COHEN RUTHERFORD + KNIGHT, PC
CERTIFIED PUBLIC ACCOUNTANTS
6903 ROCKLEDGE DRIVE, SUITE 500
BETHESDA, MD 20817
301-828-1008

****

INSTRUCTIONS FOR FILING
ATLANTIC GENERAL HOSPITAL
FORM 8879-EO - IRS E-FILE SIGNATURE AUTHORIZATION
FOR THE PERIOD ENDED JUNE 30, 2012

****

SIGNATURE...
THE ORIGINAL IRS E-FILE SIGNATURE AUTHORIZATION FORM SHOULD BE SIGNED (USE FULL NAME) AND DATED BY THE TAXPAYER.

FILING...
RETURN YOUR SIGNED FORM 8879-EO TO:

COHEN, RUTHERFORD + KNIGHT, PC
6903 ROCKLEDGE DRIVE, SUITE 500
BETHESDA MD 20817-1800

PAYMENT OF TAX...
NO PAYMENT OF TAX IS REQUIRED.

FORM 8879-EO SERVES AS A REPLACEMENT FOR YOUR SIGNATURE THAT WOULD BE AFFIXED TO FORM 990 IF YOU PAPER FILED YOUR RETURN.
PLEASE DO NOT SEPARATELY FILE FORM 990 WITH THE INTERNAL REVENUE SERVICE. DOING SO WILL DELAY THE PROCESSING OF YOUR RETURN.

WE MUST RECEIVE YOUR SIGNED FORM BEFORE WE CAN ELECTRONICALLY TRANSMIT YOUR RETURN WHICH IS DUE ON MAY 15, 2013. WE WOULD APPRECIATE YOUR RETURNING THIS FORM AS SOON AS POSSIBLE AS THIS WILL EXPEDITE THE PROCESSING OF YOUR RETURN. THE INTERNAL REVENUE SERVICE WILL NOTIFY US WHEN YOUR RETURN IS ACCEPTED. YOUR RETURN IS NOT CONSIDERED FILED UNTIL THE INTERNAL REVENUE SERVICE CONFIRMS THEIR ACCEPTANCE, WHICH MAY OCCUR AFTER THE DUE DATE OF YOUR RETURN.

IF POSSIBLE, PLEASE EMAIL THE SIGNED FORM TO TECKLOFF@CRKCPA.COM OR FAX IT TO ME AT 301-530-3625.

****

COHEN RUTHERFORD + KNIGHT, PC
CERTIFIED PUBLIC ACCOUNTANTS
6903 ROCKLEDGE DRIVE, SUITE 500
BETHESDA, MD 20817
301-828-1008

****

INSTRUCTIONS FOR FILING
ATLANTIC GENERAL HOSPITAL
FORM 990T - EXEMPT ORGANIZATION BUSINESS RETURN
FOR THE PERIOD ENDED JUNE 30, 2012

****

SIGNATURE...
THE ORIGINAL RETURN SHOULD BE SIGNED (USING FULL NAME AND TITLE) AND DATED ON PAGE 2 BY AN AUTHORIZED OFFICER OF THE ORGANIZATION.

FILING...
THE SIGNED RETURN SHOULD BE FILED ON OR BEFORE MAY 15, 2013 WITH...

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE CENTER
OGDEN, UT 84201-0027

PAYMENT OF TAX...
NO PAYMENT OF TAX IS REQUIRED.

THE RETURN SHOULD BE SENT CERTIFIED MAIL, RETURN RECEIPT REQUESTED.

****

Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS *e-file* Signature Authorization for an Exempt Organization

For calendar year 2011, or fiscal year beginning 07/01 , 2011, and ending 06/30 , 20 12

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

▶ **See instructions on back.**

OMB No. 1545-1878

2011

Name of exempt organization

ATLANTIC GENERAL HOSPITAL

Employer identification number

52-1656507

Name and title of officer

CHERYL NOTTINGHAM, VP FINANCE

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

Check the box for the return for which you are using this Form 8879-E0 and enter the applicable amount, if any, from the return. If you check the box on line **1a, 2a, 3a, 4a,** or **5a,** below, and the amount on that line for the return being filed with this form was blank, then leave line **1b, 2b, 3b, 4b,** or **5b,** whichever is applicable, blank (do not enter -0-). But, if you entered -0- on the return, then enter -0- on the applicable line below. **Do not** complete more than 1 line in Part I.

1a	Form 990 check here ▶ [X]	**b**	**Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	**1b**	89022485.
2a	Form 990-EZ check here ▶ [ ]	**b**	**Total revenue,** if any (Form 990-EZ, line 9)	**2b**	
3a	Form 1120-POL check here ▶ [ ]	**b**	**Total tax** (Form 1120-POL, line 22)	**3b**	
4a	Form 990-PF check here ▶ [ ]	**b**	**Tax based on investment income** (Form 990-PF, Part VI, line 5)	**4b**	
5a	Form 8868 check here ▶ [ ]	**b**	**Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	**5b**	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2011 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize COHEN, RUTHERFORD + KNIGH to enter my PIN 1 4 2 3 1 as my signature

ERO firm name

Enter five numbers, but do not enter all zeros

on the organization's tax year 2011 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2011 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ Date ▶

Part III Certification and Authentication

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

5 2 0 5 1 5 2 0 8 1 7

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2011 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ Date ▶ 05/13/2013

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

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements.

OMB No. 1545-0047

2011

Open to Public Inspection

A For the 2011 calendar year, or tax year beginning 07/01, **2011, and ending** 06/30, **20** 12

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
ATLANTIC GENERAL HOSPITAL

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
9733 HEALTHWAY DRIVE

City or town, state or country, and ZIP + 4
BERLIN, MD 21811

D Employer identification number
52-1656507

E Telephone number
(410) 641-1100

G Gross receipts $ 89,163,932.

F Name and address of principal officer: MICHAEL FRANKLIN
9733 HEALTHWAY DR BERLIN, MD 21811

H(a) Is this a group return for affiliates? ☐ Yes ☒ No

H(b) Are all affiliates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.ATLANTICGENERAL.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶ | **L** Year of formation: 1989 | **M** State of legal domicile: MD

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:
TO PROVIDE QUALITY CARE, PERSONALIZED SERVICE AND EDUCATION TO IMPROVE INDIVIDUAL AND COMMUNITY HEALTH.

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3 Number of voting members of the governing body (Part VI, line 1a)	3	20.
4 Number of independent voting members of the governing body (Part VI, line 1b)	4	19.
5 Total number of individuals employed in calendar year 2011 (Part V, line 2a)	5	883.
6 Total number of volunteers (estimate if necessary)	6	300.
7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	191,572.
b Net unrelated business taxable income from Form 990-T, line 34	7b	0

Revenue

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	969,058.	826,119.
9 Program service revenue (Part VIII, line 2g)	87,840,221.	87,199,389.
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	468,442.	456,832.
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	574,354.	540,145.
12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	89,852,075.	89,022,485.

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0	0
14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	45,127,446.	47,328,084.
16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 191,856.		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	43,028,718.	39,755,820.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	88,156,164.	87,083,904.
19 Revenue less expenses. Subtract line 18 from line 12	1,695,911.	1,938,581.

Net Assets or Fund Balances

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	77,078,385.	85,601,952.
21 Total liabilities (Part X, line 26)	40,063,835.	46,739,002.
22 Net assets or fund balances. Subtract line 21 from line 20	37,014,550.	38,862,950.

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 — Date

▶ Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
TINA C ECKLOFF		05/13/2013		P01074058

Firm's name ▶ COHEN, RUTHERFORD + KNIGHT, PC | Firm's EIN ▶ 52-1202280

Firm's address ▶ 6903 ROCKLEDGE DRIVE, SUITE 500 BETHESDA, MD 20817-1800 | Phone no. 301-828-1008

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2011)

JSA
1E1010 1.000

Part III **Statement of Program Service Accomplishments**

Check if Schedule O contains a response to any question in this Part III . . . . . ☐

1 Briefly describe the organization's mission:

TO PROVIDE QUALITY CARE, PERSONALIZED SERVICE AND EDUCATION TO IMPROVE INDIVIDUAL AND COMMUNITY HEALTH.

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

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ Yes ☒ No

If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code: _____) (Expenses $ 69,978,941. including grants of $ _____) (Revenue $ 87,278,064.)

ATLANTIC GENERAL HOSPITAL IS A NON PROFIT HEALTHCARE PROVIDER FOCUSING ON INPATIENT AND OUTPATIENT SERVICES FOR OUR LOCAL COMMUNITY. WE ALSO OPERATE MULTIPLE PHYSICIAN OFFICES THROUGHOUT THE REGION THAT PROVIDES FAMILY, INTERNAL AND SPECIALTY MEDICINE TO OUR LOCAL RESIDENTS. WE HAD THE FOLLOWING KEY STATISTICS DURING THE 2011 TAX YEAR: ADMISSIONS: 3,054, PATIENT DAYS: 12,267, ED VISITS: 37,200, SURGERIES: 7,515, OTHER OUTPATIENT VISITS: 72,312, TOTAL VISITS TO OUR PHYSICIAN PRACITICES WERE 62,915.

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 ▶ 69,978,941.

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)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	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? *If "Yes," complete Schedule C, Part 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? *If "Yes," complete Schedule C, Part II*	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? *If "Yes," complete Schedule C, Part III*	5		
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? *If "Yes," complete Schedule D, Part 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? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	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? *If "Yes," complete Schedule D, Part VI*	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? *If "Yes," complete Schedule D, Part VII*	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? *If "Yes," complete Schedule D, Part VIII*	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? *If "Yes," complete Schedule D, Part IX*	11d		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	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)? *If "Yes," complete Schedule D, Part X*	11f		X
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI, XII, and XIII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	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? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Parts III and IV*	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? *If "Yes," complete Schedule G, Part I (see instructions)*	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? *If "Yes," complete Schedule G, Part II*	18	X	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants and other assistance to any government or organization in the United States on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		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? *If "Yes," complete Schedule J*	23	X	
24 a	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? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		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?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25 a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		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? *If "Yes," complete Schedule L, Part I*	25b		X
26	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	26		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? *If "Yes," complete Schedule L, Part III*	27		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? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		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? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		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? *If "Yes," complete Schedule R, Part I*	33	X	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1*	34		X
35 a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a		X
b	Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b		X
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		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? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? **Note.** All Form 990 filers are required to complete Schedule O.	38	X	

Part V **Statements Regarding Other IRS Filings and Tax Compliance**

Check if Schedule O contains a response to any question in this Part V . . . . . ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	**1a**	38		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	**1b**	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?			**1c** X	
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**	883		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?			**2b** X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?			**3a** X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*			**3b** 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)?			**4a**	X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?			**5a**	X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?			**5c**	
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?			**6a**	X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
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?			**7a** X	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b** X	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	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?			**7e**	X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?			**7f**	X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**	
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?			**8**	
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?			**9a**	
b	Did the organization make a distribution to a donor, donor advisor, or related person?			**9b**	
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?			**13a**	
	Note. See the instructions for additional information the organization must report on Schedule O.				
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?			**14a**	X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*			**14b**	

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 to any question in this Part VI X

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 20		
b	Enter the number of voting members included in line 1a, above, who are independent	1b 19		
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?	2		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?	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6		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?	7a		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?	7b		X
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	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*	9		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?	10a		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?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	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*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	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*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	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	15a	X	
b	Other officers or key employees of the organization	15b	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?	16a		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?	16b		

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ MD,

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request

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, physical address, and telephone number of the person who possesses the books and records of the organization: ▶ CHERYL NOTTINGHAM 9733 HEALTHWAY DRIVE BERLIN, MD 21811 410-641-9095

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

Check if Schedule O contains a response to any question 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 (describe hours for related organizations in Schedule O)	(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) MICHAEL FRANKLIN PRESIDENT & CEO	40.00	X		X				362,974.	0	16,500.
(2) J RUSSELL BARRETT DIRECTOR	2.00	X						0	0	0
(3) ROBERT DAVIS DIRECTOR	2.00	X						0	0	0
(4) JEFFREY GREENWOOD EX OFFICIO	2.00	X						0	0	0
(5) DEBBIE GOELLER EX OFFICIO	2.00	X						0	0	0
(6) ROBERT DURKIN DIRECTOR	2.00	X						0	0	0
(7) MICHAEL JAMES DIRECTOR	2.00	X						0	0	0
(8) WILLIAM HUDSON SECRETARY	2.00	X		X				0	0	0
(9) W TODD HERSHEY EX OFFICIO	2.00	X						0	0	0
(10) IRA SHOCKLEY DIRECTOR	2.00	X						0	0	0
(11) JOHN TOWNSEND VICE CHAIR	2.00	X		X				0	0	0
(12) MICHAEL GUERRIERI DIRECTOR	2.00	X						0	0	0
(13) WINN BOOTH CHAIR	3.00	X		X				0	0	0
(14) KATHLEEN CLARK DIRECTOR	2.00	X						0	0	0

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

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) JAMES BERGEY JR TREASURER	2.00	X		X				0	0	0
(16) ERIC BONTEMPO EX OFFICIO	2.00	X						0	0	0
(17) LOUIS TAYLOR VICE CHAIR	3.00	X		X				0	0	0
(18) JOHN BURBAGE JR SECRETARY	3.00	X		X				0	0	0
(19) HUGH CROPPER DIRECTOR	2.00	X						0	0	0
(20) ELIZABETH GREGORY DIRECTOR	2.00	X						0	0	0
(21) GARRY MUMFORD DIRECTOR	2.00	X						0	0	0
(22) GREGORY SHOCKLEY DIRECTOR	2.00	X						0	0	0
(23) THOMAS D BECK EX OFFICIO	2.00	X						0	0	0
(24) CHERYL NOTTINGHAM CFO	40.00			X				181,231.	0	16,500.
(25) COLLEEN WAREING VP PATIENT CARE	40.00				X			140,841.	0	6,998.
1b Sub-total ▶								362,974.	0	16,500.
c Total from continuation sheets to Part VII, Section A ▶								2,342,682.	0	120,023.
d Total (add lines 1b and 1c) ▶								2,705,656.	0	136,523.

