

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)

2018

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 for instructions and the latest information.

Open to Public Inspection

A For the 2018 calendar year, or tax year beginning **JUL 1, 2018** and ending **JUN 30, 2019**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization UNION HOSPITAL OF CECIL COUNTY, INC. Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite 106 BOW STREET City or town, state or province, country, and ZIP or foreign postal code ELKTON, MD 21921-5596 F Name and address of principal officer: RICHARD C. SZUMEL, MD SAME AS C ABOVE	D Employer identification number 52-0607945 E Telephone number (410) 398-4000 G Gross receipts \$ 190,092,178. H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) H(c) Group exemption number ▶
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		
J Website: ▶ WWW.UHCC.COM		
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		
		L Year of formation: 1903
		M State of legal domicile: MD

Part I Summary

		1 Briefly describe the organization's mission or most significant activities: PROVIDE HEALTHCARE SERVICES TO THE RESIDENTS OF CECIL COUNTY, MD AND THE SURROUNDING AREA.		
		2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
Activities & Governance	3	Number of voting members of the governing body (Part VI, line 1a)	3	15
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	12
	5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	5	1382
	6	Total number of volunteers (estimate if necessary)	6	326
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	1,597,296.
	7b	Net unrelated business taxable income from Form 990-T, line 38	7b	0.
	Revenue	8	Contributions and grants (Part VIII, line 1h)	Prior Year 4,635,791.	Current Year 10,510,084.
9		Program service revenue (Part VIII, line 2g)	157,587,785.	160,923,585.
10		Investment income (Part VIII, column (A), lines 3, 4, and 7d)	2,311,445.	1,953,831.
11		Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,701,917.	2,627,581.
12		Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	167,236,938.	176,015,081.
13		Grants and similar amounts paid (Part IX, column (A), lines 1-3)	3,116,525.	799,694.
14		Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
Expenses	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	84,855,967.	87,612,271.
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	88,065,377.	81,859,106.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	176,037,869.	170,271,071.
19	Revenue less expenses. Subtract line 18 from line 12	-8,800,931.	5,744,010.	
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	Beginning of Current Year 166,082,740.	End of Year 163,925,550.
	21	Total liabilities (Part X, line 26)	88,978,017.	81,586,351.
	22	Net assets or fund balances. Subtract line 21 from line 20	77,104,723.	82,339,199.

Part II Signature Block

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

Sign Here	Signature of officer JAMES G. RAAB, CHIEF FINANCIAL OFFICER Type or print name and title	Date
Paid Preparer Use Only	Print/Type preparer's name KERRI N. BOGDA, CPA	Preparer's signature Date
	Firm's name ▶ BAKER TILLY VIRCHOW KRAUSE, LLP Firm's address ▶ 1570 FRUITVILLE PIKE, SUITE 400 LANCASTER, PA 17601	Check if self-employed <input type="checkbox"/> PTIN P00760402 Firm's EIN ▶ 39-0859910 Phone no. 717.740.4863

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 \$ 166,435,269. including grants of \$ 799,694.) (Revenue \$ 160,923,585.) 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 166,435,269.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

	Yes	No
22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>		X
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	X	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	X	
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		X
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		X
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		X
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>		X
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>		X
26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i>		X
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>		X
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		X
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		X
c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	X	
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>		X
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		X
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		X
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>		X
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>		X
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	X	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?		X
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>		
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		X
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>		X
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. 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

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

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

		Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return		
	2a		1382
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	X	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	X	
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		X
b	If "Yes," enter the name of the foreign country: See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
d	If "Yes," indicate the number of Forms 8282 filed during the year		7d
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
9	Sponsoring organizations maintaining donor advised funds.		
a	Did the sponsoring organization make any taxable distributions under section 4966?		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter:		
a	Initiation fees and capital contributions included on Part VIII, line 12	10a	
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b	
11	Section 501(c)(12) organizations. Enter:		
a	Gross income from members or shareholders	11a	
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b	
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b	
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O.	13a	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b	
c	Enter the amount of reserves on hand	13c	
14a	Did the organization receive any payments for indoor tanning services during the tax year?		X
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O	14b	
15	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N.	15	X
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.	16	X

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

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

Section A. Governing Body and Management

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

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

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

Section C. Disclosure

- 17** List the states with which a copy of this Form 990 is required to be filed **MD**
- 18** Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
 Own website Another's website Upon request Other (explain 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.	464,393.	48,033.
(5) KELLY ALBANESE BEDDER DIRECTOR	0.50 1.50	X						0.	0.	0.
(6) MARY BOLT, PH.D. DIRECTOR	0.50 0.50	X						0.	0.	0.
(7) REVEREND KEVIN BROWN DIRECTOR	0.50 0.50	X						0.	0.	0.
(8) CHRISTY DRYER, DNP DIRECTOR	0.50 0.50	X						0.	0.	0.
(9) JOSE MA, MD DIRECTOR	39.50 0.50	X						270,674.	0.	0.
(10) MORGAN MILLER, MLIS DIRECTOR	0.50 0.50	X						0.	0.	0.
(11) ROBERT PALSGROVE DIRECTOR	0.50 0.50	X						0.	0.	0.
(12) JUSTIN SAUSVILLE, M.D. DIRECTOR	39.50 0.50	X						558,694.	0.	0.
(13) CARL ROBERTS, PH.D. DIRECTOR	0.50 0.50	X						0.	0.	0.
(14) DAVID TROLIO DIRECTOR	0.50 0.50	X						0.	0.	0.
(15) JACQUES RENE DIRECTOR	0.50 0.50	X						0.	0.	0.
(16) STEPHANIE GARRITY DIRECTOR (UNTIL 06/19)	0.50 0.50	X						0.	0.	0.
(17) SHEELMOHAN SACHDEV, MD DIRECTOR (UNTIL 06/19)	0.50 0.50	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) RONALD GRAYBEAL DIRECTOR (UNTIL 02/19)	0.50 0.50	X						0.	0.	0.
(19) DR. RYAN GERACIMOS DIRECTOR (UNTIL 03/19)	0.50 0.50	X						0.	0.	0.
(20) MARTIN J. HEALY DIRECTOR (UNTIL 02/19)	0.50 0.50	X						0.	0.	0.
(21) JAMES G. RAAB SENIOR VP/CHIEF FINANCIAL OFFICER	29.00 11.00			X				0.	317,406.	31,760.
(22) AARON Z. ROYSTON VP OF PROVIDER ENTERPRISE	30.00 10.00				X			237,190.	0.	4,819.
(23) CRAIG M. BABBITT IN-HOUSE LEGAL COUNSEL	40.00				X			177,854.	0.	3,554.
(24) CYDNEY TEAL, MD (UNTIL 2/23/19) VP MEDICAL AFFAIRS	39.00 1.00				X			0.	348,424.	27,051.
(25) ANNE LARA (RETIRED 06/30/18) SR. VP/CHIEF INNOVATION OFFICER	33.00 7.00				X			0.	164,019.	11,995.
(26) KHADIJATU BOSTON (UNTIL 01/18) SR. VP/CHIEF NURSING OFFICER	39.00 1.00				X			0.	170,111.	1,912.
1b Sub-total								1,244,412.	1,464,353.	129,124.
c Total from continuation sheets to Part VII, Section A								3,022,975.	0.	140,549.
d Total (add lines 1b and 1c)								4,267,387.	1,464,353.	269,673.

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	3,351,073.
WHITING-TURNER CONTRACTING CO. P.O. BOX 17596, BALTIMORE, MD 21297	CONTRACTOR	3,181,460.
MDICS AT UNION CECIL COUNTY, LLC, 7250 PARKWAY DR., STE. 500, HANOVER, MD 21076	PROFESSIONAL STAFFING	1,290,346.
CLEARPATH SOLUTIONS, 2465 CENTREVILLE RD, SUITE J17-722, HERNDON, VA 20171	IT HARDWARE AND SOFTWARE	957,439.
USACS INTEGRATED ACUTE CARE SERVICES OF MAR 4535 DRESSLER RD NW, CANTON, OH 44718	ACUTE CARE SERVICES	920,041.
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		114

SEE PART VII, SECTION A CONTINUATION SHEETS

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 (check all that apply)						(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			
(27) TERRANCE LOVELL (UNTIL 01/18) VP HUMAN RESOURCES	40.00				X			307,466.	0.	1,546.
(28) FAHD RAHMAN PHYSICIAN	40.00					X		684,898.	0.	36,561.
(29) JUSTIN SAUSVILLE PHYSICIAN	40.00					X		558,694.	0.	39,166.
(30) ROGER D. WU PHYSICIAN	40.00					X		515,615.	0.	28,629.
(31) NITIN AGGARWAL PHYSICIAN	40.00					X		513,066.	0.	23,312.
(32) DANIELLE M. PRESS PHYSICIAN	40.00					X		443,236.	0.	11,335.
Total to Part VII, Section A, line 1c								3,022,975.		140,549.

Part VIII Statement of Revenue

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

			(A)	(B)	(C)	(D)	
			Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d	10,367,449.				
	e Government grants (contributions)	1e					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	142,635.				
	g Noncash contributions included in lines 1a-1f: \$						
	h Total. Add lines 1a-1f			10,510,084.			
Program Service Revenue	2 a NET PATIENT SERVICE REVENUE	Business Code 621990	159,015,886.	159,015,886.			
	b OTHER OPERATING REVENUE	621990	1,472,383.	1,472,383.			
	c ADULT DAY CARE	623990	435,316.	435,316.			
	d						
	e						
	f All other program service revenue						
	g Total. Add lines 2a-2f			160,923,585.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		1,667,296.		-108,770.	1,776,066.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real	37,036.				
		(ii) Personal					
		b Less: rental expenses	8,307.				
		c Rental income or (loss)	28,729.				
	d Net rental income or (loss)		28,729.			28,729.	
	7 a Gross amount from sales of assets other than inventory	(i) Securities	14,355,325.				
		(ii) Other					
		b Less: cost or other basis and sales expenses	14,067,475.	1,315.			
		c Gain or (loss)	287,850.	-1,315.			
	d Net gain or (loss)		286,535.			286,535.	
	8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a					
		b Less: direct expenses					
c Net income or (loss) from fundraising events							
9 a Gross income from gaming activities. See Part IV, line 19	a						
	b Less: direct expenses						
	c Net income or (loss) from gaming activities						
10 a Gross sales of inventory, less returns and allowances	a						
	b Less: cost of goods sold						
	c Net income or (loss) from sales of inventory						
Miscellaneous Revenue		Business Code					
11 a LABORATORY REVENUE	621500	1,706,066.		1,706,066.			
b CAFETERIA/FOOD SERVICE	722210	789,958.			789,958.		
c PARKING REVENUE	900099	35,760.			35,760.		
d All other revenue	900099	67,068.			67,068.		
e Total. Add lines 11a-11d			2,598,852.				
12 Total revenue. See instructions			176,015,081.	160,923,585.	1,597,296.	2,984,116.	

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 ...	799,694.	799,694.		
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	1,490,294.	1,045,009.	445,285.	
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	71,196,463.	70,424,238.	772,225.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	380,610.	380,610.		
9 Other employee benefits	9,672,454.	9,550,473.	121,981.	
10 Payroll taxes	4,872,450.	4,796,115.	76,335.	
11 Fees for services (non-employees):				
a Management	910,899.	455,450.	455,449.	
b Legal	169,686.		169,686.	
c Accounting	108,660.		108,660.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	63,551.		63,551.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch. O.)	25,660,515.	24,281,878.	1,378,637.	
12 Advertising and promotion	330,541.	330,541.		
13 Office expenses	2,162,906.	2,148,104.	14,802.	
14 Information technology	98,193.	98,193.		
15 Royalties				
16 Occupancy	4,193,912.	4,193,912.		
17 Travel	111,661.	101,637.	10,024.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials ...				
19 Conferences, conventions, and meetings	106,377.	60,774.	45,603.	
20 Interest	1,942,655.	1,942,655.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	11,026,334.	11,026,334.		
23 Insurance	2,730,287.	2,728,715.	1,572.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	19,329,569.	19,327,046.	2,523.	
b BAD DEBTS	6,959,649.	6,959,649.		
c REPAIRS & MAINTENANCE	3,274,111.	3,274,104.	7.	
d DIETARY	889,820.	883,670.	6,150.	
e All other expenses	1,789,780.	1,626,468.	163,312.	
25 Total functional expenses. Add lines 1 through 24e	170,271,071.	166,435,269.	3,835,802.	0.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				
Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	3,007,119.	1	6,198,168.
	2 Savings and temporary cash investments	162,892.	2	0.
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	16,617,200.	4	14,069,712.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	2,268,203.	8	2,307,404.
	9 Prepaid expenses and deferred charges	2,136,306.	9	2,940,202.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 225,395,847.		
	b Less: accumulated depreciation	10b 142,462,854.	88,138,296.	10c 82,932,993.
	11 Investments - publicly traded securities	31,440,920.	11	32,337,168.
	12 Investments - other securities. See Part IV, line 11	13,873,382.	12	14,486,077.
	13 Investments - program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	8,438,422.	15	8,653,826.
16 Total assets. Add lines 1 through 15 (must equal line 34)	166,082,740.	16	163,925,550.	
Liabilities	17 Accounts payable and accrued expenses	14,591,487.	17	10,375,169.
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities	59,181,386.	20	56,179,987.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties		23	
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	15,205,144.	25	15,031,195.
	26 Total liabilities. Add lines 17 through 25	88,978,017.	26	81,586,351.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	74,557,561.	27	79,490,139.
	28 Temporarily restricted net assets	2,547,162.	28	2,849,060.
	29 Permanently restricted net assets		29	
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
33 Total net assets or fund balances	77,104,723.	33	82,339,199.	
34 Total liabilities and net assets/fund balances	166,082,740.	34	163,925,550.	

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	176,015,081.
2	Total expenses (must equal Part IX, column (A), line 25)	2	170,271,071.
3	Revenue less expenses. Subtract line 2 from line 1	3	5,744,010.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	77,104,723.
5	Net unrealized gains (losses) on investments	5	-658,922.
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	149,388.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	82,339,199.

Part XII Financial Statements and Reporting

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

- 1 Accounting method used to prepare the Form 990: Cash Accrual Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.
- 2a Were the organization's financial statements compiled or reviewed by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- b Were the organization's financial statements audited by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.
- 3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits

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

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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2017 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2018. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 33 1/3% support test - 2017. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2018. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2017. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2018 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2017 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2018 (line 10c, column (f), divided by line 13, column (f))	17	%
18 Investment income percentage from 2017 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2018. 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 - 2017. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

Section C - Distributable Amount		(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	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions.	
7 Total annual distributions. Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	
9 Distributable amount for 2018 from Section C, line 6	
10 Line 8 amount divided by line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2018	(iii) Distributable Amount for 2018
1 Distributable amount for 2018 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2018 (reasonable cause required- explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2018			
a From 2013			
b From 2014			
c From 2015			
d From 2016			
e From 2017			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2018 distributable amount			
i Carryover from 2013 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2018 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2018 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2018, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI . See instructions.			
6 Remaining underdistributions for 2018. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI . See instructions.			
7 Excess distributions carryover to 2019. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2014			
b Excess from 2015			
c Excess from 2016			
d Excess from 2017			
e Excess from 2018			

Schedule B

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

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2018

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 (entering "N/A" in column (b) instead of the contributor name and address), II, and III.

