

Form **990**

**Return of Organization Exempt From Income Tax**

OMB No. 1545-0047

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

**2017**  
Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

▶ Do not enter social security numbers on this form as it may be made public.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

**A** For the 2017 calendar year, or tax year beginning **JUL 1, 2017** and ending **JUN 30, 2018**

<b>B</b> Check if applicable:  <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C</b> Name of organization <b>UNION HOSPITAL OF CECIL COUNTY, INC.</b> Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite <b>106 BOW STREET</b> City or town, state or province, country, and ZIP or foreign postal code <b>ELKTON, MD 21921-5596</b> <b>F</b> Name and address of principal officer: <b>RICHARD C. SZUMEL, MD</b> <b>SAME AS C ABOVE</b>	<b>D</b> Employer identification number <b>52-0607945</b> <b>E</b> Telephone number <b>(410) 398-4000</b> <b>G</b> Gross receipts \$ <b>173,521,323.</b> <b>H(a)</b> Is this a group return for subordinates? ..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>H(b)</b> Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) <b>H(c)</b> Group exemption number ▶
<b>I</b> Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		
<b>J</b> Website: ▶ <b>WWW.UHCC.COM</b>		
<b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		
		<b>L</b> Year of formation: <b>1903</b>
		<b>M</b> State of legal domicile: <b>MD</b>

**Part I Summary**

	<b>1</b>	Briefly describe the organization's mission or most significant activities: <b>PROVIDE HEALTHCARE SERVICES TO THE RESIDENTS OF CECIL COUNTY, MD, AND THE SURROUNDING AREA.</b>		
	<b>2</b>	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
<b>Activities &amp; Governance</b>	<b>3</b>	Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	<b>15</b>
	<b>4</b>	Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	<b>12</b>
	<b>5</b>	Total number of individuals employed in calendar year 2017 (Part V, line 2a)	<b>5</b>	<b>1375</b>
	<b>6</b>	Total number of volunteers (estimate if necessary)	<b>6</b>	<b>318</b>
	<b>7a</b>	Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	<b>1,720,821.</b>
	<b>7b</b>	Net unrelated business taxable income from Form 990-T, line 34	<b>7b</b>	<b>-522,534.</b>
	<b>Revenue</b>	<b>8</b>	Contributions and grants (Part VIII, line 1h)	<b>Prior Year</b>
<b>9</b>		Program service revenue (Part VIII, line 2g)	760,419.	4,635,791.
<b>10</b>		Investment income (Part VIII, column (A), lines 3, 4, and 7d)	160,117,692.	157,587,785.
<b>11</b>		Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,586,989.	2,311,445.
<b>12</b>		Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	2,691,662.	2,701,917.
<b>12</b>			<b>165,156,762.</b>	<b>167,236,938.</b>
<b>Expenses</b>	<b>13</b>	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	18,197,080.	3,116,525.
	<b>14</b>	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	<b>15</b>	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	83,471,094.	84,855,967.
	<b>16a</b>	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	<b>b</b>	Total fundraising expenses (Part IX, column (D), line 25) ▶	0.	
	<b>17</b>	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	79,119,434.	88,065,377.
	<b>18</b>	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	180,787,608.	176,037,869.
	<b>19</b>	Revenue less expenses. Subtract line 18 from line 12	-15,630,846.	-8,800,931.
<b>Net Assets or Fund Balances</b>	<b>20</b>	Total assets (Part X, line 16)	<b>Beginning of Current Year</b>	<b>End of Year</b>
	<b>21</b>	Total liabilities (Part X, line 26)	173,889,013.	166,082,740.
	<b>22</b>	Net assets or fund balances. Subtract line 21 from line 20	88,038,568.	88,978,017.
	<b>22</b>		85,850,445.	77,104,723.

**Part II Signature Block**

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

<b>Sign Here</b>	Signature of officer <b>JAMES G. RAAB, CHIEF FINANCIAL OFFICER</b> Type or print name and title	Date			
<b>Paid Preparer Use Only</b>	Print/Type preparer's name <b>JULIUS C. GREEN, CPA</b>	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN <b>P00350393</b>
	Firm's name ▶ <b>BAKER TILLY VIRCHOW KRAUSE, LLP</b>	Firm's EIN ▶ <b>39-0859910</b>			
	Firm's address ▶ <b>1650 MARKET STREET, SUITE 4500 PHILADELPHIA, PA 19103-7341</b>	Phone no. <b>215.972.0701</b>			

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: UNION HOSPITAL OF CECIL COUNTY'S MISSION IS TO PROVIDE HEALTHCARE SERVICES TO THE RESIDENTS OF CECIL COUNTY, MARYLAND, WESTERN NEW CASTLE COUNTY, DELAWARE, AND SOUTHERN CHESTER COUNTY, PENNSYLVANIA.

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

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

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

4a (Code: ) (Expenses \$ 171,683,578. including grants of \$ 3,116,525. ) (Revenue \$ 157,587,785. ) UNION HOSPITAL OF CECIL COUNTY'S MISSION IS TO PROVIDE QUALITY HEALTH CARE SERVICES TO THE RESIDENTS OF CECIL COUNTY, MARYLAND AND NEIGHBORING COMMUNITIES. SERVICES ARE PROVIDED WITH MODERN TECHNOLOGY AND COMPASSIONATE CARE FROM HEALTH CARE PROFESSIONALS. SERVICES ARE PROVIDED REGARDLESS OF RACE, GENDER, ETHNICITY, AGE, DISABILITY, RELIGION, OR ABILITY TO PAY. ALTHOUGH REIMBURSEMENT FOR SERVICES RENDERED IS VITALLY IMPORTANT TO THE OPERATION, STABILITY, AND VIABILITY OF UNION HOSPITAL OF CECIL COUNTY, IT IS RECOGNIZED THAT NOT ALL MEMBERS OF THE COMMUNITY ARE IN THE FINANCIAL POSITION TO PURCHASE HEALTH CARE SERVICES. FOR ELIGIBLE INDIVIDUALS, UNION HOSPITAL OF CECIL COUNTY OFFERS FREE AND/OR SUBSIDIZED CARE, AS WELL AS ACCESS TO COMMUNITY FINANCIAL ASSISTANCE. CONTINUED ON SCHEDULE "O"

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

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

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

4e Total program service expenses 171,683,578.

**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> 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> .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>2</b> Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ? .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>3</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>4 Section 501(c)(3) organizations.</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>5</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>6</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>7</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>9</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>10</b> Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V</i> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>11</b> 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.		
<b>a</b> 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> .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>b</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> .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>c</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>d</b> 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> .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i> .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>f</b> 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> .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i> .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>b</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> .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States? .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>b</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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>15</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>16</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>17</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>18</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>19</b> 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> .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**Part IV Checklist of Required Schedules** (continued)

	Yes	No
<b>20a</b> Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> .....	X	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? .....	X	
<b>21</b> 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	
<b>22</b> 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
<b>23</b> 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	
<b>24a</b> 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>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? .....		X
<b>c</b> 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
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? .....		X
<b>25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> 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>b</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
<b>26</b> Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i> .....		X
<b>27</b> Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> .....		X
<b>28</b> 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):		
<b>a</b> A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> .....		X
<b>b</b> A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> .....		X
<b>c</b> An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> .....	X	
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> .....		X
<b>30</b> 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
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> .....		X
<b>32</b> 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
<b>33</b> 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
<b>34</b> 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	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)? .....		X
<b>b</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> .....		
<b>36 Section 501(c)(3) organizations.</b> 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
<b>37</b> 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
<b>38</b> Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O .....	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

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

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

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

**Section A. Governing Body and Management**

		Yes	No
<b>1a</b>	Enter the number of voting members of the governing body at the end of the tax year ..... <b>1a</b> 15 If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.		
<b>b</b>	Enter the number of voting members included in line 1a, above, who are independent ..... <b>1b</b> 12		
<b>2</b>	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
<b>3</b>	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? .....		X
<b>4</b>	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? .....		X
<b>5</b>	Did the organization become aware during the year of a significant diversion of the organization's assets? .....		X
<b>6</b>	Did the organization have members or stockholders? .....	X	
<b>7a</b>	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>b</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	
<b>8</b>	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
<b>a</b>	The governing body? .....	X	
<b>b</b>	Each committee with authority to act on behalf of the governing body? .....	X	
<b>9</b>	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O .....		X

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

		Yes	No
<b>10a</b>	Did the organization have local chapters, branches, or affiliates? .....		X
<b>b</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? .....		
<b>11a</b>	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? .....	X	
<b>b</b>	Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
<b>12a</b>	Did the organization have a written conflict of interest policy? If "No," go to line 13 .....	X	
<b>b</b>	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? .....	X	
<b>c</b>	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done .....	X	
<b>13</b>	Did the organization have a written whistleblower policy? .....	X	
<b>14</b>	Did the organization have a written document retention and destruction policy? .....	X	
<b>15</b>	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?		
<b>a</b>	The organization's CEO, Executive Director, or top management official .....	X	
<b>b</b>	Other officers or key employees of the organization .....	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).		
<b>16a</b>	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>b</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 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
 Own website     Another's website     Upon request     Other (explain in Schedule O)
- 19** Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records: ► DERON G. BROWN, DIRECTOR OF FINANCE - (410) 398-4000  
106 BOW STREET, ELKTON, MD 21921-5596

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) RAYMOND HAMM CHAIRMAN	0.50 0.60	X		X				0.	0.	0.
(2) DWIGHT THOMEY VICE CHAIRMAN/TREASURER	0.50 0.50	X		X				0.	0.	0.
(3) DAVID FERGUSON, PH.D. SECRETARY	0.50 0.60	X		X				0.	0.	0.
(4) RICHARD C. SZUMEL, MD PRESIDENT & CEO	28.00 12.00	X		X				0.	596,750.	114,300.
(5) RONALD GRAYBEAL DIRECTOR	0.50 0.50	X						0.	0.	0.
(6) KELLY ALBANESE BEDDER DIRECTOR	0.50 1.50	X						0.	0.	0.
(7) MARY BOLT, PH.D. DIRECTOR	0.50 0.50	X						0.	0.	0.
(8) CHRISTY DRYER, DNP DIRECTOR	0.50 0.50	X						0.	0.	0.
(9) STEPHANIE GARRITY DIRECTOR	0.50 0.50	X						0.	0.	0.
(10) RYAN GERACIMOS, MD DIRECTOR	0.50 0.50	X						0.	0.	0.
(11) MARTIN J. HEALY DIRECTOR	0.50 0.50	X						0.	0.	0.
(12) JOSE MA, MD DIRECTOR	39.50 0.50	X						310,100.	0.	24,706.
(13) MORGAN MILLER, MLIS DIRECTOR	0.50 0.50	X						0.	0.	0.
(14) CARL ROBERTS, PH.D. DIRECTOR	0.50 0.50	X						0.	0.	0.
(15) SHEELMOHAN SACHDEV, MD DIRECTOR	0.50 0.50	X						0.	0.	0.
(16) JAMES G. RAAB (START 10/17) SENIOR VP/CHIEF FINANCIAL OFFICER	29.00 11.00			X				98,171.	65,981.	24,958.
(17) LAURIE R. BEYER, CPA SENIOR VP/CFO (UNTIL 10/17)	29.00 11.00			X				0.	374,688.	78,355.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) CYDNEY TEAL, MD VP MEDICAL AFFAIRS	39.00 1.00				X			0.	408,612.	23,296.
(19) ANNE LARA SR. VP/CHIEF INNOVATION OFFICER	33.00 7.00				X			0.	238,426.	18,082.
(20) AARON Z. ROYSTON VP OF PROVIDER ENTERPRISE	40.00				X			236,976.	0.	4,380.
(21) KHADIJATU BOSTON (UNTIL 01/18) SR. VP/CHIEF NURSING OFFICER	39.00 1.00				X			0.	253,604.	14,589.
(22) TERRANCE LOVELL (UNTIL 01/18) VP HUMAN RESOURCES	40.00				X			266,241.	0.	78,291.
(23) FAHD RAHMAN PHYSICIAN	40.00					X		596,909.	0.	33,338.
(24) JUSTIN SAUSVILLE PHYSICIAN	40.00					X		542,497.	0.	33,381.
(25) ROGER WU PHYSICIAN	40.00					X		494,050.	0.	23,985.
(26) TARIQ MAHMOOD PHYSICIAN	40.00					X		412,571.	0.	31,112.
<b>1b Sub-total</b>								2,957,515.	1,938,061.	502,773.
<b>c Total from continuation sheets to Part VII, Section A</b>								407,136.	0.	12,319.
<b>d Total (add lines 1b and 1c)</b>								3,364,651.	1,938,061.	515,092.

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 **101**

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
UNION RADIOLOGISTS, LLC 106 BOW STREET, EKLTON, MD 21921	RADIOLOGY SERVICES	3,091,323.
WHITING-TURNER CONTRACTING CO. P.O. BOX 17596, BALTIMORE, MD 21297	CONTRACTOR	2,545,225.
CLEARPATH SOLUTIONS, 2465 CENTREVILLE RD, SUITE J17-722, HERNDON, VA 20171	IT HARDWARE AND SOFTWARE	2,522,178.
MDICS AT UNION CECIL COUNTY, LLC, 7250 PARKWAY DR., STE. 500, HANOVER, MD 21076	PROFESSIONAL STAFFING	2,397,220.
THE NEMOURS FOUNDATION 1600 ROCKLAND RD, WILMINGTON, DE 19803	PROFESSIONAL STAFFING	1,219,416.

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 **117**

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	<b>1 a</b>	Federated campaigns .....	<b>1a</b>					
	<b>b</b>	Membership dues .....	<b>1b</b>					
	<b>c</b>	Fundraising events .....	<b>1c</b>					
	<b>d</b>	Related organizations .....	<b>1d</b>	4,635,791.				
	<b>e</b>	Government grants (contributions) .....	<b>1e</b>					
	<b>f</b>	All other contributions, gifts, grants, and similar amounts not included above .....	<b>1f</b>					
	<b>g</b>	Noncash contributions included in lines 1a-1f: \$ .....						
	<b>h</b>	<b>Total.</b> Add lines 1a-1f .....		4,635,791.				
Program Service Revenue	<b>2 a</b>	NET PATIENT SERVICE REVENUE	Business Code	621990	156,192,399.	156,192,399.		
	<b>b</b>	OTHER OPERATING REVENUE	621990	903,740.	903,740.			
	<b>c</b>	ADULT DAY CARE	623990	491,646.	491,646.			
	<b>d</b>							
	<b>e</b>							
	<b>f</b>	All other program service revenue .....						
	<b>g</b>	<b>Total.</b> Add lines 2a-2f .....		157,587,785.				
Other Revenue	<b>3</b>	Investment income (including dividends, interest, and other similar amounts) .....		1,674,113.		-57,781.	1,731,894.	
	<b>4</b>	Income from investment of tax-exempt bond proceeds .....						
	<b>5</b>	Royalties .....						
	<b>6 a</b>	Gross rents .....	(i) Real	24,336.				
			(ii) Personal					
			Less: rental expenses .....	8,305.				
			Rental income or (loss) .....	16,031.				
	<b>d</b>	Net rental income or (loss) .....		16,031.			16,031.	
	<b>7 a</b>	Gross amount from sales of assets other than inventory .....	(i) Securities	6,700,620.				
			(ii) Other	212,792.				
			Less: cost or other basis and sales expenses .....	5,984,718.	291,362.			
			Gain or (loss) .....	715,902.	-78,570.			
	<b>d</b>	Net gain or (loss) .....		637,332.			637,332.	
	<b>8 a</b>	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 .....	<b>a</b>					
			<b>b</b>	Less: direct expenses .....				
<b>c</b>			Net income or (loss) from fundraising events .....					
<b>9 a</b>	Gross income from gaming activities. See Part IV, line 19 .....	<b>a</b>						
		<b>b</b>	Less: direct expenses .....					
		<b>c</b>	Net income or (loss) from gaming activities .....					
<b>10 a</b>	Gross sales of inventory, less returns and allowances .....	<b>a</b>						
		<b>b</b>	Less: cost of goods sold .....					
		<b>c</b>	Net income or (loss) from sales of inventory .....					
Miscellaneous Revenue			Business Code					
<b>11 a</b>	LABORATORY REVENUE	621500	1,778,602.		1,778,602.			
		<b>b</b>	CAFETERIA/FOOD SERVICE	722210	797,210.		797,210.	
				<b>c</b>	PURCHASE DISCOUNTS	900099	38,674.	
		<b>d</b>	All other revenue .....	900099	71,400.		71,400.	
		<b>e</b>	<b>Total.</b> Add lines 11a-11d .....		2,685,886.			
<b>12</b>	<b>Total revenue.</b> See instructions. ....		167,236,938.	157,587,785.	1,720,821.	3,292,541.		

**Part IX Statement of Functional Expenses**

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	3,116,525.	3,116,525.		
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	1,080,398.	610,828.	469,570.	
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	70,792,597.	70,174,060.	618,537.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	779,432.	753,209.	26,223.	
9 Other employee benefits	7,401,414.	7,360,952.	40,462.	
10 Payroll taxes	4,802,126.	4,747,606.	54,520.	
11 Fees for services (non-employees):				
a Management	1,574,678.	787,339.	787,339.	
b Legal	829,498.		829,498.	
c Accounting	108,660.		108,660.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	59,449.		59,449.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch. O.)	31,519,749.	30,452,394.	1,067,355.	
12 Advertising and promotion	461,803.	461,803.		
13 Office expenses	872,580.	865,417.	7,163.	
14 Information technology	48,800.	48,800.		
15 Royalties				
16 Occupancy	2,992,064.	2,992,064.		
17 Travel	262,772.	242,251.	20,521.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	142,694.	84,766.	57,928.	
20 Interest	2,024,928.	2,024,928.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	11,476,003.	11,476,003.		
23 Insurance	3,314,387.	3,303,570.	10,817.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <b>MEDICAL SUPPLIES</b>	17,626,763.	17,623,460.	3,303.	
b <b>BAD DEBTS</b>	8,807,407.	8,807,407.		
c <b>REPAIRS &amp; MAINTENANCE</b>	2,926,951.	2,926,653.	298.	
d <b>DIETARY</b>	977,531.	971,571.	5,960.	
e All other expenses	2,038,660.	1,851,972.	186,688.	
<b>25 Total functional expenses.</b> Add lines 1 through 24e	<b>176,037,869.</b>	<b>171,683,578.</b>	<b>4,354,291.</b>	<b>0.</b>
<b>26 Joint costs.</b> Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

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

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing .....	5,412,598.	<b>1</b>	3,007,119.
	<b>2</b> Savings and temporary cash investments .....	440,529.	<b>2</b>	162,892.
	<b>3</b> Pledges and grants receivable, net .....		<b>3</b>	
	<b>4</b> Accounts receivable, net .....	17,732,375.	<b>4</b>	16,617,200.
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L .....		<b>5</b>	
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L .....		<b>6</b>	
	<b>7</b> Notes and loans receivable, net .....		<b>7</b>	
	<b>8</b> Inventories for sale or use .....	2,027,595.	<b>8</b>	2,268,203.
	<b>9</b> Prepaid expenses and deferred charges .....	3,231,364.	<b>9</b>	2,136,306.
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....	<b>10a</b> 220,281,891.		
	<b>b</b> Less: accumulated depreciation .....	<b>10b</b> 132,143,595.	89,053,840.	<b>10c</b> 88,138,296.
	<b>11</b> Investments - publicly traded securities .....	33,159,205.	<b>11</b>	31,440,920.
	<b>12</b> Investments - other securities. See Part IV, line 11 .....	13,259,622.	<b>12</b>	13,873,382.
	<b>13</b> Investments - program-related. See Part IV, line 11 .....		<b>13</b>	
	<b>14</b> Intangible assets .....		<b>14</b>	
	<b>15</b> Other assets. See Part IV, line 11 .....	9,571,885.	<b>15</b>	8,438,422.
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) .....	173,889,013.	<b>16</b>	166,082,740.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses .....	9,657,225.	<b>17</b>	14,591,487.
	<b>18</b> Grants payable .....		<b>18</b>	
	<b>19</b> Deferred revenue .....		<b>19</b>	
	<b>20</b> Tax-exempt bond liabilities .....	61,640,225.	<b>20</b>	59,181,386.
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D .....		<b>21</b>	
	<b>22</b> Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L .....		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties .....		<b>23</b>	
	<b>24</b> Unsecured notes and loans payable to unrelated third parties .....		<b>24</b>	
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D .....	16,741,118.	<b>25</b>	15,205,144.
	<b>26 Total liabilities.</b> Add lines 17 through 25 .....	88,038,568.	<b>26</b>	88,978,017.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets .....	83,405,073.	<b>27</b>	74,557,561.
	<b>28</b> Temporarily restricted net assets .....	2,445,372.	<b>28</b>	2,547,162.
	<b>29</b> Permanently restricted net assets .....		<b>29</b>	
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds .....		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building, or equipment fund .....		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds .....		<b>32</b>	
<b>33</b> Total net assets or fund balances .....	85,850,445.	<b>33</b>	77,104,723.	
<b>34</b> Total liabilities and net assets/fund balances .....	173,889,013.	<b>34</b>	166,082,740.	

**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	167,236,938.
2	Total expenses (must equal Part IX, column (A), line 25)	2	176,037,869.
3	Revenue less expenses. Subtract line 2 from line 1	3	-8,800,931.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	85,850,445.
5	Net unrealized gains (losses) on investments	5	745,063.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-689,854.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	77,104,723.

**Part XII Financial Statements and Reporting**

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

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

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

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

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

▶ Attach to Form 990 or Form 990-EZ.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2017**

**Open to Public Inspection**

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

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

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

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

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

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

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

**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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>4 Total.</b> Add lines 1 through 3 .....						
<b>5</b> 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) .....						
<b>6 Public support.</b> Subtract line 5 from line 4.						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
<b>7</b> Amounts from line 4 .....						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources .....						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on .....						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions) .....					12	
<b>13 First five years.</b> 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 <b>stop here</b> .....						<input type="checkbox"/>

**Section C. Computation of Public Support Percentage**

<b>14</b> Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) .....	14	%
<b>15</b> Public support percentage from 2016 Schedule A, Part II, line 14 .....	15	%
<b>16a 33 1/3% support test - 2017.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>b 33 1/3% support test - 2016.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>17a 10% -facts-and-circumstances test - 2017.</b> 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 <b>stop here.</b> 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>b 10% -facts-and-circumstances test - 2016.</b> 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 <b>stop here.</b> 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>18 Private foundation.</b> 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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> 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 .....						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 .....						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>6 Total.</b> Add lines 1 through 5 .....						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons .....						
<b>b</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 .....						
<b>c</b> Add lines 7a and 7b .....						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
<b>9</b> Amounts from line 6 .....						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources .....						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 .....						
<b>c</b> Add lines 10a and 10b .....						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on .....						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....						
<b>13 Total support.</b> (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**

<b>15</b> Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f)) .....	<b>15</b>	%
<b>16</b> Public support percentage from 2016 Schedule A, Part III, line 15 .....	<b>16</b>	%

**Section D. Computation of Investment Income Percentage**

<b>17</b> Investment income percentage for 2017 (line 10c, column (f) divided by line 13, column (f)) .....	<b>17</b>	%
<b>18</b> Investment income percentage from 2016 Schedule A, Part III, line 17 .....	<b>18</b>	%

**19a 33 1/3% support tests - 2017.** 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 - 2016.** 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
<b>1</b> 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>		
<b>2</b> 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>		
<b>3a</b> 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>b</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>		
<b>c</b> 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>		
<b>4a</b> 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>b</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>		
<b>c</b> 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>		
<b>5a</b> 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>b Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
<b>c Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?		
<b>6</b> 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>		
<b>7</b> Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
<b>8</b> 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>		
<b>9a</b> 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>b</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>		
<b>c</b> 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>		
<b>10a</b> 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>b</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
<b>11</b> Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b> 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>b</b> A family member of a person described in (a) above?		
<b>c</b> 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
<b>1</b> 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>		
<b>2</b> 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
<b>1</b> 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
<b>1</b> 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?		
<b>2</b> 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>		
<b>3</b> 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**

<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).		
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
<b>2</b> Activities Test. Answer (a) and (b) below.		
<b>a</b> 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>b</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>		
<b>3</b> Parent of Supported Organizations. Answer (a) and (b) below.		
<b>a</b> 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>b</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.

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

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

<b>Section C - Distributable Amount</b>		(A) Prior Year	Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<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)

<b>Section D - Distributions</b>	<b>Current Year</b>
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	
<b>4</b> Amounts paid to acquire exempt-use assets	
<b>5</b> Qualified set-aside amounts (prior IRS approval required)	
<b>6</b> Other distributions (describe in <b>Part VI</b> ). See instructions.	
<b>7 Total annual distributions.</b> Add lines 1 through 6.	
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive (provide details in <b>Part VI</b> ). See instructions.	
<b>9</b> Distributable amount for 2017 from Section C, line 6	
<b>10</b> Line 8 amount divided by line 9 amount	

<b>Section E - Distribution Allocations (see instructions)</b>	<b>(i) Excess Distributions</b>	<b>(ii) Underdistributions Pre-2017</b>	<b>(iii) Distributable Amount for 2017</b>
<b>1</b> Distributable amount for 2017 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2017 (reasonable cause required- explain in <b>Part VI</b> ). See instructions.			
<b>3</b> Excess distributions carryover, if any, to 2017			
<b>a</b>			
<b>b</b> From 2013			
<b>c</b> From 2014			
<b>d</b> From 2015			
<b>e</b> From 2016			
<b>f Total</b> of lines 3a through e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2017 distributable amount			
<b>i</b> Carryover from 2012 not applied (see instructions)			
<b>j</b> Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
<b>4</b> Distributions for 2017 from Section D, line 7: \$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2017 distributable amount			
<b>c</b> Remainder. Subtract lines 4a and 4b from 4.			
<b>5</b> Remaining underdistributions for years prior to 2017, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in <b>Part VI</b> . See instructions.			
<b>6</b> Remaining underdistributions for 2017. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in <b>Part VI</b> . See instructions.			
<b>7 Excess distributions carryover to 2018.</b> Add lines 3j and 4c.			
<b>8</b> Breakdown of line 7:			
<b>a</b> Excess from 2013			
<b>b</b> Excess from 2014			
<b>c</b> Excess from 2015			
<b>d</b> Excess from 2016			
<b>e</b> Excess from 2017			



**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](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2017**

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

501(c)( 3 ) (enter number) organization

4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

4947(a)(1) nonexempt charitable trust treated as a private foundation

501(c)(3) taxable private foundation

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

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

**General Rule**

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

**Special Rules**

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

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

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. 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).