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 ▶ 42

		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
ATTACHMENT 1		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 11

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

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) JAMES BRANNON VP PROFESSIONAL SERVICES	40.00				X			147,026.	0	7,025.
(27) CHARLES KIM PHYSICIAN	40.00					X		392,546.	0	16,500.
(28) JEFFREY FERNLEY PHYSICIAN	40.00					X		364,157.	0	16,500.
(29) JAMES SKOLKA PHYSICIAN	40.00					X		385,389.	0	22,000.
(30) SCOTT KNOWLTON PHYSICIAN	40.00					X		368,570.	0	16,500.
(31) MICHAEL STIVELMAN PHYSICIAN	40.00					X		362,922.	0	18,000.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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 ▶ 42

		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

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

Part VIII Statement of Revenue

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c	214,960.			
	d Related organizations	1d				
	e Government grants (contributions)	1e				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	611,159.			
	g Noncash contributions included in lines 1a-1f: $ 10,100.					
	h **Total.** Add lines 1a-1f ▶		826,119.			
Program Service Revenue		**Business Code**				
	2a NET PATIENT REVENUE		86,680,899.	86,680,899.		
	b OTHER OPERATING	621110	518,490.	326,918.	191,572.	
	c					
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a-2f ▶		87,199,389.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ATTACHMENT 2 ▶		257,523.			257,523.
	4 Income from investment of tax-exempt bond proceeds ▶		0			
	5 Royalties ▶		0			
		(i) Real / (ii) Personal				
	6a Gross rents	110,125.				
	b Less: rental expenses					
	c Rental income or (loss)	110,125.				
	d Net rental income or (loss) ▶		110,125.			110,125.
		(i) Securities / (ii) Other				
	7a Gross amount from sales of assets other than inventory	152,167. / 47,142.				
	b Less: cost or other basis and sales expenses					
	c Gain or (loss)	152,167. / 47,142.				
	d Net gain or (loss) ▶		199,309.			199,309.
	8a Gross income from fundraising events (not including $ 214,960. of contributions reported on line 1c). See Part IV, line 18 ATCH 3	a 69,395.				
	b Less: direct expenses	b 56,287.				
	c Net income or (loss) from fundraising events ATCH 4 ▶		13,108.			13,108.
	9a Gross income from gaming activities. See Part IV, line 19	a				
	b Less: direct expenses	b				
	c Net income or (loss) from gaming activities ▶		0			
	10a Gross sales of inventory, less returns and allowances	a 231,825.				
	b Less: cost of goods sold	b 85,160.				
	c Net income or (loss) from sales of inventory ATCH 5 ▶		146,665.			146,665.
	Miscellaneous Revenue	**Business Code**				
	11a CAFETERIA		169,151.	169,151.		
	b MISCELLANEOUS		101,096.	101,096.		
	c					
	d All other revenue					
	e **Total.** Add lines 11a-11d ▶		270,247.			
	12 **Total revenue.** See instructions ▶		89,022,485.	87,278,064.	191,572.	726,730.

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) but are not required to complete columns (B), (C), and (D).

Check if Schedule O contains a response to any question in this Part IX . . . . . ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21	0			
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	0			
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	592,865.		592,865.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	38,223,377.	32,662,859.	5,415,252.	145,266.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	534,000.	534,000.		
9 Other employee benefits	5,397,480.	5,285,845.	111,635.	
10 Payroll taxes	2,580,362.	2,187,348.	382,383.	10,631.
11 Fees for services (non-employees):				
a Management	0			
b Legal	76,333.	9,366.	66,967.	
c Accounting	171,537.		171,537.	
d Lobbying	0			
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	0			
g Other	2,940,231.	2,211,892.	728,339.	
12 Advertising and promotion	753,667.	125,007.	628,021.	639.
13 Office expenses	17,282,953.	15,199,878.	2,069,996.	13,079.
14 Information technology	1,473,449.		1,473,449.	
15 Royalties	0			
16 Occupancy	1,667,868.	1,476,730.	191,138.	
17 Travel	225,543.	130,950.	88,117.	6,476.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	62,721.	20,766.	41,955.	
20 Interest	0			
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	4,660,298.	3,728,238.	932,060.	
23 Insurance	2,380,864.	454,196.	1,926,668.	
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 OUTSIDE LAB SERVICES	819,960.	819,960.		
b REPAIRS & MAINTENANCE	3,183,718.	2,922,180.	256,445.	5,093.
c LAUNDRY AND LINENS	463,120.	463,120.		
d DATA PROCESSING	49,108.	49,108.		
e All other expenses	3,544,450.	1,697,498.	1,836,280.	10,672.
25 **Total functional expenses.** Add lines 1 through 24e	87,083,904.	69,978,941.	16,913,107.	191,856.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	0	1	0
	2	Savings and temporary cash investments	17,698,098.	2	17,259,762.
	3	Pledges and grants receivable, net	39,517.	3	11,667.
	4	Accounts receivable, net	8,214,265.	4	9,207,236.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions)	0	6	0
	7	Notes and loans receivable, net	0	7	0
	8	Inventories for sale or use	1,668,379.	8	1,955,288.
	9	Prepaid expenses and deferred charges ATCH 6	1,679,500.	9	1,609,728.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 78,518,619.			
	b	Less: accumulated depreciation — 10b: 33,370,412.	36,650,305.	10c	45,148,207.
	11	Investments - publicly traded securities ATCH 7	4,593,386.	11	4,513,706.
	12	Investments - other securities. See Part IV, line 11	6,048,647.	12	2,441,167.
	13	Investments - program-related. See Part IV, line 11	0	13	0
	14	Intangible assets	0	14	0
	15	Other assets. See Part IV, line 11	486,288.	15	3,455,191.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	77,078,385.	16	85,601,952.
Liabilities	17	Accounts payable and accrued expenses	9,816,508.	17	12,143,449.
	18	Grants payable	0	18	0
	19	Deferred revenue	0	19	0
	20	Tax-exempt bond liabilities	9,982,383.	20	20,999,672.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties ATCH 8	17,284,421.	23	4,724,056.
	24	Unsecured notes and loans payable to unrelated third parties	0	24	0
	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	2,980,523.	25	8,871,825.
	26	**Total liabilities.** Add lines 17 through 25	40,063,835.	26	46,739,002.
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	36,823,608.	27	38,622,485.
	28	Temporarily restricted net assets	190,942.	28	240,465.
	29	Permanently restricted net assets	0	29	0
		Organizations that do not follow SFAS 117, check here ▶ [ ] 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	37,014,550.	33	38,862,950.
	34	Total liabilities and net assets/fund balances	77,078,385.	34	85,601,952.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	89,022,485.
2	Total expenses (must equal Part IX, column (A), line 25)	2	87,083,904.
3	Revenue less expenses. Subtract line 2 from line 1	3	1,938,581.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	37,014,550.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-90,181.
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	38,862,950.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question in this Part XII . . . . . ☐

			Yes	No
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?	2a		X
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	X	
d	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis			
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?	3a		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b		

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

OMB No. 1545-0047

2011

Open to Public Inspection

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

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

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

1 [ ] A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 [ ] A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 [X] A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 [ ] A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____

5 [ ] An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 [ ] A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 [ ] An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 [ ] A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 [ ] An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 [ ] An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 [ ] An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a [ ] Type I **b** [ ] Type II **c** [ ] Type III - Functionally integrated **d** [ ] Type III - Other

e [ ] By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box . . . . . [ ]

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?	11g(i)	
(ii)	A family member of a person described in (i) above?	11g(ii)	
(iii)	A 35% controlled entity of a person described in (i) or (ii) above?	11g(iii)	

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

(i) Name of supported organization	**(ii)** EIN	**(iii)** Type of organization (described on lines 1-9 above or IRC section **(see instructions)**)	**(iv)** Is the organization in col. **(i)** listed in your governing document?		**(v)** Did you notify the organization in col. **(i)** of your support?		**(vi)** Is the organization in col. **(i)** organized in the U.S.?		**(vii)** Amount of support
			Yes	**No**	**Yes**	**No**	**Yes**	**No**	
(A)									
(B)									
(C)									
(D)									
(E)									
Total									

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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 IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2011 (line 6, column (f) divided by line 11, column (f)) . . . . . 14 %

15 Public support percentage from 2010 Schedule A, Part II, line 14 . . . . . 15 %

16a **33 1/3% support test - 2011.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support test - 2010.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test - 2011.** 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 IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2010.** 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 IV how the organzation meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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 IV.)						
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 2011 (line 8, column (f) divided by line 13, column (f))	15	%
16	Public support percentage from 2010 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2011** (line 10c, column (f) divided by line 13, column (f))	17	%
18	Investment income percentage from **2010** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2011.** 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 - 2010.** 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 **Supplemental Information.** Complete this part to provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

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.**

OMB No. 1545-0047

2011

Name of the organization
ATLANTIC GENERAL HOSPITAL

Employer identification number
52-1656507

Organization type (check one):

Filers of:	**Section:**
Form 990 or 990-EZ	[X] 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

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

[ ] For a section 501(c)(3) organization 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) and received from any one contributor, during the year, a contribution 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 a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of $5,000 or more during the year . . . . . ▶ $ _____

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

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

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	AGH AUXILIARY 9733 HEALTHWAY DRIVE BERLIN, MD 21811	$ 115,150.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
2	2-M ASSOCIATES 247 PATHFINDER LANE HEDGEVILLE, WV 25427	$ 5,000.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
3	AGH JUIOR AUXILIARY GROUP 9733 HEALTHWAY DRIVE BERLIN, MD 21811	$ 15,000.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
4	ATLANTIC/SMITH, CROPPER & DEELEY PO BOX 770 WILLARDS, MD 21874	$ 6,750.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
5	BAJA MANAGEMENT CORPORATION 12639 OCEAN GATEWAY OCEAN CITY, MD 21811	$ 5,000.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
6	BANK OF OCEAN CITY PO BOX 150 OCEAN CITY, MD 21843	$ 7,250.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)

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

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	ALBERT BERGER 2610 CHAPEL LAKE DRIVE, NO. 404 GAMBRILLS, MD 21054	$ 10,500.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
8	BULL ON THE BEACH RESTAURANTS 12507 SUNSET AVENUE #8 OCEAN CITY, MD 21842	$ 26,350.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
9	CAROUSEL RESORT HOTEL & CONDOMINIUMS 11700 COASTAL HIGHWAY OCEAN CITY, MD 21811	$ 1,000.	Person X Payroll Noncash X (Complete Part II if there is a noncash contribution.)
10	CALVIN B TAYLOR BANKING CO PO BOX 5 BERLIN, MD 21811	$ 11,000.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
11	CAROUSEL RESORT HOTEL & CONDO 11700 COASTAL HIGHWAY OCEAN CITY, MD 21811	$ 10,000.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
12	COMMUNITY FOUNDATION OF EASTERN SHORE 1324 BELMONT AVENUE STE 401 SALISBURY, MD 21804	$ 67,100.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)