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

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	AFFINITY HEALTH ALLIANCE, INC. 106 BOW STREET ELKTON, MD 21921	\$ 10,193,632.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	UNION HOSPITAL OF CECIL COUNTY FOUNDATION 106 BOW STREET ELKTON, MD 21921	\$ 177,042.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	MARYLAND ENERGY ADMINISTRATION 1800 WASHINGTON BLVD, STE. 755 BALTIMORE, MD 21230	\$ 139,410.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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

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

Name of organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this info. once.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

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

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

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

OMB No. 1545-0047

2018
Open to Public Inspection

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

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

(ii) Assets included in Form 990, Part X

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

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

b Assets included in Form 990, Part X

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

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

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

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

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

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

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment _____ %
 - b Permanent endowment _____ %
 - c Temporarily restricted endowment _____ %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|--------|----|
| (i) unrelated organizations | 3a(i) | |
| (ii) related organizations | 3a(ii) | |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? <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		88,087,128.	41,716,458.	46,370,670.
c Leasehold improvements		2,698,719.	612,976.	2,085,743.
d Equipment		131,692,797.	98,732,131.	32,960,666.
e Other		1,782,298.	1,401,289.	381,009.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				82,932,993.

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	5,845,430.	COST
(3) Other		
(A) MANAGED HEDGE FUNDS	4,800,000.	COST
(B) MANAGED HEDGE FUNDS	3,840,647.	END-OF-YEAR MARKET VALUE
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.)	14,486,077.	

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) OTHER ASSETS	662,806.
(2) INSURANCE CLAIMS RECEIVABLE	7,666,493.
(3) DUE FROM AFFILIATES	324,527.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.)	8,653,826.

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	3,485,157.
(3) CAPITAL LEASE OBLIGATIONS	2,273,241.
(4) ESTIMATED MEDICAL MALPRACTICE	
(5) CLAIMS LIABILITY	8,853,757.
(6) DUE TO AFFILIATES	419,040.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	15,031,195.

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.

1	Total revenue, gains, and other support per audited financial statements	1	167,682,653.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains (losses) on investments	2a	-658,922.
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIII.)	2d	-7,673,506.
e	Add lines 2a through 2d	2e	-8,332,428.
3	Subtract line 2e from line 1	3	176,015,081.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	
c	Add lines 4a and 4b	4c	0.
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)	5	176,015,081.

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

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

1	Total expenses and losses per audited financial statements	1	162,448,177.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIII.)	2d	
e	Add lines 2a through 2d	2e	0.
3	Subtract line 2e from line 1	3	162,448,177.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	7,822,894.
c	Add lines 4a and 4b	4c	7,822,894.
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)	5	170,271,071.

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 2019 AND 2018.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

PROVISION FOR BAD DEBTS NETTED AGAINST REVENUE ON FINANCIALS -6,959,649.

BANK FEES NETTED AGAINST REVENUE ON FINANCIALS -63,551.

CHANGE IN NET ASSETS OF AFFILIATES 149,388.

Part XIII Supplemental Information (continued)

TRANSFER TO AFFILIATES NETTED AGAINST REVENUE ON FINANCIALS	-799,694.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	-7,673,506.

PART XII, LINE 4B - OTHER ADJUSTMENTS:

PROVISION FOR BAD DEBTS NETTED AGAINST REVENUE ON FINANCIALS	6,959,649.
BANK FEES NETTED AGAINST REVENUE ON FINANCIALS	63,551.
TRANSFER TO AFFILIATES NETTED AGAINST REVENUE ON FINANCIALS	799,694.
TOTAL TO SCHEDULE D, PART XII, LINE 4B	7,822,894.

**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 for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

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

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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

7 Financial Assistance and Certain Other Community Benefits at Cost

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			1836442.		1836442.	1.12%
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			1836442.		1836442.	1.12%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		4,290	145,582.		145,582.	.09%
f Health professions education (from Worksheet 5)		166	175,930.		175,930.	.11%
g Subsidized health services (from Worksheet 6)		88	17813719.	8528297.	9285422.	5.69%
h Research (from Worksheet 7)			7,568.		7,568.	.00%
i Cash and in-kind contributions for community benefit (from Worksheet 8)		29,973	328,914.	211,571.	117,343.	.07%
j Total. Other Benefits		34,517	18471713.	8739868.	9731845.	5.96%
k Total. Add lines 7d and 7j		34,517	20308155.	8739868.	11568287.	7.08%

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

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

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

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>18</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		X
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	X	
7 Did the hospital facility make its CHNA report widely available to the public?	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>UHCC.COM/ABOUT-US/COMMUNITY-BENEFIT/REPOR</u>		
b <input checked="" type="checkbox"/> Other website (list url): <u>CECILCOUNTYHEALTH.ORG/ABOUT/COMMUNITY-HEALTH-AD</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	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>18</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a If "Yes," (list url): <u>UHCC.COM/ABOUT-US/COMMUNITY-BENEFIT/REPORTS/</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

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

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	X	
If "Yes," indicate the eligibility criteria explained in the FAP:		
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>300</u> %		
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input checked="" type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	X	
15 Explained the method for applying for financial assistance?	X	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
j <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
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
f	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?		X
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a	<input type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
b	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
c	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
d	<input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

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

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

Part V Facility Information *(continued)*

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

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 5: UNION HOSPITAL COLLABORATED WITH THE CECIL COUNTY HEALTH DEPARTMENT TO CONDUCT THE CURRENT COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WHOSE COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) COVERS FY 2019. THE CHNA PLANNING TEAM INCLUDED STAFF FROM UNION HOSPITAL: THE COMMUNITY BENEFIT COORDINATOR, THE DIRECTOR OF MARKETING, AND A PHYSICIAN FROM OCCUPATIONAL HEALTH (MASTER OF PUBLIC HEALTH INTERN). THE PLANNING TEAM ALSO HAD 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.

A) FOCUS GROUPS:

THE THREE FOCUS GROUPS WERE CONDUCTED WITH ADULT POPULATIONS WITHOUT ACCESS TO THE INTERNET (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.

Part V Facility Information *(continued)*

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

PARTICIPANTS WERE ASKED TO RESPOND TO THE FOLLOWING QUESTIONS:

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

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 SANT GROUP (MOBILE CRISIS), ELKTON HOUSING AUTHORITY, AMERICAN CANCER SOCIETY, MARYLAND STATE DELEGATES, CECIL COUNTY DEPT OF EMERGENCY

Part V Facility Information *(continued)*

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

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

UNION HOSPITAL OF CECIL COUNTY, INC.:

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

UNION HOSPITAL OF CECIL COUNTY, INC.:

PART V, SECTION B, LINE 11: THE CHNA, CONDUCTED DURING FISCAL YEAR (FY)
2019, REFLECTS THE CURRENT STATUS OF THE MEDICAL AND SOCIAL DETERMINANTS
OF HEALTH FOR CECIL COUNTY AND PROVIDES A QUANTITATIVE AND QUALITATIVE
DATA ANALYSIS FOR KEY HEALTH ISSUES. THE HEALTH ISSUES THAT WERE

Part V Facility Information *(continued)*

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

PRIORITIZED AS A RESULT OF THESE DATA ANALYSES WERE:

- 1. CANCER
- 2. BEHAVIORAL HEALTH (COMPRISED OF SUBSTANCE USE AND MENTAL HEALTH)
- 3. CHILDHOOD TRAUMA

CANCER

SUPPORT THE WORK CURRENTLY BEING DONE BY THE CECIL COUNTY CANCER TASK FORCE IN THE COMMUNITY FOR LUNG CANCER SCREENING, TO INCLUDE EDUCATION, AWARENESS, AND INCREASING HEALTH PROMOTIONS RELATED TO GETTING SCREENED. UNION HOSPITAL'S CANCER PROGRAM AND ITS COMMISSION ON CANCER COMMITTEE WILL OFFER SUPPORT, AS WELL AS CECIL COUNTY HEALTH DEPARTMENT'S DIVISION OF HEALTH PROMOTION.

GOALS

1: REDUCE CANCER MORTALITY IN CECIL COUNTY:

- A. RAISE AWARENESS FOR LUNG CANCER PREVENTION IN ORDER TO REDUCE STIGMA RELATED TO RISK FACTORS CONTRIBUTING TO LUNG CANCER
- B. SUPPORT AND ENGAGE MEDICAL PROVIDERS IN PROMOTING PATIENT AWARENESS OF LUNG CANCER PREVENTION EFFORTS (PRIMARY PREVENTION: EDUCATION; SECONDARY PREVENTION: SCREENING; AND TERTIARY PREVENTION: TREATMENT)
- C. EDUCATE AND SUPPORT MEDICAL PROVIDERS ON HOW TO TALK TO PATIENTS ABOUT QUITTING SMOKING
- D. SUPPORT MEDICAL PROVIDERS IN MAKING COMMUNITY PRESENTATIONS
- E. PROMOTE REFERRALS FOR SMOKING CESSATION AMONG MEDICAL PROVIDERS
- F. PROMOTE THE USE OF SELF-SCREENING TOOLS IN THE COMMUNITY FOR LOW-DOSE

Part V Facility Information (continued)

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

CT LUNG CANCER SCREENING

G. SUPPORT AND ENGAGE THE COMMUNITY (INCL. COMMUNITY GROUPS, FAITH-BASED ORGANIZATIONS, AND BUSINESSES) IN PROMOTING LUNG CANCER PREVENTION EFFORTS (PRIMARY PREVENTION: EDUCATION; SECONDARY PREVENTION: SCREENING; AND TERTIARY PREVENTION: TREATMENT)

H. PROVIDE ADVERTISING AND MEDIA SUPPORT FOR HEALTH PROMOTIONS RELATED TO THE AVAILABILITY OF PREVENTION SERVICES IN THE COMMUNITY

I. ENGAGE THE COMMUNITY ON LUNG CANCER PREVENTION EFFORTS VIA SOCIAL MEDIA AND OTHER EDUCATIONAL AND/OR ADVOCACY OUTLETS

BEHAVIORAL HEALTH

WORKING TO ENHANCE AND SUPPORT THE EFFORTS TO ADDRESS BOTH SUBSTANCE ABUSE (SA) AND MENTAL HEALTH (MH) IN CECIL COUNTY. MET WITH LEADERSHIP FROM CECIL COUNTY HEALTH DEPARTMENT'S CORE SERVICE AGENCY (MH), AS WELL AS THE DRUG-FREE COMMUNITIES COALITION (SA), CECIL COUNTY DRUG AND ALCOHOL ABUSE COUNCIL (SA), AND THE OPIOID MISUSE PREVENTION PROGRAM (SA). ALSO SUPPORT THE MOVEMENT TOWARDS INTEGRATING BEHAVIORAL HEALTH SERVICES AT THE LOCAL HEALTH DEPARTMENT AND COMMUNITY LEVEL.

GOALS

1: PREVENT THE INITIATION OF SUBSTANCE USE AMONG YOUTH AND SUPPORT YOUTH IN TREATMENT AND RECOVERY

A. EXPAND YOUTH PREVENTION ACTIVITIES FOR GRADES 3-12

B. PROVIDE ONGOING SUPPORT FOR YOUTH LEADERSHIP SUMMIT ACTIVITIES

C. EXPAND DRUG FREE CECIL YOUTH COALITION EFFORTS

D. HIRE A YOUTH ADVISOR TO COORDINATE DRUG FREE CECIL YOUTH EFFORTS

Part V Facility Information *(continued)*

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

E. INCREASE PROTECTIVE FACTORS AND COMMUNITY RESILIENCE

F. EXPAND SUPPORT MECHANISMS FOR YOUTH IN RECOVERY

G. EXPLORE THE DEVELOPMENT OF A DROP-IN COMMUNITY RECOVERY CENTER

H. EXPLORE THE DEVELOPMENT OF AN ADOLESCENT CLUBHOUSE

I. IDENTIFY AND ENGAGE WITH YOUTH WHO HAVE SUDS

2: INCREASE RECOVERY SUPPORT CAPACITY IN CECIL COUNTY

A. EXPAND PEER RECOVERY SUPPORT CAPACITY

B. INCREASE COMMUNITY ACCESS TO NARCAN

C. INCREASE RECOVERY SUPPORT FOR INDIVIDUALS TRANSITIONING FROM PRISON OR JAIL BACK INTO THE COMMUNITY

D. RESEARCH ANTI-STIGMA INITIATIVES

E. IMPLEMENT AN ANTI-STIGMA AWARENESS CAMPAIGN

3: PROVIDE SUPPORT FOR INDIVIDUALS WITH BEHAVIORAL HEALTH CONDITIONS RE-ENTERING THE COMMUNITY

A. FORM A WORKGROUP TO PURSUE RE-ENTRY PLANNING

B. RESEARCH EVIDENCE-BASED RE-ENTRY PROGRAMS

C. SEEK FUNDING TO SUPPORT RE-ENTRY INITIATIVES

D. EXPAND TREATMENT AND RE-ENTRY AFTERCARE PROGRAMS

E. PARTNER WITH THE CCHD DIVISION OF ADDICTIONS SERVICES FOR INDIVIDUALS WITH CO-OCCURRING DISORDERS

4: INTEGRATE BEHAVIORAL HEALTH SERVICES IN CECIL COUNTY TO IMPROVE OUTCOMES FOR INDIVIDUALS WITH CO-OCCURRING DISORDERS

A. FORM A BEHAVIORAL HEALTH COMMITTEE MADE UP OF STAKEHOLDERS FROM THE MENTAL HEALTH AND SUBSTANCE USE DISORDER FIELDS

Part V Facility Information *(continued)*

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

B. HOLD JOINT COUNCIL MEETINGS TO ALIGN EFFORTS

C. DEVELOP AND SUBMIT A JOINT BEHAVIORAL HEALTH PLAN FOR CECIL COUNTY

D. ENGAGE AND EDUCATE STAKEHOLDERS AND THE COMMUNITY ON CO-OCCURRING DISORDERS AND BEHAVIORAL HEALTH INTEGRATION

CHILDHOOD TRAUMA

SERVE AS SUPPORT FOR THE LOCAL MANAGEMENT BOARD'S CHILDHOOD TRAUMA SUBCOMMITTEE AS THEY WORK THROUGH ADDRESSING PLANNED RECOMMENDATIONS. CHIP PLANNING MEETINGS SOLIDIFIED RESPONSIBILITIES TO SUPPORT THE INCREASE OF COMMUNITY AND PROVIDER EDUCATION AND AWARENESS OF CHILDHOOD TRAUMA. IN ADDITION, THE CECIL COUNTY HEALTH DEPARTMENT WILL EXPLORE EVIDENCE-BASED HOME VISITING PROGRAMS TO IMPLEMENT IN CECIL COUNTY.