LHA For Paperwork Reduction Act Notice, see the instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2017)

Name of organization <b>UNION HOSPITAL OF CECIL COUNTY, INC.</b>	Employer identification number <b>52-0607945</b>
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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	<b>AFFINITY HEALTH ALLIANCE, INC.</b>  106 BOW STREET  ELKTON, MD 21921	\$ 4,000,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	<b>UNION HOSPITAL OF CECIL COUNTY FOUNDATION</b>  106 BOW STREET  ELKTON, MD 21921	\$ 635,791.	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  <b>UNION HOSPITAL OF CECIL COUNTY, INC.</b>	Employer identification number  <b>52-0607945</b>
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**Part II Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

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



Name of organization  <b>UNION HOSPITAL OF CECIL COUNTY, INC.</b>	Employer identification number  <b>52-0607945</b>
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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
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
<b>(e) Transfer of gift</b>			
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

2017

Open to Public Inspection

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

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

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include total number at end of year, aggregate value of contributions, grants, and end of year, and two yes/no questions about donor property and grant fund usage.

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

Form with multiple questions (1-9) regarding conservation easements, including checkboxes for various purposes, a table for tracking easements (2a-2d), and yes/no questions about monitoring and reporting.

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

Form with questions (1a-1b, 2a-2b) regarding reporting requirements for art and historical treasures, including revenue and asset amounts.

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

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

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

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

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

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

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment  \_\_\_\_\_ %
  - b Permanent endowment  \_\_\_\_\_ %
  - c Temporarily restricted endowment  \_\_\_\_\_ %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- |   | Yes    | No |
|---|--------|----|
| (i) unrelated organizations   | 3a(i)  |    |
| (ii) related organizations  | 3a(ii) |    |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? <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		1,134,905.		1,134,905.
b Buildings		83,950,443.	38,950,148.	45,000,295.
c Leasehold improvements		2,384,742.	461,579.	1,923,163.
d Equipment		126,515,264.	90,873,030.	35,642,234.
e Other		6,296,537.	1,858,838.	4,437,699.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				88,138,296.

**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	5,609,265.	COST
(3) Other		
(A) MANAGED HEDGE FUNDS	4,820,001.	COST
(B) MANAGED HEDGE FUNDS	3,444,116.	END-OF-YEAR MARKET VALUE
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
<b>Total.</b> (Col. (b) must equal Form 990, Part X, col. (B) line 12.)	13,873,382.	

**Part VIII Investments - Program Related.**

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

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

**Part IX Other Assets.**

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

(a) Description	(b) Book value
(1) OTHER ASSETS	596,370.
(2) LOAN ISSUANCE COSTS	451,542.
(3) INSURANCE CLAIMS RECEIVABLE	6,692,333.
(4) DUE FROM AFFILIATES	698,177.
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.)	8,438,422.

**Part X Other Liabilities.**

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) THIRD PARTY ADVANCES	3,964,220.
(3) CAPITAL LEASE OBLIGATIONS	3,075,968.
(4) ESTIMATED MEDICAL MALPRACTICE	
(5) CLAIMS LIABILITY	7,903,134.
(6) DUE TO AFFILIATES	261,822.
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.)	15,205,144.

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

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

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

<b>1</b>	Total revenue, gains, and other support per audited financial statements		<b>1</b>	155,878,722.
<b>2</b>	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
<b>a</b>	Net unrealized gains (losses) on investments	<b>2a</b>	745,063.	
<b>b</b>	Donated services and use of facilities	<b>2b</b>		
<b>c</b>	Recoveries of prior year grants	<b>2c</b>		
<b>d</b>	Other (Describe in Part XIII.)	<b>2d</b>	-12,103,279.	
<b>e</b>	Add lines <b>2a</b> through <b>2d</b>	<b>2e</b>		-11,358,216.
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b>		<b>3</b>	167,236,938.
<b>4</b>	Amounts included on Form 990, Part VIII, line 12, but not on line 1:			
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b	<b>4a</b>		
<b>b</b>	Other (Describe in Part XIII.)	<b>4b</b>		
<b>c</b>	Add lines <b>4a</b> and <b>4b</b>	<b>4c</b>		0.
<b>5</b>	Total revenue. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 12.)		<b>5</b>	167,236,938.

**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.

<b>1</b>	Total expenses and losses per audited financial statements		<b>1</b>	164,624,444.
<b>2</b>	Amounts included on line 1 but not on Form 990, Part IX, line 25:			
<b>a</b>	Donated services and use of facilities	<b>2a</b>		
<b>b</b>	Prior year adjustments	<b>2b</b>		
<b>c</b>	Other losses	<b>2c</b>		
<b>d</b>	Other (Describe in Part XIII.)	<b>2d</b>	569,956.	
<b>e</b>	Add lines <b>2a</b> through <b>2d</b>	<b>2e</b>		569,956.
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b>		<b>3</b>	164,054,488.
<b>4</b>	Amounts included on Form 990, Part IX, line 25, but not on line 1:			
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b	<b>4a</b>		
<b>b</b>	Other (Describe in Part XIII.)	<b>4b</b>	11,983,381.	
<b>c</b>	Add lines <b>4a</b> and <b>4b</b>	<b>4c</b>		11,983,381.
<b>5</b>	Total expenses. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 18.)		<b>5</b>	176,037,869.

**Part XIII Supplemental Information.**

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

**PART X, LINE 2:**

THE HOSPITAL ACCOUNTS FOR UNCERTAINTY IN INCOME TAXES BY PRESCRIBING A RECOGNITION THRESHOLD OF MORE-LIKELY-THAN-NOT TO BE SUSTAINED UPON EXAMINATION BY THE APPROPRIATE TAXING AUTHORITY. MEASUREMENT OF THE TAX UNCERTAINTY OCCURS IF THE RECOGNITION THRESHOLD HAS BEEN MET. THERE WERE NO TAX UNCERTAINTIES THAT MET THE RECOGNITION THRESHOLD IN 2018 AND 2017.

**PART XI, LINE 2D - OTHER ADJUSTMENTS:**

PROVISION FOR BAD DEBTS NETTED AGAINST REVENUE ON F/S	-8,807,407.
BANK FEES NETTED AGAINST REVENUE ON F/S	-59,449.
CHANGE IN NET ASSETS OF AFFILIATES	-119,898.
TRANSFER TO AFFILIATES NETTED AGAINST REVENUE ON F/S	-3,116,525.

**Part XIII** Supplemental Information (continued)

TOTAL TO SCHEDULE D, PART XI, LINE 2D -12,103,279.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

IMPAIRMENT LOSS 569,956.

PART XII, LINE 4B - OTHER ADJUSTMENTS:

PROVISION FOR BAD DEBTS NETTED AGAINST REVENUE ON F/S 8,807,407.

BANK FEES NETTED AGAINST REVENUE ON F/S 59,449.

TRANSFER TO AFFILIATES NETTED AGAINST REVENUE ON F/S 3,116,525.

TOTAL TO SCHEDULE D, PART XII, LINE 4B 11,983,381.

**SCHEDULE H  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Hospitals**

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

OMB No. 1545-0047

**2017**

Open to Public Inspection

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

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

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
<b>b</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 type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
<b>c</b> If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<input checked="" type="checkbox"/>	
<b>5a</b> 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>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<input checked="" type="checkbox"/>	
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		<input checked="" type="checkbox"/>
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
<b>b</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
<b>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1)			1822394.	0.	1822394.	1.09%
<b>b</b> Medicaid (from Worksheet 3, column a)			0.	0.		
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)			0.	0.		
<b>d Total</b> Financial Assistance and Means-Tested Government Programs			1822394.		1822394.	1.09%
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)		3,860	522,199.	0.	522,199.	.31%
<b>f</b> Health professions education (from Worksheet 5)		259	295,641.	0.	295,641.	.18%
<b>g</b> Subsidized health services (from Worksheet 6)		124	10914203.	5659706.	5254497.	3.14%
<b>h</b> Research (from Worksheet 7)		0	7,568.	0.	7,568.	.00%
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)		28,628	348,071.	162,403.	185,668.	.11%
<b>j Total.</b> Other Benefits		32,871	12087682.	5822109.	6265573.	3.74%
<b>k Total.</b> Add lines 7d and 7j		32,871	13910076.	5822109.	8087967.	4.83%

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing	0		0.	0.		
2 Economic development	0		14,634.	0.	14,634.	.01%
3 Community support	73		10,850.	0.	10,850.	.01%
4 Environmental improvements	0		0.	0.		
5 Leadership development and training for community members	20		1,998.	0.	1,998.	.00%
6 Coalition building	0		0.	0.		
7 Community health improvement advocacy	0		0.	0.		
8 Workforce development	157		26,202.	0.	26,202.	.02%
9 Other	0		0.	0.		
<b>10 Total</b>	<b>250</b>		<b>53,684.</b>		<b>53,684.</b>	<b>.04%</b>

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

**Section A. Bad Debt Expense**

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2   7,248,496.		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3   198,884.		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME)	5   59,050,100.
6 Enter Medicare allowable costs of care relating to payments on line 5	6   59,050,100.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other	

**Section C. Collection Practices**

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

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

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



Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

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

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

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

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

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

	Yes	No
<b>Community Health Needs Assessment</b>		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? .....	1	X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C .....	2	X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 .....	3	X
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <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>15</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 .....	5	X
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C .....	6a	X
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C .....	6b	X
7 Did the hospital facility make its CHNA report widely available to the public? .....	7	X
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>HTTPS://WWW.UHCC.COM/ABOUT-US/COMMUNITY-B</u>		
b <input checked="" type="checkbox"/> Other website (list url): <u>HTTP://CECILCOUNTYHEALTH.ORG/ABOUT/COMMUNITY-HE</u>		
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 .....	8	X
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>16</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? .....	10	X
a If "Yes," (list url): <u>HTTPS://WWW.UHCC.COM/ABOUT-US/COMMUNITY-BENEFIT/REPO</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? .....	12a	X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

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

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....	<b>X</b>	
If "Yes," indicate the eligibility criteria explained in the FAP:		
<b>a</b> <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>b</b> <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b> <input checked="" type="checkbox"/> Asset level		
<b>d</b> <input checked="" type="checkbox"/> Medical indigency		
<b>e</b> <input checked="" type="checkbox"/> Insurance status		
<b>f</b> <input checked="" type="checkbox"/> Underinsurance status		
<b>g</b> <input checked="" type="checkbox"/> Residency		
<b>h</b> <input type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients? .....	<b>X</b>	
<b>15</b> Explained the method for applying for financial assistance? .....	<b>X</b>	
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):		
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</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		
<b>c</b> <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		
<b>d</b> <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b> <input type="checkbox"/> Other (describe in Section C)		
<b>16</b> Was widely publicized within the community served by the hospital facility? .....	<b>X</b>	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b> <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)		
<b>f</b> <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)		
<b>g</b> <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		
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b> <input checked="" type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

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

	Yes	No
<b>17</b> 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? .....	<b>X</b>	
<b>18</b> 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		
<b>19</b> 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? .....		<b>X</b>
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)		
<b>20</b> 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 b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> 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? .....	<b>X</b>	
If "No," indicate why:		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)		

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

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

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

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

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

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

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 5: PLANNING THE CHNA OCCURRED FROM FEBRUARY 2015 - JUNE 2015. THE CHNA/CHIP WAS APPROVED BY BOTH THE UNION HOSPITAL BOARD (FEBRUARY 2015) AND THE COMMUNITY HEALTH ADVISORY COMMITTEE (CHAC) (JULY 2015). PRIMARY DATA COLLECTION OCCURRED FROM JULY 2015 - SEPTEMBER 2015 VIA THREE FOCUS GROUPS AND ADMINISTRATION OF AN ONLINE COMMUNITY SURVEY. SECONDARY DATA WAS TAKEN FROM A VARIETY OF RELIABLE NATIONAL AND LOCAL DATA SOURCES. ANALYSIS OF PRIMARY AND SECONDARY DATA COLLECTED OCCURRED FROM NOVEMBER 2015 THROUGH MID-JANUARY 2016.

A) FOCUS GROUPS:

THE THREE FOCUS GROUPS WERE CONDUCTED WITH ADULT POPULATIONS WITHOUT ACCESS TO THE INTERNET TO TAKE THE ONLINE SURVEY (HOMELESS, SENIORS, AND SPANISH-SPEAKING MIGRANT WORKERS). EACH FOCUS GROUP SESSION INCLUDED A DESCRIPTION OF THE CHNA, THE PURPOSE OF THE FOCUS GROUP, AN INTRODUCTION OF THE FACILITATORS, AND THE RULES OF ENGAGEMENT. ALL MATERIALS WERE TRANSLATED INTO SPANISH FOR THE FOCUS GROUP WITH MIGRANT, SPANISH-SPEAKING WORKERS, AND A SPANISH INTERPRETER WAS PROVIDED BY THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE. PARTICIPANTS WERE ASKED TO RESPOND TO THE FOLLOWING QUESTIONS:

- 1) WHAT ARE THE GREATEST STRENGTHS OF OUR COMMUNITY?
- 2) WHAT DO YOU THINK ARE THE MOST IMPORTANT HEALTH ISSUES IN CECIL COUNTY?
- 3) WHAT WOULD MOST IMPROVE THE QUALITY OF LIFE IN CECIL COUNTY?
- 4) WHAT ARE THE MOST SIGNIFICANT BARRIERS TO ACCESSING HEALTH CARE IN CECIL COUNTY?
- 5) RELATED TO HEALTH AND QUALITY OF LIFE, WHAT RESOURCES OR SERVICES DO

**Part V Facility Information** (continued)

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

YOU THINK ARE MISSING IN CECIL COUNTY?

B) ONLINE COMMUNITY SURVEY:

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

C) CHAC MEETINGS:

INPUT FROM COMMUNITY PARTNERS ENGAGED IN CECIL COUNTY'S CHAC MEETINGS, ALSO KNOWN AS THE LOCAL HEALTH IMPROVEMENT COALITION, WAS INTEGRAL TO THE PROCESS OF SELECTING THE HEALTH PRIORITIES FOR THE COUNTY AND CREATING THE CHIP. CHAC MEMBER ORGANIZATIONS THAT PARTICIPATED IN THE PRIORITIZATION AND STRATEGIC PLANNING PROCESSES INCLUDED:

AFFILIATED SANTE GROUP (MOBILE CRISIS), AMERICAN CANCER SOCIETY, CECIL COUNTY DEPT OF EMERGENCY SERVICES, CECIL COUNTY DEPT OF JUVENILE SERVICES, CECIL COUNTY DEPT OF SOCIAL SERVICES, CECIL COUNTY DIRECTOR OF ADMINISTRATION, CECIL COUNTY EXECUTIVE OFFICE, CECIL COUNTY HEALTH DEPT., CECIL COUNTY LIQUOR BOARD, CECIL COUNTY PUBLIC SCHOOLS, CECIL COUNTY SHERIFF'S OFFICE, COUNTY COUNCIL MEMBERS, DHMH - OFFICE OF POPULATION HEALTH IMPROVEMENT, CECIL COLLEGE, CECIL COUNTY DEPT OF COMMUNITY SERVICES, CECIL COUNTY DEPT OF CORRECTIONS, CECIL COUNTY HOUSING, DEEP ROOTS, ELKTON COMMUNITY KITCHEN, ELKTON POLICE DEPARTMENT, ELKTON

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

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

PRESBYTERIAN CHURCH, ELKTON HOUSING AUTHORITY, MARYLAND STATE DELEGATES, MARYLAND STATE SENATORS, MEADOW WOOD BEHAVIORAL HEALTH SYSTEM, PRIVATE CITIZENS, PRIVATE EDUCATION ORGANIZATIONS, PRIVATE HEALTH CARE PROFESSIONALS, SEVENTH DAY ADVENTIST CHURCH, UNION HOSPITAL OF CECIL COUNTY, UPPER BAY COUNSELING & SUPPORT SERVICES, WEST CECIL HEALTH CENTER, YOUTH EMPOWERMENT SOURCE, IMMACULATE CONCEPTION MEETING GROUND, ON OUR OWN OF CECIL COUNTY, PARIS FOUNDATION, SERENITY HEALTH, STONE RUN FAMILY MEDICINE, WIN FAMILY SERVICES, & YMCA.

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

UNION HOSPITAL OF CECIL COUNTY, INC.:

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



**Part V Facility Information** (continued)

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

**ASSESSMENT.**

UNION HOSPITAL OF CECIL COUNTY, INC.:

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

- 1. BEHAVIORAL HEALTH
- 2. CHRONIC DISEASE
- 3. DETERMINANTS OF HEALTH

BEHAVIORAL HEALTH

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

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

STRATEGIES:

- 1) CONTINUE TO PROVIDE NARCAN TRAINING TO LAW ENFORCEMENT OFFICERS AND THE PUBLIC
- 2) PROVIDE EDUCATION AT PHARMACIES AND PHYSICIANS' OFFICES ON PRESCRIPTION DRUG ABUSE AND NARCAN TRAINING
- 3) ADVOCATE FOR THE DEVELOPMENT OF MORE TREATMENT OPTIONS FOR ADULTS AND ADOLESCENTS IN THE COUNTY
- 4) PARTNER WITH PROVIDERS TO INCREASE THE UTILIZATION OF EXISTING SERVICES
- 5) WORK WITH THE SCHOOL SYSTEM TO REACH AT-RISK ADOLESCENTS
- 6) INCREASE PARTICIPATION IN PREVENTION AND EDUCATION PROGRAMS SUCH AS "MY FAMILY MATTERS" AND "STRENGTHENING FAMILIES"
- 7) PROVIDE INCENTIVES FOR ATTENDING PROGRAMS

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

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

8) PROMOTE THE CREATION OF EDUCATIONAL MESSAGES FOCUSING ON PREVENTION

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

REVIEW TEAM (LOFRT)

OBJECTIVE: BY JUNE 30, 2019 REDUCE THE PERCENTAGE OF YOUTH IN GRADES 9-12

REPORTING THE USE OF ALCOHOL ON ONE OR MORE OF THE PAST 30 DAYS TO NO MORE

THAN 33.8%

STRATEGIES:

1) PARTNER WITH MARYLAND STRATEGIC PREVENTION FRAMEWORK 2 (MSPF2) TO

IMPLEMENT STRATEGIES IDENTIFIED THROUGH A NEEDS ASSESSMENT

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

PUBLIC SCHOOLS

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

OBJECTIVE: BY JUNE 30, 2019, REDUCE THE PERCENTAGE OF YOUTH IN GRADES 9-12

WHO FELT SAD OR HOPELESS ALMOST EVERY DAY FOR TWO WEEKS OR MORE DURING THE

PAST 12 MONTHS TO NO MORE THAN 24.8%

STRATEGIES:

1) PROMOTE DEPRESSION SCREENING DURING WELLNESS CHECKUPS

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

3) PROMOTE BEHAVIORAL HEALTH INTEGRATION IN PEDIATRIC PRIMARY CARE

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

5%.

STRATEGIES:

1) PROMOTE THE AVAILABILITY OF CRISIS AND SUICIDE HOTLINES

2) CONTINUE TO SUPPORT, PROMOTE THE UTILIZATION OF, AND EXPAND MOBILE

CRISIS SERVICES IN CECIL COUNTY

3) PROMOTE REGULAR SCREENING FOR DEPRESSION DURING PRIMARY CARE PROVIDER

VISITS

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

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

**4) PROMOTE MENTAL HEALTH FIRST AID (MHFA) TRAINING****GOAL: IMPROVE ACCESS TO BEHAVIORAL HEALTH SERVICES IN CECIL COUNTY****OBJECTIVE: BY JUNE 30, 2019, DECREASE THE RATE OF EMERGENCY DEPARTMENT****VISITS RELATED TO MENTAL HEALTH CONDITIONS BY 10% AND EMERGENCY DEPARTMENT****VISITS RELATED TO SUBSTANCE USE DISORDERS BY 5%****STRATEGIES:**

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

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

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

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

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

**6) PARTNER IN THE DEVELOPMENT OF A REGIONAL CRISIS CENTER**

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

**8) CONTINUE TO HOLD MONTHLY ER DIVERSION MEETINGS FOR CHRONIC DISEASE**

**GOAL: REDUCE THE MORBIDITY OF DIABETES IN CECIL COUNTY****OBJECTIVE: BY JUNE 30, 2019, INCREASE PHYSICIAN PRACTICE SITES MAKING****REFERRALS TO CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS BY 2 SITES****STRATEGIES:**

**1) ENGAGE 2 PHYSICIAN PRACTICE SITES TO PARTICIPATE**

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

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

**2) TRACK THE NUMBER OF REFERRALS MADE**

**OBJECTIVE: BY JUNE 30, 2019, INCREASE THE NUMBER OF SITES HOSTING CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS BY 5 SITES**

**STRATEGIES:**

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

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

**STRATEGIES:**

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

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

**GOAL: REDUCE MORTALITY FROM LUNG CANCER IN CECIL COUNTY**

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

**STRATEGIES:**

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

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

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

**STRATEGIES:**

**1) PROMOTE COMMUNITY SMOKING CESSATION**

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

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

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

**AND PREVENTION RESOURCES****3) SUPPORT RECOMMENDATIONS OF THE CECIL COUNTY TOBACCO TASK FORCE**

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

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

**STRATEGIES:**

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

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

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

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

**STRATEGIES:**

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

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

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

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

**OBJECTIVES**

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

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

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

**SMALL BUSINESS****STRATEGIES:**

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

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

**DETERMINANTS OF HEALTH**

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

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

**STRATEGIES:**

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

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

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

4) INVESTIGATE CARROLL COUNTY'S PROGRAM MODEL

5) REVIEW ALL OPTIONS AS A GROUP

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

OBJECTIVE: BY JUNE 2018, EXPAND SERVICES AND INTERVENTIONS FOR HOMELESS

INDIVIDUALS/FAMILIES TO DECREASE PREVALENCE OF HOMELESSNESS IN CECIL

COUNTY BY 10%. SERVICES/INTERVENTIONS WILL BE BASED ON THREE TIERS, INCLUDING 1) EMERGENCY/IMMEDIATE ASSISTANCE, 2) INTERMEDIATE/SHORT-TERM

ASSISTANCE, 3) LONGER-TERM ASSISTANCE GEARED TOWARD THOSE EXPERIENCING

CHRONIC HOMELESSNESS.

**STRATEGIES:**

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

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

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

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

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

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

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

6) ESTABLISH LIASIONS BETWEEN LAW ENFORCEMENT AND PROVIDER AGENCIES

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

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

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 13B: PATIENTS WITH A HOUSEHOLD INCOME UP TO 500% OF FPL AND WITH A FINANCIAL HARDSHIP (MEDICAL DEBT, INCURRED BY A FAMILY OVER A 12-MONTH PERIOD THAT EXCEEDS 25 PERCENT OF THE FAMILY INCOME) WILL RECEIVE A 25% ADJUSTMENT.

UNION HOSPITAL OF CECIL COUNTY, INC.

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

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

PART V, LINE 16A, FAP WEBSITE:

[HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/](https://www.uhcc.com/patient-financial-services/financial-assistance/)

UNION HOSPITAL OF CECIL COUNTY, INC.

PART V, LINE 16B, FAP APPLICATION WEBSITE:

[HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/](https://www.uhcc.com/patient-financial-services/financial-assistance/)

UNION HOSPITAL OF CECIL COUNTY, INC.

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

[HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/](https://www.uhcc.com/patient-financial-services/financial-assistance/)

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 16J: UNION HOSPITAL PLACES AN ADVERTISEMENT ONCE A YEAR IN THE LOCAL NEWSPAPERS OUTLINING THE FAP AND HOW TO APPLY. FAP IS PUBLICIZED ON ALL BILLING STATEMENTS, INVOICES, AND FINANCIAL CONSENT FORMS.FAP IS COMMUNICATED TO PATIENTS UPON DISCHARGE FROM INPATIENT, OBSERVATION, OR SURGICAL SERVICES.





**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.

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**PART I, LINE 7:**

ALL INFORMATION IS BASED ON ACTUAL COST PLUS OVERHEAD. OVERHEAD IS A HOSPITAL AVERAGE PERCENTAGE OF OVERHEAD TO DIRECT COSTS. DIRECT COSTS EXCLUDE BAD DEBT EXPENSE.

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**PART I, LN 7 COL(F):**

THE AMOUNT OF BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25 BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS \$8,807,407.

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**PART II, COMMUNITY BUILDING ACTIVITIES:**

**A) ECONOMIC DEVELOPMENT (F2):-**

IN FISCAL YEAR 2018, UNION HOSPITAL SUPPORTED THE FOLLOWING ECONOMIC DEVELOPMENT ORGANIZATIONS IN CECIL COUNTY THROUGH BOARD SERVICE BY EXECUTIVE MANAGEMENT STAFF:

- 1) ECONOMIC DEVELOPMENT COMMISSION FOR CECIL COUNTY. THIS COMMISSION PROMOTES ECONOMIC DEVELOPMENT IN CECIL COUNTY, FOCUSING ON BUSINESS AND INDUSTRY DEVELOPMENT, BY BUILDING RELATIONSHIPS WITH LOCAL PARTNERS. UNION

**Part VI** Supplemental Information (Continuation)

HOSPITAL COLLABORATES WITH THIS COMMISSION TO PROMOTE STABILITY WITHIN THE HOSPITAL'S WORKFORCE AND TO BRING MUCH NEEDED PRACTITIONERS TO THE AREA, ESPECIALLY WHERE THERE ARE TOO FEW PROVIDERS OR IDENTIFIED SERVICE GAPS.