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

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13	DOUGH ROLLER RESTAURANTS PO BOX 419 OCEAN CITY, MD 21842	$ 1,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
14	DOUGH ROLLER RESTAURANTS PO BOX 419 OCEAN CITY, MD 21842	$ 4,000.	Person [X] Payroll [ ] Noncash [X] (Complete Part II if there is a noncash contribution.)
15	ESTATE OF ALICE M. EASTBURN 11021 NICHOLAS LANE, SUIT E5 OCEAN PINES, MD 21811	$ 130,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
16	EMERGENCY SERVICE ASSOCIATES 100 E CARROLL STREET SALISBURY, MD 21801	$ 6,650.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
17	ESTATE OF RAYMOND M. SAWYER 6509 10TH STREET, UNIT A2 ALEXANDRIA, VA 22307	$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
18	HAL GLICK SERVICE AWARD GALA 11036 WORCESTER HIGHWAY BERLIN, MD 21811	$ 9,200.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

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

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19	ESTATE OF VIRGINIA H MURRAY PO BOX 585 SALISBURY, MD 21803	$ 78,829.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
20	HOMER AND MARTHA GUDELSKY FAMILY FDN 11900 TECH ROAD SILVER SPRING, MD 21904	$ 50,000.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
21	THE M&T CHARITABLE FOUNDATION 25 S. CHARLES STREET BALTIMORE, MD 21201	$ 6,250.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
22	KELLY FOODS CORPORATION 33337 MEDINA ROAD MEDINA, OH 44256	$ 10,000.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
23	OCEAN CITY LIONS CLUB PO BOX 71 OCEAN CITY, MD 21842	$ 5,000.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
24	PENINSULA CARDIOLOGY ASSOCIATES, P.A. 314 FRANKLIN AVENUE, SUITE 402 BERLIN, MD 21811	$ 5,000.	Person X Payroll Noncash X (Complete Part II if there is a noncash contribution.)

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

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25	WALTER M. STANSELL, JR. 11708 GUM POINT ROAD BERLIN, MD 21811	$ 5,000.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
26	SILBERSTEIN INSURANCE GROUP 2330 W JOPPA ROAD STE 311 LUTHERVILLE, MD 21093	$ 6,530.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
27	SYSCO EASTERN MARYLAND LLC PO BOX 477 POCOMOKE, MD 21851	$ 6,000.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
28	SPECIAL EVENTS DONATION UNDER $5K 9733 HEALTHWAY DR BERLIN, MD 21811	$ 214,960.	Person X Payroll Noncash (Complete Part II if there is a noncash contribution.)
		$	Person Payroll Noncash (Complete Part II if there is a noncash contribution.)
		$	Person Payroll Noncash (Complete Part II if there is a noncash contribution.)

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

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
9	FOOD & BEVERAGE	$ 1,000.	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
14	FOOD	$ 4,000.	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
24	EQUIPMENT	$ 5,000.	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

Name of organization ATLANTIC GENERAL HOSPITAL

Employer identification number 52-1656507

Part III ***Exclusively*** **religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year.** Complete columns **(a)** through **(e) and** the following line entry.

For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once. See instructions.) ►$

Use duplicate copies of Part III if additional space is needed.

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
ATLANTIC GENERAL HOSPITAL

Employer identification number
52-1656507

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

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate 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? ☐ Yes ☐ 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? ☐ Yes ☐ No

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

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

			Held at the End of the Tax Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIV, 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) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

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

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $

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

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

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

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

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

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

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

b If "Yes," explain the arrangement in Part XIV 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? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIV.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	4,800,523.				
b Contributions					
c Net investment earnings, gains, and losses	17,498.				
d Grants or scholarships					
e Other expenditures for facilities and programs	149,677.				
f Administrative expenses	32,813.				
g End of year balance	4,635,531.				

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

- a Board designated or quasi-endowment ▶ 64.0000 %
- b Permanent endowment ▶ 36.0000 %
- c Temporarily restricted endowment ▶ _____ %

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

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

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

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

Part VI Land, Buildings, and Equipment. 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				
b Buildings		70,015,023.	33,370,412.	36,644,611.
c Leasehold improvements				
d Equipment				
e Other		8,503,596.		8,503,596.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				45,148,207.

Part VII Investments - Other Securities. See Form 990, Part X, line 12.

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

Part VIII Investments - Program Related. See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 13.)* ▶		

Part IX Other Assets. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	

Part X Other Liabilities. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) SWAP	107,733.
(3) INTEREST PAYABLE	63,971.
(4) ADVANCES FROM THIRD PARTIES	1,089,863.
(5) CAPITAL LEASE	827,202.
(6) LINE OF CREDIT	
(7) SOFTWARE LEASE	3,849,679.
(8) INSURANCE UNPAID LOSS	2,933,377.
(9)	
(10)	
(11)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	8,871,825.

2. FIN 48 (ASC 740) Footnote. In Part XIV, 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).

Part XI Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	
4	Net unrealized gains (losses) on investments	4	
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	
9	Total adjustments (net). Add lines 4 through 8	9	
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	

Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
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 XIV.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements			1	
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 XIV.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
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 XIV.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	

Part XIV Supplemental Information

Complete this part to 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, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

ENDOWMENT FUND HELD BY UNRELATED ENTITY

SCHEDULE D, PART V, LINE 3

THE COMMUNITY FOUNDATION OF THE EASTERN SHORE HOLDS, AND ACCOUNTS FOR IN ITS FINANCIAL STATEMENTS, A PERMANENT ENDOWMENT FUND (THE "FUND") ESTABLISHED IN THE HOSPITAL'S NAME. THE HOSPITAL IS THE SOLE BENEFICIARY OF THE FUND AND IS ENTITLED TO INVESTMENT INCOME EARNED BY THE FUND. THE 2011 TAX YEAR ENDING BALANCE FOR THE FUND WAS $1,662,916.

Part XIV Supplemental Information *(continued)*

SCHEDULE G
(Form 990 or 990-EZ)
Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047
2011
Open to Public Inspection

Name of the organization
ATLANTIC GENERAL HOSPITAL

Employer identification number
52-1656507

Part I **Fundraising Activities.** Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

- **a** ☐ Mail solicitations
- **b** ☐ Internet and email solicitations
- **c** ☐ Phone solicitations
- **d** ☐ In-person solicitations
- **e** ☐ Solicitation of non-government grants
- **f** ☐ Solicitation of government grants
- **g** ☐ Special fundraising events

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ **Yes** ☐ **No**

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

	(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? Yes	No	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
Total ▶							

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

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

		(a) Event #1 GOLF TOURNAMENT (event type)	(b) Event #2 PENGUIN SWIM (event type)	(c) Other Events 1. (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	119,415.	87,715.	77,225.	284,355.
	2 Less: Charitable contributions	78,395.	87,715.	48,850.	214,960.
	3 Gross income (line 1 minus line 2)	41,020.		28,375.	69,395.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes	5,382.	14,482.		19,864.
	6 Rent/facility costs	7,234.	166.		7,400.
	7 Food and beverages	5,435.		15,440.	20,875.
	8 Entertainment			200.	200.
	9 Other direct expenses	2,620.	2,893.	2,435.	7,948.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				(56,287.)
	11 Net income summary. Combine line 3, column (d), and line 10 ▶				13,108.

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

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____% ☐ No	☐ Yes ____% ☐ No	☐ Yes ____% ☐ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				( )
	8 Net gaming income summary. Combine line 1, column d, and line 7 ▶				

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

11 Does the organization operate gaming activities with nonmembers? ☐ Yes ☐ No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No

13 Indicate the percentage of gaming activity operated in:

a	The organization's facility	**13a**	%
b	An outside facility	**13b**	%

14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No

b If "Yes," enter the amount of gaming revenue received by the organization ▶ $ _____ and the amount of gaming revenue retained by the third party ▶ $ _____.

c If "Yes," enter name and address of the third party:

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ $ _____

Description of services provided ▶ _____

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No

b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $

Part IV **Supplemental Information.** Complete this part to provide the explanation required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
ATLANTIC GENERAL HOSPITAL

Employer identification number
52-1656507

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
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. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ 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) to determine eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	3a	X	
b	Did the organization use FPG to determine eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☒ 300% ☐ 350% ☐ 400% ☐ Other _____%	3b	X	
c	If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria 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, to determine 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"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
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?	5c		X
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	
	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

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			1,782,191.		1,782,191.	2.05
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			1,782,191.		1,782,191.	2.05
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			722,503.	3,175.	719,328.	.83
f Health professions education (from Worksheet 5)			651,691.		651,691.	.75
g Subsidized health services (from Worksheet 6)			10,658,436.	6,354,896.	4,303,540.	4.94
h Research (from Worksheet 7)			6,359.		6,359.	.01
i Cash and in-kind contributions for community benefit (from Worksheet 8)			97,217.		97,217.	.11
j **Total.** Other Benefits			12,136,206.	6,358,071.	5,778,135.	6.64
k **Total.** Add lines 7d and 7j			13,918,397.	6,358,071.	7,560,326.	8.69

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing		40	221.		221.	
2 Economic development		375	684.		684.	
3 Community support		2776	32,225.		32,225.	.04
4 Environmental improvements			24,730.		24,730.	.03
5 Leadership development and training for community members						
6 Coalition building		10384	81,122.	17.	81,105.	.09
7 Community health improvement advocacy		2561	32,244.	300.	31,944.	.04
8 Workforce development		548	46,016.		46,016.	.05
9 Other						
10 Total		16684	217,242.	317.	216,925.	.25

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

Section A. Bad Debt Expense

			Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1			X
2 Enter the amount of the organization's bad debt expense	2	3,991,078.		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy	3			
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit.				

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	46,546,728.		
6 Enter Medicare allowable costs of care relating to payments on line 5	6	35,122,361.		
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	11,424,367.		
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:				

☐ Cost accounting system ☐ Cost to charge ratio ☒ Other

Section C. Collection Practices

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

Part IV **Management Companies and Joint Ventures** (see instructions)

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

Part V Facility Information

Section A. Hospital Facilities

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

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

Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1 ATLANTIC GENERAL HOSPITAL 9733 HEALTHWAY DRIVE BERLIN MD 21811	X	X					X		
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: ATLANTIC GENERAL HOSPITAL

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

			Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)				
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1		
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	☐ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☐ How data was obtained			
e	☐ The health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☐ The process for consulting with persons representing the community's interests			
i	☐ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	☐ Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 __ __			
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5	Did the hospital facility make its Needs Assessment widely available to the public?	5		
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a	☐ Hospital facility's website			
b	☐ Available upon request from the hospital facility			
c	☐ Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a	☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b	☐ Execution of the implementation strategy			
c	☐ Participation in the development of a community-wide community benefit plan			
d	☐ Participation in the execution of a community-wide community benefit plan			
e	☐ Inclusion of a community benefit section in operational plans			
f	☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g	☐ Prioritization of health needs in its community			
h	☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	☐ Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X	
9	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	9	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 2 0 0 %			
	If "No," explain in Part VI the criteria the hospital facility used.			

Part V **Facility Information** *(continued)* ATLANTIC GENERAL HOSPITAL

			Yes	No
10	Used FPG to determine eligibility for providing *discounted* care?	10	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 300 %			
	If "No," explain in Part VI the criteria the hospital facility used.			
11	Explained the basis for calculating amounts charged to patients?	11	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[X] Asset level			
c	[X] Medical indigency			
d	[ ] Insurance status			
e	[ ] Uninsured discount			
f	[ ] Medicaid/Medicare			
g	[X] State regulation			
h	[ ] Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12	X	
13	Included measures to publicize the policy within the community served by the hospital facility?	13	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The policy was posted on the hospital facility's website			
b	[ ] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[X] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[ ] Other (describe in Part VI)			
Billing and Collections				
14	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 actions the hospital facility may take upon non-payment?	14	X	
15	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 patient's eligibility under the facility's FAP:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			
16	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?	16		
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Part VI)			
17	Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):			
a	[X] Notified patients of the financial assistance policy on admission			
b	[X] Notified patients of the financial assistance policy prior to discharge			
c	[X] Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	[X] Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy			
e	[ ] Other (describe in Part VI)			

Part V Facility Information *(continued)* ATLANTIC GENERAL HOSPITAL

Policy Relating to Emergency Medical Care

			Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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?	**18**	X	
	If "No," indicate why:			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d	☐ Other (describe in Part VI)			

Individuals Eligible for Financial Assistance

19	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	☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b	☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c	☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d	☒ Other (describe in Part VI)			
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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?	**20**		X
	If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient?	**21**		X
	If "Yes," explain in Part VI.			