GOALS

1: INCREASE EDUCATION OPPORTUNITIES FOR THE COMMUNITY ON CHILDHOOD TRAUMA

A. HOLD SCREENINGS OF THE DOCUMENTARY "RESILIENCE: THE BIOLOGY OF STRESS & SCIENCE OF HOPE"

B. HOLD COMMUNITY FORUMS RELATED TO CHILDHOOD TRAUMA

C. HOLD TRAININGS RELATED TO CHILDHOOD TRAUMA

D. CHANGE SOCIAL NORMS TO SUPPORT PARENTS AND POSITIVE PARENTING

E. PARTNER WITH YOUTH SERVING ORGANIZATIONS ON CHILD ABUSE PREVENTION AWARENESS AND EDUCATION

F. PARTICIPATE IN THE NATIONAL CHILD ABUSE AWARENESS "PINWHEELS FOR PREVENTION" CAMPAIGN

G. TRAIN COMMUNITY LEADERS TO ACT AS ADVOCATES AND SPREAD INFORMATION ON CHILDHOOD TRAUMA IN THEIR COMMUNITIES

Part V Facility Information *(continued)*

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

2: EDUCATE AND EMPOWER HEALTH CARE PROVIDERS TO RECOGNIZE AND TREAT THE EFFECTS OF CHILDHOOD TRAUMA

A. RESEARCH AND DEVELOP SURVEY TOOL TO ACCESS CURRENT KNOWLEDGE OF CHILDHOOD TRAUMA AND TRAINING NEEDS

B. OBTAIN LIST OF PHYSICIANS AND DISTRIBUTE SURVEY

C. ANALYZE RESULTS TO DETERMINE NEEDS

D. IDENTIFY TRAINING RESOURCES FOR PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

E. UTILIZE EVIDENCE-BASED MATERIALS TO EDUCATE PHYSICIANS ON TRAUMA-INFORMED CARE

3: ENHANCE PARENTING SKILLS TO PROMOTE HEALTHY CHILD DEVELOPMENT

A. RESEARCH EVIDENCE-BASED HOME VISITING PROGRAMS AND DETERMINE THE FEASIBILITY OF IMPLEMENTING A PROGRAM IN CECIL COUNTY

B. SUPPORT THE CREATION OF EVIDENCE-BASED HOME VISITING PROGRAMS, SUCH AS HEALTHY FAMILIES AMERICA PROGRAM IN CECIL COUNTY

THERE WERE HEALTH NEEDS AND BARRIERS TO CARE THAT WERE NOT FEASIBLE TO ADDRESS DUE TO FACTORS, LIKE RESOURCE AVAILABILITY AND COMMUNITY RESOURCES ALREADY IN PLAY. THESE NEEDS INCLUDE ACCESS TO CARE, HOMELESSNESS, CHRONIC DISEASE, DENTAL HEALTH, TOBACCO USE, INFECTIOUS & COMMUNICABLE DISEASES, VACCINATION, ENVIRONMENTAL HEALTH, INJURIES (MOTOR VEHICLE & PEDESTRIAN), CHILD ABUSE & NEGLECT, DOMESTIC VIOLENCE, VIOLENT CRIME, AND SUICIDE.

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, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

PART V, SECTION B, LINE 13B: PATIENTS WITH A HOUSEHOLD INCOME UP TO 50% 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, LINE 16A, FAP WEBSITE:

UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/

UNION HOSPITAL OF CECIL COUNTY, INC.

PART V, LINE 16B, FAP APPLICATION WEBSITE:

UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/

UNION HOSPITAL OF CECIL COUNTY, INC.

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

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.

PART I, LINE 7:

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

PART I, LN 7 COL(F):

THE AMOUNT OF BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25 BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS \$6,959,649.

PART II, COMMUNITY BUILDING ACTIVITIES:

- ECONOMIC DEVELOPMENT (F2):

IN FISCAL YEAR (FY) 2019, 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.

Part VI Supplemental Information (Continuation)

UNION 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.

- COMMUNITY SUPPORT (F3):

IN FY 2019, 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. UNITED WAY OF CECIL COUNTY FUNDS PROGRAMS THAT ADDRESS CRITICAL NEEDS IN THE COMMUNITY SURROUNDING CHILDREN AND FAMILIES, HEALTH AND WELLNESS, AND INDEPENDENT LIVING. UNION HOSPITAL SUPPORTS THE UNITED WAY TWO WAYS: A) BY PLANNING

Part VI Supplemental Information (Continuation)

AND FACILITATING A HOSPITAL-WIDE ANNUAL GIVING CAMPAIGN; AND B) BY PROVIDING A STAFF MEMBER TO SERVE ON THE UNITED WAY BOARD.

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) 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 & 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.

- LEADERSHIP DEVELOPMENT AND TRAINING FOR COMMUNITY MEMBERS (F5):
IN FY 2019, UNION HOSPITAL SUPPORTED THE FOLLOWING LEADERSHIP 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

Part VI Supplemental Information (Continuation)

EMERGING LEADERS IN NONPROFIT, BUSINESS, GOVERNMENT, AND TOURISM ENGAGE, COLLABORATE, AND COMMIT TO CECIL COUNTY'S ONGOING DEVELOPMENT. UNION HOSPITAL PARTNERS WITH CECIL COLLEGE TO PROVIDE A LEADERSHIP SESSION AT THE HOSPITAL FOR CLI PARTICIPANTS. PARTICIPANTS ENGAGE WITH HOSPITAL LEADERSHIP THROUGH PRESENTATIONS AND TEAM BUILDING EXERCISES.

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:

THE HOSPITAL ASSESSES COLLECTABILITY ON PATIENT CONTRACTS PRIOR TO THE RECOGNITION OF NET PATIENT SERVICE REVENUES. PATIENT ACCOUNTS RECEIVABLE ARE REPORTED AT THEIR NET REALIZABLE VALUE. ACCOUNTS ARE WRITTEN OFF THROUGH BAD DEBT EXPENSE WHEN THE HOSPITAL HAS EXHAUSTED ALL COLLECTION EFFORTS AND DETERMINES ACCOUNTS ARE IMPAIRED BASED ON CHANGES IN PATIENT CREDIT WORTHINESS. PATIENT ACCOUNTS 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.

Part VI Supplemental Information (Continuation)

PART III, LINE 8:

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

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

PART III, LINE 9B:

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 Supplemental Information (Continuation)

PART VI, LINE 2:

THE CHNA REFLECTS THE CURRENT STATUS OF THE MEDICAL AND SOCIAL DETERMINANTS OF HEALTH FOR CECIL COUNTY AND PROVIDES QUALITATIVE FEEDBACK ON KEY HEALTH ISSUES. THE CHNA IS COMPRISED OF AN ANALYSIS OF BOTH PRIMARY AND SECONDARY DATA. PRIMARY DATA WAS TAKEN FROM RESULTS FROM AN ONLINE COMMUNITY SURVEY CONDUCTED WITH ADULT (AGED 18 YEARS OR OLDER) CECIL COUNTY RESIDENTS AND THREE FOCUS GROUPS CONDUCTED WITH COMMUNITY RESIDENTS. SECONDARY DATA WAS TAKEN FROM A VARIETY OF RELIABLE NATIONAL AND LOCAL DATA SOURCES (LOCAL DATA WAS COMPARED, WHEN POSSIBLE, AGAINST STATE AND NATIONAL TRENDS). IN ADDITION, TWO COMMUNITY HEALTH ADVISORY COMMITTEE (CHAC) MEETINGS WERE HELD TO HELP SELECT THE HEALTH PRIORITIES FOR CECIL COUNTY AND BEGIN FORMATION OF STRATEGIES TO ADDRESS THEM. THE CHNA WAS CONDUCTED FROM QUARTER 3 OF FISCAL YEAR 2018 THROUGH QUARTER 3 OF FISCAL YEAR 2019. 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 FY 2015, UNION HOSPITAL'S FINANCE DEPARTMENT DIVISIONS OF MANAGED CARE, REVENUE

Part VI Supplemental Information (Continuation)

CYCLE, AND BILLING BEGAN WORKING ON CHANGES TO THE FAP TO REFLECT THE ACA'S HEALTH CARE COVERAGE EXPANSION OPTION EFFECTIVE JANUARY 1, 2014. THE RESULTING REVISED FAP IS MORE COMPREHENSIVE IN THAT IT INCLUDES MORE DESCRIPTIONS, PATIENT EXPECTATIONS, AND CONTENT THAT IS EASY TO FOLLOW AND DIGEST. NEW SECTIONS THAT GIVE THE FAP MORE DEPTH INCLUDE: DEFINITIONS, SCOPE, PRESUMPTIVE ELIGIBILITY, ELIGIBILITY PERIOD, RECONSIDERATION OF DENIAL OF FREE OR REDUCED-COST CARE, MEDICAL DEBT DETERMINATION (LIMIT ON CHARGES), ACTION IN THE EVENT OF NON-PAYMENT, ENSURING COMPLIANCE, PLAIN LANGUAGE SUMMARY, AND REFERENCES.

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

Part VI Supplemental Information (Continuation)

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

<HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/>.

IN ADDITION, UNION HOSPITAL PLACES AN ADVERTISEMENT ONCE A YEAR IN THE LOCAL NEWSPAPERS OUTLINING THE FAP, HOW TO ACCESS FINANCIAL ASSISTANCE MATERIALS, AND HOW TO APPLY FOR FINANCIAL ASSISTANCE.

PART VI, LINE 4:

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

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

Part VI Supplemental Information (Continuation)

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.

THE ESTIMATED TOTAL POPULATION OF CECIL COUNTY WAS 102,175 PEOPLE IN 2016. OF THE TOTAL COUNTY POPULATION, 50.5% IS FEMALE AND 49.5% IS MALE. THE MEDIAN AGE IS 40.2 YEARS, AND THE MEDIAN HOUSEHOLD INCOME IS \$67,938.

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

- 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 DEMOGRAPHICS INCLUDE:

- 6.6% UNEMPLOYMENT
- 7.3% OF FAMILIES LIVING BELOW THE POVERTY LEVEL
- 7% UNINSURED
- 32.4% MEDICAID COVERAGE

PART VI, LINE 5:

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

Part VI Supplemental Information (Continuation)

COMMUNITY HEALTH, ESPECIALLY SERVING UNDERSERVED AREAS AND VULNERABLE POPULATIONS. THE FOLLOWING IS A SUMMARY OF THE COMMUNITY BENEFIT ACTIVITIES, PROGRAMS, AND INITIATIVES THAT UNION HOSPITAL PROVIDED IN CECIL COUNTY DURING FY 2019:

A1: COMMUNITY HEALTH EDUCATION - UNION HOSPITAL PROVIDED:

- A VARIETY OF HEALTH EDUCATION PRESENTATIONS AND ACTIVITIES IN THE COMMUNITY
- EXPLORER POST AT UNION HOSPITAL, CAMP SCRUBS, AND CAMP SCRUBS JUNIOR FOR STUDENTS SEEKING EXPOSURE TO MEDICAL OR HEALTH SCIENCE EXPERIENCES
- HEALTH FAIRS IN THE COMMUNITY
- SUPPORT GROUPS FOR VARIOUS HEALTH NEEDS

A2: COMMUNITY-BASED CLINICAL SERVICES - UNION HOSPITAL PROVIDED:

- FREE SCREENINGS IN THE COMMUNITY FOR PROSTATE CANCER, HEAD AND NECK CANCERS, AND DIABETES
- FREE SPORTS PHYSICALS CLINIC FOR COUNTY PUBLIC AND PRIVATE MIDDLE SCHOOL AND 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
- SUPPORT FOR THE PEER RECOVERY ADVOCATES PROGRAM, A PARTNERSHIP BETWEEN THE ALCOHOL AND DRUG RECOVERY CENTER AT CECIL COUNTY HEALTH DEPARTMENT AND UNION HOSPITAL'S EMERGENCY DEPARTMENT, PSYCHIATRIC UNIT, AND CRISIS INTERVENTION SERVICES NURSING STAFF
- REFERRALS FOR SMOKERS IDENTIFIED IN INPATIENT AND OUTPATIENT/AMBULATORY CARE SETTINGS TO CECIL COUNTY HEALTH DEPARTMENT'S DIVISION OF HEALTH

Part VI Supplemental Information (Continuation)

PROMOTIONS' TOBACCO CESSATION PROGRAMS AND SUPPORTS

A4: SOCIAL AND ENVIRONMENTAL IMPROVEMENTS - UNION HOSPITAL:

- SUPPORTED THE HOSPITAL'S PARTNER IN EDUCATION, GILPIN MANOR ELEMENTARY SCHOOL, THROUGH STAFF COLLECTED DONATIONS, HEALTH EDUCATION OPPORTUNITIES FOR FAMILIES, AND PROFESSIONAL DEVELOPMENT SUPPORTS FOR SCHOOL STAFF
- SUPPORTED CECIL CARES' COUNTY-WIDE "DAY OF CARING" VIA PLANNING MEETINGS AND EVENT SUPPORT/PARTICIPATION
- SUPPORTED THE CHRISTMAS IN APRIL EVENT TO PROVIDE HOUSING IMPROVEMENTS FOR A VULNERABLE CECIL COUNTY RESIDENT
- PARTICIPATED IN BOARD SERVICE WITH ORGANIZATIONS SUPPORTING SOCIAL AND ENVIRONMENTAL HEALTH
- PROVIDED TRANSPORTATION DONATIONS FOR ELIGIBLE (NEEDS-BASED) PATIENTS AND THEIR FAMILIES

B1-B3: HEALTH PROFESSIONS EDUCATION

- UNION HOSPITAL STAFF PRECEPTED POST-SECONDARY STUDENTS THROUGH STUDENT EXPERIENCES FOR NURSING AND MEDICAL RESIDENCY CLINICAL ROTATIONS, GRADUATE STUDENT INTERNSHIPS, AND ALLIED HEALTH OBSERVATIONS AND INTERNSHIPS.

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

- EMPLOYED PHYSICIAN PRACTICE SUBSIDIES (C3)
- ADULT DAY SERVICES FOR OLDER ADULT CLIENTS WITH DEMENTIA AND OTHER NEUROLOGICAL DISORDERS (C7)

D1: CLINICAL RESEARCH

Part VI Supplemental Information (Continuation)

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

E3: IN-KIND CONTRIBUTIONS - UNION HOSPITAL PROVIDED DONATIONS OF TIME AND MATERIALS FOR THE CECIL COUNTY COMMUNITY BY:

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

- GIVING BLOOD AT BLOOD DRIVES HELD AT THE HOSPITAL AND OTHER LOCAL DONOR LOCATIONS

- PROVIDING A VOLUNTEER MEDICAL DIRECTORSHIP FOR THE CECIL COUNTY PREGNANCY 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, COALITIONS, ETC.)

- SERVING THE HOMELESS AND PROVIDING FOOD DONATIONS FOR MINISTRIES IN PARTNERSHIP WITH LOCAL COMMUNITY AGENCIES, CHURCHES, AND OTHER LOW-INCOME AND POOR SERVING MINISTRIES

- PROVIDING FOOD FOR THE HOME DELIVERED MEALS PROGRAM (MEALS ON WHEELS) 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 DIVISIONS

- 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

Part VI Supplemental Information (Continuation)

MEDICATIONS TO PATIENTS THAT QUALIFY FOR HOSPITAL FINANCIAL ASSISTANCE.