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

3) CECIL COUNTY SCHOOL EMPLOYEES FEDERAL CREDIT UNION BOARD. THE CREDIT UNION'S BOARD PROMOTES FINANCIAL LITERACY AND EDUCATION FOR ITS MEMBERS AND FOR LOCAL ELEMENTARY SCHOOL STUDENTS, WHICH CONTRIBUTES TO REDUCING FINANCIAL BARRIERS THAT CAN BE EXACERBATED BY SOCIAL DETERMINANTS OF HEALTH. REDUCING THE BARRIERS EXACERBATED BY THE SOCIAL DETERMINANTS OF HEALTH IS ALSO A PART OF HEALTH LITERACY WHICH UNION HOSPITAL SUPPORTS AND PROMOTES INSIDE AND OUTSIDE ITS FOUR WALLS.

B) COMMUNITY SUPPORT (F3):-

IN FISCAL YEAR 2018, UNION HOSPITAL SUPPORTED THE FOLLOWING COMMUNITY ORGANIZATIONS THROUGH BOARD SERVICE AND CAMPAIGN PLANNING IN CECIL COUNTY:

1) UNITED WAY OF CECIL COUNTY. THE UNITED WAY OF CECIL COUNTY BRINGS TOGETHER VOLUNTEERS FROM GOVERNMENT, BUSINESSES, FAITH GROUPS, NONPROFITS, AND CITIZENS IN ORDER TO IMPROVE PEOPLE'S LIVES. WITH AN ANNUAL CAMPAIGN EACH FALL, UNITED WAY OF CECIL COUNTY IS ABLE TO FUND PROGRAMS THAT ADDRESS CRITICAL NEEDS IN THE COMMUNITY SURROUNDING CHILDREN AND FAMILIES, HEALTH AND WELLNESS, AND INDEPENDENT LIVING. UNION HOSPITAL SUPPORTS THE UNITED WAY BY PLANNING AND FACILITATING A HOSPITAL-WIDE ANNUAL GIVING

**Part VI** Supplemental Information (Continuation)

## CAMPAIGN.

2) LOCAL MANAGEMENT BOARD OF CECIL COUNTY. THE CORE FUNCTION OF LOCAL MANAGEMENT BOARDS (LMBS) IS TO IDENTIFY PRIORITIES AND TARGET RESOURCES FOR THEIR COMMUNITIES, AS WELL AS SERVE AS THE COORDINATOR OF COLLABORATION FOR CHILD AND FAMILY SERVICES. LMBS BRING TOGETHER LOCAL CHILD-SERVING AGENCIES, LOCAL CHILD PROVIDERS, CLIENTS OF SERVICES, FAMILIES, AND OTHER COMMUNITY REPRESENTATIVES TO EMPOWER LOCAL STAKEHOLDERS TO ADDRESS THE NEEDS OF AND SET PRIORITIES FOR THEIR COMMUNITIES. THERE IS A LOCAL MANAGEMENT BOARD IN EACH COUNTY IN MARYLAND, INCLUDING BALTIMORE CITY. UNION HOSPITAL'S EXECUTIVE MANAGEMENT STAFF SERVES ON CECIL COUNTY'S LOCAL MANAGEMENT BOARD TO PROVIDE INSIGHT ON THE CONNECTION BETWEEN HOSPITAL SERVICES/POPULATION HEALTH INITIATIVES AND SUPPORT FOR COMMUNITY DIRECTIVES/STRATEGIC PRIORITIES.

3) RELAY FOR LIFE PLANNING. HOSPITAL STAFF PARTICIPATES WITH LOCAL CHAPTERS OF RELAY FOR LIFE TO HELP PLAN EVENTS TO SUPPORT CANCER SURVIVORS AND ACCESS TO CANCER TREATMENT, AS WELL AS CREATE AWARENESS AROUND CANCER AND ITS PREVENTION.

4) BEREAVEMENT SUPPORT. UNION HOSPITAL ESTABLISHED BEREAVEMENT SUPPORTS FOR PEOPLE, ACROSS THE AGE CONTINUUM, IN THE COMMUNITY AFFECTED BY GRIEF AND LOSS. AN EXAMPLE INCLUDES: THE BEREAVEMENT MEMORIAL SERVICE WHICH OCCURS ANNUALLY AND IS OPEN TO PATIENTS, THEIR FAMILIES, AND THE COMMUNITY AFFECTED BY GRIEF AND LOSS OF INFANTS. MATERNAL AND INFANT CENTER NURSING STAFF ARE AVAILABLE AT THE MEMORIAL TO ANSWER QUESTIONS AND TALK THROUGH ISSUES/CONCERNS. THE SERVICE INCLUDES A TREE LIGHTING AND A BALLOON AIR LIFT AS A MEMORIAL TO LOST LOVED ONES.

C) LEADERSHIP DEVELOPMENT AND TRAINING FOR COMMUNITY MEMBERS (F5):-  
IN FISCAL YEAR 2018, UNION HOSPITAL SUPPORTED THE FOLLOWING LEADERSHIP

**Part VI** Supplemental Information (Continuation)

## DEVELOPMENT AND TRAINING EFFORT IN CECIL COUNTY:

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

## D) WORKFORCE DEVELOPMENT (F8):-

IN FISCAL YEAR 2018, UNION HOSPITAL SUPPORTED THE FOLLOWING WORKFORCE DEVELOPMENT PROGRAMS/ENTITIES IN CECIL COUNTY:

1) BUSINESS AND EDUCATION PARTNERSHIP ADVISORY COUNCIL (BEPAC). BEPAC IDENTIFIES STRENGTHS, NEEDS, AND TRENDS IN JOB READINESS & STUDENT SUCCESS UPON HIGH SCHOOL GRADUATION. BEPAC MEMBERS DEVELOP AND SUSTAIN PARTNERSHIPS WITH AREA PUBLIC SCHOOLS. UNION HOSPITAL'S AFFINITY HEALTH INSTITUTE (THE CLINICAL EDUCATION DEPARTMENT) STAFF IS A MEMBER OF BEPAC AND THE HOSPITAL'S PARTNER IN EDUCATION IS GILPIN MANOR ELEMENTARY SCHOOL (GMES). WORK DONE WITH GMES IS REPORTED IN CATEGORY A4.

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

3) HIGH SCHOOL WORK ENRICHMENT PROGRAM. UNION HOSPITAL FOOD SERVICES STAFF MENTORED 97 DEVELOPMENTALLY DISABLED HIGH SCHOOL STUDENTS FROM ELKTON HIGH

**Part VI** Supplemental Information (Continuation)

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

## PART III, LINE 2:

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

## PART III, LINE 3:

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

## PART III, LINE 4:

PATIENT ACCOUNTS RECEIVABLE ARE REPORTED AT NET REALIZABLE VALUE. ACCOUNTS ARE WRITTEN OFF WHEN THEY ARE DETERMINED TO BE UNCOLLECTIBLE BASED UPON MANAGEMENT'S ASSESSMENT OF INDIVIDUAL ACCOUNTS. IN EVALUATING THE COLLECTABILITY OF PATIENT ACCOUNTS RECEIVABLE, THE HOSPITAL ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF

**Part VI** Supplemental Information (Continuation)

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

THE HOSPITAL'S SELF-PAY ACCOUNT WRITEOFFS (NET OF RECOVERIES) INCREASED FROM APPROXIMATELY \$5,423,000 IN 2017 TO APPROXIMATELY \$6,100,000 IN 2018. THE INCREASE WAS THE RESULT OF THE AVAILABILITY OF HIGHER DEDUCTIBLE INSURANCE PLANS THROUGH MARYLAND'S HEALTHCARE EXCHANGE EFFECTIVE JANUARY 1, 2014 OFFSET BY A CHANGE IN THE CHARITY CARE POLICY IN JUNE 2016 WHICH RESULTED IN AN INCREASE IN PATIENTS QUALIFYING FOR CHARITY CARE. THE HOSPITAL HAS NOT CHANGED THEIR FINANCIAL ASSISTANCE POLICY IN 2018.

PART III, LINE 8:

COSTING METHODOLOGY USED TO DETERMINE AMOUNT OF MEDICARE ALLOWABLE COSTS: MEDICARE ALLOWABLE COSTS EQUAL MEDICARE REVENUE ADJUSTED FOR THE HOSPITAL TOTAL RATIO OF PATIENT CARE COSTS TO CHARGES DUE TO THE FACT THAT MEDICARE PAYS FULL CHARGES IN MARYLAND.

**Part VI** Supplemental Information (Continuation)

EXTENT TO WHICH MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT:  
IN THE STATE OF MARYLAND, MEDICARE PAYS FULL CHARGES. THERE IS NO  
SHORTFALL THAT SHOULD BE TREATED AS A COMMUNITY BENEFIT.

## PART III, LINE 9B:

THE POLICY'S SECTION LABELED, "INTERNAL COLLECTION EFFORTS," STATES THAT A  
"PATIENT MAY ALSO APPLY FOR FINANCIAL ASSISTANCE AT ANY TIME DURING THIS  
PROCESS (COLLECTIONS)" AND THEN THE FINANCIAL ASSISTANCE POLICY (F-415) IS  
REFERENCED FOR MORE INFORMATION. THE SECTION IN F-415 THAT DESCRIBES THE  
COLLECTION PROCESS IS CALLED "ACTION IN THE EVENT OF NON-PAYMENT": "A.)  
UNION HOSPITAL MAY CONTRACT WITH OUTSIDE COLLECTION SERVICES TO PURSUE  
COLLECTION OF DELINQUENT ACCOUNTS. ALL UNPAID ACCOUNTS WITHOUT EXCEPTION  
OR PAYMENT ARRANGEMENTS ARE PLACED IN OUTSIDE COLLECTION AFTER A MINIMUM  
OF 90 DAYS FROM THE INITIAL BILLING STATEMENT AND DELIVERY OF ALL  
SCHEDULED PATIENT ACCOUNT STATEMENTS TO THE PATIENT/GUARANTOR. B.) UNION  
HOSPITAL DOES NOT CONDUCT, OR PERMIT COLLECTION AGENCIES TO CONDUCT ON  
THEIR BEHALF, EXTRAORDINARY COLLECTIONS EFFORTS AGAINST INDIVIDUALS."

IN ADDITION, THE POLICY F-416 UNDER THE SECTION, "EXTERNAL COLLECTION (BAD  
DEBT WRITE-OFF)," EXPLAINS THAT "PATIENTS WITH BALANCES BEING COLLECTED BY  
AN ASSIGNED COLLECTION AGENCY WILL HAVE THEIR BALANCES WRITTEN OFF IF THEY  
ARE DETERMINED TO BE INDIGENT".

## PART VI, LINE 2:

THE CHNA REFLECTS THE CURRENT STATUS OF THE MEDICAL AND SOCIAL  
DETERMINANTS OF HEALTH FOR CECIL COUNTY AND PROVIDES QUALITATIVE FEEDBACK  
ON KEY HEALTH ISSUES. THE CHNA IS COMPRISED OF AN ANALYSIS OF BOTH PRIMARY



**Part VI** Supplemental Information (Continuation)

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

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

PART VI, LINE 3:

UNION HOSPITAL OF CECIL COUNTY UTILIZES A FINANCIAL ASSISTANCE POLICY (FAP) TO ENSURE THAT THE HOSPITAL'S STAFF FOLLOWS A CONSISTENT AND EQUITABLE PROCESS IN GRANTING FINANCIAL ASSISTANCE TO PATIENTS, WHILE RESPECTING THE INDIVIDUAL'S DIGNITY. THE POLICY IS IN AGREEMENT WITH THE ESTABLISHED MARYLAND STATE FINANCIAL ASSISTANCE GUIDELINES. IN FACT, IN FISCAL YEAR 2015, UNION HOSPITAL'S FINANCE DEPARTMENT DIVISIONS OF MANAGED CARE, REVENUE CYCLE, AND BILLING BEGAN WORKING ON CHANGES TO THE FAP TO REFLECT THE ACA'S HEALTH CARE COVERAGE EXPANSION OPTION EFFECTIVE JANUARY 1, 2014. THE RESULTING REVISED FAP IS MORE COMPREHENSIVE IN THAT IT INCLUDES MORE DESCRIPTIONS, PATIENT EXPECTATIONS, AND CONTENT THAT IS EASY TO FOLLOW AND DIGEST. NEW SECTIONS THAT GIVE THE FAP MORE DEPTH INCLUDE:

**Part VI** Supplemental Information (Continuation)

DEFINITIONS, SCOPE, PRESUMPTIVE ELIGIBILITY, ELIGIBILITY PERIOD,  
RECONSIDERATION OF DENIAL OF FREE OR REDUCED-COST CARE, MEDICAL DEBT  
DETERMINATION (LIMIT ON CHARGES), ACTION IN THE EVENT OF NON-PAYMENT,  
ENSURING COMPLIANCE, PLAIN LANGUAGE SUMMARY, AND REFERENCES.

THE FAP CLEARLY DEFINES PATIENT EXPECTATIONS, OFFERS A STEP-BY-STEP  
PROCESS FOR PATIENT APPLICATION, DOCUMENT REVIEW, AND REQUEST FOR MORE  
INFORMATION. ANY INDIVIDUAL WHO PRESENTS TO UNION HOSPITAL IN PERSON TO  
DISCUSS HIS/HER BILL IS PROVIDED WITH A FINANCIAL ASSISTANCE APPLICATION.  
ALL INPATIENT, SELF-PAY PATIENTS ARE VISITED BY FINANCIAL ASSISTANCE  
NAVIGATORS AND ARE SCREENED FOR THE FINANCIAL ASSISTANCE PROGRAM, AS WELL  
AS FOR MEDICAID AND OTHER STATE AND COUNTY PROGRAMS. FOLLOWING DISCHARGE  
FROM THE HOSPITAL, EACH PATIENT RECEIVES A SUMMARY OF CHARGES WHICH  
INCLUDES NOTICE OF THE FINANCIAL ASSISTANCE PROGRAM AND A DESIGNATED  
CONTACT TELEPHONE NUMBER AND EMAIL. PATIENT BILLING ALSO INCLUDES  
INFORMATION ON HOW TO APPLY FOR FINANCIAL ASSISTANCE.

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

FINANCIAL ASSISTANCE APPLICATIONS AND FAP SIGNAGE ARE LOCATED THROUGHOUT  
THE HOSPITAL, EMERGENCY ROOM, AND OUTPATIENT AREAS. THE FINANCIAL  
ASSISTANCE APPLICATION AND BROCHURE (ENGLISH AND SPANISH) ARE AVAILABLE ON  
THE HOSPITAL'S WEBSITE:

**Part VI** Supplemental Information (Continuation)

[HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/](https://www.uhcc.com/patient-financial-services/financial-assistance/). IN ADDITION, UNION HOSPITAL PLACES AN ADVERTISEMENT ONCE A YEAR IN THE LOCAL NEWSPAPERS OUTLINING THE FAP, HOW TO ACCESS FINANCIAL ASSISTANCE MATERIALS, AND HOW TO APPLY FOR FINANCIAL ASSISTANCE.

## PART VI, LINE 4:

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

A MAJORITY OF UNION HOSPITAL'S COMMUNITY BENEFIT RESOURCES ARE FOCUSED WITHIN ELKTON (21921) AND NORTH EAST (21901) HOSPITAL UTILIZATION SHOWS THAT 60% OF THE HOSPITAL'S PATIENTS COME FROM ELKTON AND NORTH EAST.

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

**Part VI** Supplemental Information (Continuation)

THE ESTIMATED TOTAL POPULATION OF CECIL COUNTY IN 2017 WAS 102,175 PEOPLE. OF THE TOTAL COUNTY POPULATION, 50.5% WAS FEMALE AND 49.5% WAS MALE. THE MEDIAN AGE WAS 40.2 YEARS, AND THE MEDIAN HOUSEHOLD INCOME WAS \$67,938.

THE ETHNIC MAKE-UP OF THE COUNTY WAS 4% HISPANIC/LATINO AND 96% NON-HISPANIC/LATINO. THE RACIAL MAKE-UP OF THE COUNTY WAS:

- WHITE: 88.6%
- AFRICAN AMERICAN: 6.7%
- AMERICAN INDIAN/ALASKAN NATIVE: 0.2%
- ASIAN: 1.3%
- NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER: 0%
- SOME OTHER RACE: 0.9%
- TWO OR MORE RACES: 2.1%

ADDITIONAL CECIL COUNTY DEMOGRAPHIC ESTIMATES FOR 2017 INCLUDED:

- 6.6% UNEMPLOYMENT
- 7.3% OF FAMILIES LIVED BELOW THE POVERTY LEVEL
- OF THE CIVILIAN, NON-INSTITUTIONALIZED POPULATION, 7% WAS UNINSURED AND 93% HAD INSURANCE COVERAGE
- OF THOSE WITH HEALTH INSURANCE COVERAGE, 32.4% HAD PUBLIC COVERAGE (EX. MEDICAID) AND 72.5% WERE PRIVATELY INSURED

PART VI, LINE 5:

EACH FISCAL YEAR, UNION HOSPITAL SERVES THE CECIL COUNTY COMMUNITY BY PROVIDING ACTIVITIES, PROGRAMS, AND INITIATIVES THAT AIM TO IMPROVE COMMUNITY HEALTH, ESPECIALLY SERVING UNDERSERVED AREAS AND VULNERABLE POPULATIONS. THE FOLLOWING IS A SUMMARY OF THE COMMUNITY BENEFIT ACTIVITIES, PROGRAMS, AND INITIATIVES THAT UNION HOSPITAL PROVIDED IN

**Part VI** Supplemental Information (Continuation)

CECIL COUNTY DURING FISCAL YEAR 2018:

A1: COMMUNITY HEALTH EDUCATION

UNION HOSPITAL PROVIDED:

- A VARIETY OF HEALTH EDUCATION PRESENTATIONS AND ACTIVITIES IN THE COMMUNITY
- FREE BASIC LIFE SUPPORT INSTRUCTION IN THE COMMUNITY
- EXPLORER POST AT UNION HOSPITAL AND CAMP SCRUBS FOR HIGH SCHOOL STUDENTS SEEKING EXPOSURE TO MEDICAL OR HEALTH SCIENCE EXPERIENCES
- SUPPORT GROUPS FOR VARIOUS HEALTH NEEDS
- HEALTH FAIRS IN THE COMMUNITY
- HEALTH LITERACY ACTIVITIES IN PARTNERSHIP WITH CECIL COUNTY PUBLIC LIBRARIES AND THE CECIL COUNTY HEALTH DEPARTMENT

A2: COMMUNITY-BASED CLINICAL SERVICES

UNION HOSPITAL PROVIDED:

- A FREE DIABETES CLINIC IN PARTNERSHIP WITH CECIL COUNTY PUBLIC LIBRARIES IN ORDER TO CONNECT CLIENTS WITH EDUCATION AND SUPPORT FOR PREVENTION AND MANAGEMENT OF PRE-DIABETES AND DIABETES, AS WELL AS NUTRITION COUNSELING
- FREE SCREENINGS IN THE COMMUNITY FOR PROSTATE AND HEAD AND NECK CANCERS
- FREE SPORTS PHYSICALS CLINIC FOR COUNTY PUBLIC AND PRIVATE HIGH SCHOOL STUDENTS

A3: HEALTH CARE SUPPORT SERVICES

UNION HOSPITAL PROVIDED:

- MEDICAL EXAMINATIONS FOR ABUSED CHILDREN IN CONJUNCTION WITH DEPARTMENT OF SOCIAL SERVICES AND THE CECIL COUNTY CHILD ADVOCACY CENTER
- RENTAL RELIEF AND OPERATIONAL EXPENSE RELIEF FOR THE PERRYVILLE DENTAL

**Part VI** Supplemental Information (Continuation)

CLINIC (SERVES UNDERSERVED DENTAL NEEDS IN CECIL COUNTY)

- A PARTNERSHIP EFFORT WITH THE CECIL COUNTY HEALTH DEPARTMENT TO PROVIDE INTERVENTIONAL SUPPORT TO REDUCE FALLS INSIDE AND OUTSIDE THE HOSPITAL VIA PATIENT CONNECTION TO COMMUNITY HEALTH RESOURCES

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

- SUPPORT FOR THE PEER RECOVERY ADVOCATE PROGRAM, A PARTNERSHIP BETWEEN THE ALCOHOL AND DRUG RECOVERY CENTER AT THE CECIL COUNTY HEALTH DEPARTMENT AND UNION HOSPITAL'S EMERGENCY DEPARTMENT AND PSYCH UNIT AND CRISIS INTERVENTION SERVICES NURSING STAFF

- SUPPORT FOR TOBACCO CESSATION EFFORTS PROVIDED BY THE CECIL COUNTY HEALTH DEPARTMENT

A4: SOCIAL AND ENVIRONMENTAL IMPROVEMENTS

UNION HOSPITAL:

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

- PROVIDED TRANSPORTATION DONATIONS FOR ELIGIBLE PATIENTS AND THEIR FAMILIES

- SUPPORTED CECIL CARES' COUNTY-WIDE "DAY OF CARING" VIA PLANNING MEETINGS

- SUPPORTED A CHRISTMAS IN APRIL EVENT TO PROVIDE HOUSING IMPROVEMENTS FOR A VULNERABLE CECIL COUNTY RESIDENT

- SUPPORTED HABITAT-FOR-HUMANITY SUSQUEHANNA THROUGH BUILD DAYS AND OTHER VOLUNTEER SUPPORT

- PARTICIPATED IN BOARD SERVICE WITH ORGANIZATIONS SUPPORTING SOCIAL AND ENVIRONMENTAL HEALTH

- PROVIDED TRANSPORTATION DONATIONS FOR ELIGIBLE PATIENTS AND THEIR

**Part VI** Supplemental Information (Continuation)

## FAMILIES

## B: HEALTH PROFESSIONS EDUCATION

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

## C: MISSION DRIVEN HEALTH SERVICES

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

- A FREE OSTOMY CLINIC (C3)
- EMPLOYED PHYSICIAN PRACTICE SUBSIDIES (C3)
- ADULT DAY SERVICES FOR OLDER ADULT CLIENTS WITH DEMENTIA AND OTHER NEUROLOGICAL DISORDERS (C7)
- FREE HOSPICE SUPPORT (C9)

## D1: CLINICAL RESEARCH

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

## E1-3: FINANCIAL/IN-KIND CONTRIBUTIONS

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

- PROVIDING FREE AMBULANCE TRANSPORTS AND FREE SUPPLIES FOR AMBULANCE STOCK-UPS
- GIVING BLOOD AT HOSPITAL BLOOD DRIVES AND OTHER LOCAL DONOR LOCATIONS
- PROVIDING VOLUNTEER MEDICAL DIRECTORSHIP FOR THE CECIL COUNTY PREGNANCY

**Part VI** Supplemental Information (Continuation)

## CENTER

- COORDINATING EDUCATIONAL LECTURES AT THE HOSPITAL OPEN TO EMERGENCY SERVICES PERSONNEL AND HOSPITAL EMERGENCY DEPARTMENT STAFF FOCUSED ON IMPROVING EMERGENCY RESPONSE IN THE COMMUNITY
- ATTENDING MEETINGS FOR COMMUNITY HEALTH IMPROVEMENT (LOCAL HEALTH IMPROVEMENT COALITION, COMMUNITY BOARDS, ETC.)
- SERVING AND EDUCATING THE HOMELESS
- PROVIDING FOOD FOR MINISTRIES IN PARTNERSHIP WITH LOCAL COMMUNITY AGENCIES, CHURCHES, AND OTHER LOW-INCOME AND POOR SERVING MINISTRIES
- PROVIDING FOOD FOR THE HOME DELIVERED MEALS (MEALS ON WHEELS) PROGRAM IN A PARTNERSHIP BETWEEN UNION HOSPITAL'S FOOD SERVICE DEPARTMENT AND THE CECIL COUNTY DEPARTMENT OF COMMUNITY SERVICES' AGING AND DISABILITY RESOURCE CENTER AND COMMUNITY WELLNESS DIVISION
- PROVIDING FREE NOTARY SERVICES FOR THE COMMUNITY

## J: FOUNDATION FUNDED COMMUNITY BENEFIT

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

## PART VI, LINE 6:

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



**Part VI** Supplemental Information (Continuation)

MEDICAL, HUMAN AND RELATED SERVICE NEEDS OF THE COMMUNITY.

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

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

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

UNION HOSPITAL OF CECIL COUNTY ONCOLOGY, INC'S (THE "CORPORATION") DUTY AND MISSION IS TO PROVIDE HIGH QUALITY, ADVANCED RADIATION ONCOLOGY SERVICES TO THE CECIL COUNTY AREA IN ORDER TO FOSTER THE BEST CANCER TREATMENT PROCESS CLOSE TO HOME. CANCER-RELATED DEATHS ARE AMONG THE HIGHEST CAUSES OF MORTALITY IN CECIL COUNTY, SO IT IS THE CORPORATION'S MISSION TO BRING SOME OF THE MOST ADVANCED RADIATION THERAPIES TO CECIL COUNTY TO PROVIDE THE MOST COMPREHENSIVE CANCER CARE POSSIBLE TO THE PEOPLE LIVING WITH CANCER HERE AND IN NEIGHBORING COMMUNITIES. BY OFFERING THESE ADVANCED CANCER TREATMENT OPTIONS, THE CORPORATION FURTHERS ITS CHARITABLE PURPOSE OF PROVIDING MEDICAL SERVICES TO PROMOTE THE HEALTH AND WELFARE OF THE RESIDENTS OF CECIL COUNTY AND NEIGHBORING COMMUNITIES.