Part V Facility Information *(continued)*

Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

How many non-hospital health care facilities did the organization operate during the tax year? 14

	Name and address	Type of Facility (describe)
1	ATLANTIC HEALTH CENTER 9714 HEALTHWAY DR BERLIN MD 21811	MEDICAL OFFICE
2	TOWNSEND MEDICAL CENTER 1001 PHILADELPHIA AVE OCEAN CITY MD 21842	MEDICAL OFFICE
3	OCEAN PINES MEDICAL OFFICE 11107 RACETRACK RD BERLIN MD 21811	MEDICAL OFFICE
4	CARDIO/PULMONARY CLINIC ROUTES 346 & 50 BERLIN MD 21811	MEDICAL OFFICE
5	ATLANTIC ENDOSCOPY CENTER 10231 OLD OCEAN CITY BLVD #205 BERLIN MD 21811	MEDICAL OFFICE
6	DR MCWHITE'S OFFICE 10231 OLD OCEAN CITY BLVD #210 BERLIN MD 21811	MEDICAL OFFICE
7	THE WOUND CARE CENTER 10231 OLD OCEAN CITY BLVD #104 BERLIN MD 21811	MEDICAL OFFICE
8	MEDICAL OFFICE KIRBY 10231 OLD OCEAN CITY BLVD #208 BERLIN MD 21811	MEDICAL OFFICE
9	POCOMOKE MEDICAL OFFICE 101-A MARKET STREET POCOMOKE MD 21851	MEDICAL OFFICE
10	IMMEDICARE CLINIC 101 EAST DUPONT HIGHWAY MILLSBORO DE 11192	MEDICAL OFFICE

Part V Facility Information *(continued)*

Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

	Name and address	Type of Facility (describe)
1	IMMEDICARE CLINIC 11011 MANKLIN CREEK RD BERLIN MD 21811	MEDICAL OFFICE
2	SELBYVILLE MEDICAL OFFICE 38394 DUPONT HIGHWAY SELBYVILLE DE 19944	MEDICAL OFFICE
3	MEDICAL OFFICE 10311 OLD OCEAN CITY STE 2 BERLIN MD 21801	MEDICAL OFFICE
4	MEDICAL OFFICE 314 FRANKLIN AVE STE 103 BERLIN MD 21811	MEDICAL OFFICE
5		
6		
7		
8		
9		
10		

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 3C

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

ONLY INCOME AND FAMILY SIZE WILL BE CONSIDERED IN APPROVING APPLICATIONS FOR FINANCIAL ASSISTANCE, UNLESS THE AMOUNT OWED IS GREATER THAN $20,000, THE PATIENT'S TAX RETURN SHOWS A SIGNIFICANT AMOUNT OF INTEREST INCOME, OR THE PATIENT INDICATES THAT THE PATIENT HAS BEEN LIVING OFF OF THEIR SAVINGS ACCOUNT. IF ONE OF THE SCENARIOS LISTED ABOVE IS APPLICABLE, THEN THE ORGANIZATION MAY CONSIDER THE PATIENT'S LIQUID ASSETS, INCLUDING THE PATIENT'S CHECKING AND SAVINGS ACCOUNTS, STOCKS, BONDS, CD'S, MONEY MARKET OR ANY OTHER ACCOUNTS FOR THE PAST THREE MONTHS. HOWEVER, THE

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

FOLLOWING ASSETS ARE ALWAYS EXCLUDED: THE FIRST $10,000 OF MONETARY

ASSETS, UP TO $150,000 IN A PRIMARY RESIDENCE, AND CERTAIN RETIREMENT

BENEFITS, SUCH AS 401K PLANS WHERE THE IRS HAS GRANTED PREFERENTIAL TAX

TREATMENT.

IF THE PATIENT IS ALREADY ENROLLED IN A MEANS-TESTED PROGRAM, THE PATIENT

IS DEEMED ELIGIBLE FOR FREE CARE ON A PRESUMPTIVE BASIS, WITHOUT

REQUIRING ANY OF THE FINANCIAL DOCUMENTS REQUIRED ON A FULL APPLICATION.

PART I, LINE 5

IT IS THE ORGANIZATION'S POLICY TO PROVIDE FINANCIAL ASSISTANCE TO ANY

INDIVIDUAL THAT QUALIFIES UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE

POLICY, REGARDLESS OF THE AMOUNT OF CHARITY CARE BUDGETED FOR BY THE

ORGANIZATIONDURING THE YEAR.

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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 6

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

PART I LINES 7A, 7B AND 7F

MARYLAND HOSPITAL ASSOCIATION UNIFIED MARYLAND HOSPITAL RESPONSES

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

7A. CHARITY CARE AT COST AND 7F. HEALTH PROFESSIONS EDUCATION ARE EXPLAINED IN THE FOLLOWING:

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

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

7B. UNREIMBURSED MEDICAID IS EXPLAINED IN THE FOLLOWING:

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION, (HSCRC) DETERMINES PAYMENT THROUGH A RATE SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY DIRECTED OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. COMMUNITY BENEFIT EXPENSES ARE EQUAL TO MEDICAID REVENUES IN MARYLAND, AS SUCH, THE NET EFFECT IS ZERO. THE EXCEPTION TO THIS IS THE IMPACT ON THE HOSPITAL OF ITS SHARE OF THE MEDICAID ASSESSMENT. IN RECENT YEARS, THE STATE OF MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING HOSPITALS THROUGH THE RATE SETTING SYSTEM. DURING THE 2011 TAX YEAR, THE MEDICAID PROVIDER ASSESSMENT WAS $350,315.

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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 7G

ATLANTIC GENERAL HOSPITAL INCURRED $4,271,230 OF NET COMMUNITY BENEFIT EXPENSE FROM UNDERTAKING SUBSIDIZED HEALTH SERVICES DURING ITS 2011 TAX YEAR. OF THIS AMOUNT, $4,090,614 WAS RELATED TO LOSSES ASSOCIATED WITH OPERATING PHYSICIAN PRACTICES RUN DIRECTLY BY ATLANTIC GENERAL HOSPITAL. ATLANTIC GENERAL HOSPITAL HAS PUT TOGETHER THIS PHYSICIAN NETWORK, DESPITE THE FINANCIAL LOSS IT CREATES FOR THE ORGANIZATION, IN ORDER TO MEET AN IDENTIFIED COMMUNITY NEED. IN PARTICULAR, THERE IS A SHORTAGE OF PRIMARY CARE AND SPECIALIST PHYSICIANS IN THE COMMUNITY, AND IN ORDER TO HELP PROVIDE ADEQUATE PHYSICIAN COVERAGE TO ITS COMMUNITY, ATLANTIC GENERAL HAS RECRUITED AND EMPLOYED PHYSICIANS TO REDUCE THE GAP. THIS SHORTAGE OF PHYSICIANS IS PARTICULARLY ACUTE IN THE RURAL AREAS SURROUNDING THE HOSPITAL, WHICH ATLANTIC GENERAL HOSPITAL HAS ATTEMPTED TO ALLEVIATE BY LOCATING ITS PHYSICIAN OFFICES THROUGHOUT THE COMMUNITY (INCLUDING IN RURAL AREAS).

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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 III, LINE 4

TEXT FROM THE ORGANIZATION'S FOOTNOTE:

NET PATIENT SERVICE REVENUE AND PATIENT ACCOUNTS RECEIVABLE

NET PATIENT SERVICE REVENUE IS REPORTED AT ESTIMATED NET REALIZABLE AMOUNTS FROM PATIENTS, THIRD PARTY PAYERS, AND OTHERS FOR SERVICES RENDERED. PATIENT ACCOUNTS RECEIVABLE INCLUDE HOSPITAL AND PHYSICIAN CHARGES FOR ACCOUNTS DUE FROM MEDICARE, MARYLAND MEDICAL ASSISTANCE (MEDICAID), CAREFIRST, COMMERCIAL AND MANAGED CARE INSURERS, AND SELF-PAYING PATIENTS. DEDUCTED FROM PATIENT ACCOUNTS RECEIVABLE ARE ESTIMATES OF ALLOWANCES FOR THE EXCESS OF CHARGES OVER THE PAYMENTS ON PATIENT ACCOUNTS TO BE RECEIVED FROM THIRD PARTY PAYERS AND UNCOLLECTIBLE AMOUNTS RELATED TO SELF-PAYING PATIENTS. THESE ESTIMATES ARE CALCULATED BY MANAGEMENT BASED ON HISTORICAL COLLECTION EXPERIENCE AND ANALYSIS OF FINANCIAL CLASS AND AGE OF GROUPS OF ACCOUNTS RECEIVABLE. THESE ESTIMATES OF ALLOWANCES ARE INCLUDED IN NET PATIENT SERVICE REVENUE, WHEREAS THE PROVISION FOR UNCOLLECTIBLE ACCOUNTS IS REPORTED AS AN

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

OPERATING EXPENSE.

THE BAD DEBT EXPENSE REPORTED ON LINE 2 WAS THE AMOUNT OF GROSS PATIENT CHARGES UNCOLLECTED FROM PATIENTS THAT DID NOT QUALIFY FOR FINANCIAL ASSISTANCE.

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

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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 III, LINE 8

WE USED THE MEDICARE COST REPORT TO DETERMINE MEDICARE ALLOWABLE COSTS

COMPARED TO MEDICARE TOTAL REVENUE.

PART III, LINE 9B

THE CURRENT FINANCIAL ASSISTANCE APPLICATION PROCESS ALLOWS FOR PATIENTS

TO APPLY FOR, AND RECEIVE, FINANCIAL ASSISTANCE, AT ANY POINT, POST

DISCHARGE. WHEN A PATIENT IS SUBSEQUENTLY FOUND ELIGIBLE FOR FINANCIAL

ASSISTANCE POST DISCHARGE, THE ORGANIZATION WILL APPLY THE APPLICABLE

FINANCIAL ASSISTANCE DISCOUNT TO ALL OUTSTANDING BALANCES ON THE

PATIENT'S ACCOUNT AND IMMEDIATELY CEASE TO ATTEMPT TO COLLECT ANY AMOUNTS

IN EXCESS OF ANY FINANCIAL ASSISTANCE DISCOUNTED AMOUNT STILL DUE. THE

HOSPITAL WILL PROVIDE A REFUND FOR AMOUNTS PAID BY A PATIENT THAT WAS

SUBSEQUENTLY FOUND TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE ON THE DATE OF

SERVICE, WHICH AMOUNTS WERE IN EXCESS OF THE AMOUNT DUE AFTER THE

APPLICATION OF THE APPLICABLE FINANCIAL ASSISTANCE DISCOUNT, SO LONG AS

THE APPLICATION FOR FINANCIAL ASSISTANCE WAS SUBMITTED BY THE PATIENT

WITHIN TWO YEARS OF THE DATE OF SERVICE.

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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 V, LINE 17

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

PART V, LINE 19D

THE HOSPITAL FACILITY PROVIDES A DISCOUNT OF AT LEAST 50% OFF OF GROSS CHARGES FOR THE PROVISION OF EMERGENCY AND OTHER MEDICALLY NECESSARY CARE TO ANY INDIVIDUAL THAT IS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY.

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

PURSUANT TO THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) ALL-PAYOR SYSTEM FOR HOSPITALS IN THE STATE OF MARYLAND, THE GREATEST DISCOUNT OFF OF GROSS CHARGES FOR THE PROVISION OF EMERGENCY AND OTHER MEDICALLY NECESSARY CARE PERMITTED TO ANY COMMERCIAL INSURER OR MEDICARE IS ONLY 6%. AS A RESULT, THE HOSPITAL FACILITY WAS ABLE TO DETERMINE THAT THE MAXIMUM AMOUNT CHARGED TO INDIVIDUALS THAT WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY WAS NOT GREATER THAN THE AMOUNT GENERALLY BILLED TO INDIVIDUALS WHO HAVE INSURANCE COVERING SUCH CARE.