PART VI, LINE 6:

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

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

Part VI Supplemental Information (Continuation)

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.

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 for the latest information.**

OMB No. 1545-0047

2018

**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.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
UNION HOSPITAL OF CECIL COUNTY HEALTH SERVICES, INC. - 106 BOW STREET - ELKTON, MD 21921	52-1794553	501(C)(3)	348,833.	0.	N/A	N/A	CHARITABLE ACTIVITIES
UNION HOSPITAL OF CECIL COUNTY VENTURES, INC. - 106 BOW STREET - ELKTON, MD 21921	52-1793691		450,861.	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 ▶ 1.

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

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

Schedule I (Form 990) (2018)

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 for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Part I Questions Regarding Compensation

	Yes	No
1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. <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 If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b	
2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?	2	
3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. <input checked="" type="checkbox"/> Compensation committee <input checked="" type="checkbox"/> 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		
4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:		
a Receive a severance payment or change-of-control payment?	4a	X
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X
c Participate in, or receive payment from, an equity-based compensation arrangement?	4c	X
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.		
Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.		
5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:		
a The organization?	5a	X
b Any related organization?	5b	X
If "Yes" on line 5a or 5b, describe in Part III.		
6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:		
a The organization?	6a	X
b Any related organization?	6b	X
If "Yes" on line 6a or 6b, describe in Part III.		
7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III	7	X
8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8	X
9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9	

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

Schedule J (Form 990) 2018

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)	443,928.	0.	20,465.	37,679.	10,354.	512,426.	0.
(2) JOSE MA, MD DIRECTOR	(i)	270,674.	0.	0.	0.	0.	270,674.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) JUSTIN SAUSVILLE, M.D. DIRECTOR	(i)	558,694.	0.	0.	0.	0.	558,694.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) JAMES G. RAAB SENIOR VP/CHIEF FINANCIAL OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	270,184.	20,000.	27,222.	4,125.	27,635.	349,166.	0.
(5) AARON Z. ROYSTON VP OF PROVIDER ENTERPRISE	(i)	201,790.	20,000.	15,400.	3,327.	1,492.	242,009.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) CRAIG M. BABBITT IN-HOUSE LEGAL COUNSEL	(i)	168,940.	0.	8,914.	2,462.	1,092.	181,408.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) CYDNEY TEAL, MD (UNTIL 2/23/19) VP MEDICAL AFFAIRS	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	321,630.	0.	26,794.	4,125.	22,926.	375,475.	0.
(8) ANNE LARA (RETIRED 06/30/18) SR. VP/CHIEF INNOVATION OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	106,388.	30,000.	27,631.	2,046.	9,949.	176,014.	0.
(9) KHADIJATU BOSTON (UNTIL 01/18) SR. VP/CHIEF NURSING OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	11,938.	17,931.	140,242.	239.	1,673.	172,023.	0.
(10) TERRANCE LOVELL (UNTIL 01/18) VP HUMAN RESOURCES	(i)	8,432.	19,214.	279,820.	126.	1,420.	309,012.	54,460.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) FAHD RAHMAN PHYSICIAN	(i)	455,308.	229,050.	540.	4,125.	32,436.	721,459.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) JUSTIN SAUSVILLE PHYSICIAN	(i)	430,900.	107,308.	20,486.	4,125.	35,041.	597,860.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) ROGER D. WU PHYSICIAN	(i)	480,093.	35,036.	486.	4,125.	24,504.	544,244.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) NITIN AGGARWAL PHYSICIAN	(i)	470,046.	42,588.	432.	4,125.	19,187.	536,378.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) DANIELLE M. PRESS PHYSICIAN	(i)	418,750.	14,000.	10,486.	3,441.	7,894.	454,571.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(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:

THE FOLLOWING INDIVIDUALS RECEIVED SEVERANCE PAYMENTS DURING THE CALENDAR YEAR 2018:

- TERRENCE LOVELL, VP HUMAN RESOURCES
- KHADIJATU BOSTON, SENIOR VP / CHIEF NURSING OFFICER

DR. RICHARD C. SZUMEL (PRESIDENT & CEO) PARTICIPATES IN A SUPPLEMENTAL, NON-QUALIFIED RETIREMENT PLAN UNDER SECTION 457(F) OF THE INTERNAL REVENUE CODE WITH CONTRIBUTION AMOUNT OF \$26,878 DURING THE CALENDAR YEAR 2018.

TERRENCE LOVELL, VP HUMAN RESOURCES, RECEIVED DISTRIBUTIONS FROM THE 457(F) PLAN IN THE AMOUNT OF \$54,460 DURING THE CALENDAR YEAR 2018.

FOLLOWING INDIVIDUALS' PAYMENTS WERE FORFEITED DURING THE CALENDAR YEAR 2018:

- TERRENCE LOVELL, VP HUMAN RESOURCES, \$156,323
- LAURIE BEYER, SENIOR VP/CFO, \$211,872

Part III Supplemental Information

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

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

PART I, LINE 7:

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

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

Supplemental Information on Tax-Exempt Bonds

ENTITY 1

OMB No. 1545-0047

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

2018
Open to Public Inspection

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

Part I Bond Issues											
(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A TOWN OF ELKTON - SERIES 2012A	52-6000790	NONE	05/18/12	10000000.	SEE PART VI		X		X		X
B TOWN OF ELKTON - SERIES 2012B1/B2	52-6000790	NONE	05/18/12	8,662,336.	SEE PART VI		X		X		X
C TOWN OF ELKTON - SERIES 2012C	52-6000790	NONE	05/18/12	9,000,000.	SEE PART VI		X		X		X
D MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AUT	52-0936091	NONE	07/18/12	9,924,000.	SEE PART VI		X		X		X

Part II Proceeds										
	A		B		C		D			
1 Amount of bonds retired	2,752,828.		3,792,563.				6,631,922.			
2 Amount of bonds legally defeased										
3 Total proceeds of issue	10,000,000.		8,662,336.		9,000,000.		9,924,000.			
4 Gross proceeds in reserve funds										
5 Capitalized interest from proceeds										
6 Proceeds in refunding escrows										
7 Issuance costs from proceeds										
8 Credit enhancement from proceeds										
9 Working capital expenditures from proceeds										
10 Capital expenditures from proceeds										
11 Other spent proceeds	10,000,000.		8,662,336.		9,000,000.		9,924,000.			
12 Other unspent proceeds										
13 Year of substantial completion	2012		2012		2012		2012			
	Yes	No	Yes	No	Yes	No	Yes	No		
14 Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X		X		X		X			
15 Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X		X		X		X		
16 Has the final allocation of proceeds been made?	X		X		X		X			
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X			

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

Schedule K (Form 990) 2018

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 for instructions and the latest information.**

2018
Open to Public Inspection

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

Part I Bond Issues											
(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AUT	52-0936091	NONE	07/18/12	4,007,000.	SEE PART VI		X		X		X
B MARYLAND HEALTH & HIGHER EDUCATION FACILITIES AUT	52-0936091	NONE	12/01/14	30778000.	SEE PART VI		X		X		X
C											
D											

Part II Proceeds										
	A		B		C		D			
1 Amount of bonds retired	2,546,699.		540,000.							
2 Amount of bonds legally defeased										
3 Total proceeds of issue	4,007,000.		30,778,000.							
4 Gross proceeds in reserve funds										
5 Capitalized interest from proceeds										
6 Proceeds in refunding escrows										
7 Issuance costs from proceeds										
8 Credit enhancement from proceeds										
9 Working capital expenditures from proceeds										
10 Capital expenditures from proceeds	4,007,000.									
11 Other spent proceeds			30,778,000.							
12 Other unspent proceeds										
13 Year of substantial completion	2012		2014							
	Yes	No	Yes	No	Yes	No	Yes	No		
14 Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X		X							
15 Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X		X						
16 Has the final allocation of proceeds been made?	X		X							
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X							

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

Schedule K (Form 990) 2018

Part III Private Business Use

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

Part IV Arbitrage

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

Part III Private Business Use

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

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X		X
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								
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):

PURPOSE OF THE BONDS:

ISSUE A: TO REFUND PORTION OF SERIES 2009 BONDS.

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

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

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

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

ISSUE F: TO REFINANCE THE 2005 BONDS.

Part IV Arbitrage (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X				
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								
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):

PURPOSE OF THE BONDS:

ISSUE A: TO REFUND PORTION OF SERIES 2009 BONDS.

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

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

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

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

ISSUE F: TO REFINANCE THE 2005 BONDS.

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
DR. RYAN GERACIMOS	SEE PART V	3,351,073.	SEE PART V		X

Part V Supplemental Information.

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

SCHEDULE L, PART IV:

NAME OF INTERESTED PERSON: DR. RYAN GERACIMOS

RELATIONSHIP WITH ORGANIZATION: FORMER BOARD MEMBER & CMO

DESCRIPTION OF TRANSACTION: UNION HOSPITAL OF CECIL COUNTY (UHCC)

CONTRACTS WITH UNION RADIOLOGISTS, LLC FOR RADIOLOGY SERVICES. DR.

GERACIMOS WAS A PRINCIPAL IN UNION RADIOLOGISTS, LLC. HE BECAME THE CHIEF MEDICAL OFFICER (CMO) OF UHCC IN MARCH 2019. PRIOR TO THAT, HE WAS A BOARD MEMBER. DR. GERACIMOS IS NO LONGER AFFILIATED WITH UNION RADIOLOGISTS (UPON BEING HIRED AS CMO).

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2018

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 \$8,796,096 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 4,923 DISCHARGES PROVIDING

19,313 PATIENT DAYS TO INPATIENTS IN FISCAL YEAR 2019 OF WHICH:

1) PATIENTS COVERED UNDER THE MEDICARE PROGRAM WERE 2,248 DISCHARGES

AND 10,192 PATIENT DAYS

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

594 PATIENT DAYS

3) PATIENTS COVERED UNDER THE MEDICAID HMO PROGRAM WERE 1,236

DISCHARGES AND 4,114 PATIENT DAYS

4) PATIENTS COVERED UNDER THE MEDICARE HMO PROGRAM WERE 225 DISCHARGES

AND 927 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

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

OR SURVEYS, TO SET COMPENSATION. DURING FISCAL YEAR 2019, 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	9,051,820.
MANAGEMENT AND GENERAL EXPENSES	716,233.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	9,768,053.

PHYSICIAN SERVICES:

PROGRAM SERVICE EXPENSES	8,554,930.
MANAGEMENT AND GENERAL EXPENSES	85,793.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	8,640,723.

PURCHASED SERVICES & FEES:

PROGRAM SERVICE EXPENSES	1,519,398.
MANAGEMENT AND GENERAL EXPENSES	6,947.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,526,345.

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

PROGRAM SERVICE EXPENSES	2,663,855.
MANAGEMENT AND GENERAL EXPENSES	569,664.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	3,233,519.

TRANSCRIPTION SERVICES:

PROGRAM SERVICE EXPENSES	217,197.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	217,197.

RECORD FILE STORAGE:

PROGRAM SERVICE EXPENSES	122,074.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	122,074.

CLEANING SERVICES:

PROGRAM SERVICE EXPENSES	190,294.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	190,294.

BILLING & COLLECTIONS:

PROGRAM SERVICE EXPENSES	1,782,610.
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 1,782,610.

ADMIN FEES:

PROGRAM SERVICE EXPENSES 179,700.

MANAGEMENT AND GENERAL EXPENSES 0.

FUNDRAISING EXPENSES 0.

TOTAL EXPENSES 179,700.

TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A 25,660,515.

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

CHANGE IN INTEREST IN NET ASSETS OF SUBSIDIARIES 149,388.

OTHER CHANGES

TOTAL TO FORM 990, PART XI, LINE 9 149,388.

**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 for instructions and the latest information.

OMB No. 1545-0047

2018

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) 2018

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

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

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

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

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

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

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

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

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

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

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

2018

For calendar year 2018 or other tax year beginning JUL 1, 2018, and ending JUN 30, 2019

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

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

Department of the Treasury
Internal Revenue Service

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

<p>A <input type="checkbox"/> Check box if address changed</p> <p>B Exempt under section <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 408(e) <input type="checkbox"/> 220(e) <input type="checkbox"/> 408A <input type="checkbox"/> 530(a) <input type="checkbox"/> 529(a)</p>	Print or Type	<p>Name of organization (<input type="checkbox"/> Check box if name changed and see instructions.) UNION HOSPITAL OF CECIL COUNTY, INC.</p> <p>Number, street, and room or suite no. If a P.O. box, see instructions. 106 BOW STREET</p> <p>City or town, state or province, country, and ZIP or foreign postal code ELKTON, MD 21921-5596</p>	<p>D Employer identification number (Employees' trust, see instructions.) 52-0607945</p> <p>E Unrelated business activity code (See instructions.) 621500</p>
--	---------------------	---	---

C Book value of all assets at end of year **163,925,550.**

F Group exemption number (See instructions.) ▶

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

H Enter the number of the organization's unrelated trades or businesses. ▶ 2 Describe the only (or first) unrelated trade or business here ▶ **SEE STATEMENT 1**. If only one, complete Parts I-V. If more than one, describe the first in the blank space at the end of the previous sentence, complete Parts I and II, complete a Schedule M for each additional trade or business, then complete Parts III-V.

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

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

Part I Unrelated Trade or Business Income	(A) Income	(B) Expenses	(C) Net
1a Gross receipts or sales <u>1,900,181.</u>			
b Less returns and allowances <u>194,115.</u> c Balance ▶	1c <u>1,706,066.</u>		
2 Cost of goods sold (Schedule A, line 7)	2		
3 Gross profit. Subtract line 2 from line 1c	3 <u>1,706,066.</u>		<u>1,706,066.</u>
4a Capital gain net income (attach Schedule D)	4a		
b Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b		
c Capital loss deduction for trusts	4c		
5 Income (loss) from a partnership or an S corporation (attach statement)	5		
6 Rent income (Schedule C)	6		
7 Unrelated debt-financed income (Schedule E)	7		
8 Interest, annuities, royalties, and rents from a controlled organization (Schedule F)	8		
9 Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9		
10 Exploited exempt activity income (Schedule I)	10		
11 Advertising income (Schedule J)	11		
12 Other income (See instructions; attach schedule)	12		
13 Total. Combine lines 3 through 12	13 <u>1,706,066.</u>		<u>1,706,066.</u>

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

14 Compensation of officers, directors, and trustees (Schedule K)	14		
15 Salaries and wages	15		<u>554,687.</u>
16 Repairs and maintenance	16		<u>44,287.</u>
17 Bad debts	17		<u>48,500.</u>
18 Interest (attach schedule) (see instructions)	18		
19 Taxes and licenses	19		
20 Charitable contributions (See instructions for limitation rules)	20		
21 Depreciation (attach Form 4562)	21	<u>73,256.</u>	
22 Less depreciation claimed on Schedule A and elsewhere on return	22a		<u>73,256.</u>
23 Depletion	23		
24 Contributions to deferred compensation plans	24		
25 Employee benefit programs	25		<u>92,084.</u>
26 Excess exempt expenses (Schedule I)	26		
27 Excess readership costs (Schedule J)	27		
28 Other deductions (attach schedule)	28	<u>SEE STATEMENT 3</u>	<u>1,250,388.</u>
29 Total deductions. Add lines 14 through 28	29		<u>2,063,202.</u>
30 Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13	30		<u>-357,136.</u>
31 Deduction for net operating loss arising in tax years beginning on or after January 1, 2018 (see instructions)	31		
32 Unrelated business taxable income. Subtract line 31 from line 30	32		<u>-357,136.</u>

Part III Total Unrelated Business Taxable Income

Table with 3 columns: Line number, Description, and Amount. Includes lines 33-38 for unrelated business taxable income calculation.

