))	(b) Section 965(b)(4)(A) (section 959(c)(1)(A))	(c) Earnings Invested in U.S. Property (section 959(c)(1)(A))	(d) Section 951A Inclusion (section 959(c)(1)(A))	(e) Section 245A(e)(2) Inclusion (section 959(c)(1)(A))	(f) Section 959(e) (section 959(c)(1)(A))	(g) Section 964(e)(4) Inclusion (section 959(c)(1)(A))
1a Balance at beginning of year (see instructions)							
b Beginning balance adjustments (attach statement)							
c Adjusted beginning balance (combine lines 1a and 1b)							
2 Reduction for taxes unsuspended under anti-splitter rules							
3 Previously taxed E&P attributable to distributions of previously taxed E&P from lower-tier foreign corporation							
4 Previously taxed E&P carried over in nonrecognition transaction							
5 Other adjustments (attach statement)							
6 Total previously taxed E&P (combine lines 1c through 5)							
7 Amounts reclassified to section 959(c)(2) E&P from section 959(c)(3) E&P							
8 Actual distributions of previously taxed E&P							
9 Amounts reclassified to section 959(c)(1) E&P from section 959(c)(2) E&P							
10 Amounts included as earnings invested in U.S. property and reclassified to section 959(c)(1) E&P (see instructions)							
11 Other adjustments (attach statement)							
12 Balance at beginning of next year (combine lines 6 through 11)							

Schedule P (Form 5471) (Rev. 12-2019)

Part II Previously Taxed E&P in U.S. Dollars *(continued)*

	(h) Section 951(a)(1)(A) Inclusion (section 959(c)(1)(A))	(i) Earnings Invested in Excess Passive Assets (section 959(c)(1)(B))	(j) Section 965(a) Inclusion (section 959(c)(2))	(k) Section 965(b)(4)(A) (section 959(c)(2))	(l) Section 951A Inclusion (section 959(c)(2))	(m) Section 245A(e)(2) Inclusion (section 959(c)(2))	(n) Section 959(e) (section 959(c)(2))	(o) Section 964(e)(4) Inclusion (section 959(c)(2))	(p) Section 951(a)(1)(A) Inclusion (section 959(c)(2))	(q) Total
1a										
b										
c										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

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

▶ Go to www.irs.gov/Form926 for instructions and the latest information.
 ▶ Attach to your income tax return for the year of the transfer or distribution.

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

Name of transferor ATLANTIC GENERAL HOSPITAL	Identifying number (see instructions) 52-1656507
--	--

- 1** Is the transferee a specified 10%-owned foreign corporation that is not a controlled foreign corporation? Yes No
- 2** If the transferor was a corporation, complete questions 2a through 2d.
- a** If the transfer was a section 361(a) or (b) transfer, was the transferor controlled (under section 368(c)) by five or fewer domestic corporations? Yes No
- b** Did the transferor remain in existence after the transfer? Yes No
 If not, list the controlling shareholder(s) and their identifying number(s).

Controlling shareholder	Identifying number

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

Name of parent corporation	EIN of parent corporation

- d** Have basis adjustments under section 367(a)(4) been made? Yes No

- 3** If the transferor was a partner in a partnership that was the actual transferor (but is not treated as such under section 367), complete questions 3a through 3d.
- a** List the name and EIN of the transferor's partnership.

Name of partnership	EIN of partnership

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

Part II Transferee Foreign Corporation Information (see instructions)

4 Name of transferee (foreign corporation) FREESTATE HEALTHCARE INSURANCE COMPANY, LTD	5a Identifying number, if any 98-0464065
---	---

6 Address (including country) P.O. BOX 10233 GRAND CAYMAN KY1-1002 CAYMAN ISLANDS	5b Reference ID number
--	-------------------------------

7 Country code of country of incorporation or organization
CJ

8 Foreign law characterization (see instructions)
CORPORATION

- 9** Is the transferee foreign corporation a controlled foreign corporation? Yes No

Part III Information Regarding Transfer of Property (see instructions)

Section A - Cash

Type of property	(a) Date of transfer	(b) Description of property	(c) Fair market value on date of transfer	(d) Cost or other basis	(e) Gain recognized on transfer
Cash			1,007,114.		

10 Was cash the only property transferred? Yes No
 If "Yes," skip the remainder of Part III and go to Part IV.

Section B - Other Property (other than intangible property subject to section 367(d))

Type of property	(a) Date of transfer	(b) Description of property	(c) Fair market value on date of transfer	(d) Cost or other basis	(e) Gain recognized on transfer
Stock and securities					
Inventory					
Other property (not listed under another category)					
Property with built-in loss					
Totals					

11 Did the transferor transfer stock or securities subject to section 367(a) with respect to which a gain recognition agreement was filed? Yes No

12 a Were any assets of a foreign branch (including a branch that is a foreign disregarded entity) transferred to a foreign corporation? Yes No
 If "Yes," go to line 12b.

b Was the transferor a domestic corporation that transferred substantially all of the assets of a foreign branch (including a branch that is a foreign disregarded entity) to a specified 10%-owned foreign corporation? Yes No
 If "Yes," continue to line 12c. If "No," skip lines 12c and 12d, and go to line 13.

c Immediately after the transfer, was the domestic corporation a U.S. shareholder with respect to the transferee foreign corporation? Yes No
 If "Yes," continue to line 12d. If "No," skip line 12d, and go to line 13.

d Enter the transferred loss amount included in gross income as required under section 91 ► \$ _____

13 Did the transferor transfer property described in section 367(d)(4)? Yes No
 If "No," skip Section C and questions 14a through 15.