PART V, LINE 21

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

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

ANY PATIENT ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY IN EXCESS OF THE REDUCED AMOUNT THAT IS ACTUALLY BILLED TO SUCH FINANCIAL ASSISTANCE PATIENT.

PART VI, LINE 2 NEEDS ASSESSMENT

THE ORGANIZATION ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITY IT SERVES THROUGH MANY DIFFERENT ACTIVITIES, STUDIES AND COLLABORATIONS WITH LOCAL GOVERNMENT AND NON-GOVERNMENT ORGANIZATIONS.

THE HOSPITAL IS CURRENTLY WORKING UNDER THE STRATEGIC INITIATIVES WHICH WERE DEVELOPED FOR PLANNING THROUGH 2015. EACH YEAR, WITHIN THIS FRAMEWORK THE HOSPITAL MAKES PLANS FOR THE UPCOMING YEAR USING THE SWOT/GAP ANALYSIS MODEL. USING THIS MODEL THE LEADERSHIP TEAM MEETS WITH THE MEDICAL STAFF TO LOOK AT STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS TO PLAN FOR THE COMING FISCAL YEAR. THIS INFORMATION THEN GOES TO THE BOARD TO, ALONG WITH SENIOR LEADERSHIP, FINALIZE THE STRATEGIC INITIATIVES FOR THE COMING YEAR. USING THIS INFORMATION THE COMMUNITY BENEFITS COMMITTEE AND THE VISIONS FOR TOTAL HEALTH ADVISORY BOARD

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

DETERMINE THE GOALS FOR THE COMING YEAR.

THE DOCUMENTS USED BY THE HOSPITAL TO DETERMINE COMMUNITY NEEDS ARE:

THE HEALTH ASSESSMENT PUBLICATION FROM THE HEALTH DEPARTMENT, LOCAL

AGENCIES AND 3 HOSPITALS,

WORCESTER COUNTY LOCAL HEALTH PLAN, FY2008

TRI-COUNTY ADOLESCENTS ASSOCIATION

STATE OF MARYLAND CANER REGISTRY

LATEST CENSUS UPDATE

FEEDBACK FROM AREA PHYSICIANS AND COMMUNITY MEMBERS

QUESTIONNAIRES AND EVALUATIONS FROM OUR COMMUNITY EVENTS

NCR PICKER PATIENT EVALUATIONS AND FEEDBACK

HOSPITAL PERCEPTION SURVEY 2010

IN ADDITION, INFORMATION REGARDING COMMUNITY HEALTH NEEDS IS OBTAINED AS

A RESULT OF THE ORGANIZATION'S LEADERSHIP MEMBERS SITTING ON THE BOARDS

OF MANY COMMUNITY ORGANIZATIONS, INCLUDING:

PUBLIC SAFETY NET COUNCIL

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

CHILD ADVOCACY BOARD

WORCESTER COUNTY SCHOOL BOARD

YMCA

TRI COUNTY DIABETES

CHAMBERS OF COMMERCE OF TOWNS THROUGHOUT THE REGION

MANY HEALTH DEPARTMENT COUNCILS

MHA COMMITTEES

STATE HEALTH DEPARTMENT BOARDS

WE ALSO HAVE A "VISIONS FOR TOTAL HEALTH ADVISORY BOARD" COMPRISED OF COMMUNITY PROVIDERS OF HEALTH RELATED SERVICES INCLUDING TRADITIONAL AS WELL AS INTEGRATIVE HEALTH SERVICES. THROUGH THIS COMMITTEE WE CAN KEEP OUR FINGER ON THE PULSE OF THE AREA IN WHICH WE SERVE. THIS COMMITTEE GIVES US GREAT FEEDBACK ON SERVICES AND PROGRAMS THAT ARE NEEDED THOSE THAT ARE WORKING AND THOSE THAT AREN'T. IT IS THROUGH THIS COMMITTEE THAT PUTS ON A MAJOR HEALTH CONFERENCE EACH YEAR, WHICH PROVIDES HEALTH EDUCATION AS WELL AS SCREENINGS. IN THE 2010 TAX YEAR, THE COMMITTEE DECIDED TO TAKE HEALTH CONFERENCE "ON THE ROAD" AND TO HOLD IT IN

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

DIFFERENT TOWNS IN OUR SERVICE AREA EACH YEAR. HAVING HELD IT IN THE NORTHERN END OF THE COUNTY SINCE ITS INCEPTION, IT WAS HELD IN THE SOUTHERNMOST TOWN IN THE COUNTY IN NOVEMBER 2010.WE MET WITH GREAT SUCCESS, AND ACCORDING TO THE EVALUATIONS, WERE ABLE TO PROVIDE SERVICES TO PEOPLE WHO OTHERWISE WOULD NOT HAVE GOTTEN THEM.

THE ORGANIZATION'S AUXILIARY VOLUNTEERS ARE ANOTHER GREAT RESOURCE FOR DETERMINING COMMUNITY HEALTH NEEDS. THE ORGANIZATION HAS OVER 400 AUXILLIANS. THEY ARE ACTIVE ON MANY COMMITTEES WITHIN THE HOSPITAL AND ALSO REPRESENT THE HOSPITAL ON DIFFERENT COMMUNITY BOARDS.

IN ADDITION, THE ORGANIZATION WORKS VERY CLOSELY WITH ITS LOCAL HEALTH DEPARTMENT TO PLAN SERVICES TO MEET COMMUNITY NEEDS AND DECREASE THE DUPLICATION OF SERVICES IN THE COMMUNITY. MEMBERS OF THE HOSPITAL STAFF SIT ON MANY COMMITTEES AND BOARDS OF THE LOCAL HEALTH DEPARTMENT.

PART VI, LINE 3 PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

WE INFORM INDIVIDUALS IN THE COMMUNITY ABOUT THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY IN A NUMBER OF WAYS. FIRST, THERE IS SIGNAGE THROUGHOUT THE HOSPITAL, AS WELL AS BROCHURES IN ALL WAITING AREAS,

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

EXPLAINING THAT THE ORGANIZATION PROVIDES FINANCIAL ASSISTANCE. IN ADDITION, ARTICLES ARE PUBLISHED IN NEWSLETTERS THAT ARE DISTRIBUTED TO THE HOMES OF ALL RESIDENTS IN THE COMMUNITY NOTING THE EXISTENCE OF THE ORGANIZATION'S FINANCIAL ASSISTANCE PROGRAM. HOSPITAL STAFF IS EDUCATED TO ANSWER QUESTIONS RELATED TO APPLYING FOR FINANCIAL ASSISTANCE, AND HOSPITAL SUPPORT SERVICES HELPS PATIENTS APPLY FOR MEDICAL ASSISTANCE (SUCH AS MEDICAID). FURTHERMORE,HOSPITAL FINANCIAL COUNSELORS HELP GUIDE PATIENTS TO FINANCIAL AID SERVICES THEY MAY QUALIFY FOR.

ALL INPATIENTS ARE PROVIDED WITH A FINANCIAL ASSISTANCE APPLICATION IN THEIR DISCHARGE PACKAGE. IN ADDITION, DURING THE REGISTRATION PROCESS, IF THE PATIENT DOES NOT HAVE INSURANCE THE REGISTRAR OR FINANCIAL COUNSELOR WILL ASK IF THEY ARE INTERESTED IN APPLYING FOR FINANCIAL ASSISTANCE AND HELP WITH FILLING OUT THE APPLICATION. ANY PATIENT WHO SEEKS FINANCIAL OR MEDICAL ASSISTANCE WILL READILY FIND INFORMATION AND HOSPITAL STAFF TO HELP WITH THE PROCESS.

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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 VI, LINE 4 COMMUNITY INFORMATION

ATLANTIC GENERAL IS LOCATED IN WORCESTER COUNTY, WHICH IS THE EASTERNMOST COUNTY LOCATED IN THE U.S. STATE OF MARYLAND. WORCESTER COUNTY COMPRISES ATLANTIC GENERAL'S PRIMARY SERVICE AREA. WORCESTER COUNTY CONTAINS THE ENTIRE LENGTH OF THE STATE'S ATLANTIC COAST LINE. IT IS HOME TO THE POPULAR VACATION RESORT AREA OF OCEAN CITY. THE COUNTY IS APPROXIMATELY 60 MILES LONG. ACCORDING TO THE U.S. CENSUS BUREAU, THE COUNTY HAS A TOTAL AREA OF 695 SQUARE MILES OF WHICH, 473 SQUARE MILES OF IT IS LAND AND 221 SQUARE MILES OF IT IS WATER.

ATLANTIC GENERAL IS LOCATED IN A NON-URBAN AREA OF WORCESTER COUNTY, 10 MILES FROM THE ATLANTIC OCEAN. THE 2010 CENSUS SHOWED A POPULATION OF THE COUNTY OF 51,454. THE LARGEST CONCENTRATION OF THE POPULATION IS IN THE NORTHERN PART OF THE COUNTY, WHICH IS WHERE THE OCEAN CITY RESORT AREA IS LOCATED, AS WELL AS THE BERLIN/OCEAN PINES AREA. THE AREA IS A MECCA FOR RETIREES WHO LIVE HERE FULL TIME OR DIVIDE THEIR TIME BETWEEN MARYLAND AND FLORIDA.

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

MEDIAN HOUSEHOLD INCOME OF RESIDENTS OF WORCESTER COUNTY IN 2008 WAS $50,347 (BELOW THE STATEWIDE AVERAGE OF $70,482). THE PERCENTAGE OF RESIDENTS BELOW THE POVERTY LEVEL IS 10.5% COMPARED TO A 8.2% STATEWIDE.

THE AVERAGE AGE OF THE RESIDENTS IS BROKEN DOWN AS FOLLOWS: 5> 5%, 18>18.8%, 65< 23%. 51.6% OF THE POPULATION IS FEMALE, 14.8% OF THE POPULATION IS BLACK AND 83% OF THE POPULATION IS WHITE. 51% OF THE PATIENTS CARED FOR AT THE HOSPITAL ARE MEDICARE PATIENTS. THE REMAINING PAYOR MIX IS THE FOLLOWING: MEDICAID 6%, COMMERCIAL AND HMO'S 23%, CARE FIRST 13%, AND SELF PAY AND OTHERS 7%.

IN THE WORCESTER COUNTY HEALTH DEPARTMENT REPORT FROM 2005, THE AGE-ADJUSTED MORTALITY RATE IS 800/100,000 AND FOR THE OVER 64 YEARS OF AGE POPULATION IT WAS 4,000/100,000. INFORMATION FROM THE SAME REPORT SHOWED THE TOP THREE LEADING CAUSES OF DEATH IN THE COUNTY WERE: #1 CANCER, #2 CARDIOVASCULAR DISEASES, #3 ACCIDENTS.

DURING THE SUMMER MONTHS, THE ORGANIZATION PROVIDES A SIGNIFICANT AMOUNT

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

OF HEALTH CARE SERVICES (PREDOMINANTLY EMERGENCY CARE) TO TOURISTS

VISITING THE OCEAN RESORT OF OCEAN CITY, MD. THIS IS RELATED TO THE FACT

THAT THE POPULATION OF OCEAN CITY INCREASES BY ABOUT 100,000 EACH YEAR

DURING THE TOURIST SEASON.

PART VI, LINE 5 PROMOTION OF COMMUNITY HEALTH

THE ORGANIZATION UNDERTAKES NUMEROUS ACTIVITIES TO PROMOTE THE HEALTH OF

ITS COMMUNITY. IN PARTICULAR, THE ORGANIZATION HAS IDENTIFIED A

COMMUNITY NEED FOR ACESS TO ADDITIONAL PHYSICIANS LOCATED IN THE

COMMUNITY. IN ORDER TO MEET THIS IDENTIFIED COMMUNITY NEED, THE

ORGANIZATION HAS DIRECTLY EMPLOYED NUMEROUS PHYSICIANS AT A SUBSTANTIAL

COST TO THE ORGANIZATION. IN 2011, THE NET COST TO THE ORGANIZATION FROM

THE PHYSICIAN PRACTICES WAS $4,649,626.

IN ADDITION, THE ORGANIZATION UNDERTAKES COMMUNITY BUILDING ACTIVITIES TO

PROMOTE THE PROGRAMS THE ORGANIZATION OFFERS AND ASSURE THEY ARE REACHING

THE TARGETED AUDIENCE. EXAMPLES OF THESE SPECIFIC ACTIVITIES WOULD BE THE

SMALL NEIGHBORHOOD-TYPE HEALTH FAIRS IN WHICH WE ARE INVOLVED, AT WHICH

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

EVENTS YOUNG PEOPLE ARE TARGETED AND NEEDS THAT ARE FILLED THROUGH OUR

SPEAKERS BUREAU.