Part IV Tax Computation

Table with 3 columns: Line number, Description, and Amount. Includes lines 39-44 for tax computation.

Part V Tax and Payments

Table with 3 columns: Line number, Description, and Amount. Includes lines 45a-45e, 46-49, and 50a-50g for tax and payments.

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

Table with 3 columns: Question number, Question text, and Yes/No response. Includes questions 56-58 regarding foreign activities and tax-exempt interest.

Sign Here section containing a declaration of preparer, signature of officer, date, title, and a box for 'May the IRS discuss this return with the preparer shown below?' with Yes/No options.

Paid Preparer Use Only section containing fields for preparer's name, signature, date, firm's name, address, and phone number.

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

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

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

(see instructions)

1. Description of property

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

2. Rent received or accrued

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

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

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

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

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

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

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

Nonexempt Controlled Organizations

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

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

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

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

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
	Enter here and on page 1, Part I, line 10, col. (A).	Enter here and on page 1, Part I, line 10, col. (B).				Enter here and on page 1, Part II, line 26.
Totals	0.	0.				0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

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

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

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I	0.	0.				0.
Totals, Part II (lines 1-5)	Enter here and on page 1, Part I, line 11, col. (A). 0.	Enter here and on page 1, Part I, line 11, col. (B). 0.				Enter here and on page 1, Part II, line 27. 0.

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

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

FOOTNOTES

STATEMENT 2

THE NET OPERATING LOSS CARRYFORWARD (SEE STATEMENT 4) HAS BEEN ADJUSTED TO REFLECT THE EFFECT OF THE REPEAL OF TRANSPORTATION FRINGE BENEFITS TAXATION (IRC SECTION 512(A)(7)). THE HOSPITAL DID NOT HAVE A CHANGE TO ITS TAX LIABILITY AND THEREFORE WILL NOT BE FILING AN AMENDED RETURN.

FORM 990-T

OTHER DEDUCTIONS

STATEMENT 3

DESCRIPTION	AMOUNT
SUPPLIES	426,149.
PURCHASED SERVICES	209,116.
VEHICLE COSTS	51.
UTILITIES	1,949.
RENTAL EQUIPMENT	1,522.
ACCREDITATION FEES	10,601.
MINOR EQUIPMENT	1,671.
MISCELLANEOUS	2,392.
OVERHEAD ALLOCATION	596,937.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	1,250,388.

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.
06/30/18	546,322.	0.	546,322.	546,322.
NOL CARRYOVER AVAILABLE THIS YEAR			6,839,981.	6,839,981.

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

**Unrelated Business Taxable Income for
Unrelated Trade or Business**

ENTITY 1

OMB No. 1545-0687

2018

For calendar year 2018 or other tax year beginning JUL 1, 2018, and ending JUN 30, 2019.

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

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

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

Department of the Treasury
Internal Revenue Service (99)

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Unrelated business activity code (see instructions) ▶ 541900

Describe the unrelated trade or business ▶ **INCOME / (LOSS) FROM PARTNERSHIPS**

Part I Unrelated Trade or Business Income		(A) Income	(B) Expenses	(C) Net
1 a Gross receipts or sales				
b Less returns and allowances	c Balance ▶	1c		
2 Cost of goods sold (Schedule A, line 7)		2		
3 Gross profit. Subtract line 2 from line 1c		3		
4 a Capital gain net income (attach Schedule D)		4a		
b Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)		4b		
c Capital loss deduction for trusts		4c		
5 Income (loss) from a partnership or an S corporation (attach statement) <u>STATEMENT 5</u>		5 -108,770.		-108,770.
6 Rent income (Schedule C)		6		
7 Unrelated debt-financed income (Schedule E)		7		
8 Interest, annuities, royalties, and rents from a controlled organization (Schedule F)		8		
9 Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)		9		
10 Exploited exempt activity income (Schedule I)		10		
11 Advertising income (Schedule J)		11		
12 Other income (See instructions; attach schedule)		12		
13 Total. Combine lines 3 through 12		13 -108,770.		-108,770.

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

14 Compensation of officers, directors, and trustees (Schedule K)		14		
15 Salaries and wages		15		
16 Repairs and maintenance		16		
17 Bad debts		17		
18 Interest (attach schedule) (see instructions)		18		
19 Taxes and licenses		19		
20 Charitable contributions (See instructions for limitation rules)		20		
21 Depreciation (attach Form 4562)	21			
22 Less depreciation claimed on Schedule A and elsewhere on return	22a		22b	
23 Depletion		23		
24 Contributions to deferred compensation plans		24		
25 Employee benefit programs		25		
26 Excess exempt expenses (Schedule I)		26		
27 Excess readership costs (Schedule J)		27		
28 Other deductions (attach schedule)		28		
29 Total deductions. Add lines 14 through 28		29		0.
30 Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13		30		-108,770.
31 Deduction for net operating loss arising in tax years beginning on or after January 1, 2018 (see instructions)		31		
32 Unrelated business taxable income. Subtract line 31 from line 30		32		-108,770.

LHA For Paperwork Reduction Act Notice, see instructions.

Schedule M (Form 990-T) 2018

FORM 990-T (M)

INCOME (LOSS) FROM PARTNERSHIPS

STATEMENT 5

DESCRIPTION	NET INCOME OR (LOSS)
BTAS 2015 PRIVATE INVESTORS US LP - ORDINARY BUSINESS INCOME (LOSS)	-73,966.
MILESTONE REAL ESTATE INVESTORS IV, LP - ORDINARY BUSINESS INCOME (LOSS)	-42,134.
PREMIER HEALTHCARE ALLIANCE LP - ORDINARY BUSINESS INCOME (LOSS)	5,154.
SECONDARY OPPORTUNITIES FUND II - ORDINARY BUSINESS INCOME (LOSS)	2,176.
TOTAL INCLUDED ON SCHEDULE M, PART I, LINE 5	-108,770.

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

(Rev. December 2018)
Department of the Treasury
Internal Revenue Service

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

Information furnished for the foreign corporation's annual accounting period (tax year required by section 898) (see instructions) beginning **JAN 1, 2018**, and ending **DEC 31, 2018**

Attachment
Sequence No. **121**

Name of person filing this return UNION HOSPITAL OF CECIL COUNTY, INC. <small>Number, street, and room or suite no. (or P.O. box number if mail is not delivered to street address)</small> 106 BOW STREET City or town, state, and ZIP code ELKTON, MD 21921-5596	A Identifying number 52-0607945 B Category of filer (See instructions. Check applicable box(es): 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input checked="" type="checkbox"/> C Enter the total percentage of the foreign corporation's voting stock you owned at the end of its annual accounting period 20.00 %
Filer's tax year beginning JUL 1, 2018 , and ending JUN 30, 2019	

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

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

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

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

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

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

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

a Name, address, and identifying number of branch office or agent (if any) in the United States N/A	b If a U.S. income tax return was filed, enter:	
	(i) Taxable income or (loss)	(ii) U.S. income tax paid (after all credits)

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

Schedule A Stock of the Foreign Corporation		
(a) Description of each class of stock	(b) Number of shares issued and outstanding	
	(i) Beginning of annual accounting period	(ii) End of annual accounting period
COMMON	100,000	100,000

Schedule C Income Statement

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

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

Schedule F Balance Sheet

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

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

Schedule G Other Information

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

Schedule G Other Information (continued)

Yes No

6a Is the filer of this Form 5471 claiming a foreign-derived intangible income deduction (under section 250) with respect to any amounts listed on Schedule M? [] [X]

If "Yes," complete lines 6b, 6c, and 6d.

b Enter the amount of gross income derived from sales, leases, exchanges, or other dispositions (but not licenses) from transactions with the foreign corporation that the filer included in its computation of foreign-derived deduction eligible income (FDDEI) (see instructions) [] \$

c Enter the amount of gross income derived from a license of property to the foreign corporation that the filer included in its computation of FDDEI (see instructions) [] \$

d Enter the amount of gross income derived from services provided to the foreign corporation that the filer included in its computation of FDDEI (see instructions) [] \$

7 During the tax year, was the foreign corporation a participant in any cost sharing arrangement? [] [X]

8 During the course of the tax year, did the foreign corporation become a participant in any cost sharing arrangement? [] [X]

9 If the answer to question 7 is "Yes," was the foreign corporation a participant in a cost sharing arrangement that was in effect before January 5, 2009? [] [X]

10 If the answer to question 7 is "Yes," did a U.S. taxpayer make any platform contributions as defined under Regulations section 1.482-7(c) to that cost sharing arrangement during the taxable year? [] [X]

11 If the answer to question 10 is "Yes," enter the present value of the platform contributions in U.S. dollars [] \$

12 If the answer to question 10 is "Yes," check the box for the method under Regulations section 1.482-7(g) used to determine the price of the platform contribution transaction(s):

- Comparable uncontrolled transaction method [] Income method [] Acquisition price method [] Market capitalization method [] Residual profit split method [] Unspecified methods []

13 From April 25, 2014, to December 31, 2017, did the foreign corporation purchase stock or securities of a shareholder of the foreign corporation for use in a triangular reorganization (within the meaning of Regulations section 1.358-6(b)(2))? [] [X]

14a Did the foreign corporation receive any intangible property in a prior year or the current tax year for which the U.S. transferor is required to report a section 367(d) annual income inclusion for the taxable year? [] [X] If "Yes," go to line 14b.

b Enter the amount of the earnings and profits reduction pursuant to section 367(d)(2)(B) for the taxable year [] \$

15 During the tax year, was the foreign corporation an expatriated foreign subsidiary under Regulations section 1.7874-12(a)(9)? [] [X] If "Yes," see instructions and attach statement.

16 During the tax year, did the foreign corporation participate in any reportable transaction as defined in Regulations section 1.6011-4? [] [X] If "Yes," attach Form(s) 8886 if required by Regulations section 1.6011-4(c)(3)(i)(G).

17 During the tax year, did the foreign corporation pay or accrue any foreign tax that was disqualified for credit under section 901(m)? [] [X]

18 During the tax year, did the foreign corporation pay or accrue foreign taxes to which section 909 applies, or treat foreign taxes that were previously suspended under section 909 as no longer suspended? [] [X]

19 Did you answer "Yes" to any of the questions in the instructions for line 19? [X] [] If "Yes," enter the corresponding code(s) from the instructions and attach statement (see instructions) []

Schedule I Summary of Shareholder's Income From Foreign Corporation

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

Name of U.S. shareholder ▶	Identifying number ▶		
1a Section 964(e)(4) Subpart F dividend income from the sale of stock of a lower-tier foreign corporation (see instructions)		1a	
b Section 245A(e)(2) Subpart F income from hybrid dividends of tiered corporations (see instructions)		1b	
c Other Subpart F income (enter the result from Worksheet A in the instructions)		1c	
2 Earnings invested in U.S. property (enter the result from Worksheet B in the instructions)		2	
3 Previously excluded export trade income withdrawn from investment in export trade assets (enter the result from Worksheet C in the instructions)		3	
4 Factoring income		4	
See instructions for reporting amounts on lines 1 through 4 on your income tax return.			
5 Dividends received (translated at spot rate on payment date under section 989(b)(1))		5	
6 Exchange gain or (loss) on a distribution of previously taxed income		6	

- 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 STATEMENT 6
 CORPORATION TO THE RELATED PERSONS DESCRIBED
 IN REGULATIONS SECTION 1.6046-1(B)(11)

AMOUNT	DESCRIPTION
	N/A

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

NAME AND ADDRESS	IDENTIFYING NUMBER	NUMBER OF SHARES

N/A

**SCHEDULE E
(Form 5471)**

(December 2018)

Department of the Treasury
Internal Revenue Service

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

▶ **Attach to Form 5471.**

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

OMB No. 1545-0123

Name of person filing Form 5471

UNION HOSPITAL OF CECIL COUNTY, INC.

Identifying number

52-0607945

Name of foreign corporation

FREESTATE HEALTHCARE INSURANCE COMPANY, LTD

EIN (if any)

98-0464065

Reference ID number (see instructions)

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

Part I Taxes for Which a Foreign Tax Credit Is Allowed

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

Part II Election

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

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

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

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

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

IMPORTANT: Enter amounts in U.S. dollars unless otherwise noted (see instructions).

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

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

	(i) Earnings Invested in U.S. Property (section 959(c)(1)(A))	(ii) Section 965(a) Inclusion (section 959(c)(1)(A))	(iii) Section 965(b)(4)(A) (section 959(c)(1)(A))	(iv) Section 951A Inclusion (section 959(c)(1)(A))	(v) Earnings Invested in Excess Passive Assets (section 959(c)(1)(B))	(vi) Subpart F Income (section 959(c)(2))	(vii) Section 965(a) Inclusion (section 959(c)(2))	(viii) Section 965(b)(4)(A) (section 959(c)(2))	(ix) Section 951A Inclusion (section 959(c)(2))
1a									
b									
c									
2									
3a									
b									
4									
5a									
b									
6									
7									
8									
9									
10									
11									
12									
13									
14									

**SCHEDULE H
(Form 5471)**

(December 2018)
Department of the Treasury
Internal Revenue Service

Current Earnings and Profits

▶ Attach to Form 5471.

OMB No. 1545-0123

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

Name of person filing Form 5471
UNION HOSPITAL OF CECIL COUNTY, INC.

Identifying number
52-0607945

Name of foreign corporation
FREESTATE HEALTHCARE INSURANCE CO

EIN (if any)
98-0464065

Reference ID number (see instr.)

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

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

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

1	Current year net income or (loss) per foreign books of account			1	
2	Net adjustments made to line 1 to determine current earnings and profits according to U.S. financial and tax accounting standards (see instructions):				
		Net Additions	Net Subtractions		
a	Capital gains or losses	2a 1,910,754.			
b	Depreciation and amortization	2b			
c	Depletion	2c			
d	Investment or incentive allowance	2d			
e	Charges to statutory reserves	2e			
f	Inventory adjustments	2f			
g	Income taxes (see Schedule E, Part I, line 9, column (j))	2g			
h	Foreign currency gains or losses	2h			
i	Other (attach statement) SEE STATEMENT 8	2i 3,005,533.	4,916,437.		
3	Total net additions	3 4,916,287.			
4	Total net subtractions	4	4,916,437.		
5a	Current earnings and profits (line 1 plus line 3 minus line 4)			5a	-150.
b	DASTM gain or (loss) for foreign corporations that use DASTM (see instructions)			5b	
c	Combine lines 5a and 5b			5c	-150.
d	Current earnings and profits in U.S. dollars (line 5c translated at the average exchange rate, as defined in section 989(b)(3) and the related regulations (see instructions))			5d	-150.
	Enter exchange rate used for line 5d ▶		1.000000		

LHA For Paperwork Reduction Act Notice, see instructions.