**Part VI** Supplemental Information (Continuation)

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

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

MD

**SCHEDULE I  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

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

▶ **Attach to Form 990.**

▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.**

OMB No. 1545-0047

**2017**

**Open to Public  
Inspection**

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

**Part I General Information on Grants and Assistance**

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

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

<b>1 (a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section (if applicable)	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of noncash assistance	<b>(h)</b> Purpose of grant or assistance
UNION HOSPITAL OF CECIL COUNTY HEALTH SERVICES, INC. - 106 BOW STREET - ELKTON, MD 21921	52-1794553	501(C)(3)	2,094,180.	0.	N/A	N/A	CHARITABLE ACTIVITIES
UNION HOSPITAL OF CECIL COUNTY ONCOLOGY, INC. - 106 BOW STREET - ELKTON, MD 21921	81-2662359	501(C)(3)	931,648.	0.	N/A	N/A	CHARITABLE ACTIVITIES
UNION HOSPITAL OF CECIL COUNTY FOUNDATION, INC. - 106 BOW STREET - ELKTON, MD 21921	52-1794552	501(C)(3)	90,697.	0.	N/A	N/A	CHARITABLE ACTIVITIES

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

**3** Enter total number of other organizations listed in the line 1 table ..... ▶ **0.**

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

Schedule I (Form 990) (2017)

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

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

**Part IV Supplemental Information.** Provide the information required in Part I, line 2; Part III, column (b); and any other additional information.

PART I, LINE 2:

THE ORGANIZATION ONLY PROVIDES ASSISTANCE TO ITS AFFILIATED ENTITIES. IT DOES NOT PROVIDE GRANTS TO OTHER ORGANIZATIONS. USE OF FUNDS IS MONITORED BY MANAGEMENT.

**SCHEDULE J  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Compensation Information**

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

OMB No. 1545-0047

**2017**

Open to Public Inspection

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

**Part I Questions Regarding Compensation**

	Yes	No
<b>1a</b> 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"/> Travel for companions <input type="checkbox"/> Tax indemnification and gross-up payments <input type="checkbox"/> Discretionary spending account <input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (such as, maid, chauffeur, chef)		
<b>b</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 .....	<b>1b</b>	
<b>2</b> 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? .....	<b>2</b>	
<b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. <input checked="" type="checkbox"/> Compensation committee <input checked="" type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations <input type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <input checked="" type="checkbox"/> Approval by the board or compensation committee		
<b>4</b> 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:		
<b>a</b> Receive a severance payment or change-of-control payment? .....	<b>4a</b>	X
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan? .....	<b>4b</b>	X
<b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? .....	<b>4c</b>	X
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.		
<b>Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>		
<b>5</b> 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:		
<b>a</b> The organization? .....	<b>5a</b>	X
<b>b</b> Any related organization? .....	<b>5b</b>	X
If "Yes" on line 5a or 5b, describe in Part III.		
<b>6</b> 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:		
<b>a</b> The organization? .....	<b>6a</b>	X
<b>b</b> Any related organization? .....	<b>6b</b>	X
If "Yes" on line 6a or 6b, describe in Part III.		
<b>7</b> 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 .....	<b>7</b>	X
<b>8</b> 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 .....	<b>8</b>	X
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? .....	<b>9</b>	

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

Schedule J (Form 990) 2017

**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) RICHARD C. SZUMEL, MD PRESIDENT & CEO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	456,750.	0.	140,000.	86,783.	27,517.	711,050.	0.
(2) JOSE MA, MD DIRECTOR	(i)	310,100.	0.	0.	3,618.	21,088.	334,806.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) JAMES G. RAAB (START 10/17) SENIOR VP/CHIEF FINANCIAL OFFICER	(i)	91,691.	5,291.	1,189.	1,536.	17,920.	117,627.	0.
	(ii)	50,568.	0.	15,413.	779.	4,723.	71,483.	0.
(4) LAURIE R. BEYER, CPA SENIOR VP/CFO (UNTIL 10/17)	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	246,387.	75,991.	52,310.	52,960.	25,395.	453,043.	0.
(5) CYDNEY TEAL, MD VP MEDICAL AFFAIRS	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	316,333.	62,656.	29,623.	4,050.	19,246.	431,908.	0.
(6) ANNE LARA SR. VP/CHIEF INNOVATION OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	189,032.	30,289.	19,105.	2,032.	16,050.	256,508.	0.
(7) AARON Z. ROYSTON VP OF PROVIDER ENTERPRISE	(i)	188,125.	31,500.	17,351.	3,294.	1,086.	241,356.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) KHADIJATU BOSTON (UNTIL 01/18) SR. VP/CHIEF NURSING OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	202,258.	34,488.	16,858.	3,591.	10,998.	268,193.	0.
(9) TERRANCE LOVELL (UNTIL 01/18) VP HUMAN RESOURCES	(i)	209,538.	36,723.	19,980.	50,121.	28,170.	344,532.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) FAHD RAHMAN PHYSICIAN	(i)	342,869.	193,500.	60,540.	4,050.	29,288.	630,247.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) JUSTIN SAUSVILLE PHYSICIAN	(i)	368,448.	142,127.	31,922.	4,050.	29,331.	575,878.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) ROGER WU PHYSICIAN	(i)	435,755.	45,220.	13,075.	4,050.	19,935.	518,035.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) TARIQ MAHMOOD PHYSICIAN	(i)	258,939.	148,160.	5,472.	2,790.	28,322.	443,683.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) DANIELLE PRESS PHYSICIAN	(i)	365,439.	25,750.	15,947.	3,338.	8,981.	419,455.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							

**Part III** Supplemental Information

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

**PART I, LINES 4A-B:**

TERRENCE LOVELL, VP HUMAN RESOURCES, AND KHADIJATU BOSTON, SENIOR VP /  
CHIEF NURSING OFFICER RECEIVED SEVERANCE PAYMENTS DURING CALENDAR YEAR  
2018.

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

LAURIE BEYER, SENIOR VP/CFO  
TERRENCE LOVELL, VP HUMAN RESOURCES

THE FOLLOWING PAYMENTS HAVE BEEN CONTRIBUTED TO THE PLAN EACH CALENDAR YEAR  
SINCE 2011:

12/31/2011 - \$51,431 (LAURIE BEYER)  
12/31/2012 - \$54,576 (LAURIE BEYER)  
12/31/2013 - \$59,861 (LAURIE BEYER)  
12/31/2014 - \$62,999 (LAURIE BEYER)  
12/31/2015 - \$56,574 (LAURIE BEYER)

**Part III Supplemental Information**

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

12/31/2016 - \$65,921 (LAURIE BEYER)

12/31/2017 - \$48,910 (LAURIE BEYER)

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

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

12/31/2016 - \$45,317 (TERRANCE LOVELL)

12/31/2017 - \$46,281 (TERRANCE LOVELL)

NO ONE RECEIVED A PAYMENT FROM THE PLAN IN CALENDAR YEAR 2017.

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

PART I, LINE 7:

A PORTION OF THE BONUSES AND MERIT INCREASE ARE TIED TO THE ORGANIZATIONAL  
GOALS, SUCH AS PATIENT SATISFACTION, QUALITY, EMPLOYEE TURNOVER, ETC.



**Part III Supplemental Information**

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

A PORTION OF THE BONUSES AND MERIT INCREASE ARE ALSO TIED TO EXPENSES PER  
EQUIVALENT INPATIENT DAYS OF UNION HOSPITAL OF CECIL COUNTY.

**Supplemental Information on Tax-Exempt Bonds**

ENTITY 1

OMB No. 1545-0047

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

**2017**  
**Open to Public**  
**Inspection**

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

<b>Part I Bond Issues</b>											
(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
<b>A</b> MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AUT	52-0936091	NONE	12/01/14	30778000.	SEE PART VI		X		X		X
<b>B</b> TOWN OF ELKTON	52-6000790	NONE	05/18/12	10000000.	SEE PART VI		X		X		X
<b>C</b> TOWN OF ELKTON	52-6000790	NONE	05/18/12	8,662,336.	SEE PART VI		X		X		X
<b>D</b> TOWN OF ELKTON	52-6000790	NONE	05/18/12	9,000,000.	SEE PART VI		X		X		X

<b>Part II Proceeds</b>									
	A		B		C		D		
<b>1</b> Amount of bonds retired	420,000.		1,922,012.		3,216,314.				
<b>2</b> Amount of bonds legally defeased									
<b>3</b> Total proceeds of issue	30,778,000.		10,000,000.		8,662,336.		9,000,000.		
<b>4</b> Gross proceeds in reserve funds									
<b>5</b> Capitalized interest from proceeds									
<b>6</b> Proceeds in refunding escrows									
<b>7</b> Issuance costs from proceeds									
<b>8</b> Credit enhancement from proceeds									
<b>9</b> Working capital expenditures from proceeds									
<b>10</b> Capital expenditures from proceeds									
<b>11</b> Other spent proceeds	30,778,000.		10,000,000.		8,662,336.		9,000,000.		
<b>12</b> Other unspent proceeds									
<b>13</b> Year of substantial completion	2014		2012		2012		2012		
	Yes	No	Yes	No	Yes	No	Yes	No	
<b>14</b> Were the bonds issued as part of a current refunding issue?	X		X		X		X		
<b>15</b> Were the bonds issued as part of an advance refunding issue?		X		X		X		X	
<b>16</b> Has the final allocation of proceeds been made?	X		X		X		X		
<b>17</b> Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X		

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

**Supplemental Information on Tax-Exempt Bonds**

ENTITY 2

OMB No. 1545-0047

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

**2017**  
**Open to Public Inspection**

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

<b>Part I Bond Issues</b>											
(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
<b>A</b> MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AUT	52-0936091	NONE	07/18/12	9,924,000.	SEE PART VI		X		X		X
<b>B</b> MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AUT	52-0936091	NONE	07/18/12	4,007,000.	SEE PART VI		X		X		X
<b>C</b>											
<b>D</b>											

<b>Part II Proceeds</b>									
	A		B		C		D		
<b>1</b> Amount of bonds retired	5,594,216.		2,085,922.						
<b>2</b> Amount of bonds legally defeased									
<b>3</b> Total proceeds of issue	9,924,000.		4,007,000.						
<b>4</b> Gross proceeds in reserve funds									
<b>5</b> Capitalized interest from proceeds									
<b>6</b> Proceeds in refunding escrows									
<b>7</b> Issuance costs from proceeds									
<b>8</b> Credit enhancement from proceeds									
<b>9</b> Working capital expenditures from proceeds									
<b>10</b> Capital expenditures from proceeds			4,007,000.						
<b>11</b> Other spent proceeds	9,924,000.								
<b>12</b> Other unspent proceeds									
<b>13</b> Year of substantial completion	2012		2012						
	Yes	No	Yes	No	Yes	No	Yes	No	
<b>14</b> Were the bonds issued as part of a current refunding issue?	X		X						
<b>15</b> Were the bonds issued as part of an advance refunding issue?		X		X					
<b>16</b> Has the final allocation of proceeds been made?	X		X						
<b>17</b> Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X						

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

**Part III Private Business Use** (Continued)

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

**Part IV Arbitrage**

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

**Part III Private Business Use** (Continued)

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

**Part IV Arbitrage**

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

**Part IV Arbitrage (Continued)**

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

**Part V Procedures To Undertake Corrective Action**

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

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

**PART I, COLUMN (F)**

ISSUE A: TO REFINANCE THE 2005 BONDS.

ISSUE B: TO REFUND PORTION OF SERIES 2009 BONDS.

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

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

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

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

**Part IV Arbitrage (Continued)**

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

**Part V Procedures To Undertake Corrective Action**

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

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

**PART I, COLUMN (F)**

ISSUE A: TO REFINANCE THE 2005 BONDS.

ISSUE B: TO REFUND PORTION OF SERIES 2009 BONDS.

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

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

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

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

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

**Transactions With Interested Persons**

OMB No. 1545-0047

**2017**

**Open To Public Inspection**

Department of the Treasury  
Internal Revenue Service

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**  
▶ **Attach to Form 990 or Form 990-EZ.**  
▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

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

**Part I Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

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

- 2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ..... ▶ \$ \_\_\_\_\_
- 3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ..... ▶ \$ \_\_\_\_\_

**Part II Loans to and/or From Interested Persons.**

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No

Total ..... ▶ \$ \_\_\_\_\_

**Part III Grants or Assistance Benefiting Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance





**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](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2017**

Open to Public  
Inspection

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

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

DURING THE YEAR, UNION HOSPITAL OF CECIL COUNTY PROVIDED \$10,629,804 IN  
UNCOMPENSATED CARE (CHARITY CARE).

IN ADDITION, COMMUNITY BENEFIT ACTIVITIES ARE PROVIDED TO SERVE  
VULNERABLE POPULATIONS (I.E. MEDICALLY UNDERSERVED, WORKING POOR,  
HOMELESS). ACTIVITIES ARE CREATED BASED ON COMMUNITY NEED AND ARE  
PROVIDED IN AN EFFORT TO IMPROVE THE HEALTH OF THE COMMUNITY.

COMMUNITY BENEFITS INCLUDE:

- A) ADULT DAY SERVICES FOR ADULTS WITH DEMENTIA
- B) COMMUNITY SUPPORT GROUPS FOR CANCER, DIABETES, STROKE, ALZHEIMER'S,  
AND BREASTFEEDING
- C) HEALTH EDUCATION FOR DIABETES AND NUTRITION, CANCER PREVENTION,  
STROKE RISK, AND HOW TO CARE FOR SUBSTANCE-EFFECTED NEWBORNS
- D) FREE SCREENINGS IN THE COMMUNITY FOR PROSTATE CANCER, HEAD AND NECK  
CANCER, SKIN CANCER, AND DIABETES (EYES AND FEET)
- E) PROVIDING MEETING FACILITIES FOR LOCAL NONPROFITS AND AGENCIES
- F) ENHANCING FOOD SECURITY WITH MEALS ON WHEELS AND FOOD DONATIONS TO  
HOMELESS SERVING PROVIDERS IN THE COMMUNITY
- G) HOSPITAL STAFF PARTICIPATION ON COMMUNITY BOARDS AND COALITIONS,  
LIKE THE DENTAL HEALTH ADVISORY BOARD, UNITED WAY, VOICES OF HOPE,  
CECIL COUNTY DRUG-FREE COMMUNITIES COALITION, CORE SERVICE AGENCY  
MENTAL HEALTH ADVISORY BOARD, AND CECIL COUNTY COMMUNITY HEALTH  
ADVISORY COALITION

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

UNION HOSPITAL OF CECIL COUNTY SERVICED 5,140 DISCHARGES PROVIDING

18,475 PATIENT DAYS TO INPATIENTS IN FISCAL YEAR 2018 OF WHICH:

1) PATIENTS COVERED UNDER THE MEDICARE PROGRAM WERE 2,309 DISCHARGES

AND 9,615 PATIENT DAYS

2) PATIENTS COVERED UNDER THE MEDICAID PROGRAM WERE 152 DISCHARGES AND

564 PATIENT DAYS

3) PATIENTS COVERED UNDER THE MEDICAID HMO PROGRAM WERE 1,308

DISCHARGES AND 3,843 PATIENT DAYS

4) PATIENTS COVERED UNDER THE MEDICARE HMO PROGRAM WERE 204 DISCHARGES

AND 894 PATIENT DAYS

FORM 990, PART VI, SECTION A, LINE 6:

AFFINITY HEALTH ALLIANCE, INC. ("AHA"), A TAX-EXEMPT ORGANIZATION, IS THE  
SOLE MEMBER OF THE UNION HOSPITAL OF CECIL COUNTY, INC.

FORM 990, PART VI, SECTION A, LINE 7A:

THE BYLAWS OF THE HOSPITAL PROVIDE THAT ITS DIRECTORS ARE APPOINTED BY ITS  
SOLE MEMBER, AHA.

FORM 990, PART VI, SECTION A, LINE 7B:

THE BYLAWS OF THE HOSPITAL PROVIDE THAT ITS SOLE MEMBER (AHA) MAY AMEND ITS  
BYLAWS.

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

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

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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FORM 990, PART VI, SECTION B, LINE 12C:

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

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

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

THE COMPENSATION COMMITTEE OF THE ORGANIZATION'S BOARD OF DIRECTORS IS RESPONSIBLE FOR SETTING THE OVERALL COMPENSATION PHILOSOPHY OF THE ORGANIZATION, AS WELL AS SETTING, MONITORING AND REVIEWING THE COMPENSATION PACKAGE OF THE ORGANIZATION'S CEO AND OTHER MEMBERS OF THE EXECUTIVE MANAGEMENT TEAM. THE COMMITTEE USES RELEVANT MARKET INFORMATION, INCLUDING THE USE OF AN INDEPENDENT COMPENSATION CONSULTANT AND COMPENSATION STUDIES

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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OR SURVEYS, TO SET COMPENSATION. DURING 2015, AN INDEPENDENT COMPENSATION CONSULTANT PROVIDED THE FOLLOWING SERVICES: EXECUTIVE COMPENSATION AND PERFORMANCE EVALUATION.

COMPENSATION REVIEW AND APPROVAL IS DOCUMENTED VIA BOARD MINUTES.

FORM 990, PART VI, SECTION C, LINE 19:

THE ORGANIZATION WILL MAKE ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.

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

CONTRACTED SERVICES:

PROGRAM SERVICE EXPENSES	8,930,190.
MANAGEMENT AND GENERAL EXPENSES	852,757.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	9,782,947.

PHYSICIAN SERVICES AND FEES:

PROGRAM SERVICE EXPENSES	14,697,098.
MANAGEMENT AND GENERAL EXPENSES	150,800.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	14,847,898.

PURCHASED SERVICES:

PROGRAM SERVICE EXPENSES	1,675,791.
MANAGEMENT AND GENERAL EXPENSES	5,185.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,680,976.

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

PROGRAM SERVICE EXPENSES	3,888,415.
MANAGEMENT AND GENERAL EXPENSES	58,613.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	3,947,028.

---

**TRANSCRIPTION:**

PROGRAM SERVICE EXPENSES	198,027.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	198,027.

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**RECORD FILE STORAGE:**

PROGRAM SERVICE EXPENSES	147,370.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	147,370.

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**CLEANING SERVICES:**

PROGRAM SERVICE EXPENSES	67,524.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	67,524.

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**BILLING & COLLECTIONS:**

PROGRAM SERVICE EXPENSES	847,979.
MANAGEMENT AND GENERAL EXPENSES	0.

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

FUNDRAISING EXPENSES 0.

TOTAL EXPENSES 847,979.

TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A 31,519,749.

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

CHANGE IN INTEREST IN NET ASSETS OF SUBSIDIARIES -119,898.

IMPAIRMENT LOSS -569,956.

TOTAL TO FORM 990, PART XI, LINE 9 -689,854.

**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Related Organizations and Unrelated Partnerships**

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

▶ Attach to Form 990.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2017**

Open to Public Inspection

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

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
UNION HOSPITAL OF CECIL COUNTY FOUNDATION, INC. - 52-1794552, 106 BOW STREET, ELKTON, MD 21921	FUNDRAISING & SUPPORT	MARYLAND	501(C)(3)	LINE 7	AFFINITY HEALTH ALLIANCE, INC.		X
UNION HOSPITAL OF CECIL COUNTY HEALTH SERVICES, INC. - 52-1794553, 106 BOW STREET, ELKTON, MD 21921	HEALTHCARE PROPERTY MANAGEMENT	MARYLAND	501(C)(3)	LINE 10	AFFINITY HEALTH ALLIANCE, INC.		X
AFFINITY HEALTH ALLIANCE, INC. - 52-1794697 106 BOW STREET ELKTON, MD 21921	MANAGEMENT & SUPPORT	MARYLAND	501(C)(3)	LINE 12B, II	N/A		X
UNION HOSPITAL OF CECIL COUNTY ONCOLOGY, INC. - 81-2662359, 106 BOW STREET, ELKTON, MD 21921	HEALTHCARE	MARYLAND	501(C)(3)	LINE 3	AFFINITY HEALTH ALLIANCE, INC.		X

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

Schedule R (Form 990) 2017



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

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

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

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

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

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

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

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

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

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

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

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

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



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

For calendar year 2017 or other tax year beginning JUL 1, 2017, and ending JUN 30, 2018

**2017**

▶ Go to [www.irs.gov/Form990T](http://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><b>A</b> <input type="checkbox"/> Check box if address changed</p> <p><b>B</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.)  <b>UNION HOSPITAL OF CECIL COUNTY, INC.</b></p> <p>Number, street, and room or suite no. If a P.O. box, see instructions.  <b>106 BOW STREET</b></p> <p>City or town, state or province, country, and ZIP or foreign postal code  <b>ELKTON, MD 21921-5596</b></p>	<p><b>D</b> Employer identification number (Employees' trust, see instructions.)  <b>52-0607945</b></p> <p><b>E</b> Unrelated business activity codes (See instructions.)  <b>621500 541900</b></p>
---	---------------------	---	---

<p><b>C</b> Book value of all assets at end of year  <b>166,082,740.</b></p>	<p><b>F</b> Group exemption number (See instructions.) ▶</p> <p><b>G</b> 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** Describe the organization's primary unrelated business activity. ▶ **SEE STATEMENT 1**

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

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

		(A) Income	(B) Expenses	(C) Net
<b>1a</b> Gross receipts or sales <u>1,942,870.</u>				
<b>b</b> Less returns and allowances <u>164,268.</u> <b>c</b> Balance ▶	<b>1c</b>	<b>1,778,602.</b>		
<b>2</b> Cost of goods sold (Schedule A, line 7) .....	<b>2</b>			
<b>3</b> Gross profit. Subtract line 2 from line 1c .....	<b>3</b>	<b>1,778,602.</b>		<b>1,778,602.</b>
<b>4a</b> Capital gain net income (attach Schedule D) .....	<b>4a</b>			
<b>b</b> Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797) .....	<b>4b</b>			
<b>c</b> Capital loss deduction for trusts .....	<b>4c</b>			
<b>5</b> Income (loss) from partnerships and S corporations (attach statement) .....	<b>5</b>	<b>-57,781.</b>		<b>-57,781.</b>
<b>6</b> Rent income (Schedule C) .....	<b>6</b>			
<b>7</b> Unrelated debt-financed income (Schedule E) .....	<b>7</b>			
<b>8</b> Interest, annuities, royalties, and rents from controlled organizations (Sch. F) ...	<b>8</b>			
<b>9</b> Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	<b>9</b>			
<b>10</b> Exploited exempt activity income (Schedule I) .....	<b>10</b>			
<b>11</b> Advertising income (Schedule J) .....	<b>11</b>			
<b>12</b> Other income (See instructions; attach schedule) <b>STATEMENT 2</b> .....	<b>12</b>	<b>23,788.</b>		<b>23,788.</b>
<b>13 Total.</b> Combine lines 3 through 12 .....	<b>13</b>	<b>1,744,609.</b>		<b>1,744,609.</b>

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

<b>14</b> Compensation of officers, directors, and trustees (Schedule K) .....				
<b>15</b> Salaries and wages .....	<b>15</b>			<b>596,644.</b>
<b>16</b> Repairs and maintenance .....	<b>16</b>			<b>37,730.</b>
<b>17</b> Bad debts .....	<b>17</b>			<b>30,254.</b>
<b>18</b> Interest (attach schedule) .....	<b>18</b>			
<b>19</b> Taxes and licenses .....	<b>19</b>			
<b>20</b> Charitable contributions (See instructions for limitation rules) .....	<b>20</b>			
<b>21</b> Depreciation (attach Form 4562) .....	<b>21</b>	<b>80,467.</b>		
<b>22</b> Less depreciation claimed on Schedule A and elsewhere on return .....	<b>22a</b>			<b>80,467.</b>
<b>23</b> Depletion .....	<b>23</b>			
<b>24</b> Contributions to deferred compensation plans .....	<b>24</b>			
<b>25</b> Employee benefit programs .....	<b>25</b>			<b>97,288.</b>
<b>26</b> Excess exempt expenses (Schedule I) .....	<b>26</b>			
<b>27</b> Excess readership costs (Schedule J) .....	<b>27</b>			
<b>28</b> Other deductions (attach schedule) .....	<b>28</b>			<b>1,424,760.</b>
<b>29 Total deductions.</b> Add lines 14 through 28 .....	<b>29</b>			<b>2,267,143.</b>
<b>30</b> Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13 .....	<b>30</b>			<b>-522,534.</b>
<b>31</b> Net operating loss deduction (limited to the amount on line 30) .....	<b>31</b>			
<b>32</b> Unrelated business taxable income before specific deduction. Subtract line 31 from line 30 .....	<b>32</b>			<b>-522,534.</b>
<b>33</b> Specific deduction (Generally \$1,000, but see line 33 instructions for exceptions) .....	<b>33</b>			<b>1,000.</b>
<b>34 Unrelated business taxable income.</b> Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32 .....	<b>34</b>			<b>-522,534.</b>

**Part III Tax Computation**

<b>35 Organizations Taxable as Corporations.</b> See instructions for tax computation. Controlled group members (sections 1561 and 1563) check here <input type="checkbox"/> See instructions and:			
<b>a</b>	Enter your share of the \$50,000, \$25,000, and \$9,925,000 taxable income brackets (in that order): (1) \$ _____ (2) \$ _____ (3) \$ _____		
<b>b</b>	Enter organization's share of: (1) Additional 5% tax (not more than \$11,750) \$ _____ (2) Additional 3% tax (not more than \$100,000) \$ _____		
<b>c</b>	Income tax on the amount on line 34	<b>35c</b>	0.
<b>36 Trusts Taxable at Trust Rates.</b> See instructions for tax computation. Income tax on the amount on line 34 from: <input type="checkbox"/> Tax rate schedule or <input type="checkbox"/> Schedule D (Form 1041)		<b>36</b>	
<b>37 Proxy tax.</b> See instructions		<b>37</b>	
<b>38 Alternative minimum tax</b>		<b>38</b>	
<b>39 Tax on Non-Compliant Facility Income.</b> See instructions		<b>39</b>	
<b>40 Total.</b> Add lines 37, 38 and 39 to line 35c or 36, whichever applies		<b>40</b>	0.