OTHER INVOLVEMENT IN COMMUNITY BUILDING ACTIVITIES INCLUDE: OUR

PARTICIPATION IN THE LOCAL HABITAT FOR HUMANITY. THROUGH THIS GROUP OUR

STAFF HAS LOGGED MANY HOURS OF SERVICE TO BUILD HOUSES FOR 3 LOCAL

FAMILIES. SCHOOL MENTORING PROGRAMS IS ANOTHER COMMUNITY BUILDING

ACTIVITY IN WHICH OUR STAFF IS VERY ACTIVE. WE HAVE STUDENTS FROM OUR

LOCAL HIGH SCHOOL WHO DO A SHADOWING PROGRAM THROUGHOUT ALL DEPARTMENTS

OF OUR HOSPITAL. THIS HELPS THEM IN MAKING A CAREER CHOICE THROUGH

EXPOSURE TO DIFFERENT JOBS IN THE HEALTH CARE ARENA.

WE HAVE STAFF WHO REPRESENT THE HOSPITAL ON MANY CIVIC BOARDS SUCH AS ALL

THE LOCAL AREA CHAMBERS, VARIOUS CIVIC GROUPS SUCH AS LIONS CLUB AND

ROTARY, YMCA AND THE LOCAL COUNTY SCHOOL BOARD. WE ALSO PARTICIPATE IN

THE ACS RELAY FOR LIFE, MARCH OF DIMES WALK FOR BABIES.

WE PROVIDE EMS TRAINING FOR THE LOCAL FIRE COMPANIES, MOST OF WHOM ARE

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

VOLUNTEER STAFFED. WE OFFER AN EXCHANGE PROGRAM OF EQUIPMENT WHICH HELPS THEM WITH TRANSPORTS TO THE EMERGENCY DEPARTMENT.

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

ONE OF OUR BUILDINGS ON CAMPUS HOUSES OUR COUNTY CHILD ADVOCACY CENTER. THROUGH THIS STATE OF THE ART FACILITY THE VICTIM HAS TO TELL THEIR STORY ONLY ONCE TO ONE PERSON WHILE ALL THE OTHERS WHO NEED TO SEE AND HEAR THE TESTIMONY CAN WATCH THROUGH A CLOSED CIRCUIT SYSTEM.

ALSO PART OF OUR COMMUNITY BUILDING PROGRAM INCLUDES OUR PARTICIPATION IN DISASTER PREPAREDNESS. BECAUSE WE ARE GEOGRAPHICALLY LOCATED IN AN AREA OF EXTREME POTENTIAL DISASTER, ONLY 6 MILES FROM THE ATLANTIC OCEAN, WE WOULD BE THE SOURCE OF CARE AND PROTECTION FOR MANY IN THE AREA SHOULD A

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

MAJOR HURRICANE HIT OUR AREA OF COASTLINE. PART OF THE HOSPITAL'S PROVISION FOR THE COMMUNITY IN SUCH A DISASTER WOULD BE TO PROVIDE CLEAN DRINKING WATER FOR THEM; THROUGH THE NEW WATER PURIFICATION SYSTEM WHICH WE RECENTLY PURCHASED AND INSTALLED WE HAVE THE ABILITY TO PROVIDE CLEAN WATER FOR NOT JUST OUR PATIENTS AND STAFF BUT FOR THE COMMUNITY AT LARGE.

WE ALSO WORK CLOSELY WITH OUR LOCAL PUBLIC AND PRIVATE SCHOOLS TO OFFER EDUCATION PROGRAMMING. EACH YEAR WE HOST OVER 500 KINDERGARTEN STUDENTS FOR OUR HOSPITAL TOURS. THIS SERVES TO INTRODUCE THEM TO THE SERVICES OF THE HOSPITAL IN HOPES THAT THEIR TRIP FOR SERVICES WILL NOT BE A FRIGHTENING. FOR THE PAST SEVERAL YEARS WE HAVE SPONSORED A MAJOR ASSEMBLY PROGRAM WHICH FIGHTS CHILDHOOD OBESITY INTO THE ELEMENTARY SCHOOLS. MANY OF OUR ASSOCIATES SERVE ON VARIOUS BOARDS OF THE SCHOOL SYSTEM OFFERING OUR EXPERTISE. THROUGH OUR SPEAKER'S BUREAU WE SEND SPEAKERS INTO MANY CLASSROOMS FOR INSTRUCTION.

SOME ADDITIONAL SERVICES WHICH THE HOSPITAL PROVIDES FOR FREE TO

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

THE COMMUNITY, WHICH PROMOTE HEALTH INCLUDE:

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

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

3. HEALTHFAIRS - THE HOSPITAL IS INVOLVED IN SEVERAL LARGE AND SMALL HEALTHFAIR EVENTS IN VARIOUS LOCATIONS THROUGHOUT THE YEAR. ONE SUCH EVENT IS A PARTNERSHIP WITH AARP TO OFFER A FAIR WITH MANY SCREENINGS AND HEALTH INFORMATION. WE ALSO SPONSOR AN EDUCATIONAL AND SCREENING CONFERENCE ONCE A YEAR CALLED OUR VISIONS FOR TOTAL HEALTH CONFERENCE. THIS IS HELD IN VARIOUS LOCATIONS WITHIN OUR SERVICE AREA WHICH ALLOWS US

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

TO PROVIDE FREE SERVICES TO THOSE WHO MIGHT NOT OTHERWISE BE ABLE TO

ACCESS HEALTH CARE. WE ALSO PARTNER WITH MANY CHURCHES AND COMMUNITY

GROUPS TO OFFER SMALL HEALTH FAIRS.

4. WE PROVIDE EDUCATION IN WRITTEN FORM THROUGH LOCAL PUBLICATIONS

(NEWSPAPERS AND MAGAZINES) AND OUR OWN ON CALL QUARTERLY PUBLICATION.

MANY OF OUR PHYSICIANS PROVIDE ARTICLES FOR THESE.

5. WE ALSO HAVE A SPEAKER'S BUREAU WHICH PROVIDES EDUCATIONAL

PRESENTATIONS FOR AREA CIVIC GROUPS, BUSINESSES, CHURCHES, SCHOOLS AND

CONVENTIONS WHICH ARE HELD IN OUR RESORT AREA.

6. WE PROVIDE EDUCATION FOR THE LOCAL SCHOOLS THROUGH OUR HOSPITAL TOUR

PROGRAM AND SPONSORSHIP OF FOOD PLAY PRODUCTIONS. THESE PROGRAMS ALLOW US

TO SPREAD THE HEALTH MESSAGE AGAINST CHILDHOOD OBESITY TO THE YOUNGER

GENERATION.

7. BEING IN A BEACH RESORT COMMUNITY THERE ARE MANY SPORTING EVENTS WHICH

Part VI Supplemental Information

Complete this part to provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.

OCCUR LOCALLY. WE PARTICIPATE IN MANY OF THESE BY PROVIDING FIRST AID ON

SITE FOR THOSE IN ATTENDANCE AND THOSE PARTICIPATING IN THE ACTIVITY.

PART VI, LINE 6 AFFILIATED HEALTH CARE SYSTEM

ATLANTIC GENERAL HOSPITAL EMPLOYS A NETWORK OF PRIMARY CARE AND

SPECIALIST PHYSICIANS THAT PROVIDE NEEDED HEALTH CARE SERVICES

THROUGHOUT ATLANTIC GENERAL'S COMMUNITY, INCLUDING SERVING SOME OF THE

HOSPITAL'S MORE RURAL AREAS. BECAUSE OF THE RURAL NATURE OF THE

COMMUNITIES THE HOSPITAL SERVES, TRANSPORTATION FOR HEALTHCARE CAN BE

CHALLENGING. BY LOCATING THESE EMPLOYED PHYSICIANS' OFFICES THROUGHOUT

THE HOSPITAL'S SERVICE REGION, THE HOSPITAL IS ABLE TO HELP IMPROVE

ACCESS TO PHYSICIANS' SERVICES FOR MEMBERS OF THE COMMUNITY. AGH'S

EMPLOYED PHYSICIANS PROVIDED $226,199 OF CHARITY CARE AT GROSS CHARGES

DURING THE 2011 TAX YEAR.

IN ADDITION, THE HOSPITAL RUNS ATLANTIC HEALTH CLINIC, WHICH IS A

FACILITY THAT OFFERS CARE ON A SLIDING FEE COST BASIS.

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" to Form 990, Part IV, line 23.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization: ATLANTIC GENERAL HOSPITAL

Employer identification number: 52-1656507

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 in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in 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. Explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☐ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**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) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**		X
b	Any related organization?	**5b**		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**		X
b	Any related organization?	**6b**		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

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

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

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

(A) Name		(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 reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 MICHAEL FRANKLIN	(i)	311,944.	34,530.	16,500.	16,500.	0	379,474.	0
	(ii)	0	0	0	0	0	0	0
2 CHERYL NOTTINGHAM	(i)	170,331.	10,900.	0	16,500.	0	197,731.	0
	(ii)	0	0	0	0	0	0	0
3 CHARLES KIM	(i)	373,481.	2,565.	16,500.	16,500.	0	409,046.	0
	(ii)	0	0	0	0	0	0	0
4 JEFFREY FERNLEY	(i)	340,617.	7,040.	16,500.	16,500.	0	380,657.	0
	(ii)	0	0	0	0	0	0	0
5 JAMES SKOLKA	(i)	362,363.	1,026.	22,000.	22,000.	0	407,389.	0
	(ii)	0	0	0	0	0	0	0
6 SCOTT KNOWLTON	(i)	368,000.	570.	0	16,500.	0	385,070.	0
	(ii)	0	0	0	0	0	0	0
7 JAMES BRANNON	(i)	138,757.	8,269.	0	7,025.	0	154,051.	0
	(ii)	0	0	0	0	0	0	0
8 MICHAEL STIVELMAN	(i)	360,727.	2,195.	0	18,000.	0	380,922.	0
	(ii)	0	0	0	0	0	0	0
9	(i)							
	(ii)							
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

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

SCHEDULE K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
ATLANTIC GENERAL HOSPITAL

Employer identification number
52-1656507

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	MAYOR AND COUNCIL OF BERLIN, MD			06/29/2010	2,200,000.	2010 A REVENUE BOND CANCER CENTER,		X		X		X
B	MAYOR AND COUNCIL OF BERLIN, MD			12/13/2010	10,000,000.	2010 SERIES B&C REV BOND CANCER CT		X		X		X
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	281,111.	457,351.		
2	Amount of bonds legally defeased				
3	Total proceeds of issue	2,200,000.	10,000,867.		
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	44,000.	59,584.		
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	2,156,000.	7,500,117.		
11	Other spent proceeds				
12	Other unspent proceeds		2,441,166.		
13	Year of substantial completion	2012	2012		

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X		X				
15	Were the bonds issued as part of an advance refunding issue?		X		X				
16	Has the final allocation of proceeds been made?	X			X				
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

Part III Private Business Use

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

Part III Private Business Use *(Continued)* TAX EXEMPT BONDS

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?		X		X				
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
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 ▶	%		%		%		%	
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	%		%		%		%	
6	Total of lines 4 and 5	%		%		%		%	
7	Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?	X		X					

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has a Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate, been filed with respect to the bond issue?		X		X				
2	Is the bond issue a variable rate issue?		X	X					
3a	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?								
4a	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?								
5	Were any gross proceeds invested beyond an available temporary period?		X		X				
6	Did the bond issue qualify for an exception to rebate?	X			X				

Part V Procedures To Undertake Corrective Action

Check the box if the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations . . . . . ☐ Yes ☒ No

Part VI Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K (see instructions).