Section C - Intangible Property Subject to Section 367(d)

Type of property	(a) Date of transfer	(b) Description of property	(c) Useful life	(d) Arm's length price on date of transfer	(e) Cost or other basis	(f) Income inclusion for year of transfer
Property described in sec. 367(d)(4)						
Totals						

- 14 a Did the transferor transfer any intangible property that, at the time of the transfer, had a useful life reasonably anticipated to exceed 20 years? Yes No
- b At the time of the transfer, did any of the transferred intangible property have an indefinite useful life? Yes No
- c Did the transferor choose to apply the 20-year inclusion period provided under Regulations section 1.367(d)-1(c)(3)(ii) for any intangible property? Yes No
- d If the answer to line 14c is "Yes," enter the total estimated anticipated income or cost reduction attributable to the intangible property's, or properties', as applicable, use(s) beyond the 20-year period described in Regulations section 1.367(d)-1(c)(3)(ii) ▶ \$ _____
- 15 Was any intangible property transferred considered or anticipated to be, at the time of the transfer or at any time thereafter, a platform contribution as defined in Regulations section 1.482-7(c)(1)? Yes No

Supplemental Part III Information Required To Be Reported (see instructions)
SEE STATEMENT 7

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

- 16 Enter the transferor's interest in the transferee foreign corporation before and after the transfer.
 (a) Before 20.000 % (b) After 20.000 %
- 17 Type of nonrecognition transaction (see instructions) ▶ IRC SECTION 351
- 18 Indicate whether any transfer reported in Part III is subject to any of the following.
 - a Gain recognition under section 904(f)(3) Yes No
 - b Gain recognition under section 904(f)(5)(F) Yes No
 - c Recapture under section 1503(d) Yes No
 - d Exchange gain under section 987 Yes No
- 19 Did this transfer result from a change in entity classification? Yes No
- 20 a Did a domestic corporation make a distribution of property covered by section 367(e)(2)? (see instructions) Yes No
 If "Yes," complete lines 20b and 20c.
 b Enter the total amount of gain or loss recognized pursuant to Regulations section 1.367(e)-2(b) ▶ \$ _____
 c Did the domestic corporation not recognize gain or loss on the distribution of property because the property was used in the conduct of U.S. trade or business under Regulations section 1.367(e)-2(b)(2)? Yes No
- 21 Did a domestic corporation make a section 355 distribution of stock in a foreign controlled corporation covered by section 367(e)(1)? See instructions Yes No

FREESTATE HEALTHCARE INSURANCE COMPANY, LTD

FOLLOWING IS ADDITIONAL INFORMATION AS REQUESTED BY REGULATIONS 1.6038B-1(C)
AND TEMPORARY REGULATIONS 1.6038B-1T(C)(5) AND 1.6038B-1T(D).

REGULATION 1.6038B-1T(C)(1): TRANSFEROR:

ATLANTIC GENERAL HOSPITAL CORPORATION
EIN: 52-1656507
9733 HEALTHWAY DRIVE
BERLIN, MD 21811

REGULATION 1.6038B-1T(C)(2): TRANSFEREE:

(I.): FREESTATE HEALTHCARE INSURANCE COMPANY, LTD.
EIN: 98-0464065
P.O. BOX 10233
GRAND CAYMAN KY1-1002, CAYMAN ISLANDS

INCORPORATED IN THE CAYMAN ISLANDS

(II.): INSURANCE PREMIUMS RECEIVED FROM RELATED PARTIES CONSIDERED TO BE DEEMED
CONTRIBUTIONS TO CAPITAL OF THE ABOVE CORPORATION OCCURRED ON VARIOUS DATES
THROUGHOUT THE YEAR. THE TOTAL AMOUNT OF THE DEEMED CONTRIBUTIONS WAS
\$1,007,114.

FREESTATE HEALTHCARE INSURANCE COMPANY, LTD

FOLLOWING IS ADDITIONAL INFORMATION AS REQUESTED BY REGULATIONS 1.6038B-1(C)
AND TEMPORARY REGULATIONS 1.6038B-1T(C)(5) AND 1.6038B-1T(D).