**Part IV Tax and Payments**

<b>41a</b>	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	<b>41a</b>	
<b>b</b>	Other credits (see instructions)	<b>41b</b>	
<b>c</b>	General business credit. Attach Form 3800	<b>41c</b>	
<b>d</b>	Credit for prior year minimum tax (attach Form 8801 or 8827)	<b>41d</b>	
<b>e</b>	<b>Total credits.</b> Add lines 41a through 41d	<b>41e</b>	
<b>42</b>	Subtract line 41e from line 40	<b>42</b>	0.
<b>43</b>	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)	<b>43</b>	
<b>44</b>	<b>Total tax.</b> Add lines 42 and 43	<b>44</b>	0.
<b>45a</b>	Payments: A 2016 overpayment credited to 2017	<b>45a</b>	
<b>b</b>	2017 estimated tax payments	<b>45b</b>	
<b>c</b>	Tax deposited with Form 8868	<b>45c</b>	
<b>d</b>	Foreign organizations: Tax paid or withheld at source (see instructions)	<b>45d</b>	
<b>e</b>	Backup withholding (see instructions)	<b>45e</b>	
<b>f</b>	Credit for small employer health insurance premiums (Attach Form 8941)	<b>45f</b>	
<b>g</b>	Other credits and payments: <input type="checkbox"/> Form 2439 <input type="checkbox"/> Form 4136 <input type="checkbox"/> Other _____ Total	<b>45g</b>	
<b>46</b>	<b>Total payments.</b> Add lines 45a through 45g	<b>46</b>	
<b>47</b>	Estimated tax penalty (see instructions). Check if Form 2220 is attached <input type="checkbox"/>	<b>47</b>	
<b>48</b>	<b>Tax due.</b> If line 46 is less than the total of lines 44 and 47, enter amount owed	<b>48</b>	0.
<b>49</b>	<b>Overpayment.</b> If line 46 is larger than the total of lines 44 and 47, enter amount overpaid	<b>49</b>	0.
<b>50</b>	Enter the amount of line 49 you want: <b>Credited to 2018 estimated tax</b> <input type="checkbox"/> <b>Refunded</b> <input type="checkbox"/>	<b>50</b>	

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

<b>51</b>	At any time during the 2017 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
<b>52</b>	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
<b>53</b>	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 **CHIEF FINANCIAL OFFICER**

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

**Paid Preparer Use Only**

Print/Type preparer's name: **JULIUS C. GREEN, CPA**  
 Preparer's signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Check  if self-employed PTIN: **P00350393**  
 Firm's name: **BAKER TILLY VIRCHOW KRAUSE, LLP** Firm's EIN: **39-0859910**  
 1650 MARKET STREET, SUITE 4500  
 Firm's address: **PHILADELPHIA, PA 19103-7341** Phone no. **215.972.0701**

**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	<b>Cost of goods sold.</b> 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							
b	Other costs (attach schedule) .....	4b							
5	<b>Total.</b> 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)		%		
<b>Totals</b> .....			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.
<b>Total dividends-received deductions</b> 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).
<b>Totals</b> .....			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).
<b>Totals</b> .....		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 26.
<b>Totals</b> .....	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)						
<b>Totals</b> (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)						
<b>Totals from Part I</b> .....	<b>0.</b>	<b>0.</b>				<b>0.</b>
<b>Totals, Part II (lines 1-5)</b> .....	Enter here and on page 1, Part I, line 11, col. (A). <b>0.</b>	Enter here and on page 1, Part I, line 11, col. (B). <b>0.</b>				Enter here and on page 1, Part II, line 27. <b>0.</b>

**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)		%	
<b>Total.</b> Enter here and on page 1, Part II, line 14 .....			<b>0.</b>



## FORM 990-T

## NET OPERATING LOSS DEDUCTION

## STATEMENT 4

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
06/30/99	11,989.	0.	11,989.	11,989.
06/30/00	79,821.	0.	79,821.	79,821.
06/30/01	265,922.	0.	265,922.	265,922.
06/30/02	224,674.	0.	224,674.	224,674.
06/30/03	171,199.	0.	171,199.	171,199.
06/30/04	227,215.	0.	227,215.	227,215.
06/30/05	337,011.	0.	337,011.	337,011.
06/30/06	363,778.	0.	363,778.	363,778.
06/30/07	364,490.	0.	364,490.	364,490.
06/30/08	355,554.	0.	355,554.	355,554.
06/30/09	513,265.	0.	513,265.	513,265.
06/30/10	412,749.	0.	412,749.	412,749.
06/30/11	480,796.	0.	480,796.	480,796.
06/30/12	487,240.	0.	487,240.	487,240.
06/30/13	571,243.	0.	571,243.	571,243.
06/30/14	788,791.	0.	788,791.	788,791.
06/30/15	344,190.	0.	344,190.	344,190.
06/30/16	32,535.	0.	32,535.	32,535.
06/30/17	261,197.	0.	261,197.	261,197.
NOL CARRYOVER AVAILABLE THIS YEAR			6,293,659.	6,293,659.

## FORM 990-T

## INCOME (LOSS) FROM PARTNERSHIPS

## STATEMENT 5

PARTNERSHIP NAME	GROSS INCOME	DEDUCTIONS	NET INCOME OR (LOSS)
BTAS 2015 PRIVATE INVESTORS US LP (EIN: 47-3930651)	-10,684.	20,495.	-31,179.
MILESTONE REAL ESTATE INVESTORS IV, LP (EIN: 38-3981213)	-17,403.	0.	-17,403.
PREMIER HEALTHCARE ALLIANCE LP (EIN: 33-0387407)	4,769.	0.	4,769.
SECONDARY OPPORTUNITIES FUND II (EIN: 99-0383162)	-7,437.	6,531.	-13,968.
TOTAL TO FORM 990-T, PAGE 1, LINE 5	-30,755.	27,026.	-57,781.

Form **5471**

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

OMB No. 1545-0704

(Rev. December 2015)  
Department of the Treasury  
Internal Revenue Service

▶ For more information about Form 5471, see [www.irs.gov/form5471](http://www.irs.gov/form5471)  
Information furnished for the foreign corporation's annual accounting period (tax year required by section 898) (see instructions) beginning **JAN 1, 2017**, and ending **DEC 31, 2017**

Attachment  
Sequence No. **121**

Name of person filing this return  <b>UNION HOSPITAL OF CECIL COUNTY, INC.</b> <small>Number, street, and room or suite no. (or P.O. box number if mail is not delivered to street address)</small> <b>106 BOW STREET</b> City or town, state, and ZIP code <b>ELKTON, MD 21921-5596</b>	<b>A Identifying number</b>  <b>52-0607945</b>  <b>B Category of filer</b> (See instructions. Check applicable box(es): 1 (repealed) 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input checked="" type="checkbox"/>
<b>C Enter the total percentage of the foreign corporation's voting stock you owned at the end of its annual accounting period</b> <b>20.00 %</b>	
Filer's tax year beginning <b>JUL 1, 2017</b> , and ending <b>JUN 30, 2018</b>	

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

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

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

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

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

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

<b>a</b> Name, address, and identifying number of branch office or agent (if any) in the United States <b>N/A</b>		<b>b</b> If a U.S. income tax return was filed, enter: (i) Taxable income or (loss)      (ii) U.S. income tax paid (after all credits)	
<b>c</b> Name and address of foreign corporation's statutory or resident agent in country of incorporation <b>ARTEX RISK SOLUTIONS (CAYMAN) LTD.</b> <b>P.O. BOX 10233</b> <b>GRAND CAYMAN KY1-1102</b> <b>CAYMAN ISLANDS</b>		<b>d</b> 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 <b>SAME AS 2C</b>	

**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

LHA For Paperwork Reduction Act Notice, see instructions.

Form **5471** (Rev. 12-2015)

SEE STATEMENT 6

SEE STATEMENT 7



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

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

**Schedule F Balance Sheet**

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

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

Schedule G Other Information

1 During the tax year, did the foreign corporation own at least a 10% interest, directly or indirectly, in any foreign partnership? Yes No
2 During the tax year, did the foreign corporation own an interest in any trust? Yes No
3 During the tax year, did the foreign corporation own any foreign entities that were disregarded as entities separate from their owners under Regulations sections 301.7701-2 and 301.7701-3? Yes No
4 During the tax year, was the foreign corporation a participant in any cost sharing arrangement? Yes No
5 During the course of the tax year, did the foreign corporation become a participant in any cost sharing arrangement? Yes No
6 During the tax year, did the foreign corporation participate in any reportable transaction as defined in Regulations section 1.6011-4? Yes No
7 During the tax year, did the foreign corporation pay or accrue any foreign tax that was disqualified for credit under section 901(m)? Yes No
8 During the tax year, did the foreign corporation pay or accrue foreign taxes to which section 909 applies, or treat foreign taxes that were previously suspended under section 909 as no longer suspended? Yes No

Schedule H Current Earnings and Profits

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

1 Current year net income or (loss) per foreign books of account
2 Net adjustments made to line 1 to determine current earnings and profits according to U.S. financial and tax accounting standards (see instructions):
a Capital gains or losses
b Depreciation and amortization
c Depletion
d Investment or incentive allowance
e Charges to statutory reserves
f Inventory adjustments
g Taxes
h Other (attach statement) STATEMENT 8
3 Total net additions
4 Total net subtractions
5a Current earnings and profits (line 1 plus line 3 minus line 4)
5b DASTM gain or (loss) for foreign corporations that use DASTM
5c Combine lines 5a and 5b
5d Current earnings and profits in U.S. dollars (line 5c translated at the appropriate exchange rate as defined in section 989(b) and the related regulations)
Enter exchange rate used for line 5d 1.000000

Schedule I Summary of Shareholder's Income From Foreign Corporation

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

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

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

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

FORM 5471 AMOUNT AND TYPE OF INDEBTEDNESS OF FOREIGN CORPORATION TO THE RELATED PERSONS DESCRIBED IN REGULATIONS SECTION 1.6046-1(B)(11) STATEMENT 6

AMOUNT	DESCRIPTION
	N/A

FORM 5471 NAME, ADDRESS, IDENTIFYING NUMBER AND NUMBER OF SHARES SUBSCRIBED TO BY EACH SUBSCRIBER TO THE STOCK OF THE FOREIGN CORPORATION STATEMENT 7

NAME AND ADDRESS	IDENTIFYING NUMBER	NUMBER OF SHARES
N/A		

FORM 5471 OTHER NET ADJUSTMENTS STATEMENT 8

DESCRIPTION	NET ADDITIONS	NET SUBTRACTIONS
RELATED PARTY PREMIUMS		4,748,550.
REL. PARTY LOSS RESERVE/CLAIMS PD	5,728,431.	
TOTAL TO 5471, PAGE 4, SCHEDULE H, LINE 2H	5,728,431.	4,748,550.



**SCHEDULE J  
(Form 5471)**

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

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

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

OMB No. 1545-0704

Name of person filing Form 5471

Identifying number

**UNION HOSPITAL OF CECIL COUNTY, INC.**

**52-0607945**

Name of foreign corporation

EIN (if any)

Reference ID number

**FREESTATE HEALTHCARE INSURANCE COMPANY, LTD**

**98-0464065**

Important: Enter amounts in functional currency.	(a) Post-1986 Undistributed Earnings (post-86 section 959(c)(3) balance)	(b) Pre-1987 E&P Not Previously Taxed (pre-87 section 959(c)(3) balance)	(c) Previously Taxed E&P (sections 959(c)(1) and (2) balances)			(d) Total Section 964(a) E&P (combine columns (a), (b), and (c))
			(i) Earnings Invested in U.S. Property	(ii) Earnings Invested in Excess Passive Assets	(iii) Subpart F Income	
<b>1</b> Balance at beginning of year	-12,050,525.					-12,050,525.
<b>2a</b> Current year E&P						
<b>b</b> Current year deficit in E&P	826,586.					
<b>3</b> Total current and accumulated E&P not previously taxed (line 1 plus line 2a or line 1 minus line 2b)	-12,877,111.					
<b>4</b> Amounts included under section 951(a) or reclassified under section 959(c) in current year						
<b>5a</b> Actual distributions or reclassifications of previously taxed E&P						
<b>b</b> Actual distributions of nonpreviously taxed E&P						
<b>6a</b> Balance of previously taxed E&P at end of year (line 1 plus line 4, minus line 5a)						
<b>b</b> Balance of E&P not previously taxed at end of year (line 3 minus line 4, minus line 5b)	-12,877,111.					
<b>7</b> Balance at end of year. (Enter amount from line 6a or line 6b, whichever is applicable.)	-12,877,111.					-12,877,111.

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

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

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

OMB No. 1545-0026

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

Attachment  
 Sequence No. **128**

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

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

Controlling shareholder	Identifying number

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

Name of parent corporation	EIN of parent corporation

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

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

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

Name of partnership	EIN of partnership

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

**Part II Transferee Foreign Corporation Information** (see instructions)

<b>3</b> Name of transferee (foreign corporation) <b>FREESTATE HEALTHCARE INSURANCE COMPANY LTD.</b>	<b>4a</b> Identifying number, if any <b>98-0464065</b>
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<b>5</b> Address (including country) <b>PO BOX 10233 GRAND CAYMAN, KY1-1002 CAYMAN ISLANDS</b>	<b>4b</b> Reference ID number
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**6** Country code of country of incorporation or organization  
**CJ**

**7** Foreign law characterization (see instructions)  
**CORPORATION**

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

LHA For Paperwork Reduction Act Notice, see separate instructions.

**Part III Information Regarding Transfer of Property** (see instructions)

**Section A - Cash, Stock, and Securities**

Type of property	(a) Date of transfer	(b) Description of property	(c) Fair market value on date of transfer	(d) Cost or other basis	(e) Gain recognized on transfer
Cash	07/01/2017		1,626,020.		
Stock and securities (other than those that qualify as eligible property under Regs. sec. 1.367(a)-2(b)(3))					

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

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

**Section B - Property qualifying for Active Trade or Business exception under Regs. sec. 1.367(a)-2(a)(2)(i) and (ii)**

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*
Tangible property (not listed under another category)					
Working interest in oil and gas property (as described in Regs. sec. 1.367(a)-2(b)(2) and (f))					
Financial asset (as described in Regs. sec. 1.367(a)-2(b)(3))					
Certain tangible property to be leased (see Regs. sec. 1.367(a)-2(e))					
Totals					

\* If property listed in this section is subject to depreciation recapture or branch loss recapture, see instructions.

**Section C - Property not qualifying for Active Trade or Business exception (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*
Inventory					
Installment obligations, etc. (as described in Regs. sec. 1.367(a)-2(c)(2))					
Nonfunctional currency, etc. (as described in Regs. sec. 1.367(a)-2(c)(3))					
Certain leased tangible property (as described in Regs. sec. 1.367(a)-2(c)(4))					
Certain property to be retransferred (see Regs. sec. 1.367(a)-2(g))					
Property described in Regs. sec. 1.6038B-1(c)(4)(iv)					
Property described in Regs. sec. 1.6038B-1(c)(4)(vii)					
<b>Totals</b>					

\* If property listed in this section is subject to depreciation recapture or branch loss recapture, see instructions.

- 11** Did the transferor transfer assets that qualify for the trade or business exception under section 367(a)(3)?  Yes  No
- 12** Indicate whether the transferor was required to recognize income under final and Temporary Regulations sections 1.367(a)-2 through 1.367(a)-7 for any of the following. **SEE STATEMENT 10**
- a** Transfer of property subject to section 367(a)(1) gain recognition  Yes  No
  - b** Depreciation recapture  Yes  No
  - c** Branch loss recapture  Yes  No
  - d** If the answer to 12c is "Yes," enter the amount of foreign branch loss recapture  Yes  No
  - e** Any other income recognition provision contained in the above-referenced regulations  Yes  No
- If the answer to line 12a, 12b, 12c, or 12e is "Yes," see instructions for information that must be included in the *Supplemental Part III Information Required To Be Reported* section below.

**Section D - Intangible property under Regs. sec. 1.367(a)-1(d)(5)**

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. 936(h)(3)(B)						
Property subject to sec. 367(d) pursuant to Regs. sec. 1.367(a)-1(b)(5)						
<b>Totals</b>						

- 13 a Did the transferor transfer property described in section 936(h)(3)(B) (not including section 1221(a)(3) property or a working interest in oil and gas property)?  Yes  No
- b If the answer to line 13a is "Yes," enter the total amount included in income under section 367(d), if any, for the transfer of all such property on the income tax return for the year of the transfer ► \$ \_\_\_\_\_
- 14 a Did the transferor apply section 367(d) to a transfer of any property pursuant to Regulations section 1.367(a)-1(b)(5)?  Yes  No
- b If the answer to line 14a is "Yes," enter the total amount included in income under section 367(d), if any, for the transfer of all such property on the income tax return for the year of the transfer ► \$ \_\_\_\_\_
- c If the answer to line 14a is "No," did the transferor transfer any property for which it could have applied section 367(d) pursuant to Regulations section 1.367(a)-1(b)(5) but did not?  Yes  No
- d If the answer to line 14c is "Yes," enter the total amount of gain recognized, if any, under section 367(a)(1) on the transfer of all such property on the income tax return for the year of the transfer ► \$ \_\_\_\_\_
- 15 a Did the transferor transfer any intangible property that, at the time of the transfer, had a useful life reasonably anticipated to exceed twenty 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 15c 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) ► \$ \_\_\_\_\_
- 16 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 9

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

- 17 Enter the transferor's interest in the foreign transferee corporation before and after the transfer.  
(a) Before 20.000 % (b) After 20.000 %
- 18 Type of nonrecognition transaction (see instructions) ► IRC SECTION 351
- 19 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
- 20 Did this transfer result from a change in entity classification?  Yes  No
- 21 a Did a domestic corporation make a distribution of property covered by section 367(e)(2) (see instructions)?  Yes  No  
If "Yes," complete lines 21b and 21c.
- 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

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FORM 926

STATEMENT 9

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

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

NAME: FREESTATE HEALTHCARE INSURANCE COMPANY, LTD.

EIN: 98-0464065

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

VARIOUS DATES BETWEEN JULY 1, 2017 AND JUNE 30, 2018

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

VALUE: \$1,626,020 (CASH)

BASIS: \$1,626,020

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

FORM 926

ADDITIONAL INFORMATION REQUIRED BY TEMPORARY STATEMENT 10  
REGULATION SECTIONS 1.6038B-1T(C)(4)(III)  
1.6038B-1T(C)(5)(I), (II), (III), (IV), AND (VII)

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:

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

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 THESE DEEMED CONTRIBUTIONS WAS \$1,626,020.

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

CONSIDERATION RECEIVED:

NOTHING WAS RECEIVED IN CONSIDERATION IN EXCHANGE FOR DEEMED CASH CONTRIBUTIONS  
TO CAPITAL OF \$1,626,020. 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 \$1,626,020 (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

Electronic Filing PDF Attachment





**The Union Hospital of Cecil County, Inc.**

Financial Statements

June 30, 2018 and 2017

# **The Union Hospital of Cecil County, Inc.**

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June 30, 2018 and 2017

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Statement of Cash Flows	6
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## **Independent Auditors' Report**

Board of Directors  
The Union Hospital of Cecil County, Inc.

We have audited the accompanying financial statements of The Union Hospital of Cecil County, Inc. (a Maryland not-for-profit corporation) (the "Hospital"), which comprise the balance sheet as of June 30, 2018 and 2017, and the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

### **Management's Responsibility for the Financial Statements**

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

### **Auditors' Responsibility**

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

## Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The Union Hospital of Cecil County as of June 30, 2018 and 2017, and the results of its operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

*Baker Tilly Virchow Krause, LLP*

Philadelphia, Pennsylvania  
February 13, 2019

**The Union Hospital of Cecil County, Inc.**

Balance Sheet  
June 30, 2018 and 2017

	<b>2018</b>	<b>2017</b>		<b>2018</b>	<b>2017</b>
<b>Assets</b>				<b>Liabilities and Net Assets</b>	
<b>Current Assets</b>				<b>Current Liabilities</b>	
Cash and cash equivalents	\$ 3,170,011	\$ 5,853,127		Accounts payable and accrued expenses	\$ 10,111,574    \$ 4,813,703
Investments	39,705,037	40,780,859		Accrued salaries and benefits	4,479,913    4,843,522
Accounts receivable, patients (net of estimated allowances for doubtful accounts of \$20,392,000 in 2018 and \$15,756,000 in 2017)	14,900,301	17,252,373		Third-party advances	3,964,220    3,260,426
Other receivables	1,716,899	480,002		Current portion of long-term debt and capital lease obligations	<u>3,572,129</u> <u>3,546,960</u>
Inventories of supplies	2,268,203	2,027,595		Total current liabilities	22,127,836    16,464,611
Prepaid expenses	<u>2,136,306</u>	<u>3,231,364</u>		<b>Due to Affiliates, Net</b>	261,822    2,065,236
Total current assets	63,896,757	69,625,320		<b>Long-Term Debt and Capital Lease Obligations, Net</b>	58,233,683    60,027,628
<b>Property and Equipment, Net</b>	88,138,296	89,053,840		<b>Estimated Medical Malpractice Claims Liability</b>	<u>7,903,134</u> <u>8,962,968</u>
<b>Due from Affiliates, Net</b>	698,177	-		Total liabilities	<u>88,526,475</u> <u>87,520,443</u>
<b>Other Assets, Net</b>	7,899,867	9,573,729		<b>Net Assets</b>	
<b>Interest in Net Assets of Affiliate</b>	<u>4,998,101</u>	<u>5,117,999</u>		Unrestricted	74,557,561    83,405,073
				Temporarily restricted	<u>2,547,162</u> <u>2,445,372</u>
				Total net assets	<u>77,104,723</u> <u>85,850,445</u>
Total assets	<u>\$ 165,631,198</u>	<u>\$ 173,370,888</u>		Total liabilities and net assets	<u>\$ 165,631,198</u> <u>\$ 173,370,888</u>

See notes to financial statements

# The Union Hospital of Cecil County, Inc.

## Statement of Operations

Years Ended June 30, 2018 and 2017

	<u>2018</u>	<u>2017</u>
<b>Unrestricted Revenues, Gains, and Other Support</b>		
Net patient service revenues	\$ 157,971,001	\$ 159,374,030
Provision for bad debts	<u>(8,807,407)</u>	<u>(5,273,173)</u>
Net patient service revenues less provision for bad debts	149,163,594	154,100,857
Other operating revenues	2,218,243	3,390,477
Net assets released from restrictions for use in operations	<u>582,275</u>	<u>732,110</u>
Total unrestricted revenues, gains, and other support	<u>151,964,112</u>	<u>158,223,444</u>
<b>Expenses</b>		
Salaries and employee benefits	84,855,967	83,471,093
Supplies and other expenses	28,461,005	28,008,393
Purchased services	37,236,585	32,539,389
Depreciation and amortization	11,476,003	11,378,371
Interest	<u>2,024,928</u>	<u>1,863,137</u>
Total expenses	<u>164,054,488</u>	<u>157,260,383</u>
Operating (loss) income before impairment loss	(12,090,376)	963,061
Impairment loss	<u>(569,956)</u>	<u>-</u>
Total operating (loss) income	<u>(12,660,332)</u>	<u>963,061</u>
<b>Nonoperating (Loss) Income</b>		
Investment income	3,135,075	5,005,080
Other (loss) income, net	<u>(133,907)</u>	<u>10,658</u>
Total nonoperating income	<u>3,001,168</u>	<u>5,015,738</u>
Revenues (less than) in excess of expenses	(9,659,164)	5,978,799
<b>Change in Interest in Net Assets of Affiliate</b>	(221,688)	(183,388)
<b>Net Transfers from (to) Affiliates</b>	974,172	(18,197,080)
<b>Net Assets Released from Restriction Used for Purchase of Property and Equipment</b>	<u>59,168</u>	<u>-</u>
Decrease in unrestricted net assets	<u>\$ (8,847,512)</u>	<u>\$ (12,401,669)</u>

See notes to financial statements

## The Union Hospital of Cecil County, Inc.

Statement of Changes in Net Assets  
Years Ended June 30, 2018 and 2017

	<u>2018</u>	<u>2017</u>
<b>Unrestricted Net Assets</b>		
Revenues (less than) in excess of expenses	\$ (9,659,164)	\$ 5,978,799
Change in interest in net assets of affiliate	(221,688)	(183,388)
Net transfer from (to) affiliates	974,172	(18,197,080)
Net assets released from restriction used for purchase of property and equipment	<u>59,168</u>	<u>-</u>
Decrease in unrestricted net assets	<u>(8,847,512)</u>	<u>(12,401,669)</u>
<b>Temporarily Restricted Net Assets</b>		
Contributions, net of event expenses of \$216,673 and \$152,727 in 2018 and 2017, respectively	737,581	559,429
Net assets released from restriction	<u>(635,791)</u>	<u>(739,310)</u>
Increase (decrease) in temporarily restricted net assets	<u>101,790</u>	<u>(179,881)</u>
Decrease in net assets	(8,745,722)	(12,581,550)
<b>Net Assets, Beginning</b>	<u>85,850,445</u>	<u>98,431,995</u>
<b>Net Assets, Ending</b>	<u>\$ 77,104,723</u>	<u>\$ 85,850,445</u>

See notes to financial statements

**The Union Hospital of Cecil County, Inc.**

## Statement of Cash Flows

Years Ended June 30, 2018 and 2017

	<u>2018</u>	<u>2017</u>
<b>Cash Flows from Operating Activities</b>		
Decrease in net assets	\$ (8,745,722)	\$ (12,581,550)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Depreciation and amortization	11,476,003	11,378,371
Loss on disposal of property plant and equipment	78,570	9,441
Impairment loss on property plant and equipment	569,470	-
Provision for bad debts	8,807,407	5,273,173
Amortization of deferred financing costs	66,584	66,584
Net transfers (from) to affiliates	(974,172)	18,197,080
Net realized and unrealized gains and losses on investments	(1,460,963)	(3,412,562)
Restricted contributions	(737,581)	(559,429)
Changes in assets and liabilities:		
Accounts receivable, patients	(6,455,335)	(7,865,397)
Other receivables, inventories of supplies, and prepaid expenses	(382,447)	274,981
Due to/from affiliates	(2,501,591)	2,090,286
Other assets, net	1,673,862	834,315
Accounts payable and accrued expenses	4,163,925	(893,269)
Accrued salaries and benefits	(363,609)	56,142
Third-party advances	703,794	(376,867)
Estimated medical malpractice claims liability	(1,059,834)	(1,521,256)
Net cash provided by operating activities	<u>4,858,361</u>	<u>10,970,043</u>
<b>Cash Flows from Investing Activities</b>		
Purchases of property and equipment	(8,437,713)	(14,668,393)
Purchases and sales of investments	2,536,785	16,307,698
Change in beneficial interest in net assets of The Union Hospital of Cecil County Foundation, Inc.	119,898	363,266
Net cash (used in) provided by investing activities	<u>(5,781,030)</u>	<u>2,002,571</u>
<b>Cash Flows from Financing Activities</b>		
Restricted contributions	737,581	559,429
Transfers to affiliates	1,356,975	(8,072,570)
Payment of long-term debt and capital lease obligations	(3,855,003)	(3,545,374)
Net cash used in financing activities	<u>(1,760,447)</u>	<u>(11,058,515)</u>
Net (decrease) increase in cash and cash equivalents	(2,683,116)	1,914,099
<b>Cash and Cash Equivalents, Beginning</b>	<u>5,853,127</u>	<u>3,939,028</u>
<b>Cash and Cash Equivalents, Ending</b>	<u>\$ 3,170,011</u>	<u>\$ 5,853,127</u>
<b>Supplemental Disclosure of Cash Flow Information</b>		
Cash paid for interest	<u>\$ 1,814,945</u>	<u>\$ 1,710,532</u>
<b>Supplemental Disclosure of Noncash Investing and Financing Activities</b>		
Payable for property and equipment	<u>\$ 1,133,946</u>	<u>\$ 1,011,836</u>
Capital lease obligation incurred for equipment	<u>\$ 2,019,643</u>	<u>\$ 1,326,117</u>
Net transfer of property and equipment to affiliates	<u>\$ -</u>	<u>\$ 10,124,510</u>

See notes to financial statements



# **The Union Hospital of Cecil County, Inc.**

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Notes to Financial Statements

June 30, 2018 and 2017

## **1. Organizational Structure and Nature of Operations**

The Union Hospital of Cecil County, Inc. (the "Hospital") is a Maryland not-for-profit corporation and is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. The Hospital operates a general community hospital in Elkton, Maryland, which serves residents from Cecil County and the surrounding area.