PROCESS OF REVIEWING RETURN

PART VI LINE 11B

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

MONITORING AND ENFORCING CONFLICTS OF INTEREST

PART VI, LINE 12C

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

DETERMINATION OF COMPENSATION

PART VI, LINE 15

THE ORGANIZATION UTILIZES A COMPENSATION COMMITTEE, A WRITTEN EMPLOYMENT

Name of the organization: ATLANTIC GENERAL HOSPITAL

Employer identification number: 52-1656507

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

DOCUMENT AVAILABILITY

PART VI, LINE 19

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

RECONCILIATION OF NET ASSETS

PART XI, LINE 5

DONATED SERVICES	$ 14,250
RESTRICTED CONTRIBUTION	132,694
OTHER CONTRIBUTION	(248,678)
CHANGE IN SWAP FAIR VALUE	312,759
UNREALIZED GAIN	(243,816)
NET ASSETS RELEASED	(53,171)
INCOME FROM MD ECARE K-1	(4,218)
ROUNDING	(1)
	(90,181)

ATTACHMENT 1

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
WAVELENGTH INFORMATION SYSTEMS PO BOX 739	IT SERVICES	1,533,230.

Name of the organization: ATLANTIC GENERAL HOSPITAL

Employer identification number: 52-1656507

ATTACHMENT 1 (CONT'D)

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
BERLIN, MD 21811		
GENESIS ELDERCARE REHABILITATION SERVICE PO BOX 7247-6524 PHILADELPHIA, PA 13170-6524	PT, OT & ST SERVICES	368,627.
WOUND CARE CENTERS INC. PO BOX 637114 CINCINNATI, OH 45263-7114	WOUND CARE SVCS	336,286.
ATLANTIC ENDOSCOPY CENTER, LLC P.O. BOX 242 BERLIN, MD 21811	MANAGEMENT OF EDNO	332,637.
ATS, INC. 2040 SHIPLEY DRIVE SALISBURY, MD 21801	IT AND COMMUNICATION	259,830.
TOTAL COMPENSATION		2,830,610.

ATTACHMENT 2

FORM 990, PART VIII - INVESTMENT INCOME

DESCRIPTION	(A) TOTAL REVENUE	(B) RELATED OR EXEMPT REVENUE	(C) UNRELATED BUSINESS REV.	(D) EXCLUDED REVENUE
INTEREST INCOME	253,305.			253,305.
MD ECARE K-1	4,218.			4,218.
TOTALS	257,523.			257,523.

ATTACHMENT 3

FORM 990, PART VIII - EXCLUDED CONTRIBUTIONS

DESCRIPTION	AMOUNT
GOLF TOURNAMENT	78,395.
PENGUIN SWIM	87,715.

Name of the organization: ATLANTIC GENERAL HOSPITAL

Employer identification number: 52-1656507

ATTACHMENT 3 (CONT'D)

FORM 990, PART VIII - EXCLUDED CONTRIBUTIONS

DESCRIPTION	AMOUNT
HOSPITAL ANNIVERSARY CELEBRATE	48,850.
TOTAL	214,960.

ATTACHMENT 4

FORM 990, PART VIII - FUNDRAISING EVENTS

DESCRIPTION	GROSS INCOME	DIRECT EXPENSES	NET INCOME
GOLF TOURNAMENT	41,020.	20,671.	20,349.
PENGUIN SWIM		17,541.	-17,541.
HOSPITAL ANNIVERSARY CELEBRATE	28,375.	18,075.	10,300.
TOTALS	69,395.	56,287.	13,108.

ATTACHMENT 5

FORM 990, PART VIII - GROSS SALES AND COST OF GOODS SOLD

GROSS SALES LESS RETURNS AND ALLOWANCES	231,825.
INVENTORY AT BEGINNING OF YEAR	
PURCHASES	85,160.
SALARIES AND WAGES	
OTHER COSTS	
SUBTOTAL	85,160.
MINUS ENDING INVENTORY	
COST OF GOODS SOLD	85,160.

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

ATTACHMENT 6

FORM 990, PART X - PREPAID EXPENSES AND DEFERRED CHARGES

DESCRIPTION	ENDING BOOK VALUE
PREPAID EXPENSES	1,609,728.
TOTALS	1,609,728.

ATTACHMENT 7

FORM 990, PART X - INVESTMENTS - PUBLICLY TRADED SECURITIES

DESCRIPTION	ENDING BOOK VALUE	COST OR FMV
EQUITY SECURITIES	4,481,626.	FMV
TREASURY SECURITIES	32,080.	FMV
TOTALS	4,513,706.	

ATTACHMENT 8

FORM 990, PART X - SECURED MORTGAGES AND NOTES PAYABLE

LENDER: BANK OF OCEAN CITY
ORIGINAL AMOUNT: 472,500.
INTEREST RATE: 7.880000
MATURITY DATE: 01/01/2016
REPAYMENT TERMS: MONTHLY PRINCIPAL AND INTEREST INSTALLMENTS

BEGINNING BALANCE DUE ..... 185,768.
ENDING BALANCE DUE ..... 147,899.

LENDER: M&T BANK
ORIGINAL AMOUNT: 2,200,000.
INTEREST RATE: 5.190000
DATE OF NOTE: 06/30/2010
MATURITY DATE: 06/30/2020
REPAYMENT TERMS: MONTHLY

BEGINNING BALANCE DUE ..... 2,065,556.

Name of the organization: ATLANTIC GENERAL HOSPITAL

Employer identification number: 52-1656507

ATTACHMENT 8 (CONT'D)

ENDING BALANCE DUE .....

LENDER: M&T BANK
ORIGINAL AMOUNT: 1,570,000.
MATURITY DATE: 04/09/2013

BEGINNING BALANCE DUE	575,667.
ENDING BALANCE DUE	261,667.

Name of the organization: ATLANTIC GENERAL HOSPITAL

Employer identification number: 52-1656507

ATTACHMENT 8 (CONT'D)

LENDER: M&T BANK
ORIGINAL AMOUNT: 5,172,000.
MATURITY DATE: 04/09/2013

BEGINNING BALANCE DUE	4,516,880.
ENDING BALANCE DUE	4,310,000.

LENDER: GMAC
ORIGINAL AMOUNT: 32,325.
INTEREST RATE:
MATURITY DATE: 11/13/2012
REPAYMENT TERMS: 36 MONTHLY INSTALLMENTS AND ONE FINAL PYMT

BEGINNING BALANCE DUE	15,263.
ENDING BALANCE DUE	4,490.

Name of the organization: ATLANTIC GENERAL HOSPITAL

Employer identification number: 52-1656507

ATTACHMENT 8 (CONT'D)

LENDER: M&T BANK
ORIGINAL AMOUNT: 2,600,000.
INTEREST RATE: 5.080000
MATURITY DATE: 06/30/2020
REPAYMENT TERMS: MONTHLY

BEGINNING BALANCE DUE	2,525,287.
ENDING BALANCE DUE	

LENDER: M&T BANK
ORIGINAL AMOUNT: 7,400,000.
MATURITY DATE: 06/30/2020
REPAYMENT TERMS: MONTHLY

BEGINNING BALANCE DUE	7,400,000.
ENDING BALANCE DUE	

TOTAL BEGINNING MORTGAGES AND OTHER NOTES PAYABLE	17,284,421.
TOTAL ENDING MORTGAGES AND OTHER NOTES PAYABLE	4,724,056.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization
ATLANTIC GENERAL HOSPITAL

Employer identification number
52-1656507

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

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) ATLANTIC IMMEDICARE LLC 20-5095845 9733 HEALTHWAY DRIVE BERLIN, MD 21811	HEALTHCARE	MD	398,996.	340,313.	AGH
(2)					
(3)					
(4)					
(5)					
(6)					

Part II Identification of Related Tax-Exempt Organizations (Complete if the organization answered "Yes" to 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	(g) Section 512(b)(13) controlled entity? No
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

Part III **Identification of Related Organizations Taxable as a Partnership** (Complete if the organization answered "Yes" to 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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** (Complete if the organization answered "Yes" to 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
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

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

			Yes	No
Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.				
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II–IV?			
a	Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	1a		
b	Gift, grant, or capital contribution to related organization(s)	1b		
c	Gift, grant, or capital contribution from related organization(s)	1c		
d	Loans or loan guarantees to or for related organization(s)	1d		
e	Loans or loan guarantees by related organization(s)	1e		
f	Sale of assets to related organization(s)	1f		
g	Purchase of assets from related organization(s)	1g		
h	Exchange of assets with related organization(s)	1h		
i	Lease of facilities, equipment, or other assets to related organization(s)	1i		
j	Lease of facilities, equipment, or other assets from related organization(s)	1j		
k	Performance of services or membership or fundraising solicitations for related organization(s)	1k		
l	Performance of services or membership or fundraising solicitations by related organization(s)	1l		
m	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1m		
n	Sharing of paid employees with related organization(s)	1n		
o	Reimbursement paid to related organization(s) for expenses	1o		
p	Reimbursement paid by related organization(s) for expenses	1p		
q	Other transfer of cash or property to related organization(s)	1q		
r	Other transfer of cash or property from related organization(s)	1r		

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 other organization	(b) Transaction type (a–r)	(c) Amount involved	(d) Method of determining amount involved
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

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

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

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

Part VII **Supplemental Information**

Complete this part to provide additional information for responses to questions on Schedule R (see instructions).

RENT AND ROYALTY INCOME

Taxpayer's Name	Identifying Number
ATLANTIC GENERAL HOSPITAL	52-1656507

DESCRIPTION OF PROPERTY

RENTAL PROPERTY-MOB

☐ Yes ☐ No Did you actively participate in the operation of the activity during the tax year?

TYPE OF PROPERTY:

REAL RENTAL INCOME	110,125.	
OTHER INCOME:		
TOTAL GROSS INCOME		110,125.
OTHER EXPENSES:		
DEPRECIATION (SHOWN BELOW)		
LESS: Beneficiary's Portion		
AMORTIZATION		
LESS: Beneficiary's Portion		
DEPLETION		
LESS: Beneficiary's Portion		
TOTAL EXPENSES		
TOTAL RENT OR ROYALTY INCOME (LOSS)		110,125.

Less Amount to	
Rent or Royalty	
Depreciation	
Depletion	
Investment Interest Expense	
Other Expenses	
Net Income (Loss) to Others	
Net Rent or Royalty Income (Loss)	110,125.
Deductible Rental Loss (if Applicable)	

SCHEDULE FOR DEPRECIATION CLAIMED

(a) Description of property	(b) Cost or unadjusted basis	(c) Date acquired	(d) ACRS des.	(e) Bus. %	(f) Basis for depreciation	(g) Depreciation in prior years	(h) Method	(i) Life or rate	(j) Depreciation for this year
Totals									

RENT AND ROYALTY SUMMARY

PROPERTY	TOTAL INCOME	DEPLETION/ DEPRECIATION	OTHER EXPENSES	ALLOWABLE NET INCOME
RENTAL PROPERTY-MOB	110,125.			110,125.
TOTALS	110,125.			110,125.

SCHEDULE D (Form 1041)

Department of the Treasury
Internal Revenue Service

Capital Gains and Losses

▶ **Attach to Form 1041, Form 5227, or Form 990-T. See the Instructions for Schedule D (Form 1041) (also for Form 5227 or Form 990-T, if applicable).**

OMB No. 1545-0092

2011

Name of estate or trust: ATLANTIC GENERAL HOSPITAL

Employer identification number: 52-1656507

Note: *Form 5227 filers need to complete **only** Parts I and II.*

Part I Short-Term Capital Gains and Losses - Assets Held One Year or Less

(a) Description of property (Example: 100 shares 7% preferred of "Z" Co.)	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Sales price	(e) Cost or other basis (see instructions)	(f) Gain or (loss) for the entire year Subtract (e) from (d)
1a					

b	Enter the short-term gain or (loss), if any, from Schedule D-1, line 1b	1b	
2	Short-term capital gain or (loss) from Forms 4684, 6252, 6781, and 8824	2	
3	Net short-term gain or (loss) from partnerships, S corporations, and other estates or trusts	3	
4	Short-term capital loss carryover. Enter the amount, if any, from line 9 of the 2010 Capital Loss Carryover Worksheet	4	( )
5	**Net short-term gain or (loss).** Combine lines 1a through 4 in column (f). Enter here and on line 13, column (3) on the back ▶	5	

Part II Long-Term Capital Gains and Losses - Assets Held More Than One Year

(a) Description of property (Example: 100 shares 7% preferred of "Z" Co.)	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Sales price	(e) Cost or other basis (see instructions)	(f) Gain or (loss) for the entire year Subtract (e) from (d)
6a					

b	Enter the long-term gain or (loss), if any, from Schedule D-1, line 6b	6b	152,167.
7	Long-term capital gain or (loss) from Forms 2439, 4684, 6252, 6781, and 8824	7	
8	Net long-term gain or (loss) from partnerships, S corporations, and other estates or trusts	8	
9	Capital gain distributions	9	
10	Gain from Form 4797, Part I	10	47,142.
11	Long-term capital loss carryover. Enter the amount, if any, from line 14 of the 2010 Capital Loss Carryover Worksheet	11	( )
12	**Net long-term gain or (loss).** Combine lines 6a through 11 in column (f). Enter here and on line 14a, column (3) on the back ▶	12	199,309.