Schedule H (Form 5471) (12-2018)

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

(December 2018)

Department of the Treasury
Internal Revenue Service

Information for Global Intangible Low-Taxed Income

▶ Attach to Form 5471.

OMB No. 1545-0123

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

Name of person filing Form 5471
UNION HOSPITAL OF CECIL COUNTY, INC.

Identifying number
52-0607945

Name of foreign corporation
FREESTATE HEALTHCARE INSURANCE COMP

EIN (if any)
98-0464065

Reference ID number (see instr.)

Separate Category (enter code - see instructions) ▶		Functional Currency	Conversion Rate	U.S. Dollars
1	Gross income	1 4916437.		
2	Exclusions			
a	Effectively connected income			
b	Subpart F income	2b 4916437.		
c	High-tax exception income per section 954(b)(4)	2c		
d	Related party dividends	2d		
e	Foreign oil and gas extraction income	2e		
3	Total exclusions (total of lines 2a-2e)	3 4916437.		
4	Gross income less total exclusions (line 1 minus line 3)	4		
5	Deductions properly allocable to amount on line 4	5		
6	Tested income (loss) (line 4 minus line 5) (see instructions for line 6)	6	1.000000	
Other Amounts (see instructions)				
7	Tested foreign income taxes	7	1.000000	
8	Qualified business asset investment (QBAI)	8	1.000000	
9	Interest expense	9	1.000000	

LHA For Paperwork Reduction Act Notice, see instructions.

Schedule I-1 (Form 5471) (12-2018)

**SCHEDULE J
(Form 5471)**

(Rev. December 2018)
Department of the Treasury
Internal Revenue Service

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

▶ Attach to Form 5471.

OMB No. 1545-0123

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

Name of person filing Form 5471

Identifying number

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

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

Part I Accumulated E&P of Controlled Foreign Corporation

Check the box if person filing return does not have all U.S. Shareholders' information to complete amount for columns (e)(ii)-(e)(iv) and (e)(vii)-(ix) (see instructions).

Important: Enter amounts in functional currency.

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

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

	(e) Previously Taxed E&P (see instructions)							(f)
	(iii) Section 965(b)(4)(A) (section 959(c)(1)(A))	(iv) Section 951A Inclusion (section 959(c)(1)(A))	(v) Earnings Invested in Excess Passive Assets (section 959(c)(1)(B))	(vi) Subpart F Income (section 959(c)(2))	(vii) Section 965(a) Inclusion (section 959(c)(2))	(viii) Section 965(b)(4)(A) (section 959(c)(2))	(ix) Section 951A Inclusion (section 959(c)(2))	Total Section 964(a) E&P (combine columns (a), (b), (c), and (e)(i) through (e)(ix))
1a								-12877111.
1b								
1c								-12877111.
2a								
2b								
3								
4								
5a								
5b								
6								
7								
8								
9								
10								
11								
12								
13								
14								-12877261.

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

Enter amounts in functional currency.

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

**SCHEDULE P
(Form 5471)**

(December 2018)

Department of the Treasury
Internal Revenue Service

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

OMB No. 1545-0123

▶ **Attach to Form 5471.**

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

Name of person filing Form 5471

UNION HOSPITAL OF CECIL COUNTY, INC.

Identifying number

52-0607945

Name of foreign corporation

FREESTATE HEALTHCARE INSURANCE COMPANY, LTD

EIN (if any)

98-0464065

Reference ID number (see instructions)

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

Previously Taxed E&P (see instructions)

	Important: Enter amounts in functional currency.	(a) Earnings Invested in U.S. Property (section 959(c)(1)(A))	(b) Section 965(a) Inclusion (section 959(c)(1)(A))	(c) Section 965(b)(4)(A) (section 959(c)(1)(A))	(d) Section 951A Inclusion (section 959(c)(1)(A))	(e) Earnings Invested in Excess Passive Assets (section 959(c)(1)(B))	(f) Subpart F Income (section 959(c)(2))	(g) Section 965(a) Inclusion (section 959(c)(2))	(h) Section 965(b)(4)(A) (section 959(c)(2))	(i) Section 951A Inclusion (section 959(c)(2))	(j) Total
1a	Balance at beginning of year (see instructions)										
1b	Beginning balance adjustments (attach statement)										
1c	Adjusted beginning balance (combine lines 1a and 1b)										
2	Reduction for taxes unsuspended under anti-splitter rules										
3	E&P attributable to distributions of previously taxed E&P from lower-tier foreign corporation										
4	E&P carried over in nonrecognition transaction										
5	Other adjustments (attach statement)										
6	Total current and accumulated E&P (combine lines 1c through 5)										
7	Amounts reclassified to section 959(c)(2) E&P from section 959(c)(3) E&P										
8	Actual distributions of previously taxed income										
9	Amounts reclassified to section 959(c)(1) E&P from section 959(c)(2) E&P										

LHA **For Paperwork Reduction Act Notice, see instructions.**

Schedule P (Form 5471) (12-2018)

Previously Taxed E&P (see instructions) *(continued)*

	(a) Earnings Invested in U.S. Property (section 959(c)(1)(A))	(b) Section 965(a) Inclusion (section 959(c)(1)(A))	(c) Section 965(b)(4)(A) (section 959(c)(1)(A))	(d) Section 951A Inclusion (section 959(c)(1)(A))	(e) Earnings Invested in Excess Passive Assets (section 959(c)(1)(B))	(f) Subpart F Income (section 959(c)(2))	(g) Section 965(a) Inclusion (section 959(c)(2))	(h) Section 965(b)(4)(A) (section 959(c)(2))	(i) Section 951A Inclusion (section 959(c)(2))	(j) Total
10	Amounts included as earnings invested in U.S. property and reclassified to section 959(c)(1) E&P (see instructions)									
11	Other adjustments (attach statement)									
12	Balance at beginning of next year (combine lines 6 through 11)									

FORM 5471

OTHER NET ADJUSTMENTS

STATEMENT 8

<u>DESCRIPTION</u>	<u>NET ADDITIONS</u>	<u>NET SUBTRACTIONS</u>
RELATED PARTY PREMIUMS	0.	4,916,437.
REL. PARTY LOSS RESERVE/CLAIMS PD	3,005,533.	0.
TOTAL TO 5471, SCHEDULE H, LINE 2I	<u>3,005,533.</u>	<u>4,916,437.</u>

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

OMB No. 1545-0026

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

Attachment
 Sequence No. **128**

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

Name of transferor UNION HOSPITAL OF CECIL COUNTY, INC.	Identifying number (see instructions) 52-0607945
---	--

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

Controlling shareholder	Identifying number

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

Name of parent corporation	EIN of parent corporation

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

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

Name of partnership	EIN of partnership

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

Part II Transferee Foreign Corporation Information (see instructions)

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

6 Address (including country) PO BOX 10233 GRAND CAYMAN, KY1-1002 CAYMAN ISLANDS	5b Reference ID number
---	-------------------------------

7 Country code of country of incorporation or organization
CJ

8 Foreign law characterization (see instructions)
CORPORATION

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

Part III Information Regarding Transfer of Property (see instructions)

Section A - Cash

Type of property	(a) Date of transfer	(b) Description of property	(c) Fair market value on date of transfer	(d) Cost or other basis	(e) Gain recognized on transfer
Cash	08/01/2018		1,211,548.		

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

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

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

- 11** Did the transferor transfer stock or securities subject to section 367(a) with respect to which a gain recognition agreement was filed? **Yes** **No**
- 12 a** Were any assets of a foreign branch (including a branch that is a foreign disregarded entity) transferred to a foreign corporation? **Yes** **No**
 If "Yes," go to line 12b.
- b** Was the transferor a domestic corporation that transferred substantially all of the assets of a foreign branch (including a branch that is a foreign disregarded entity) to a specified 10%-owned foreign corporation? **Yes** **No**
 If "Yes," continue to line 12c. If "No," skip lines 12c and 12d, and go to line 13.
- c** Immediately after the transfer, was the domestic corporation a U.S. shareholder with respect to the transferee foreign corporation? **Yes** **No**
 If "Yes," continue to line 12d. If "No," skip line 12d, and go to line 13.
- d** Enter the transferred loss amount included in gross income as required under section 91 ► \$ _____
- 13** Did the transferor transfer property described in section 367(d)(4)? **Yes** **No**
 If "No," skip Section C and questions 14a through 15.

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

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

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

Supplemental Part III Information Required To Be Reported (see instructions)
SEE STATEMENT 9

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

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

FORM 926

SUPPLEMENTAL PART III INFORMATION
REQUIRED TO BE REPORTED

STATEMENT 9

FREESTATE HEALTHCARE INSURANCE COMPANY LTD.

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, 2018 AND JUNE 30, 2019

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

VALUE: \$1,211,548 (CASH)

BASIS: \$1,211,548

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

FREESTATE HEALTHCARE INSURANCE COMPANY LTD.

H

STATEMENT REQUIRED 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 \$1,211,548.

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

CONSIDERATION RECEIVED: NOTHING WAS RECEIVED IN CONSIDERATION IN EXCHANGE FOR DEEMED CASH CONTRIBUTIONS TO CAPITAL OF \$1,211,548. THE TAXPAYER OWNED 20% OF THE STOCK OF THE TRANSFeree CORPORATION BOTH BEFORE AND AFTER THESE TRANSFERS.

FREESTATE HEALTHCARE INSURANCE COMPANY LTD.

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

PROPERTY TRANSFERRED: CASH IN THE AMOUNT OF \$1,211,548 (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

TAX RETURN FILING INSTRUCTIONS

CALIFORNIA FORM 199

FOR THE YEAR ENDING

June 30, 2019

Prepared For:

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

Prepared By:

Baker Tilly Virchow Krause, LLP
1570 Fruitville Pike
Suite 400
Lancaster, PA 17601

To be Signed and Dated By:

Not applicable

Amount of Tax:

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

Overpayment:

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

Make Check Payable To:

Franchise Tax Board

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.

Return Must be Mailed On or Before:

Not applicable

Special Instructions:

Your payment should be made as instructed below on or before May 15, 2020.

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, 2019

Prepared For:

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

Prepared By:

Baker Tilly Virchow Krause, LLP
1570 Fruitville Pike
Suite 400
Lancaster, PA 17601

To be Signed and Dated By:

The authorized individual(s).

Amount of Tax:

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

Overpayment:

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

Make Check Payable To:

Not applicable

Mail Tax Return and Check (if applicable) To:

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

Return Must be Mailed On or Before:

May 15, 2020

Special Instructions:

**California Exempt Organization
Annual Information Return**

Calendar Year 2018 or fiscal year beginning (mm/dd/yyyy) **07/01/2018**, and ending (mm/dd/yyyy) **06/30/2019**

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

<p>A First Return <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>B Amended Return <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>C IRC Section 4947(a)(1) trust <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>D Final Information Return? <input type="checkbox"/> Dissolved <input type="checkbox"/> Surrendered (Withdrawn) <input type="checkbox"/> Merged/Reorganized Enter date: (mm/dd/yyyy) _____</p> <p>E Check accounting method: (1) <input type="checkbox"/> Cash (2) <input checked="" type="checkbox"/> Accrual (3) <input type="checkbox"/> Other</p> <p>F 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>G Is this a group filing? See instructions <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>H 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>I 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>J If exempt under R&TC Section 23701d, has the organization engaged in political activities? See instructions. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>K Is the organization exempt under R&TC Section 23701g? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," enter the gross receipts from nonmember sources \$ _____</p> <p>L If organization is a public charity exempt under R&TC Section 23701d and meets the filing fee exception, check box. No filing fee is required <input type="checkbox"/></p> <p>M Is the organization a Limited Liability Company? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>N Did the organization file Form 100 or Form 109 to report taxable income? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>O 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>P Is federal Form 1023/1024 pending? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date filed with IRS _____</p>
--	--

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

Receipts and Revenues	1	Gross sales or receipts from other sources. From Side 2, Part II, line 8	1	179,582,094	00
	2	Gross dues and assessments from members and affiliates	2		00
	3	Gross contributions, gifts, grants, and similar amounts received STMT 1	3	10,510,084	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	190,092,178	00
	5	Cost of goods sold	5		00
	6	Cost or other basis, and sales expenses of assets sold	6	14,068,790	00
	7	Total costs. Add line 5 and line 6	7	14,068,790	00
	8	Total gross income. Subtract line 7 from line 4	8	176,023,388	00
Expenses	9	Total expenses and disbursements. From Side 2, Part II, line 18	9	170,279,378	00
	10	Excess of receipts over expenses and disbursements. Subtract line 9 from line 8	10	5,744,010	00
Filing Fee	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	Balance due. 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.

Sign Here	Signature of officer	Title CHIEF FINANCIA	Date	• Telephone
Paid Preparer's Use Only	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	• PTIN P00760402
	Firm's name (or yours, if self-employed) and address BAKER TILLY VIRCHOW KRAUSE, LLP 1570 FRUITVILLE PIKE, SUITE 400 LANCASTER, PA 17601			• Firm's FEIN 39-0859910
				• Telephone 717.740.4863

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.