Affinity Health Alliance, Inc. (the "Health System") is a non-stock, not-for-profit corporation and the sole corporate member of the Hospital. The Health System is also the sole corporate member or sole stockholder of other related healthcare organizations, one of which is a for-profit corporation.

### **Subsequent Events**

The Hospital evaluated subsequent events for recognition or disclosure through February 13, 2019, the date the financial statements were issued.

## **2. Summary of Significant Accounting Policies**

### **Use of Estimates**

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

### **Cash and Cash Equivalents**

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturities of three months or less at date of purchase, excluding investments and assets held in trust.

### **Patient Accounts Receivable**

Patient accounts receivable are reported at net realizable value. Accounts are written off when they are determined to be uncollectible based upon management's assessment of individual accounts. In evaluating the collectability of patient accounts receivable, the Hospital analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. For receivables associated with services provided to patients who have third-party coverage (which includes patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Hospital analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary. For receivables associated with self-pay patients, the Hospital records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable to pay the portion of their bill for which they are financially responsible. The difference between the billed rates and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

## **The Union Hospital of Cecil County, Inc.**

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Notes to Financial Statements  
June 30, 2018 and 2017

The Hospital's self-pay account writeoffs (net of recoveries) increased from approximately \$5,423,000 in 2017 to approximately \$6,100,000 in 2018. The increase was the result of the availability of higher deductible insurance plans through Maryland's healthcare exchange effective January 1, 2014 offset by a change in the charity care policy in June 2016 which resulted in an increase in patients qualifying for charity care. The Hospital has not changed their financial assistance policy in 2018.

### **Other Receivables**

Other receivables are reported at net realizable value. Accounts are written off when they are determined to be uncollectible based upon management's assessment of individual accounts. No allowance for doubtful accounts was recorded because management believes realization losses on other receivables will be immaterial.

### **Inventories of Supplies**

Inventories, which consist primarily of medical supplies and drugs, are recorded at the lower of cost (using the weighted average method) or net realizable value.

### **Investments and Investment Risk**

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value. Mutual funds are valued at quoted market prices, which represent the net asset value of shares held. Cash and cash equivalents are carried at cost which approximates fair value. Managed hedge funds represent ownership in limited partnerships that invest in hedge funds, limited partnerships and private equity capital funds. Managed hedge funds are valued based on the current market values of the underlying assets reported by the investment advisor using audited financial statements of the funds at year end using net asset value of shares held. Due to redemption restrictions, these funds are classified as Level 3 on the fair value table. Investments in limited partnerships representing less than 3% ownership are recorded at cost and excluded from the fair value table. Investments representing greater than 3% ownership are accounted for under the equity method which approximates fair value. Investment income or loss (including realized gains and losses on investments, interest and dividends and unrealized gains and losses on investments) is included in the determination of revenues (less than) in excess of expenses unless the income or loss is restricted by donor or law.

The Hospital's investments are comprised of a variety of financial instruments and are managed by investment advisors. The fair values reported in the balance sheet are subject to various risks including changes in the equity markets, the interest rate environment, and general economic conditions. Due to the level of risk associated with certain investment securities and the level of uncertainties related to changes in the fair value of investment securities, it is reasonably possible that the amounts reported in the accompanying financial statements could change materially in the near term.

# **The Union Hospital of Cecil County, Inc.**

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Notes to Financial Statements  
June 30, 2018 and 2017

## **Property and Equipment**

Property and equipment acquisitions are recorded at cost. Donated property and equipment are recorded at fair market value at the date of receipt. Depreciation is computed using the straight-line method based on estimated useful lives.

Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the improvements and equipment. Such amortization is included in depreciation and amortization in the financial statements.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

In 2018, management reviewed certain related party subsidiary's long-lived assets for potential impairment noting the carrying value of their leasehold improvements and equipment were not recoverable in the ordinary course of business. As such, an impairment loss of \$569,956 was recognized for the year ended June 30, 2018, which represents the write-down to fair value of the building the Hospital leases to Union Hospital of Cecil County Oncology, Inc.

## **Interest in Net Assets of Affiliate**

Generally accepted accounting principles establish standards for transactions in which a donor makes a contribution by transferring assets to a not-for-profit recipient organization that agrees to use those assets on behalf of or transfer them to a beneficiary entity. Under certain circumstances, a beneficiary organization is required to recognize its rights to assets held by a recipient organization as an asset on the balance sheet, and changes in value of that asset as a change in net assets in the period of change. The Hospital is the beneficiary of the net assets of an unconsolidated affiliate, The Union Hospital of Cecil County Foundation, Inc. (the "Foundation"). The Hospital's interest in the net assets of the Foundation as of June 30, 2018 and 2017 was \$4,998,101 and \$5,117,999, respectively.

## **Temporarily Restricted Net Assets**

Temporarily restricted net assets for various capital and other Hospital related expenditures are those whose use by the Hospital has been limited by donors to a specific time period or purpose. Restricted net assets of \$635,791 and \$739,310 were released from restriction during 2018 and 2017, respectively, in accordance with donor restrictions.

## **The Union Hospital of Cecil County, Inc.**

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Notes to Financial Statements  
June 30, 2018 and 2017

### **Deferred Financing Costs**

The Hospital accounts for deferred financing costs in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") No. 2015-03, *Interest-Imputations of Interest: Simplifying the Presentation of Debt Issuance Costs*.

Costs incurred in connection with the issuance of long-term debt have been deferred and are being amortized over the terms of the related debt using the straight-line method, which approximates the effective interest method. Amortization expense was \$66,584 in 2018 and 2017.

### **Donor-Restricted Gifts**

Unconditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support as they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statement of operations. Donor-restricted contributions whose restrictions are met within the same year as received are reported as additions to unrestricted net assets in the accompanying financial statements.

### **Estimated Malpractice Claims Liability**

The provision for estimated medical malpractice claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported, including costs associated with litigating or settling claims. Anticipated insurance recoveries associated with reported claims are reported separately in the Hospital's balance sheet at net realizable value.

### **Revenues (Less Than) in Excess of Expenses**

The statement of operations includes the determination of revenues (less than) in excess of expenses. Changes in unrestricted net assets which are excluded from the determination of revenues (less than) in excess of expenses, consistent with industry practice, include permanent transfers of assets to and from subsidiaries for other than goods and services, changes in unrestricted net assets of affiliate and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such long-lived assets).

### **Net Patient Service Revenues and Allowances**

Patient service revenues are recorded at established rates on the accrual basis in the period during which the service is provided. Allowances to give recognition to third-party arrangements and charity care are also accounted for on the accrual basis. Revenues received under certain reimbursement agreements are subject to audit and retroactive adjustments by third-party payors. Provision for estimated retroactive adjustments under these agreements are recorded as required. There were no such adjustments in 2018 and 2017.

# The Union Hospital of Cecil County, Inc.

Notes to Financial Statements  
June 30, 2018 and 2017

A substantial portion of the Hospital's revenue is from patient services reimbursed by the Medicare and Medicaid programs and by Blue Cross plans. For Medicare and Medicaid patients, payments for services are based upon the Hospital's standard billing rates less a six percent discount. In addition, Blue Cross and other payors are eligible for discounts of two percent based on advances made to the Hospital or one percent of the payment of services within 30 days from the date billed. The differences between the payments (the reimbursable amount) and the standard billing rates have been recorded as contractual allowances in arriving at net patient service revenues in the accompanying statement of operations.

Patient accounts receivables are reported at net realizable value and include charges for accounts due from Medicare, Medicaid, other commercial and managed care insurers, and self-paying patients. Patient account receivable also includes management's estimate of the impact of certain undercharges to be recouped or overcharges to be paid back for inpatient and outpatient services in subsequent years rates as discussed above. Deducted from patient accounts receivable are estimates of doubtful collections related to patients and allowances for the excess of charges over the payments to be received from third party payors.

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. The Hospital recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of these established rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenues on the basis of its standard rates, discounted in accordance with the Hospital's policy. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to the uninsured patients in the period the services are provided.

Patient service revenues, net of contractual allowances and discounts (but before the provision for bad debts), recognized in 2018 and 2017 from these major payor sources, are as follows:

	<b>June 30, 2018</b>			
	<b>Third-Party Government Payors</b>	<b>Third-Party Commercial Payors</b>	<b>Self-Pay</b>	<b>Total All Payors</b>
Patient service revenues (net of contractual allowances and discounts)	<u>\$ 91,724,000</u>	<u>\$ 60,696,000</u>	<u>\$ 5,551,000</u>	<u>\$ 157,971,000</u>
	<b>June 30, 2017</b>			
Patient service revenues (net of contractual allowances and discounts)	<u>\$ 65,032,000</u>	<u>\$ 88,249,000</u>	<u>\$ 6,093,000</u>	<u>\$ 159,374,000</u>

# **The Union Hospital of Cecil County, Inc.**

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Notes to Financial Statements  
June 30, 2018 and 2017

## **Uncompensated Care**

The Hospital provides care to patients who meet certain criteria under its uncompensated care programs; the services are offered and/or provided at a reduced cost based on demonstrated inability to pay or at amounts less than its established rates. Records are maintained to estimate the level of patient service revenue forgone. Uncompensated care includes charity care, amounts in excess of allowable day limits for out of state Medicaid, and bad debt write-offs.

The amount of uncompensated care, based on estimated direct and indirect costs incurred, provided during fiscal years 2018 and 2017 was approximately \$10,030,000 and \$6,685,000, respectively.

## **Income Taxes**

The Hospital is a not-for-profit corporation as described in Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income taxes on their exempt income under Section 501(a) of the Internal Revenue Code.

The Hospital accounts for uncertainty in income taxes by prescribing a recognition threshold of more-likely-than-not to be sustained upon examination by the appropriate taxing authority. Measurement of the tax uncertainty occurs if the recognition threshold has been met. There were no tax uncertainties that met the recognition threshold in 2018 and 2017.

The Hospital's policy is to recognize interest related to unrecognized tax benefits in interest expense and penalties in operating expenses.

## **3. Regulatory Environment**

In 1983, Congress approved a Medicare prospective payment plan for most inpatient services as part of the Social Security Amendment Act of 1983. Hospitals in Maryland are currently exempt from these federal reimbursement regulations under a special waiver. The waiver currently in effect is subject to renewal based upon criteria defined in the federal law. Under these payment arrangements with Medicare, a retroactive adjustment could occur if certain performance standards are not attained by all hospitals on a statewide basis. The impact, if any, of any retroactive adjustment of the Medicare prospective payment system, should hospitals in Maryland become subject to such system, on future operations of the Hospital has not been determined.

The Hospital's rate structure is subject to review and approval by the Maryland Health Services Cost Review Commission. During 2011, the Hospital adopted the Total Patient Revenue Reimbursement System ("TPR"). The Hospital's patient revenue is 100% fixed regardless of increases and decreases in volumes and changes in case mix. The original TPR system was in effect for a three-year period ending June 30, 2013.

The agreement was renewed for another three-year period commencing on July 1, 2016. The renewal does not include any additional incentives, but does include a provision for an annual rate increase for inflation and a population adjustment. The agreement was amended to bring all existing TPR agreements into the global budget revenue format, but this process made no material modifications to the Hospital's existing agreement.

# The Union Hospital of Cecil County, Inc.

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Notes to Financial Statements  
June 30, 2018 and 2017

## 4. New Accounting Standards

### Revenue Recognition

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. ASU No. 2014-09 supersedes the revenue recognition requirements in *Topic 605, Revenue Recognition*, and most industry-specific guidance. Under the requirements of ASU No. 2014-09, the core principle is that entities should recognize revenue to depict the transfer of promised goods or services to customers (patients) in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Hospital will be required to retrospectively adopt the guidance in ASU No. 2014-09 in the year ending June 30, 2019. The Hospital has not yet determined the impact of adoption of ASU No. 2014-09 on its financial statements.

### Not-for-Profit Entities

In August 2016, the FASB issued ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*. The new guidance is intended to improve and simplify the current net asset classification requirements and information presented in financial statements and notes that is useful in assessing a not-for-profit's liquidity, financial performance and cash flows. The Hospital will be required to adopt the guidance in ASU No. 2016-14 in the year ending June 30, 2019. ASU 2016-14 is to be applied retrospectively with transition provisions. The Hospital is assessing the impact ASU No. 2016-14 will have on its financial statements.

### Financial Instruments

In 2016, the FASB issued ASU No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities (Subtopic 825-10)*. ASU No. 2016-01 was issued to enhance the reporting model for financial instruments in financial statements. The provisions of ASU 2016-01 requires marketable equity securities to be reported at fair value with changes in fair value recognized within the performance indicator, establishes a qualitative factor in evaluating impairment on equity investments without readily determinable fair values, and eliminates the requirement to disclose the fair value on financial instruments measured at amortized cost. The Hospital will be required to prospectively adopt the guidance in ASU 2016-01 in the year ending June 30, 2019. The Hospital has not yet determined the impact of adoption of ASU No. 2016-01 on its financial statements.

### Lease Accounting

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)*. ASU No. 2016-02 was issued to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. Under the provisions of ASU No. 2016-02, a lessee is required to recognize a right-to-use asset and lease liability, initially measured at the present value of the lease payments, in the balance sheet. In addition, lessees are required to provide qualitative and quantitative disclosures that enable users to understand more about the nature of the Hospital's leasing activities. The Hospital will be required to retrospectively adopt the guidance in ASU No. 2016-02 in the year ending June 30, 2020. The Hospital has not yet determined the impact of adoption of ASU No. 2016-02 on its financial statements.

## The Union Hospital of Cecil County, Inc.

Notes to Financial Statements  
June 30, 2018 and 2017

### 5. Investments

Investments consist of the following as of June 30:

	<u>2018</u>	<u>2017</u>
Investments:		
Cash and cash equivalents	\$ 779,884	\$ 325,393
Common stock	-	700,000
Corporate bonds	1,701,195	2,000,815
Mutual funds:		
Fixed income	12,344,327	7,524,444
International equities	3,730,129	6,422,141
Large value	1,098,009	2,545,977
Large growth	2,693,366	2,731,935
Mid cap	782,599	828,198
Small growth	-	428,472
Small cap	703,167	298,302
Other	3,696,971	4,943,883
Exchange-traded products	3,911,273	4,409,645
Managed hedge funds	8,264,117	7,621,654
	<u>\$ 39,705,037</u>	<u>\$ 40,780,859</u>

Investment income and unrealized gains and losses for investments and cash and cash equivalents are comprised of the following for the years ended June 30:

	<u>2018</u>	<u>2017</u>
Investment income:		
Interest and dividend income, net	\$ 1,674,111	\$ 1,592,518
Realized gains, net	715,902	696,828
Changes in unrealized gains and losses on investments	745,063	2,715,734
	<u>\$ 3,135,076</u>	<u>\$ 5,005,080</u>

### 6. Fair Value Measurements

The Hospital measures its investments on a recurring basis in accordance with accounting principles generally accepted in the United States of America.

Fair value is defined as the price that would be received to sell an asset or the price that would be paid to transfer a liability in an orderly transaction between market participants at the measurement date. The framework that the authoritative guidance establishes for measuring fair value includes a hierarchy used to classify the inputs used in measuring fair value. The hierarchy prioritizes the inputs used in determining valuations into three levels. The level in the fair value hierarchy within which the fair value measurement falls is determined based on the lowest level input that is significant to the fair value measurement.



# The Union Hospital of Cecil County, Inc.

Notes to Financial Statements  
June 30, 2018 and 2017

The levels of the fair value hierarchy are as follows:

Level 1 - Fair value is based on unadjusted quoted prices in active markets that are accessible to the Hospital for identical assets. These generally provide the most reliable evidence and are used to measure fair value whenever available.

Level 2 - Fair value is based on significant inputs, other than Level 1 inputs, that are observable either directly or indirectly for substantially the full term of the asset through corroboration with observable market data. Level 2 inputs include quoted market prices in active markets for similar assets, quoted market prices in markets that are not active for identical or similar assets, and other observable inputs.

Level 3 - Fair value would be based on significant unobservable inputs. Examples of valuation methodologies that would result in Level 3 classification include option pricing models, discounted cash flows, and other similar techniques.

The following tables present financial instruments measured at fair value at June 30, 2018 and 2017, by caption on the balance sheet:

	June 30, 2018			
	Total	Level 1	Level 2	Level 3
<b>Reported at Fair Value</b>				
Cash and cash equivalents	\$ 779,884	\$ 779,884	\$ -	\$ -
Corporate bonds	1,701,195	-	1,701,195	-
Mutual funds	25,048,568	25,048,568	-	-
Exchange-traded products	3,911,273	3,911,273	-	-
Managed hedge funds	3,444,116	-	-	3,444,116
<b>Managed hedge funds at cost</b>	4,820,001			
<b>Disclosed at Fair Value</b>				
Cash and cash equivalents	3,170,011	3,170,011	-	-
Long-term debt, excluding capital leases (carrying value of \$59,181,386)	59,181,386	-	59,181,386	-

# The Union Hospital of Cecil County, Inc.

Notes to Financial Statements  
June 30, 2018 and 2017

	June 30, 2017			
	Total	Level 1	Level 2	Level 3
<b>Reported at Fair Value</b>				
Cash and cash equivalents	\$ 325,393	\$ 325,393	\$ -	\$ -
Common stock	700,000	700,000	-	-
Corporate bonds	2,000,815	-	2,000,815	-
Mutual funds	25,723,352	25,723,352	-	-
Exchange-traded products	4,409,645	4,409,645	-	-
Managed hedge funds	2,731,658	-	-	2,731,658
<b>Managed hedge funds at cost</b>	4,889,996			
<b>Disclosed at Fair Value</b>				
Cash and cash equivalents	5,853,127	5,853,127	-	-
Long-term debt, excluding capital leases (carrying value of \$61,640,224)	61,640,224	-	61,640,224	-

The following is a description of the valuation methodologies used for assets measured at fair value and for financial instruments disclosed at fair value. There have been no changes in methodologies used at June 30, 2018.

**Cash and cash equivalents:** Include certain investments in highly liquid debt instruments with original maturities of three months or less at date of purchase. The carrying amount approximates fair value due to the short-term nature of these investments.

**Mutual funds and exchange-traded products:** Valued at the net asset value ("NAV") of shares held by the Hospital at year end.

**Managed hedge funds:** These investments are not readily marketable, and are recognized using the cost method or equity method of accounting based on the percentage of the fund owned. Those with redemption restrictions are valued based on the current market values of the underlying assets reported by the investment advisor using audited financial statements of the funds at year end using NAV. Investments in limited partnerships representing less than 3% ownership are recorded at cost. Funds in which the Hospital owns greater than 3% of the fund are recognized on the equity method. The equity method recognizes gains and losses on these investments.

**Corporate bonds:** Based on quoted market prices, if available, or estimated using quoted market prices of similar securities.

**Common stock** is valued based on quoted market prices in the active markets on which the individual securities are traded.

**Long-term debt, excluding capital lease obligations:** Fair value is calculated based on quoted market prices, if available, or estimated using quoted market prices of similar securities.

# The Union Hospital of Cecil County, Inc.

Notes to Financial Statements  
June 30, 2018 and 2017

## 7. Property and Equipment and Accumulated Depreciation and Amortization

Property and equipment consisted of the following as of June 30:

	<u>2018</u>	<u>2017</u>
Land and improvements	\$ 2,624,182	\$ 2,707,340
Buildings and improvements	86,283,092	85,988,373
Fixed equipment	46,037,103	44,457,577
Major movable equipment	80,478,161	78,581,754
Construction in progress	4,859,353	1,645,528
Total	220,281,891	213,380,572
Less accumulated depreciation and amortization	<u>(132,143,595)</u>	<u>(124,326,732)</u>
Property and equipment, net	<u>\$ 88,138,296</u>	<u>\$ 89,053,840</u>

Included above is leased equipment at a cost of \$9,324,853 and \$7,831,572 with accumulated amortization of \$6,374,210 and \$4,828,304 as of June 30, 2018 and 2017, respectively.

During 2018 and 2017, \$382,803 and \$10,250,031, respectively, in assets were transferred to an affiliate of the Hospital and subsidiary of the Health System and \$705,908 and \$125,521, respectively, in assets were transferred to the Hospital from an affiliate and subsidiary of the Health System.

During 2018, certain property and equipment was disposed of, reducing accumulated depreciation by \$3,691,596. In addition, as described in Note 2, one of the Hospital's buildings was impaired in 2018, reducing accumulated depreciation by \$687,167.

## 8. Long-Term Debt and Capital Lease Obligations

Long-term debt and capital lease obligations consists of the following as of June 30:

	<u>2018</u>	<u>2017</u>
MHHEFA Series 2014 Revenue Bonds	\$ 30,358,000	\$ 30,478,000
MHHEFA Series 2012 Revenue Bonds	6,250,863	7,707,841
Town of Elkton, Maryland Series 2012 Revenue Bonds (held by SunTrust Bank)	22,572,523	23,454,383
Capital lease obligations (Note 9)	3,075,968	2,452,490
Total	62,257,354	64,092,714
Less: unamortized deferred financing costs, net	(451,542)	(518,126)
Less current portion	<u>(3,572,129)</u>	<u>(3,546,960)</u>
Long-term debt and capital lease obligations, net	<u>\$ 58,233,683</u>	<u>\$ 60,027,628</u>

## The Union Hospital of Cecil County, Inc.

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Notes to Financial Statements  
June 30, 2018 and 2017

On December 1, 2014, the Hospital participated in MHHEFA revenue bond issuances that totaled \$30,778,000. The MHHEFA Series 2014 Revenue Bonds (the "2014 Revenue Bonds") were issued to refund the remaining portion of the MHHEFA Series 2005 Revenue Bonds and finance certain capital projects. The 2014 Revenue Bonds bear interest at 3.01% and are payable in monthly annual installments through July 2039.

On July 18, 2012, the Hospital participated in MHHEFA revenue bond issuances that totaled \$13,931,000. The MHHEFA Series 2012 Revenue Bonds (the "2012 Revenue Bonds") were issued to refund the remaining portion of the MHHEFA Series 2002 Revenue Bonds, finance certain capital projects and increase the debt service reserve fund for the 2005 Revenue Bonds. The 2012 Revenue Bonds bear interest at 2.75% and are payable in monthly annual installments through June 2022.

On May 18, 2012, the Town of Elkton, Maryland ("Elkton") issued \$27,662,336 in Economic Development Refunding Revenue Bonds ("EDRRB"), Series 2012 ("Series 2012 Bonds"). Also on May 18, 2012, the Hospital entered into a Loan and Financing Agreement with Elkton (the "Agreement") to borrow the proceeds from the Series 2012 Bonds in a series of notes as follows:

- \$10,000,000 from the EDRRB, Series 2012A Bonds to partially refund the Economic Development Revenue Bond, Series 2009, and pay costs of issuance. The note bears interest at 2.25% and is payable in monthly installments of \$44,477 through December 2036.
- \$5,842,234 from the EDRRB, Series 2012B-1 Bonds to refund the remaining portion of the Economic Development Revenue Bond, Series 2009, and pay costs of issuance. This note bears interest at 2.25% and is payable in monthly installments of \$25,995 through December 2036.
- \$2,820,102 from the EDRRB, Series 2012B-2 Bonds to refund Elkton's 2000 Revenue Bonds and pay costs of issuance. This note bears interest at 1.87% and is payable in monthly installments of \$31,708 through June 2020.
- \$9,000,000 from the EDRRB, Series 2012C Bonds to partially refund the MHHEFA Series 2002 Revenue Bonds and pay costs of issuance. This note bears interest at 2.25% and provides interest-only installments until July 2022, at which time \$92,268 in monthly installments through June 2031.