REGULATION 1.6038B-1T(C)(1): TRANSFEROR:

ATLANTIC GENERAL HOSPITAL CORPORATION
EIN: 52-1656507
9733 HEALTHWAY DRIVE
BERLIN, MD 21811

REGULATION 1.6038B-1T(C)(2): TRANSFEREE:

(I.): FREESTATE HEALTHCARE INSURANCE COMPANY, LTD.
EIN: 98-0464065
P.O. BOX 10233
GRAND CAYMAN KY1-1002, CAYMAN ISLANDS

INCORPORATED IN THE CAYMAN ISLANDS

(II.): INSURANCE PREMIUMS RECEIVED FROM RELATED PARTIES CONSIDERED TO BE DEEMED
CONTRIBUTIONS TO CAPITAL OF THE ABOVE CORPORATION OCCURRED ON VARIOUS DATES
THROUGHOUT THE YEAR. THE TOTAL AMOUNT OF THE DEEMED CONTRIBUTIONS WAS
\$1,007,114.

FREESTATE HEALTHCARE INSURANCE COMPANY, LTD

REGULATION 1.6038B-1T(C)(3): CONSIDERATION RECEIVED:

NOTHING WAS RECEIVED IN CONSIDERATION IN EXCHANGE FOR DEEMED CASH CONTRIBUTIONS TO CAPITAL OF \$1,007,114. THE TAXPAYER OWNED 20% OF THE STOCK OF THE TRANSFEREE CORPORATION BOTH BEFORE AND AFTER THESE TRANSFERS.

REGULATION 1.6038B-1T(C)(4): PROPERTY TRANSFERRED:

CASH IN THE AMOUNT OF \$1,007,114. (US DOLLARS)

REGULATION 1.6038B-1T(C)(5): TRANSFER OF FOREIGN BRANCH WITH PREVIOUSLY DEDUCTED LOSSES:

NOT APPLICABLE

REGULATION 1.6038B-1T(C)(6): APPLICATION OF IRC 367(A)(5):

NOT APPLICABLE NOT APPLICABLE

FREESTATE HEALTHCARE INSURANCE COMPANY, LTD

STATEMENT PURSUANT TO 1.351-3(A) BY ATLANTIC GENERAL HOSPITAL CORPORATION,
52-1656507, A SIGNIFICANT TRANSFEROR

ATLANTIC GENERAL HOSPITAL CORPORATION, BETWEEN JULY 1, 2019 AND JUNE 30, 2020,
TRANSFERRED CASH WITH AN AGGREGATE FAIR MARKET VALUE AND A BASIS OF \$1,007,114
TO FREESTATE HEALTHCARE INSURANCE COMPANY, LTD., 98-0464065. NO PRIVATE LETTER
RULINGS WERE ISSUED BY THE INTERNAL REVENUE SERVICE IN CONNECTION WITH THE
SECTION 351 EXCHANGE.

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

Department of the Treasury
Internal Revenue Service

▶ **File a separate application for each return.**
▶ **Go to www.irs.gov/Form8868 for the latest information.**

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/e-file-providers/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.

Type or print	Name of exempt organization or other filer, see instructions. ATLANTIC GENERAL HOSPITAL	Taxpayer identification number (TIN) 52-1656507
File by the due date for filing your return. See instructions.	Number, street, and room or suite no. If a P.O. box, see instructions. 9733 HEALTHWAY DRIVE	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. BERLIN, MD 21811	

Enter the Return Code for the return that this application is for (file a separate application for each return) 0 | 1

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 990-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

CHERYL NOTTINGHAM

- The books are in the care of ▶ **9733 HEALTHWAY DRIVE - BERLIN, MD 21811**
Telephone No. ▶ **410-641-9095** 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 TINs of all members the extension is for.

1 I request an automatic 6-month extension of time until **MAY 17, 2021**, to file the exempt organization return for the organization named above. The extension is for the organization's return for:
 ▶ calendar year _____ or
 ▶ tax year beginning **JUL 1, 2019**, and ending **JUN 30, 2020**.

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

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

Caution: If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

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

Department of the Treasury
Internal Revenue Service

▶ **File a separate application for each return.**
▶ **Go to www.irs.gov/Form8868 for the latest information.**

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/e-file-providers/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.

Type or print	Name of exempt organization or other filer, see instructions. ATLANTIC GENERAL HOSPITAL	Taxpayer identification number (TIN) 52-1656507
File by the due date for filing your return. See instructions.	Number, street, and room or suite no. If a P.O. box, see instructions. 9733 HEALTHWAY DRIVE	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. BERLIN, MD 21811	

Enter the Return Code for the return that this application is for (file a separate application for each return) 0 | 7

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

CHERYL NOTTINGHAM

- The books are in the care of ▶ **9733 HEALTHWAY DRIVE - BERLIN, MD 21811**
Telephone No. ▶ **410-641-9095** 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 TINs of all members the extension is for.

1 I request an automatic 6-month extension of time until **MAY 17, 2021**, to file the exempt organization return for the organization named above. The extension is for the organization's return for:
 ▶ calendar year _____ or
 ▶ tax year beginning **JUL 1, 2019**, and ending **JUN 30, 2020**.

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

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

Caution: If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.