828951 12-12-18

Receipts from Other Sources	1	Gross sales or receipts from all business activities. See instructions	•	1		00		
	2	Interest	•	2	1,667,296	00		
	3	Dividends	•	3		00		
	4	Gross rents	•	4	37,036	00		
	5	Gross royalties	•	5		00		
	6	Gross amount received from sale of assets (See Instructions)	STATEMENT 2	•	6	14,355,325	00	
	7	Other income	SEE STATEMENT 3	•	7	163,522,437	00	
	8	Total gross sales or receipts from other sources. Add line 1 through line 7. Enter here and on Side 1, Part I, line 1		•	8	179,582,094	00	
	9	Contributions, gifts, grants, and similar amounts paid	STATEMENT 4	•	9	799,694	00	
	10	Disbursements to or for members		•	10		00	
	11	Compensation of officers, directors, and trustees	SEE STATEMENT 5	•	11	1,490,294	00	
	12	Other salaries and wages		•	12	71,196,463	00	
	Expenses and Disbursements	13	Interest	•	13	1,942,655	00	
		14	Taxes	•	14	4,872,450	00	
		15	Rents	•	15	4,193,912	00	
		16	Depreciation and depletion (See instructions)		•	16	11,026,334	00
		17	Other Expenses and Disbursements	SEE STATEMENT 6	•	17	74,757,576	00
		18	Total expenses and disbursements. Add line 9 through line 17. Enter here and on Side 1, Part I, line 9		•	18	170,279,378	00

Schedule L Balance Sheet	Beginning of taxable year		End of taxable year	
	(a)	(b)	(c)	(d)
Assets				
1 Cash		3,170,011		6,198,168
2 Net accounts receivable		16,617,200		14,069,712
3 Net notes receivable				
4 Inventories		2,268,203		2,307,404
5 Federal and state government obligations				
6 Investments in other bonds				
7 Investments in stock				
8 Mortgage loans				
9 Other investments STMT 7		45,314,302		46,823,245
10 a Depreciable assets	219,146,986		224,260,942	
b Less accumulated depreciation	(132,143,595)	87,003,391	(142,462,854)	81,798,088
11 Land		1,134,905		1,134,905
12 Other assets STMT 8		10,574,728		11,594,028
13 Total assets		166,082,740		163,925,550
Liabilities and net worth				
14 Accounts payable		14,591,487		10,375,169
15 Contributions, gifts, or grants payable				
16 Bonds and notes payable STMT 9		59,181,386		56,179,987
17 Mortgages payable				
18 Other liabilities STMT 10		15,205,144		15,031,195
19 Capital stock or principal fund				
20 Paid-in or capital surplus. Attach reconciliation				
21 Retained earnings or income fund		77,104,723		82,339,199
22 Total liabilities and net worth		166,082,740		163,925,550

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	•	5,234,476	7 Income recorded on books this year not included in this return STMT 12	•	149,388
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		149,388
4 Income not recorded on books this year	•		10 Net income per return. Subtract line 9 from line 6		5,744,010
5 Expenses recorded on books this year not deducted in this return STMT 11	•	658,922			
6 Total. Add line 1 through line 5		5,893,398			

CA 199

CASH CONTRIBUTIONS
INCLUDED ON PART I, LINE 3

STATEMENT 1

CONTRIBUTOR'S NAME	CONTRIBUTOR'S ADDRESS	DATE OF GIFT	AMOUNT
AFFINITY HEALTH ALLIANCE, INC.	106 BOW STREET ELKTON, MD 21921	06/30/19	10,193,632.
UNION HOSPITAL OF CECIL COUNTY FOUNDATION	106 BOW STREET ELKTON, MD 21921	06/30/19	177,042.
MARYLAND ENERGY ADMINISTRATION	1800 WASHINGTON BLVD, STE. 755 BALTIMORE, MD 21230	03/25/19	139,410.
TOTAL INCLUDED ON LINE 3			<u>10,510,084.</u>

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
	14,067,475.	0.	0.	14,355,325.
DESCRIPTION	DATE ACQUIRED	DATE SOLD	METHOD ACQUIRED	
			PURCHASED	
	COST OR OTHER BASIS	DEPREC.	EXPENSE OF SALE	GROSS SALES PRICE
	708,395.	707,080.	0.	0.
TOTAL TO FORM 199, PAGE 2, LN 6	<u>14,775,870.</u>	<u>707,080.</u>	<u>0.</u>	<u>14,355,325.</u>

CA 199

OTHER INCOME

STATEMENT 3

DESCRIPTIONAMOUNT

CAFETERIA/FOOD SERVICE	789,958.
PURCHASE DISCOUNTS	26,995.
LABORATORY REVENUE	1,706,066.
PARKING REVENUE	35,760.
OTHER REVENUE	19,887.
OTHER REVENUE 2	19,887.
OTHER	299.
NET PATIENT SERVICE REVENUE	159,015,886.
OTHER OPERATING REVENUE	1,472,383.
ADULT DAY CARE	435,316.
TOTAL TO FORM 199, PART II, LINE 7	163,522,437.

CA 199

CASH CONTRIBUTIONS, GIFTS, GRANTS
AND SIMILAR AMOUNTS PAID

STATEMENT 4

ACTIVITY CLASSIFICATION: CHARITABLE ACTIVITIES

<u>DONEES NAME</u>	<u>DONEES ADDRESS</u>	<u>RELATIONSHIP</u>	<u>AMOUNT</u>
UNION HOSPITAL OF CECIL COUNTY HEALTH SE	106 BOW STREET - ELKTON, MD 21921	RELATED PARTY	348,832.

<u>DONEES NAME</u>	<u>DONEES ADDRESS</u>	<u>RELATIONSHIP</u>	<u>AMOUNT</u>
UNION HOSPITAL OF CECIL COUNTY VENTURES,	106 BOW STREET - ELKTON, MD 21921	RELATED PARTY	450,862.

TOTAL FOR THIS ACTIVITY	799,694.
-------------------------	----------

TOTAL INCLUDED ON FORM 199, PART II, LINE 9

799,694.

CA 199

COMPENSATION OF OFFICERS, DIRECTORS AND TRUSTEES

STATEMENT 5

<u>NAME AND ADDRESS</u>	<u>TITLE AND AVERAGE HRS WORKED/WK</u>	<u>COMPENSATION</u>
JOSE MA, MD 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 39.50	274,265.
JUSTIN SAUSVILLE, M.D. 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 39.50	541,742.
JACQUES RENE 106 BOW STREET ELKTON, MD 21921-5596	DIRECTOR 0.50	0.
AARON Z. ROYSTON 106 BOW STREET ELKTON, MD 21921-5596	VP OF PROVIDER ENTERPRISE 30.00	229,002.
CRAIG M. BABBITT 106 BOW STREET ELKTON, MD 21921-5596	IN-HOUSE LEGAL COUNSEL 40.00	300,282.
MICHELLE TWUM-DANSO (START 1/6/19) 106 BOW STREET ELKTON, MD 21921-5596	ASSOCIATE VP HUMAN RESOURC 39.00	7,616.
TERRANCE LOVELL (UNTIL 01/18) 106 BOW STREET ELKTON, MD 21921-5596	VP HUMAN RESOURCES 40.00	137,387.
TOTAL TO FORM 199, PART II, LINE 11		<u>1,490,294.</u>

CA 199	OTHER EXPENSES	STATEMENT 6
DESCRIPTION		AMOUNT
MEDICAL SUPPLIES		19,329,569.
BAD DEBTS		6,959,649.
REPAIRS & MAINTENANCE		3,274,111.
DIETARY		889,820.
RENTAL EXPENSES		8,307.
EXPENSES		0.
PENSION PLAN CONTRIBUTIONS		380,610.
OTHER EMPLOYEE BENEFITS		9,672,454.
MANAGEMENT FEES		910,899.
LEGAL FEES		169,686.
ACCOUNTING FEES		108,660.
INVESTMENT MANAGEMENT FEES		63,551.
OTHER PROFESSIONAL FEES		25,660,515.
ADVERTISING AND PROMOTION		330,541.
OFFICE EXPENSES		2,162,906.
INFORMATION TECHNOLOGY		98,193.
TRAVEL		111,661.
CONFERENCES AND CONVENTIONS		106,377.
INSURANCE		2,730,287.
ALL OTHER EXPENSES		1,789,780.
TOTAL TO FORM 199, PART II, LINE 17		74,757,576.

CA 199	OTHER INVESTMENTS	STATEMENT 7
DESCRIPTION	BEG. OF YEAR	END OF YEAR
INTEREST IN NET ASSETS OF UNION HOSPITAL OF CECIL COUNTY FOUNDATION	4,998,101.	5,147,489.
PREMIER PURCHASING PARTNERS, LP	591,164.	677,941.
FREESTATE HEALTHCARE COMPANY	20,000.	20,000.
MANAGED HEDGE FUNDS	4,820,001.	4,800,000.
MANAGED HEDGE FUNDS	3,444,116.	3,840,647.
OTHER PUBLICLY TRADED SECURITIES	31,440,920.	32,337,168.
TOTAL TO FORM 199, SCHEDULE L, LINE 9	45,314,302.	46,823,245.

CA 199	OTHER ASSETS	STATEMENT 8
DESCRIPTION	BEG. OF YEAR	END OF YEAR
PREPAID EXPENSES AND DEFERRED CHARGES	2,136,306.	2,940,202.
OTHER ASSETS	596,370.	662,806.
LOAN ISSUANCE COSTS	451,542.	0.
INSURANCE CLAIMS RECEIVABLE	6,692,333.	7,666,493.
DUE FROM AFFILIATES	698,177.	324,527.
TOTAL TO FORM 199, SCHEDULE L, LINE 12	10,574,728.	11,594,028.

CA 199	BONDS AND NOTES PAYABLE	STATEMENT 9
DESCRIPTION	BEG. OF YEAR	END OF YEAR
TAX-EXEMPT BONDS LIABILITIES	59,181,386.	56,179,987.
TOTAL TO FORM 199, SCHEDULE L, LINE 16	59,181,386.	56,179,987.

CA 199	OTHER LIABILITIES	STATEMENT 10
DESCRIPTION	BEG. OF YEAR	END OF YEAR
THIRD PARTY ADVANCES	3,964,220.	3,485,157.
CAPITAL LEASE OBLIGATIONS	3,075,968.	2,273,241.
ESTIMATED MEDICAL MALPRACTICE CLAIMS LIABILITY	7,903,134.	8,853,757.
DUE TO AFFILIATES	261,822.	419,040.
TOTAL TO FORM 199, SCHEDULE L, LINE 18	15,205,144.	15,031,195.

CA 199	EXPENSES RECORDED ON BOOKS THIS YEAR NOT DEDUCTED IN THIS RETURN	STATEMENT 11
DESCRIPTION		AMOUNT
UNREALIZED LOSS ON INVESTMENTS		658,922.
TOTAL TO FORM 199, SCHEDULE M-1, LINE 5		658,922.

CA 199	INCOME RECORDED ON BOOKS THIS YEAR NOT INCLUDED IN THIS RETURN	STATEMENT 12
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DESCRIPTION	AMOUNT
CHANGE IN INTEREST IN NET ASSETS OF SUBSIDIARIES	149,388.
TOTAL TO FORM 199, SCHEDULE M-1, LINE 7	149,388.

CA 199	FUND BALANCES	STATEMENT 13
--------	---------------	--------------

DESCRIPTION	BEG. OF YEAR	END OF YEAR
UNRESTRICTED ASSETS	74,557,561.	79,490,139.
TEMPORARILY RESTRICTED ASSETS	2,547,162.	2,849,060.
TOTAL TO FORM 199, SCHEDULE L, LINE 21	77,104,723.	82,339,199.

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, FEIN, CA SOS file number and "2018 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.

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 for more information.

839035 12-12-18

--- 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 **2018** **Payment Voucher for Corporations and Exempt Organizations e-filed Returns**

CALIFORNIA FORM
3586 (e-file)

0000000 UNIO 52-0607945 9612036 18 FORM 3
TYB 07-01-2018 TYE 06-30-2019
UNION HOSPITAL OF CECIL COUNTY INC

106 BOW STREET
ELKTON MD 21921-5596

(410) 398-4000

Amount of Payment 10.

TAXABLE YEAR

2018

California e-file Return Authorization for Exempt Organizations

FORM
8453-EO

Exempt Organization name

Identifying number

UNION HOSPITAL OF CECIL COUNTY, INC.

52-0607945

Part I Electronic Return Information (whole dollars only)

1	Total gross receipts (Form 199, line 4)	1	190,092,178
2	Total gross income (Form 199, line 8)	2	176,023,388
3	Total expenses and disbursements (Form 199, line 9)	3	170,279,378

Part II Settle Your Account Electronically for Taxable Year 2018

4 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 _____

6 Account number _____ 7 Type of account: Checking Savings

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 2018 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 _____



CHIEF FINANCIAL OFFICER

Title

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, 2018 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	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	Paid preparer's signature	Date	Check if self-employed <input type="checkbox"/>	Paid preparer's PTIN	
Must Sign	Firm's name (or yours if self-employed) and address				FEIN
					ZIP code

California Exempt Organization
Business Income Tax Return

Calendar Year 2018 or fiscal year beginning (mm/dd/yyyy) **07/01/2018**, and ending (mm/dd/yyyy) **06/30/2019**

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 14**
- H Is the organization a non-exempt charitable trust as described in IRC Section 4947(a)(1)? Yes No
- I Is this organization claiming any former; Enterprise Zone (EZ), Los Angeles Revitalization Zone (LARZ), Local Agency Military Base Recovery Area (LAMBRA), Targeted Tax Area (TTA), or Manufacturing Enhancement Area (MEA) tax benefits? Yes No
- J Is this organization a qualified pension, profit-sharing, or stock bonus plan as described in IRC Section 401(a)? Yes No
- K Unrelated Business Activity (UBA) Code **621500**
- L Is this a Hospital? Yes No
If "Yes," attach federal Schedule H (Form 990)

Taxable Corporation	1	Unrelated business taxable income from Side 2, Part II, line 30	•	1	347	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	347	00
Taxable Trust	4	Unrelated business taxable income from Side 2, Part II, line 30	•	4		00
Tax Computation	5	Unrelated business taxable income from line 3 or line 4	•	5	347	00
	6	EZ, LARZ, LAMBRA, or TTA NOL carryover deduction	•	6		00
	7	Net Operating Loss deduction. See General Information N	•	7	347	00
	8	Add line 6 and line 7	•	8	347	00
	9	Net unrelated business taxable income. Subtract line 8 from line 5	•	9	0	00
	10	Tax 8.84 % x line 9. See General Information J	•	10		00
	11	Tax credits from Schedule B. See instructions	•	11		00
Total Tax	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
Payments	15	Overpayment from a prior year allowed as a credit	•	15		00
	16	2018 estimated tax payments. See instructions	•	16		00
	17	Withholding (Form 592-B and/or 593.) See instructions	•	17		00
	18	Amount paid with extension (form FTB 3539)	•	18		00
	19	Total payments and credits. Add line 15 through line 18	•	19		00
Use Tax/Tax Due/Overpayment	20	Use tax. See instructions	•	20		00
	21	Payments balance. If line 19 is more than line 20, subtract line 20 from line 19	•	21		00
	22	Use tax balance. If line 20 is more than line 19, subtract line 19 from line 20	•	22		00
	23	Tax due. Subtract line 21 from line 14. Pay entire amount with return. See instructions	•	23		00
	24	Overpayment. Subtract line 14 from line 21. See instructions	•	24		00
	25	Enter amount of line 24 to be applied to 2019 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 16	• 5	347	00
6 Rental income (Schedule C)			• 6		00
7 Unrelated debt-financed income (Schedule D)			• 7		00
8 Investment income of an R&TC Section 23701g, 23701i, or 23701n organization (Schedule E)			• 8		00
9 Interest, Annuities, Royalties and Rents from controlled organizations (Schedule F)			• 9		00
10 Exploited exempt activity income (Schedule G)			• 10		00
11 Advertising income (Schedule H, Part III, Column A)			• 11		00
12 Other income. Attach schedule			• 12		00
13 Total unrelated trade or business income. Add line 3 through line 12			• 13	347	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
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	347	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	347	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	347	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 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 CHIEF FINANCIAL OF	Date	• Telephone
Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	• PTIN P00760402
Firm's name (or yours, if self-employed) and address BAKER TILLY VIRCHOW KRAUSE, LLP 1570 FRUITVILLE PIKE, SUITE 400 LANCASTER, PA 17601			• FEIN 39-0859910 • Telephone 717.740.4863
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

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

Schedule E Investment Income of an R&TC Section 23701g, Section 23701i, or Section 23701n Organization

1 Description	2 Amount	3 Deductions directly connected	4 Net investment income, column 2 less column 3	5 Set-asides	6 Balance of investment income, column 4 less column 5
Total. Enter here and on Side 2, Part I, line 8					
Enter gross income from members (dues, fees, charges, or similar amounts)					

Schedule F Interest, Annuities, Royalties and Rents from Controlled Organizations

Exempt Controlled Organizations					
1 Name of controlled organizations	2 Employer Identification Number	3 Net unrelated income (loss)	4 Total of specified payments made	5 Part of column (4) that is included in the controlling organization's gross income	6 Deductions directly connected with income in column (5)
1					
2					
3					
Nonexempt Controlled Organizations					
7 Taxable Income	8 Net unrelated income (loss)	9 Total of specified payments made	10 Part of column (9) that is included in the controlling organization's gross income	11 Deductions directly connected with income in column (10)	
1					
2					
3					
4 Add columns 5 and 10					
5 Add columns 6 and 11					
6 Subtract line 5 from line 4. Enter here and on Side 2, Part I, line 9					

Schedule G Exploited Exempt Activity Income, other than Advertising Income

1 Description of exploited activity (attach schedule if more than one unrelated activity is exploiting the same exempt activity)	2 Gross unrelated business income from trade or business	3 Expenses directly connected with production of unrelated business income	4 Net income from unrelated trade or business, column 2 less column 3	5 Gross income from activity that is not unrelated business income	6 Expenses attributable to column 5	7 Excess exempt expense, column 6 less column 5 but not more than column 4	8 Net income includible, column 4 less column 7 but not less than zero
Total. Enter here and on Side 2, Part I, line 10							

Schedule H Advertising Income and Excess Advertising Costs

Part I Income from Periodicals Reported on a Consolidated Basis

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 for reporting separate basis periodicals.