At June 30, 2018, the Hospital did not meet certain restrictive debt covenants required under the 2014 Revenue Bonds, 2012 Revenue Bonds and Series 2012 Bonds. The Hospital received a waiver from the banks, who are the bond creditors, on certain events of default related to financial statements and other information, financial covenants, as defined in the bond agreements.

## The Union Hospital of Cecil County, Inc.

Notes to Financial Statements  
June 30, 2018 and 2017

Scheduled repayments of long-term debt, exclusive of capital lease obligations discussed in Note 9, are as follows:

Years ending June 30:	
2019	\$ 2,548,190
2020	2,609,453
2021	2,290,577
2022	2,348,833
2023	2,318,377
Thereafter	<u>47,065,956</u>
Total	<u>\$ 59,181,386</u>

### 9. Capital Lease Obligations

The Hospital has various capital lease agreements for medical equipment, which expire through 2023. Future minimum lease payments under these agreements are as follows:

Years ending June 30:	
2019	\$ 1,129,461
2020	857,503
2021	700,630
2022	535,631
2023	<u>82,687</u>
Total minimum lease payments	3,305,912
Less amount representing interest	<u>229,944</u>
Total	3,075,968
Less current portion, principal	<u>1,023,939</u>
Long term portion, principal	<u>\$ 2,052,029</u>

### 10. Pension Plan

Effective January 1, 1999, the Hospital established a 403(b) defined contribution plan (the "403(b) plan") which includes a matching provision, for employees of the Health System, the Hospital and the Foundation. The Hospital has used the 403(b) plan as its primary retirement plan as of January 1, 2000. The 403(b) plan expenses may include a discretionary employer contribution for employees who work at least 1,000 hours in a calendar year and a 50% employer match contribution up to 1.5% of gross wages for those employees who choose to make voluntary contributions. Pension expense related to the 403(b) plan was \$784,000 and \$727,008 for the years ended June 30, 2018 and 2017, respectively, and is included in salaries and employee benefits in the accompanying statement of operations. There was no discretionary contribution made during 2018 and 2017.

## The Union Hospital of Cecil County, Inc.

Notes to Financial Statements  
June 30, 2018 and 2017

### 11. Concentration of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of gross revenues from patients and third-party payors was as follows for the years ended June 30:

	<u>2018</u>	<u>2017</u>
Medicare	42 %	43 %
Medicaid	26	26
Blue Cross/Blue Shield	17	16
Health maintenance organizations	1	1
Self-pay patients	3	3
Other third-party payors	11	11
	<u>100 %</u>	<u>100 %</u>

The Hospital maintains its cash and cash equivalents with several financial institutions. Cash and cash equivalents on deposit with any one financial institution exceed FDIC coverage from time to time.

### 12. Functional Expenses

The Hospital provides health care services to residents within its geographic location. Expenses related to providing these services are approximately as follows for the years ended June 30:

	<u>2018</u>	<u>2017</u>
Healthcare services	\$ 104,697,000	\$ 102,101,000
Support services	59,927,000	55,159,000
	<u>\$ 164,624,000</u>	<u>\$ 157,260,000</u>

### 13. Commitments and Contingencies

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, governmental activity has increased with respect to investigations and allegations concerning possible violations and fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs, together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

The Hospital has been named as a defendant in several lawsuits arising from the performance of its normal activities. In the opinion of the Hospital's management, after consultation with legal counsel, the amount, if any, of the Hospital's ultimate liability under these lawsuits will not have a significant impact on the financial position of the Hospital.

## **The Union Hospital of Cecil County, Inc.**

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### Notes to Financial Statements

June 30, 2018 and 2017

After June 30, 2018, the Company submitted a voluntary refund to Novitas Solutions, the Medicare Administrative Contractor, for Medicare overpayments associated with inpatient services provided to Medicare patients of certain physicians for whom the Company had not completed the re-credentialing process. The Hospital has accrued approximately \$2.7 million within accounts payable and accrued liabilities in the Balance Sheet. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time. Also, future changes in federal and state reimbursement funding mechanisms and related government budgeting constraints could have an adverse effect on the Hospital.

The Hospital also self-reported to the Office of Inspector General ("OIG") under the Self Disclosure Matter, related to Federal Stark and Anti-Kickback laws and other physician based services. The Hospital is working with the OIG regarding this matter and is currently awaiting a settlement proposal. As of June 30, 2018, the Hospital has accrued approximately \$1.3 million for this matter, which is included in accounts payable and accrued liabilities in the accompanying balance sheet.

#### **14. Medical Malpractice Claims Coverage**

For the period October 17, 2003 through December 31, 2004, the Hospital maintained its malpractice insurance coverage with the Zurich Insurance Company under a claims-made policy.

As of January 1, 2005, when existing policies expired, the Hospital elected to obtain its professional and general liability insurance from Freestate Healthcare Insurance Company, Ltd., a Cayman Islands company ("Freestate"). Freestate was incorporated as of January 1, 2005 as a chartered captive insurance company for eight nonprofit hospitals in the State of Maryland, including the Hospital. Each of the hospitals contributed an equal amount of \$15,000 as capital to Freestate in return for a one-eighth share interest in Freestate. Freestate is governed by a Board of Directors selected by the shareholders. The policy has no stated deductible.

Freestate's primary insurance is under the terms of a claims-made insurance policy and has limits of liability of \$1 million per claim and no aggregate limit per policy year. Freestate's excess liability coverage insures against losses in excess of the above primary coverage reported during the period of policy coverage. This excess liability insurance policy has an individual occurrence limit of \$10 million and an annual aggregate limit of \$10 million. Prior acts of coverage for newly employed physicians will not be provided without prior approval of Freestate's Board of Directors. Each hospital's annual premium will be established through a retrospective rating process, with initial premiums based on actuarial estimates. Initial premiums will be charged at the 75% confidence level and retrospective premium assessments will be capped at an amount equal to the expected losses for the policy period at an 85% confidence level, in each case as determined by an independent actuary.

The total estimated reported medical malpractice claims liability is \$7,903,134 at June 30, 2018 and \$8,962,968 at June 30, 2017. The Hospital has recorded a receivable, and related claim liability, for anticipated insurance recoveries of \$6,692,333 at June 30, 2018 and \$7,952,182 at June 30, 2017. The estimated insurance recoveries receivable is included in other assets in the balance sheet.

## The Union Hospital of Cecil County, Inc.

Notes to Financial Statements  
June 30, 2018 and 2017

The Hospital believes that it has adequate insurance coverages for all asserted claims and has no knowledge of unasserted claims which would exceed insurance coverages. The Hospital would claim charitable immunity for claims exceeding coverage limits. Legal expenses associated with covered claims are also covered and included under policy limits.

### 15. Related Party Transactions

The Hospital periodically receives or advances funds for working capital purposes. Interest is not charged and there are no fixed repayment terms on these transactions. Receivables (payables) from (to) other affiliates of the Hospital as of June 30, 2018 and 2017 are shown below:

	<u>2018</u>	<u>2017</u>
Health System	\$ (124,455)	\$ (2,129,889)
Union Hospital of Cecil County Foundation, Inc.	<u>560,810</u>	<u>64,653</u>
Total	<u>\$ 436,355</u>	<u>\$ (2,065,236)</u>

The Hospital pays a management fee to the Health System for administrative, finance, and human resources services. The management fee was calculated at 1% of the Hospital's net operating revenues (including the provision for doubtful accounts) for fiscal years 2018 and 2017. Fees of \$1,574,678 and \$1,603,663 are included in purchased services in the accompanying statement of operations for the years ended June 30, 2018 and 2017, respectively.

During 2018 and 2017, the Hospital recorded net asset transfers from (to) affiliates of \$974,172 and \$(18,197,080), respectively. These amounts included \$323,105 and \$10,124,510 in fixed assets transferred, respectively.

Effective February 1, 2014, the Hospital entered into a 2 year management services agreement with the University of Maryland Medical System ("UMMS"). Under the agreement, UMMS provides support for quality initiatives, physician recruitment, supply chain saving and for the oncology programs. The agreement was renewed January 1, 2016 until June 30, 2018; however, it was terminated early on January 31, 2018. For the years ending June 30, 2018 and 2017, the Hospital paid approximately \$70,000 and \$715,000, respectively, to UMMS.



# TAX RETURN FILING INSTRUCTIONS

CALIFORNIA FORM 199

FOR THE YEAR ENDING

June 30, 2018

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**Prepared For:**

Union Hospital of Cecil County, Inc.  
106 Bow Street  
Elkton, MD 21921-5596

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**Prepared By:**

Baker Tilly Virchow Krause, LLP  
One Liberty Place  
1650 Market Street, Suite 4500  
Philadelphia, PA 19103-7341

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**To be Signed and Dated By:**

Not applicable

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**Amount of Tax:**

Total tax	\$	10
Less: payments and credits	\$	0
Plus: other amount	\$	0
Plus: interest and penalties	\$	0
Balance due	\$	10

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**Overpayment:**

Credited to your estimated tax	\$	0
Other amount	\$	0
Refunded to you	\$	0

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**Make Check Payable To:**

Franchise Tax Board

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**Mail Tax Return and Check (if applicable) To:**

This return has qualified for electronic filing. After you have reviewed your return for completeness and accuracy, please sign, date and return Form 8453-EO to our office. We will then transmit your return electronically to the FTB. Do not mail the paper copy of the return to the FTB.

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**Return Must be Mailed On or Before:**

Not applicable

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**Special Instructions:**

Your payment should be made as instructed below on or before May 15, 2019.

Separately mail California Form FTB 3586 with a check or money order for \$10, payable to Franchise Tax Board.

Mail to:

Franchise Tax Board  
PO BOX 942857  
Sacramento CA 94257-0531

# TAX RETURN FILING INSTRUCTIONS

CALIFORNIA FORM 109

FOR THE YEAR ENDING

June 30, 2018

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**Prepared For:**

Union Hospital of Cecil County, Inc.  
106 Bow Street  
Elkton, MD 21921-5596

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**Prepared By:**

Baker Tilly Virchow Krause, LLP  
One Liberty Place  
1650 Market Street, Suite 4500  
Philadelphia, PA 19103-7341

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**To be Signed and Dated By:**

The authorized individual(s).

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**Amount of Tax:**

Total Tax	\$	0
Less: payments and credits	\$	0
Plus: other amount		0
Plus: interest and penalties	\$	0
No payment required	\$	

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**Overpayment:**

Credited to your estimated tax	\$	0
Other amount	\$	0
Refunded to you	\$	0

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**Make Check Payable To:**

Not applicable

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**Mail Tax Return and Check (if applicable) To:**

Franchise Tax Board  
P.O. Box 942857  
Sacramento, CA 94257-0500

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**Return Must be Mailed On or Before:**

May 15, 2019

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**Special Instructions:**

**California Exempt Organization  
Annual Information Return**

Calendar Year 2017 or fiscal year beginning (mm/dd/yyyy) **07/01/2017**, and ending (mm/dd/yyyy) **06/30/2018**

Corporation/Organization name <b>UNION HOSPITAL OF CECIL COUNTY, INC.</b>		California corporation number <b>9612036</b>	
Additional information. See instructions.		FEIN <b>52-0607945</b>	
Street address (suite or room) <b>106 BOW STREET</b>		PMB no.	
City <b>ELKTON</b>		State <b>MD</b>	ZIP code <b>21921-5596</b>
Foreign country name		Foreign province/state/county	
		Foreign postal code	

<p><b>A</b> First Return <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>B</b> Amended Return <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>C</b> IRC Section 4947(a)(1) trust <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>D</b> Final Information Return?  <input type="checkbox"/> Dissolved <input type="checkbox"/> Surrendered (Withdrawn) <input type="checkbox"/> Merged/Reorganized          Enter date: (mm/dd/yyyy) _____</p> <p><b>E</b> Check accounting method: (1) <input type="checkbox"/> Cash (2) <input checked="" type="checkbox"/> Accrual (3) <input type="checkbox"/> Other</p> <p><b>F</b> Federal return filed? (1) <input checked="" type="checkbox"/> 990T (2) <input type="checkbox"/> 990PF (3) <input checked="" type="checkbox"/> Sch H (990) (4) <input checked="" type="checkbox"/> Other 990 series</p> <p><b>G</b> Is this a group filing? See instructions <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>H</b> Is this organization in a group exemption <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," what is the parent's name? _____</p> <p><b>I</b> Did the organization have any changes to its guidelines not reported to the FTB? See instructions <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b>J</b> If exempt under R&amp;TC Section 23701d, has the organization engaged in political activities? See instructions. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>K</b> Is the organization exempt under R&amp;TC Section 23701g? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," enter the gross receipts from nonmember sources \$ _____</p> <p><b>L</b> If organization is exempt under R&amp;TC Section 23701d and meets the filing fee exception, check box. No filing fee is required. <input type="checkbox"/></p> <p><b>M</b> Is the organization a Limited Liability Company? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>N</b> Did the organization file Form 100 or Form 109 to report taxable income? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>O</b> Is the organization under audit by the IRS or has the IRS audited in a prior year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>P</b> Is federal Form 1023/1024 pending? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date filed with IRS _____</p>
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**Part I Complete Part I unless not required to file this form. See General Information B and C.**

<b>Receipts and Revenues</b>	1	Gross sales or receipts from other sources. From Side 2, Part II, line 8	1	168,885,532.00
	2	Gross dues and assessments from members and affiliates	2	00
	3	Gross contributions, gifts, grants, and similar amounts received <b>STMT 1</b>	3	4,635,791.00
	4	Total gross receipts for filing requirement test. Add line 1 through line 3. This line must be completed. If the result is less than \$50,000, see General Information B	4	173,521,323.00
	5	Cost of goods sold	5	00
	6	Cost or other basis, and sales expenses of assets sold	6	6,276,080.00
	7	Total costs. Add line 5 and line 6	7	6,276,080.00
	8	Total gross income. Subtract line 7 from line 4	8	167,245,243.00
<b>Expenses</b>	9	Total expenses and disbursements. From Side 2, Part II, line 18	9	176,046,174.00
	10	Excess of receipts over expenses and disbursements. Subtract line 9 from line 8	10	-8,800,931.00
<b>Filing Fee</b>	11	Total payments	11	00
	12	Use tax. See General Information K	12	00
	13	Payments balance. If line 11 is more than line 12, subtract line 12 from line 11	13	00
	14	Use tax balance. If line 12 is more than line 11, subtract line 11 from line 12	14	00
	15	Filing fee \$10 or \$25. See General Information F	15	10.00
	16	Penalties and Interest. See General Information J	16	00
	17	<b>Balance due.</b> Add line 12, line 15, and line 16. Then subtract line 11 from the result	17	10.00

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

<b>Sign Here</b>	Signature of officer <b>CHIEF FINANCIA</b>	Title	Date	• Telephone
<b>Paid Preparer's Use Only</b>	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	• PTIN <b>P00350393</b>
	Firm's name (or yours, if self-employed) and address	• FEIN <b>39-0859910</b>		
		• Telephone <b>215.972.0701</b>		

May the FTB discuss this return with the preparer shown above? See instructions  Yes  No

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

728951 12-06-17

<b>Receipts from Other Sources</b>	1	Gross sales or receipts from all business activities. See instructions	•	1	00	
	2	Interest	•	2	1,674,113.00	
	3	Dividends	•	3	00	
	4	Gross rents	•	4	24,336.00	
	5	Gross royalties	•	5	00	
	6	Gross amount received from sale of assets (See Instructions) STATEMENT 2	•	6	6,913,412.00	
	7	Other income SEE STATEMENT 3	•	7	160,273,671.00	
	8	<b>Total</b> gross sales or receipts from other sources. Add line 1 through line 7. Enter here and on Side 1, Part I, line 1	•	8	168,885,532.00	
	9	Contributions, gifts, grants, and similar amounts paid	•	9	3,116,525.00	
	10	Disbursements to or for members	•	10	00	
	11	Compensation of officers, directors, and trustees SEE STATEMENT 4	•	11	1,080,398.00	
	12	Other salaries and wages	•	12	70,792,597.00	
	<b>Expenses and Disbursements</b>	13	Interest	•	13	2,024,928.00
		14	Taxes	•	14	4,802,126.00
		15	Rents	•	15	2,992,064.00
		16	Depreciation and depletion (See instructions)	•	16	11,476,003.00
		17	Other Expenses and Disbursements SEE STATEMENT 5	•	17	79,761,533.00
		18	<b>Total</b> expenses and disbursements. Add line 9 through line 17. Enter here and on Side 1, Part I, line 9	•	18	176,046,174.00

Schedule L Balance Sheet	Beginning of taxable year		End of taxable year	
	(a)	(b)	(c)	(d)
<b>Assets</b>				
1 Cash		5,853,127.		• 3,170,011.
2 Net accounts receivable		17,732,375.		• 16,617,200.
3 Net notes receivable				•
4 Inventories		2,027,595.		• 2,268,203.
5 Federal and state government obligations				•
6 Investments in other bonds				•
7 Investments in stock				•
8 Mortgage loans				•
9 Other investments STMT 6		46,418,827.		• 45,314,302.
10 a Depreciable assets	212,159,267.		219,146,986.	
b Less accumulated depreciation	( 124326732. )	87,832,535.	( 132143595. )	87,003,391.
11 Land		1,221,305.		• 1,134,905.
12 Other assets STMT 7		12,803,249.		• 10,574,728.
13 <b>Total assets</b>		173,889,013.		166,082,740.
<b>Liabilities and net worth</b>				
14 Accounts payable		9,657,225.		• 14,591,487.
15 Contributions, gifts, or grants payable				•
16 Bonds and notes payable STMT 8		61,640,225.		• 59,181,386.
17 Mortgages payable				•
18 Other liabilities STMT 9		16,741,118.		15,205,144.
19 Capital stock or principal fund				•
20 Paid-in or capital surplus. Attach reconciliation				•
21 Retained earnings or income fund		85,850,445.		• 77,104,723.
22 <b>Total liabilities and net worth</b>		173,889,013.		166,082,740.

Schedule M-1 Reconciliation of income per books with income per return			
Do not complete this schedule if the amount on Schedule L, line 13, column (d), is less than \$50,000.			
1 Net income per books	• -8,745,722.	7 Income recorded on books this year not included in this return STMT 11	• 745,063.
2 Federal income tax	•	8 Deductions in this return not charged against book income this year	•
3 Excess of capital losses over capital gains	•	9 Total. Add line 7 and line 8	745,063.
4 Income not recorded on books this year	•	10 Net income per return. Subtract line 9 from line 6	-8,800,931.
5 Expenses recorded on books this year not deducted in this return STMT 10	• 689,854.		
6 Total. Add line 1 through line 5	-8,055,868.		

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

CONTRIBUTOR'S NAME	CONTRIBUTOR'S ADDRESS	DATE OF GIFT	AMOUNT
AFFINITY HEALTH ALLIANCE, INC.	106 BOW STREET ELKTON, MD 21921		4,000,000.
UNION HOSPITAL OF CECIL COUNTY FOUNDATION	106 BOW STREET ELKTON, MD 21921		635,791.
TOTAL INCLUDED ON LINE 3			4,635,791.

CA 199 GROSS AMOUNT FROM SALE OF ASSETS STATEMENT 2

DESCRIPTION	DATE ACQUIRED	DATE SOLD	METHOD ACQUIRED	
			PURCHASED	
	COST OR OTHER BASIS	DEPREC.	EXPENSE OF SALE	GROSS SALES PRICE
	5,984,718.		0.	6,700,620.

DESCRIPTION	DATE ACQUIRED	DATE SOLD	METHOD ACQUIRED	
			PURCHASED	
	COST OR OTHER BASIS	DEPREC.	EXPENSE OF SALE	GROSS SALES PRICE
	3,963,330.	3,671,968.	0.	212,792.

TOTAL TO FORM 199, PAGE 2, LN 6	9,948,048.	3,671,968.	0.	6,913,412.
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CA 199

OTHER INCOME

STATEMENT 3

DESCRIPTION

AMOUNT

CAFETERIA/FOOD SERVICE	797,210.
PURCHASE DISCOUNTS	38,674.
LABORATORY REVENUE	1,778,602.
PARKING REVENUE	34,870.
OTHER REVENUE	36,530.
NET PATIENT SERVICE REVENUE	156,192,399.
OTHER OPERATING REVENUE	903,740.
ADULT DAY CARE	491,646.
TOTAL TO FORM 199, PART II, LINE 7	160,273,671.

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CA 199                    COMPENSATION OF OFFICERS, DIRECTORS AND TRUSTEES                    STATEMENT 4

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NAME AND ADDRESS	TITLE AND AVERAGE HRS WORKED/WK	COMPENSATION
RAYMOND HAMM 106 BOW STREET ELKTON, MD 21921-5596	CHAIRMAN 0.50	0.
DWIGHT THOMEY 106 BOW STREET ELKTON, MD 21921-5596	VICE CHAIRMAN/TREASURER 0.50	0.
DAVID FERGUSON, PH.D. 106 BOW STREET ELKTON, MD 21921-5596	SECRETARY 0.50	0.
RICHARD C. SZUMEL, MD 106 BOW STREET ELKTON, MD 21921-5596	PRESIDENT & CEO 28.00	0.
RONALD GRAYBEAL 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
KELLY ALBANESE BEDDER 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
MARY BOLT, PH.D. 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
CHRISTY DRYER, DNP 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
STEPHANIE GARRITY 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
RYAN GERACIMOS, MD 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
MARTIN J. HEALY 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.



UNION HOSPITAL OF CECIL COUNTY, INC.

52-0607945

JOSE MA, MD 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 39.50	0.
MORGAN MILLER, MLIS 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
CARL ROBERTS, PH.D. 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
SHEELMOHAN SACHDEV, MD 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
JAMES G. RAAB (START 10/17) 106 BOW STREET ELKTON, MD 21921-5596	SENIOR VP/CHIEF FINANCIAL 29.00	0.
LAURIE R. BEYER, CPA 106 BOW STREET ELKTON, MD 21921-5596	SENIOR VP/CFO (UNTIL 10/17) 29.00	0.
CYDNEY TEAL, MD 106 BOW STREET ELKTON, MD 21921-5596	VP MEDICAL AFFAIRS 39.00	0.
ANNE LARA 106 BOW STREET ELKTON, MD 21921-5596	SR. VP/CHIEF INNOVATION OF 33.00	0.
AARON Z. ROYSTON 106 BOW STREET ELKTON, MD 21921-5596	VP OF PROVIDER ENTERPRISE 40.00	0.
EDWARD HENRY 106 BOW STREET ELKTON, MD 21921-5596	VP OF PROVIDER SERVICES 40.00	0.
CRAIG M. BABBITT (START 04/18) 106 BOW STREET ELKTON, MD 21921-5596	IN-HOUSE LEGAL COUNSEL 40.00	0.
KHADIJATU BOSTON (UNTIL 01/18) 106 BOW STREET ELKTON, MD 21921-5596	SR. VP/CHIEF NURSING OFFIC 39.00	0.

UNION HOSPITAL OF CECIL COUNTY, INC.

52-0607945

TERRANCE LOVELL (UNTIL 01/18)  
106 BOW STREET  
ELKTON, MD 21921-5596

VP HUMAN RESOURCES  
40.00

0.

FAHD RAHMAN  
106 BOW STREET  
ELKTON, MD 21921-5596

PHYSICIAN  
40.00

0.

JUSTIN SAUSVILLE  
106 BOW STREET  
ELKTON, MD 21921-5596

PHYSICIAN  
40.00

0.

ROGER WU  
106 BOW STREET  
ELKTON, MD 21921-5596

PHYSICIAN  
40.00

0.

TARIQ MAHMOOD  
106 BOW STREET  
ELKTON, MD 21921-5596

PHYSICIAN  
40.00

0.

DANIELLE PRESS  
106 BOW STREET  
ELKTON, MD 21921-5596

PHYSICIAN  
40.00

0.

TOTAL TO FORM 199, PART II, LINE 11

0.

CA 199	OTHER EXPENSES	STATEMENT 5
DESCRIPTION		AMOUNT
MEDICAL SUPPLIES		17,626,763.
BAD DEBTS		8,807,407.
REPAIRS & MAINTENANCE		2,926,951.
DIETARY		977,531.
RENTAL EXPENSES		8,305.
EXPENSES		0.
PENSION PLAN CONTRIBUTIONS		779,432.
OTHER EMPLOYEE BENEFITS		7,401,414.
MANAGEMENT FEES		1,574,678.
LEGAL FEES		829,498.
ACCOUNTING FEES		108,660.
INVESTMENT MANAGEMENT FEES		59,449.
OTHER PROFESSIONAL FEES		31,519,749.
ADVERTISING AND PROMOTION		461,803.
OFFICE EXPENSES		872,580.
INFORMATION TECHNOLOGY		48,800.
TRAVEL		262,772.
CONFERENCES AND CONVENTIONS		142,694.
INSURANCE		3,314,387.
ALL OTHER EXPENSES		2,038,660.
TOTAL TO FORM 199, PART II, LINE 17		79,761,533.

CA 199	OTHER INVESTMENTS	STATEMENT 6
DESCRIPTION	BEG. OF YEAR	END OF YEAR
INTEREST IN NET ASSETS OF UNION HOSPITAL OF CECIL COUNTY FOUNDATION	5,117,999.	4,998,101.
PREMIER PURCHASING PARTNERS, LP	499,969.	591,164.
FREESTATE HEALTHCARE COMPANY	20,000.	20,000.
MANAGED HEDGE FUNDS	4,889,996.	4,820,001.
MANAGED HEDGE FUNDS	2,731,658.	3,444,116.
OTHER PUBLICLY TRADED SECURITIES	33,159,205.	31,440,920.
TOTAL TO FORM 199, SCHEDULE L, LINE 9	46,418,827.	45,314,302.

CA 199	OTHER ASSETS	STATEMENT 7
DESCRIPTION	BEG. OF YEAR	END OF YEAR
PREPAID EXPENSES AND DEFERRED CHARGES	3,231,364.	2,136,306.
OTHER ASSETS	1,101,577.	596,370.
LOAN ISSUANCE COSTS	518,126.	451,542.
INSURANCE CLAIMS RECEIVABLE	7,952,182.	6,692,333.
DUE FROM AFFILIATES	0.	698,177.
TOTAL TO FORM 199, SCHEDULE L, LINE 12	12,803,249.	10,574,728.

CA 199	BONDS AND NOTES PAYABLE	STATEMENT 8
DESCRIPTION	BEG. OF YEAR	END OF YEAR
TAX-EXEMPT BONDS LIABILITIES	61,640,225.	59,181,386.
TOTAL TO FORM 199, SCHEDULE L, LINE 16	61,640,225.	59,181,386.

CA 199	OTHER LIABILITIES	STATEMENT 9
DESCRIPTION	BEG. OF YEAR	END OF YEAR
THIRD PARTY ADVANCES	3,260,426.	3,964,220.
CAPITAL LEASE OBLIGATIONS	2,452,488.	3,075,968.
ESTIMATED MEDICAL MALPRACTICE CLAIMS LIABILITY	8,962,968.	7,903,134.
DUE TO AFFILIATES	2,065,236.	261,822.
TOTAL TO FORM 199, SCHEDULE L, LINE 18	16,741,118.	15,205,144.

CA 199	EXPENSES RECORDED ON BOOKS THIS YEAR NOT DEDUCTED IN THIS RETURN	STATEMENT 10
DESCRIPTION		AMOUNT
CHANGE IN INTEREST IN NET ASSETS OF SUBSIDIARIES		119,898.
IMPAIRMENT LOSS		569,956.
TOTAL TO FORM 199, SCHEDULE M-1, LINE 5		689,854.

CA 199	INCOME RECORDED ON BOOKS THIS YEAR NOT INCLUDED IN THIS RETURN	STATEMENT 11
DESCRIPTION		AMOUNT
UNREALIZED GAIN ON INVESTMENTS		745,063.
TOTAL TO FORM 199, SCHEDULE M-1, LINE 7		745,063.

CA 199	FUND BALANCES	STATEMENT 12	
DESCRIPTION		BEG. OF YEAR	END OF YEAR
UNRESTRICTED ASSETS		83,405,073.	74,557,561.
TEMPORARILY RESTRICTED ASSETS		2,445,372.	2,547,162.
TOTAL TO FORM 199, SCHEDULE L, LINE 21		85,850,445.	77,104,723.

**Voucher at bottom of page.**

**DO NOT MAIL A PAPER COPY OF THE CORPORATE OR EXEMPT ORGANIZATION TAX RETURN WITH THE PAYMENT VOUCHER.**  
If the amount of payment is zero, do not mail this voucher.

**WHERE TO FILE:** Using black or blue ink, make check or money order payable to the "Franchise Tax Board." Write the corporation number or FEIN and "2017 FTB 3586" on the check or money order. Detach voucher below. Enclose, but **do not** staple, payment with voucher and mail to:

**FRANCHISE TAX BOARD  
PO BOX 942857  
SACRAMENTO CA 94257-0531**

Make all checks or money orders payable in U.S. dollars and drawn against a U.S. financial institution.

**WHEN TO FILE:** **Corporations - File and Pay by the 15th day of the 4th month following the close of the taxable year.**  
**S corporations - File and Pay by the 15th day of the 3rd month following the close of the taxable year.**  
**Exempt organizations - File and Pay by the 15th day of the 5th month following the close of the taxable year.**

When the due date falls on a weekend or holiday, the deadline to file and pay without penalty is extended to the next business day.  
Due to the federal Emancipation Day holiday on April 16, 2018, tax returns filed and payments mailed or submitted on April 17, 2018, will be considered timely.

**ONLINE SERVICES:** Corporations can make payments online using Web Pay for Businesses. Corporations can make an immediate payment or schedule payments up to a year in advance. Go to [ftb.ca.gov/pay](http://ftb.ca.gov/pay) for more information.

739035 11-29-17

--- DETACH HERE --- IF NO PAYMENT IS DUE, DO NOT MAIL THIS VOUCHER --- DETACH HERE ---

**CAUTION:** You may be required to pay electronically, see instructions.

TAXABLE YEAR **Payment Voucher for Corporations and Exempt Organizations e-filed Returns**

CALIFORNIA FORM  
**3586 (e-file)**

0000000 UNIO 52-0607945 9612036 17 FORM 3  
TYB 07-01-2017 TYE 06-30-2018  
UNION HOSPITAL OF CECIL COUNTY INC

106 BOW STREET  
ELKTON MD 21921-5596

(410) 398-4000

Amount of Payment 10.

TAXABLE YEAR

2017

# California e-file Return Authorization for Exempt Organizations

FORM  
8453-EO

Exempt Organization name	Identifying number
<b>UNION HOSPITAL OF CECIL COUNTY, INC.</b>	<b>52-0607945</b>

### Part I Electronic Return Information (whole dollars only)

1 Total gross receipts (Form 199, line 4)	1	173,521,323.00
2 Total gross income (Form 199, line 8)	2	167,245,243.00
3 Total expenses and disbursements (Form 199, line 9)	3	176,046,174.00

### Part II Settle Your Account Electronically for Taxable Year 2017

4 <input type="checkbox"/> Electronic funds withdrawal	4a Amount	4b Withdrawal date (mm/dd/yyyy)
--	-----------	---------------------------------

### Part III Banking Information (Have you verified the exempt organization's banking information?)

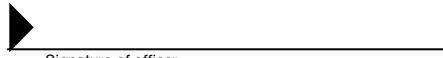
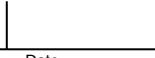
5 Routing number _____	7 Type of account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings
6 Account number _____	

### Part IV Declaration of Officer

I authorize the exempt organization's account to be settled as designated in Part II. If I check Part II, Box 4, I authorize an electronic funds withdrawal for the amount listed on line 4a.

Under penalties of perjury, I declare that I am an officer of the above exempt organization and that the information I provided to my electronic return originator (ERO), transmitter, or intermediate service provider and the amounts in Part I above agree with the amounts on the corresponding lines of the exempt organization's 2017 California electronic return. To the best of my knowledge and belief, the exempt organization's return is true, correct, and complete. If the exempt organization is filing a balance due return, I understand that if the Franchise Tax Board (FTB) does not receive full and timely payment of the exempt organization's fee liability, the exempt organization will remain liable for the fee liability and all applicable interest and penalties. I authorize the exempt organization return and accompanying schedules and statements be transmitted to the FTB by the ERO, transmitter, or intermediate service provider. **If the processing of the exempt organization's return or refund is delayed, I authorize the FTB to disclose to the ERO or intermediate service provider the reason(s) for the delay.**


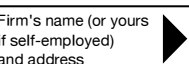
Sign Here


  
 Signature of officer \_\_\_\_\_ Date \_\_\_\_\_


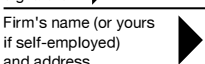
  
 Title \_\_\_\_\_ **CHIEF FINANCIAL OFFICER**

### Part V Declaration of Electronic Return Originator (ERO) and Paid Preparer.

I declare that I have reviewed the above exempt organization's return and that the entries on form FTB 8453-EO are complete and correct to the best of my knowledge. (If I am only an intermediate service provider, I understand that I am not responsible for reviewing the exempt organization's return. I declare, however, that form FTB 8453-EO accurately reflects the data on the return.) I have obtained the organization officer's signature on form FTB 8453-EO before transmitting this return to the FTB; I have provided the organization officer with a copy of all forms and information that I will file with the FTB, and I have followed all other requirements described in FTB Pub. 1345, 2017 e-file Handbook for Authorized e-file Providers. I will keep form FTB 8453-EO on file for **four** years from the due date of the return or **four** years from the date the exempt organization return is filed, whichever is later, and I will make a copy available to the FTB upon request. If I am also the paid preparer, under penalties of perjury, I declare that I have examined the above exempt organization's return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. I make this declaration based on all information of which I have knowledge.

ERO's signature 	Date _____	Check if also paid preparer <input type="checkbox"/>	Check if self-employed <input type="checkbox"/>	ERO's PTIN _____
Must Sign Firm's name (or yours if self-employed) and address 	FEIN _____			ZIP code _____

Under penalties of perjury, I declare that I have examined the above organization's return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. I make this declaration based on all information of which I have knowledge.

Paid Preparer Must Sign Paid preparer's signature 	Date _____	Check if self-employed <input type="checkbox"/>	Paid preparer's PTIN <b>P00350393</b>
Firm's name (or yours if self-employed) and address 	FEIN <b>39-0859910</b>		ZIP code <b>19103-7341</b>
<b>BAKER TILLY VIRCHOW KRAUSE, LLP</b>			
<b>1650 MARKET STREET, SUITE 4500</b>			
<b>PHILADELPHIA, PA</b>			

**California Exempt Organization  
Business Income Tax Return**

Calendar Year 2017 or fiscal year beginning (mm/dd/yyyy) **07/01/2017**, and ending (mm/dd/yyyy) **06/30/2018**

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

Additional information. See instructions. FEIN  
**52-0607945**

Street address (suite/room no.)  
**106 BOW STREET** PMB no.

City (If the corporation has a foreign address, see instructions.)  
**ELKTON** State  
**MD** ZIP code  
**21921-5596**

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

- A First Return Filed?  Yes  No
- B Is this an education IRA within the meaning of R&TC Section 23712?  Yes  No
- C Is the organization under audit by the IRS or has the IRS audited in a prior year?  Yes  No
- D Final Return?  
  - Dissolved  Surrendered (Withdrawn)  Merged/Reorganized
  - Enter date (mm/dd/yyyy) \_\_\_\_\_
- E Amended Return  Yes  No
- F Accounting Method Used: (1)  Cash (2)  Accrual (3)  Other
- G Nature of trade or business **SEE STATEMENT 13**
- H Is the organization a non-exempt charitable trust as described in IRC Section 4947(a)(1)?  Yes  No
- I Is this organization claiming any former; Enterprise Zone (EZ), Los Angeles Revitalization Zone (LARZ), Local Agency Military Base Recovery Area (LAMBRA), Targeted Tax Area (TTA), or Manufacturing Enhancement Area (MEA) tax benefits?  Yes  No
- J Is this organization a qualified pension, profit-sharing, or stock bonus plan as described in IRC Section 401(a)?  Yes  No
- K Unrelated Business Activity (UBA) Code **621500**
- L Is this a Hospital?  Yes  No  
If "Yes," attach federal Schedule H (Form 990)

<b>Taxable Corporation</b>	1	Unrelated business taxable income from Side 2, Part II, line 30	•	1	24,586.00
	2	Mult. In 1 by the avg. apport. pctg _____ % from the Sch. R, Apport. Formula Wksht, Part A, In 2 or Part B, In 5. See instr.	•	2	00
	3	Enter the lesser amt from In 1 or In 2. If the unrelated bus. activity is wholly in CA and Sch. R was not compltd, enter the amt from In 1	•	3	24,586.00
<b>Taxable Trust</b>	4	Unrelated business taxable income from Side 2, Part II, line 30	•	4	00
<b>Tax Computation</b>	5	Unrelated business taxable income from line 3 or line 4	•	5	24,586.00
	6	EZ, LARZ, LAMBRA, or TTA NOL carryover deduction	•	6	00
	7	Net Operating Loss deduction. See General Information N	•	7	24,586.00
	8	Add line 6 and line 7	•	8	24,586.00
	9	Net unrelated business taxable income. Subtract line 8 from line 5	•	9	0.00
	10	Tax <b>8.84</b> % x line 9. See General Information J	•	10	00
	11	Tax credits from Schedule B. See instructions	•	11	00
<b>Total Tax</b>	12	Balance. Subtract line 11 from line 10. If line 11 is greater than line 10, enter -0-	•	12	00
	13	Alternative minimum tax. See General Information O	•	13	00
	14	Total tax. Add line 12 and line 13	•	14	0.00
<b>Payments</b>	15	Overpayment from a prior year allowed as a credit	•	15	00
	16	2017 estimated tax payments. See instructions	•	16	00
	17	Withholding (Form 592-B and/or 593.) See instructions	•	17	00
	18	Amount paid with extension (form FTB 3539)	•	18	00
	19	Total payments and credits. Add line 15 through line 18	•	19	00
<b>Use Tax/Tax Due/Overpayment</b>	20	Use tax. See instructions	•	20	00
	21	Payments balance. If line 19 is more than line 20, subtract line 20 from line 19	•	21	00
	22	Use tax balance. If line 20 is more than line 19, subtract line 19 from line 20	•	22	00
	23	Tax due. Subtract line 21 from line 14. Pay entire amount with return. See instructions	•	23	00
	24	Overpayment. Subtract line 14 from line 21. See instructions	•	24	00
	25	Enter amount of line 24 to be applied to 2018 estimated tax	•	25	00



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

**Unrelated Business Taxable Income**

**Part I Unrelated Trade or Business Income**

1 a Gross receipts or gross sales	b Less returns and allowances	c Balance	1c	00
2 Cost of goods sold and/or operations (Schedule A, line 7)			2	00
3 Gross profit. Subtract line 2 from line 1c			3	00
4 a Capital gain net income. See Specific Line Instructions - Trusts attach Schedule D (541)			4a	00
b Net gain (loss) from Part II, Schedule D-1			4b	00
c Capital loss deduction for trusts			4c	00
5 Income (or loss) from partnerships, limited liability companies, or S corporations. See specific line instructions. Attach Schedule K-1 (565, 568, or 100S) or similar schedule	SEE STATEMENT 14		5	798.00
6 Rental income (Schedule C)			6	00
7 Unrelated debt-financed income (Schedule D)			7	00
8 Investment income of an R&TC Section 23701g, 23701i, or 23701n organization (Schedule E)			8	00
9 Interest, Annuities, Royalties and Rents from controlled organizations (Schedule F)			9	00
10 Exploited exempt activity income (Schedule G)			10	00
11 Advertising income (Schedule H, Part III, Column A)			11	00
12 Other income. Attach schedule	SEE STATEMENT 15		12	23,788.00
13 Total unrelated trade or business income. Add line 3 through line 12			13	24,586.00

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

14 Compensation of officers, directors, and trustees from Schedule I		14	00	
15 Salaries and wages		15	00	
16 Repairs		16	00	
17 Bad debts		17	00	
18 Interest		18	00	
19 Taxes		19	00	
20 Contributions		20	00	
21 a Depreciation (Corporations and Associations - Schedule J) (Trusts - form FTB 3885F)	21a	00		
b Less: depreciation claimed on Schedule A	21b	00	21	00
22 Depletion		22	00	
23 a Contributions to deferred compensation plans		23a	00	
b Employee benefit programs		23b	00	
24 Other deductions		24	00	
25 Total deductions. Add line 14 through line 24		25	00	
26 Unrelated business taxable income before allowable excess advertising costs. Subtract line 25 from line 13		26	24,586.00	
27 Excess advertising costs (Schedule H, Part III, Column B)		27	00	
28 Unrelated business taxable income before specific deduction. Subtract line 27 from line 26		28	24,586.00	
29 Specific deduction		29	00	
30 Unrelated business taxable income. Subtract line 29 from line 28. If line 28 is a loss, enter line 28		30	24,586.00	

**Sign Here**

To learn about your privacy rights, how we may use your information, and the consequences for not providing the requested information, go to [ftb.ca.gov/forms](http://ftb.ca.gov/forms) and search for 1131. To request this notice by mail, call 800.852.5711.  
Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature of officer	Title <b>CHIEF FINANCIAL OF</b>	Date	Telephone
Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN <b>P00350393</b>
Firm's name (or yours, if self-employed) and address	<b>BAKER TILLY VIRCHOW KRAUSE, LLP</b> <b>1650 MARKET STREET, SUITE 4500</b> <b>PHILADELPHIA, PA 19103-7341</b>		FEIN <b>39-0859910</b> Telephone <b>215.972.0701</b>
May the FTB discuss this return with the preparer shown above? See instructions			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

**Schedule A Cost of Goods Sold and/or Operations.**

Method of inventory valuation (specify)

N/A

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

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

**Schedule B Tax Credits.**

1	Enter credit name	code	1	00	
2	Enter credit name	code	2	00	
3	Enter credit name	code	3	00	
4	Total. Add line 1 through line 3. If claiming more than 3 credits, enter the total of all claimed credits on line 4. Enter here and on Side 1, line 11			4	00

**Schedule K Add-On Taxes or Recapture of Tax.**

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

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

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

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

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

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

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

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

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

Add columns 4(b) and column 5(c). Enter here and on Side 2, Part I, line 6

Schedule D Unrelated Debt-Financed Income

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

Total. Enter here and on Side 2, Part I, line 7

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

Table with 6 columns: 1 Description, 2 Amount, 3 Deductions directly connected, 4 Net investment income, column 2 less column 3, 5 Set-asides, 6 Balance of investment income, column 4 less column 5.

Total. Enter here and on Side 2, Part I, line 8

Enter gross income from members (dues, fees, charges, or similar amounts)

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

Table with 6 columns: 1 Name of controlled organizations, 2 Employer Identification Number, 3 Net unrelated income (loss), 4 Total of specified payments made, 5 Part of column (4) that is included in the controlling organization's gross income, 6 Deductions directly connected with income in column (5). Includes sub-section for Exempt Controlled Organizations.

Table with 6 columns: 7 Taxable Income, 8 Net unrelated income (loss), 9 Total of specified payments made, 10 Part of column (9) that is included in the controlling organization's gross income, 11 Deductions directly connected with income in column (10). Includes sub-section for Nonexempt Controlled Organizations.

Schedule G Exploited Exempt Activity Income, other than Advertising Income

Table with 8 columns: 1 Description of exploited activity (attach schedule if more than one unrelated activity is exploiting the same exempt activity), 2 Gross unrelated business income from trade or business, 3 Expenses directly connected with production of unrelated business income, 4 Net income from unrelated trade or business, column 2 less column 3, 5 Gross income from activity that is not unrelated business income, 6 Expenses attributable to column 5, 7 Excess exempt expense, column 6 less column 5 but not more than column 4, 8 Net income includible, column 4 less column 7 but not less than zero.

Total. Enter here and on Side 2, Part I, line 10

Schedule H Advertising Income and Excess Advertising Costs

Part I Income from Periodicals Reported on a Consolidated Basis

Table with 7 columns: 1 Name of periodical, 2 Gross advertising income, 3 Direct advertising costs, 4 Advertising income or excess advertising costs, 5 Circulation income, 6 Readership costs, 7 Instructions for calculation.

Part II Income from Periodicals Reported on a Separate Basis

Table with 7 columns, same structure as Part I, for separate basis reporting.

Part III Column A - Net Advertising Income

Part III Column B - Excess Advertising Costs

Table with 4 columns: (a) Enter "consolidated periodical" and/or names of non-consolidated periodicals, (b) Enter total amount from Part I, column 4 or 7, and amount listed in Part II, column 4 or 7.

Enter total here and on Side 2, Part I, line 11

Enter total here and on Side 2, Part II, line 27

Schedule I Compensation of Officers, Directors, and Trustees

Table with 6 columns: 1 Name of Officer, 2 SSN or ITIN, 3 Title, 4 Percent of time devoted to business, 5 Compensation attributable to unrelated business, 6 Expense account allowances.

Total. Enter here and on Side 2, Part II, line 14

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

Table with 7 columns: 1 Group and guideline class or description of property, 2 Date acquired (mm/dd/yyyy), 3 Cost or other basis, 4 Depreciation allowed or allowable in prior years, 5 Method of computing depreciation, 6 Life or rate, 7 Depreciation for this year.

CA 109	NATURE OF TRADE OR BUSINESS	STATEMENT 13
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LABORATORY SERVICES TO NON-PATIENTS  
INCOME FROM PARTNERSHIPS

TO FORM 109, PAGE 1

CA 109	INCOME OR (LOSS) FROM PARTNERSHIPS, LIMITED LIABILITY COMPANIES OR S CORPORATIONS	STATEMENT 14
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DESCRIPTION	AMOUNT
BTAS 2015 PRIVATE INVESTORS US LP (EIN: 47-3930651)	395.
PREMIER HEALTHCARE ALLIANCE LP (EIN: 33-0387407)	403.
TOTAL TO FORM 109, PAGE 2, LINE 5	798.

CA 109	OTHER INCOME	STATEMENT 15
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DESCRIPTION	AMOUNT
DISALLOWED PARKING FRINGE BENEFITS	23,788.
TOTAL TO FORM 109, PAGE 2, LINE 12	23,788.

Attach to Form 100, Form 100W, Form 100S, or Form 109.

Corporation name

California corporation number

UNION HOSPITAL OF CECIL COUNTY, INC.

9612036

During the taxable year the corporation incurred the NOL, the corporation was a(n):   C Corporation  
  S Corporation   Exempt Organization   Limited liability company (electing to be taxed as a corporation)

FEIN  
52-0607945

If the corporation previously filed California tax returns under another corporate name, enter the corporation name and California corporation number:

If the corporation is included in a combined report of a unitary group, see instructions, General Information C, Combined Reporting.

Part I Current year NOL. If the corporation does not have a current year NOL, go to Part II.

1	Net loss from Form 100, line 18; Form 100W, line 18; Form 100S, line 15; or Form 109, line 2. Enter as a positive number	1	0.00
2	2017 disaster loss included in line 1. Enter as a positive number	2	00
3	Subtract line 2 from line 1. If zero or less, enter -0- and see instructions	3	00
4	a Enter the amount of the loss incurred by a new business included in line 3	4a	00
	b Enter the amount of the loss incurred by an eligible small business included in line 3	4b	00
	c Add line 4a and line 4b	4c	00
5	General NOL. Subtract line 4c from line 3	5	00
6	Current Year NOL. Add line 2, line 4c, and line 5. See instructions	6	00

If the corporation is using the current year NOL to carryback to offset net income for taxable years 2015 and/or 2016, complete

Part III, NOL carryback, on Side 2 before completing Part I, lines 7-9 below.

7	2017 NOL carryback used to offset 2015 net income. Enter the amount from Part III, line 3, column (e)	7	00
8	2017 NOL carryback used to offset 2016 net income. Enter the amount from Part III, line 3, column (g)	8	00
9	2017 NOL carryover to 2018. Add line 7 and line 8, then subtract the result from line 6. See instructions.	9	00

Election to waive carryback

Check the box if the corporation elects to relinquish the entire carryback period with respect to 2017 NOL under Internal Revenue Code (IRC) Section 172(b)(3).  
 By making the election, the corporation is electing to carry an NOL forward instead of carrying it back in the previous two years. Once the election is made, it's irrevocable. See instructions. Continue with Part II, NOL carryover and disaster loss carryover limitations. Do not complete Part III, NOL carryback.

Part II NOL carryover and disaster loss carryover limitations. See instructions.

1	Net income - Enter the amount from Form 100, line 18; Form 100W, line 18; Form 100S, line 15 less line 16; or Form 109, line 2; (but not less than -0-).	(g) Available balance	
		24,586.	

Prior Year NOLs

(a) Year of loss	(b) Code - See instructions	(c) Type of NOL - See below *	(d) Initial loss - See instructions	(e) Carryover from 2016	(f) Amount used in 2017	(g) Available balance	(h) Carryover to 2018 col. (e) minus col. (f)
2015		GEN	35,991.	34,207.	24,586.	0.	9,621.

Current Year NOLs

(a) Year of loss	(b) Code - See instructions	(c) Type of NOL - See below *	(d) Initial loss - See instructions	(e) Carryover from 2016	(f) Amount used in 2017	(g) Available balance	(h) Carryover to 2018 col. (d) minus col. (f) See instructions.
3 2017		DIS					
4 2017							
2017							
2017							
2017							

\* Type of NOL: General (GEN), New Business (NB), Eligible Small Business (ESB), or Disaster (DIS).

**Part III NOL carryback**

1	2015 Net income - Enter the amount from 2015 Form 100, line 22; Form 100W, line 22; Form 100S line 20; or taxable income from Form 109, line 9; (but not less than -0-)	<b>- 35,991.</b>
2	2016 Net income - Enter the amount from 2016 Form 100, line 22; Form 100W, line 22; Form 100S, line 20; or taxable income from Form 109, line 9; (but not less than -0-)	

(a) Year of Loss	(b) Code - See Instructions	(c) Type of NOL - See below*	(d) Initial loss - See Instructions	2015		2016		(i) Carryover to 2018 col. (d) minus col. (e) plus col. (g))
				(e) Carryback used - See instructions	(f) After carryback col. (d) minus col. (e)	(g) Carryback used - See instructions	(h) After carryback col. (f) minus col. (g)	
3 2017								
2017								
2017								
2017								
2017								

\* **Type of NOL:** General (GEN), New Business (NB), Eligible Small Business (ESB), or NOL attributable to a qualified disaster loss (DIS).

**Part IV 2017 NOL deduction**

1	Total the amounts in Part II, line 2, column (f)	<input checked="" type="radio"/> 1 <b>24,586.00</b>
2	Enter the total amount from line 1 that represents disaster loss carryover deduction here and on Form 100, line 21; Form 100W, line 21; or Form 100S, line 19. Form 109 filers enter -0-	2 <b>0.00</b>
3	Subtract line 2 from line 1. Enter the result here and on Form 100, line 19; Form 100W, line 19; Form 100S, line 17; or Form 109, line 7	<input checked="" type="radio"/> 3 <b>24,586.00</b>