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

Enter total here and on Side 2, Part 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 14

LABORATORY SERVICES TO NON-PATIENTS

TO FORM 109, PAGE 1

FOOTNOTES

STATEMENT 15

THE NET OPERATING LOSS CARRYFORWARD (SEE FORM 3805Q, PART II) HAS BEEN ADJUSTED TO REFLECT THE EFFECT OF THE REPEAL OF TRANSPORTATION FRINGE BENEFITS TAXATION (IRC SECTION 512(A)(7)). THE HOSPITAL DID NOT HAVE A CHANGE TO ITS TAX LIABILITY AND THEREFORE WILL NOT BE FILING AN AMENDED RETURN.

CA 109 INCOME OR (LOSS) FROM PARTNERSHIPS, LIMITED LIABILITY COMPANIES OR S CORPORATIONS STATEMENT 16

DESCRIPTION	AMOUNT
PREMIER HEALTHCARE ALLIANCE LP - ORDINARY BUSINESS INCOME (LOSS)	347.
TOTAL TO FORM 109, PAGE 2, LINE 5	347.

Attach to Form 100, Form 100W, Form 100S, or Form 109.

Corporation name UNION HOSPITAL OF CECIL COUNTY, INC.	California corporation number 9612036
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During the taxable year the corporation incurred the NOL, the corporation was a(n): <input checked="" type="radio"/> <input type="checkbox"/> C Corporation <input checked="" type="radio"/> <input type="checkbox"/> S Corporation <input checked="" type="radio"/> <input checked="" type="checkbox"/> Exempt Organization <input type="radio"/> <input type="checkbox"/> 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 2018 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	<input checked="" type="radio"/> 6			00

If the corporation is using the current year NOL to carryback to offset net income for taxable years 2016 and/or 2017, complete

Part III, NOL carryback, on Side 2 before completing Part I, lines 7-9 below.

7 2018 NOL carryback used to offset 2016 net income. Enter the amount from Part III, line 3, column (e)	<input checked="" type="radio"/> 7		00
8 2018 NOL carryback used to offset 2017 net income. Enter the amount from Part III, line 3, column (g)	<input checked="" type="radio"/> 8		00
9 2018 NOL carryover to 2019. Add line 7 and line 8, then subtract the result from line 6. See instructions.	<input checked="" type="radio"/> 9		00

Election to waive carryback

Check the box if the corporation elects to relinquish the entire carryback period with respect to 2018 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-).	<input checked="" type="radio"/>	(g) Available balance	347
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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 2017	(f) Amount used in 2018		(h) Carryover to 2019 col. (e) minus col. (f)
2 <input checked="" type="radio"/> 2015		GEN	35,991	<input checked="" type="radio"/> 33,409	347	0	<input checked="" type="radio"/> 33,062
<input checked="" type="radio"/>				<input checked="" type="radio"/>			<input checked="" type="radio"/>
<input checked="" type="radio"/>				<input checked="" type="radio"/>			<input checked="" type="radio"/>
<input checked="" type="radio"/>				<input checked="" type="radio"/>			<input checked="" type="radio"/>

Current Year NOLs

3 2018		DIS					col. (d) minus col. (f) See instructions.
4 2018							
2018							
2018							
2018							

* **Type of NOL:** General (GEN), New Business (NB), Eligible Small Business (ESB), or Disaster (DIS).

Part III NOL carryback

- 1 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-)
- 2 2017 Net income - Enter the amount from 2017 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	2016		2017		(i) Carryover to 2019 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 2018								
2018								
2018								
2018								
2018								

* **Type of NOL:** General (GEN), New Business (NB), Eligible Small Business (ESB), or NOL attributable to a qualified disaster loss (DIS).

Part IV 2018 NOL deduction

- | | | |
|--|-----|----|
| 1 Total the amounts in Part II, line 2, column (f) | 347 | 00 |
| 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- | 0 | 00 |
| 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 | 347 | 00 |

TAX RETURN FILING INSTRUCTIONS

ILLINOIS FORM IL-990-T

FOR THE YEAR ENDING

June 30, 2019

Prepared For:

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

Prepared By:

Baker Tilly Virchow Krause, LLP
1570 Fruitville Pike
Suite 400
Lancaster, PA 17601

To be Signed and Dated By:

The authorized individual(s).

Amount of Tax:

Total tax	\$	22
Less: payments and credits	\$	0
Plus: other amount	\$	0
Plus: interest and penalties	\$	0
Balance due	\$	22

Overpayment:

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

Make Check Payable To:

Illinois Department of Revenue

Mail Tax Return and Check (if applicable) To:

Illinois Department of Revenue
P.O. Box 19053
Springfield, IL 62794-9053

Return Must be Mailed On or Before:

June 15, 2020

Special Instructions:

Include the organization's FEIN, tax year ending and IL-990-T-V on the check or money order.

898031 01-17-19

Illinois Department of Revenue

2018 IL-990-T-V

IL-990-T-V (R-12/18)

ID: 2BX

Payment Voucher for Exempt Organization
Income and Replacement Tax

Official use only

Mail to: Illinois Department of Revenue, P.O. Box 19053, Springfield, IL 62794-9053

STOP If no payment is due or you make your payment electronically, do not file this form.

Tax year ending

FEIN 52-0607945 000 0

06 19
Month Year

UNION HOSPITAL OF CECIL COUNTY, INC.
106 BOW STREET
ELKTON, MD 21921-5596

\$ 22.00

Amount of payment (Whole dollars only)

WRITE YOUR FEIN ON YOUR CHECK

Return this voucher with check or money
order payable to "Illinois Department of
Revenue."

Preparer's phone number 717.740.4863



990200619 1 520607945 000 0 00000002200

2018 Form IL-990-T

Exempt Organization Income and Replacement Tax Return

Due on or before the 15th day of the 5th month (4th month for employee trusts) following the close of the tax year.

If this return is not for calendar year 2018, enter your fiscal tax year here. Tax year beginning <u>JUL 1</u> , <u>2018</u> , ending <u>JUN 30</u> , <u>2019</u> <small>month day year month day year</small> This form is for tax years ending on or after December 31, 2018, and before December 31, 2019. For tax years ending in 2018 but before December 31, 2018, use the 2017 form. For prior years, use the form for that year.	Enter the amount you are paying. \$ <u>22.</u>
---	---

Step 1: Identify your exempt organization

A Enter your complete legal business name.
 If you have a name change, check this box.
 Name: UNION HOSPITAL OF CECIL COUNTY, INC.

B Enter your mailing address.
 Check this box if either of the following apply:
 • this is your **first return**, or
 • you have an **address change**.
 C/O: _____

Mailing address: 106 BOW STREET

City: ELKTON State: MD ZIP: 21921-5596

C If this is the first or final return, check the applicable box(es).
 First return
 Final return (Enter the date of termination. _____)
mm dd yyyy

D Enter your federal employer identification no. (FEIN).
52-0607945

E Check if you are taxed as a corporation.

F Check if you are taxed as a trust.

G Provide the nature of your unrelated trade or business. SEE STATEMENT 1

H Check this box if you attached Illinois Schedule 1299-D, Income Tax Credits.

I Enter your North American Industry Classification System (NAICS) Code, if applicable. See instructions.
621500

Step 2: Figure your base income or loss

	(Whole dollars only)
1 Unrelated business taxable income or loss from U.S. Form 990-T, Line 38. Attach a copy of Page 2 of your U.S. Form 990-T.	1 _____ .00
2 Illinois income and replacement tax and surcharge deducted in arriving at Line 1.	2 _____ .00
3 Base income or loss. Add Lines 1 and 2.	3 _____ .00

STOP	A If the amount on Line 3 is derived inside Illinois only or if you are an Illinois resident trust, check this box and enter the amount from Step 2, Line 3 on Step 4, Line 12. You may not complete Step 3. (You must leave Step 3, Lines 4 through 11 blank.) <input type="checkbox"/>
	B If any portion of the amount on Line 3 is derived outside Illinois, check this box and complete all lines of Step 3. (Do not leave Lines 6 through 8 blank.) See instructions. <input checked="" type="checkbox"/>

Step 3: Figure your income allocable to Illinois (Complete only if you checked the box on Line B, above.)

4 Business income or loss included in Line 3 from non-unitary partnerships, partnerships included on a Schedule UB, S corporations, trusts, or estates. See instructions.	4 _____	0	.00
5 Business income or loss. Subtract Line 4 from Line 3.	5 _____	0	.00
6 Total sales everywhere. This amount cannot be negative.	6 _____	N/A	
7 Total sales inside Illinois. This amount cannot be negative.	7 _____		
8 Apportionment factor. Divide Line 7 by Line 6. (Round to six decimal places.)	8 _____		
9 Business income or loss apportionable to Illinois. Multiply Line 5 by Line 8.	9 _____	0	.00
10 Business income or loss apportionable to Illinois from non-unitary partnerships, partnerships included on a Schedule UB, S corporations, trusts, or estates. See instructions.	10 _____	222	.00
11 Base income or loss allocable to Illinois. Add Lines 9 and 10.	11 _____	222	.00

Step 4: Figure your net replacement tax

▼	12 Net income or loss from Line 3 or Line 11.	12 _____	222	.00
▲	13 Replacement tax. Corporations multiply Line 12 by 2.5% (.025); Trusts multiply by 1.5% (.015).	13 _____	6	.00
▲	14 Recapture of investment credits. Attach Schedule 4255.	14 _____		
▲	15 Replacement tax before investment credits. Add Lines 13 and 14.	15 _____	6	.00
▲	16 Investment credits. Attach Form IL-477.	16 _____		
▲	17 Net replacement tax. Subtract Line 16 from Line 15. If the amount is negative, enter "0."	17 _____	6	.00

Attach your payment and Form IL-990-T-V here.



Step 5: Figure your net income tax

18	Net income or loss from Line 12.	18	222 .00
19	Income Tax. Corporations multiply Line 18 by 7.00% (.07). Trusts multiply Line 18 by 4.95% (.0495).	19	16 .00
20	Recapture of investment credits. Attach Schedule 4255.	20	.00
21	Income tax before credits. Add Lines 19 and 20.	21	16 .00
22	Income tax credits. Attach Schedule 1299-D.	22	.00
23	Net income tax. Subtract Line 22 from Line 21. If the amount is negative, enter "0."	23	16 .00

Step 6: Figure your refund or balance due

24	Net replacement tax from Line 17.	24	6 .00
25	Net income tax from Line 23.	25	16 .00
26	Compassionate Use of Medical Cannabis Pilot Program Act surcharge. See instructions.	26	.00
27	Total net income and replacement taxes and surcharge. Add Lines 24, 25, and 26.	27	22 .00
28	Payments. See instructions.		
	a Credits and payments made before the original tax due date. 28a		.00
	b Pass-through withholding reported to you on Schedule(s) K-1-P or K-1-T. Attach Schedule(s) K-1-P or K-1-T. 28b		.00
	c Illinois gambling withholding. Attach Form(s) W-2G. 28c		.00
29	Total payments. Add Lines 28a through 28c.	29	.00
30	Overpayment. If Line 29 is greater than Line 27, subtract Line 27 from Line 29.	30	.00
31	Amount to be credited forward. See instructions.	31	.00
32	Refund. Subtract Line 31 from Line 30. This is the amount to be refunded.	32	.00

33 **Complete to direct deposit your refund**

Routing Number _____ Checking or Savings

Account Number _____

34 **Tax Due.** If Line 27 is greater than Line 29, subtract Line 29 from Line 27. This is the amount you owe. **34** 22 .00

▶ If you owe tax on Line 34, complete a payment voucher, Form IL-990-T-V. Write your FEIN, tax year ending, and "IL-990-T-V" on your check or money order and make it payable to "Illinois Department of Revenue." Attach your voucher and payment to the front of this form.

Special Note → Enter the amount of your payment on the top of Page 1 in the space provided.

Step 7: Sign below - Under penalties of perjury, I state that I have examined this return and, to the best of my knowledge, it is true, correct, and complete.

Sign Here	Signature of authorized officer	Date (mm/dd/yyyy)	Title	Phone	<input checked="" type="checkbox"/> Check if the Department may discuss this return with the paid preparer shown in this step. <input type="checkbox"/> Check if self-employed
	KERRI N. BOGDA, CPA		CHIEF FINANCIAL OFFI			P00760402
Paid Preparer Use Only	Print/Type paid preparer's name	Paid preparer's signature	Date (mm/dd/yyyy)	Firm's name ▶	Paid Preparer's PTIN
	Firm's name ▶	BAKER TILLY VIRCHOW KRAUSE, LLP	Firm's FEIN ▶	39-0859910	
	Firm's address ▶	LANCASTER, PA 17601	Firm's phone ▶	717.740.4863	

- ▶ If a payment is **not** enclosed, mail this return to: **Illinois Department of Revenue, P.O. Box 19009, Springfield, IL 62794-9009**
- ▶ If a payment is enclosed, mail this return to: **Illinois Department of Revenue, P.O. Box 19053, Springfield, IL 62794-9053**



FORM IL-990-T

NATURE OF TRADE OR BUSINESS

STATEMENT 1

INCOME FROM INVESTMENT IN PARTNERSHIP

TO FORM IL-990-T, PAGE 1