Part III Summary of Parts I and II

Caution: *Read the instructions **before** completing this part.*

			(1) Beneficiaries' (see instr.)	(2) Estate's or trust's	(3) Total
13	Net short-term gain or (loss)	13			
14	Net long-term gain or (loss):				
a	Total for year	14a			199,309.
b	Unrecaptured section 1250 gain (see line 18 of the wrksht.)	14b			
c	28% rate gain	14c			
15	**Total net gain or (loss).** Combine lines 13 and 14a ▶	15			199,309.

Note: *If line 15, column (3), is a net gain, enter the gain on Form 1041, line 4 (or Form 990-T, Part I, line 4a). If lines 14a and 15, column (2), are net gains, go to Part V, and **do not** complete Part IV. If line 15, column (3), is a net loss, complete Part IV and the **Capital Loss Carryover Worksheet,** as necessary.*

Part IV Capital Loss Limitation

16 Enter here and enter as a (loss) on Form 1041, line 4 (or Form 990-T, Part I, line 4c, if a trust), the **smaller** of:

a The loss on line 15, column (3) **or** b $3,000 . . . . . 16 ( )

Note: *If the loss on line 15, column (3), is more than $3,000, **or** if Form 1041, page 1, line 22 (or Form 990-T, line 34), is a loss, complete the **Capital Loss Carryover Worksheet** in the instructions to figure your capital loss carryover.*

Part V Tax Computation Using Maximum Capital Gains Rates

Form 1041 filers. Complete this part **only** if both lines 14a and 15 in column (2) are gains, or an amount is entered in Part I or Part II and there is an entry on Form 1041, line 2b(2), **and** Form 1041, line 22, is more than zero.

Caution: *Skip this part and complete the **Schedule D Tax Worksheet** in the instructions if:*

- *Either line 14b, col. (2) or line 14c, col. (2) is more than zero, or*
- *Both Form 1041, line 2b(1), and Form 4952, line 4g are more than zero.*

Form 990-T trusts. Complete this part **only** if both lines 14a and 15 are gains, or qualified dividends are included in income in Part I of Form 990-T, **and** Form 990-T, line 34, is more than zero. Skip this part and complete the **Schedule D Tax Worksheet** in the instructions if either line 14b, col. (2) or line 14c, col. (2) is more than zero.

17	Enter taxable income from Form 1041, line 22 (or Form 990-T, line 34)			17		
18	Enter the **smaller** of line 14a or 15 in column (2) but not less than zero	18				
19	Enter the estate's or trust's qualified dividends from Form 1041, line 2b(2) (or enter the qualified dividends included in income in Part I of Form 990-T)	19				
20	Add lines 18 and 19	20				
21	If the estate or trust is filing Form 4952, enter the amount from line 4g; otherwise, enter -0- ▶	21				
22	Subtract line 21 from line 20. If zero or less, enter -0-			22		
23	Subtract line 22 from line 17. If zero or less, enter -0-			23		
24	Enter the **smaller** of the amount on line 17 or $2,300			24		
25	Is the amount on line 23 equal to or more than the amount on line 24? ☐ **Yes.** Skip lines 25 and 26; go to line 27 and check the "No" box. ☐ **No.** Enter the amount from line 23			25		
26	Subtract line 25 from line 24			26		
27	Are the amounts on lines 22 and 26 the same? ☐ **Yes.** Skip lines 27 thru 30; go to line 31. ☐ **No.** Enter the smaller of line 17 or line 22			27		
28	Enter the amount from line 26 (If line 26 is blank, enter -0-)			28		
29	Subtract line 28 from line 27			29		
30	Multiply line 29 by 15% (.15)				30	
31	Figure the tax on the amount on line 23. Use the 2011 Tax Rate Schedule for Estates and Trusts (see the Schedule G instructions in the instructions for Form 1041)				31	
32	Add lines 30 and 31				32	
33	Figure the tax on the amount on line 17. Use the 2011 Tax Rate Schedule for Estates and Trusts (see the Schedule G instructions in the instructions for Form 1041)				33	
34	**Tax on all taxable income.** Enter the **smaller** of line 32 or line 33 here and on Form 1041, Schedule G, line 1a (or Form 990-T, line 36)				34	

Name of estate or trust as shown on Form 1041. Do not enter name and employer identification number if shown on the other side.
ATLANTIC GENERAL HOSPITAL

Employer identification number
52-1656507

Part II **Long-Term Capital Gains and Losses - Assets Held More Than One Year**

(a) Description of property (Example: 100 sh. 7% preferred of "Z" Co.)	**(b)** Date acquired (mo., day, yr.)	**(c)** Date sold (mo., day, yr.)	**(d)** Sales price	**(e)** Cost or other basis (see instructions)	**(f) Gain or (loss)** Subtract (e) from (d)
6a SECURITIES			152,167.		152,167.

6b Total. Combine the amounts in column (f). Enter here and on Schedule D, line 6b . . . . 152,167.

Form **4797**

Department of the Treasury
Internal Revenue Service (99)

Sales of Business Property
(Also Involuntary Conversions and Recapture Amounts Under Sections 179 and 280F(b)(2))

▶ Attach to your tax return. ▶ See separate instructions.

OMB No. 1545-0184

2011

Attachment Sequence No. **27**

Name(s) shown on return

ATLANTIC GENERAL HOSPITAL

Identifying number

52-1656507

1 Enter the gross proceeds from sales or exchanges reported to you for 2011 on Form(s) 1099-B or 1099-S (or substitute statement) that you are including on line 2, 10, or 20 (see instructions)	**1**	

Part I **Sales or Exchanges of Property Used in a Trade or Business and Involuntary Conversions From Other Than Casualty or Theft - Most Property Held More Than 1 Year** (see instructions)

2 (a) Description of property	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Gross sales price	(e) Depreciation allowed or allowable since acquisition	(f) Cost or other basis, plus improvements and expense of sale	(g) Gain or (loss) Subtract (f) from the sum of (d) and (e)
ATTACHMENT 1						47,142.

3	Gain, if any, from Form 4684, line 39	**3**	
4	Section 1231 gain from installment sales from Form 6252, line 26 or 37	**4**	
5	Section 1231 gain or (loss) from like-kind exchanges from Form 8824	**5**	
6	Gain, if any, from line 32, from other than casualty or theft	**6**	
7	Combine lines 2 through 6. Enter the gain or (loss) here and on the appropriate line as follows:	**7**	47,142.
	Partnerships (except electing large partnerships) and S corporations. Report the gain or (loss) following the instructions for Form 1065, Schedule K, line 10, or Form 1120S, Schedule K, line 9. Skip lines 8, 9, 11, and 12 below.		
	Individuals, partners, S corporation shareholders, and all others. If line 7 is zero or a loss, enter the amount from line 7 on line 11 below and skip lines 8 and 9. If line 7 is a gain and you did not have any prior year section 1231 losses, or they were recaptured in an earlier year, enter the gain from line 7 as a long-term capital gain on the Schedule D filed with your return and skip lines 8, 9, 11, and 12 below.		
8	Nonrecaptured net section 1231 losses from prior years (see instructions)	**8**	
9	Subtract line 8 from line 7. If zero or less, enter -0-. If line 9 is zero, enter the gain from line 7 on line 12 below. If line 9 is more than zero, enter the amount from line 8 on line 12 below and enter the gain from line 9 as a long-term capital gain on the Schedule D filed with your return (see instructions)	**9**	

Part II **Ordinary Gains and Losses** (see instructions)

10 Ordinary gains and losses not included on lines 11 through 16 (include property held 1 year or less):

11	Loss, if any, from line 7	**11**	( )
12	Gain, if any, from line 7 or amount from line 8, if applicable	**12**	
13	Gain, if any, from line 31	**13**	
14	Net gain or (loss) from Form 4684, lines 31 and 38a	**14**	
15	Ordinary gain from installment sales from Form 6252, line 25 or 36	**15**	
16	Ordinary gain or (loss) from like-kind exchanges from Form 8824	**16**	
17	Combine lines 10 through 16	**17**	
18	For all except individual returns, enter the amount from line 17 on the appropriate line of your return and skip lines a and b below. For individual returns, complete lines a and b below:		
a	If the loss on line 11 includes a loss from Form 4684, line 35, column (b)(ii), enter that part of the loss here. Enter the part of the loss from income-producing property on Schedule A (Form 1040), line 28, and the part of the loss from property used as an employee on Schedule A (Form 1040), line 23. Identify as from "Form 4797, line 18a." See instructions	**18a**	
b	Redetermine the gain or (loss) on line 17 excluding the loss, if any, on line 18a. Enter here and on Form 1040, line 14	**18b**	

Part III **Gain From Disposition of Property Under Sections 1245, 1250, 1252, 1254, and 1255** (see instructions)

19 (a) Description of section 1245, 1250, 1252, 1254, or 1255 property:	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)
A		
B		
C		
D		

These columns relate to the properties on lines 19A through 19D. ▶		Property A	Property B	Property C	Property D
20 Gross sales price (**Note:** *See line 1 before completing.*)	20				
21 Cost or other basis plus expense of sale	21				
22 Depreciation (or depletion) allowed or allowable	22				
23 Adjusted basis. Subtract line 22 from line 21	23				
24 Total gain. Subtract line 23 from line 20	24				
25 If section 1245 property:					
a Depreciation allowed or allowable from line 22	25a				
b Enter the **smaller** of line 24 or 25a	25b				
26 If section 1250 property: If straight line depreciation was used, enter -0- on line 26g, except for a corporation subject to section 291.					
a Additional depreciation after 1975 (see instructions)	26a				
b Applicable percentage multiplied by the **smaller** of line 24 or line 26a (see instructions)	26b				
c Subtract line 26a from line 24. If residential rental property **or** line 24 is not more than line 26a, skip lines 26d and 26e	26c				
d Additional depreciation after 1969 and before 1976	26d				
e Enter the **smaller** of line 26c or 26d	26e				
f Section 291 amount (corporations only)	26f				
g Add lines 26b, 26e, and 26f	26g				
27 If section 1252 property: Skip this section if you did not dispose of farmland or if this form is being completed for a partnership (other than an electing large partnership).					
a Soil, water, and land clearing expenses	27a				
b Line 27a multiplied by applicable percentage (see instructions)	27b				
c Enter the **smaller** of line 24 or 27b	27c				
28 If section 1254 property:					
a Intangible drilling and development costs, expenditures for development of mines and other natural deposits, mining exploration costs, and depletion (see instructions)	28a				
b Enter the **smaller** of line 24 or 28a	28b				
29 If section 1255 property:					
a Applicable percentage of payments excluded from income under section 126 (see instructions)	29a				
b Enter the **smaller** of line 24 or 29a (see instructions)	29b				

Summary of Part III Gains. Complete property columns A through D through line 29b before going to line 30.

30 Total gains for all properties. Add property columns A through D, line 24	30	
31 Add property columns A through D, lines 25b, 26g, 27c, 28b, and 29b. Enter here and on line 13	31	
32 Subtract line 31 from line 30. Enter the portion from casualty or theft on Form 4684, line 33. Enter the portion from other than casualty or theft on Form 4797, line 6	32	

Part IV **Recapture Amounts Under Sections 179 and 280F(b)(2) When Business Use Drops to 50% or Less** (see instructions)

		(a) Section 179	(b) Section 280F(b)(2)
33 Section 179 expense deduction or depreciation allowable in prior years	33		
34 Recomputed depreciation (see instructions)	34		
35 Recapture amount. Subtract line 34 from line 33. See the instructions for where to report	35		

Description	Date Acquired	Date Sold	Gross Sales Price	Depreciation Allowed or Allowable	Cost or Other Basis	Gain or (Loss) for entire year
PROPERTY			47,142.			47,142.
Totals						47,142.

Form **990-T**

Department of the Treasury
Internal Revenue Service

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

For calendar year 2011 or other tax year beginning 07/01, 2011, and ending 06/30, 2012.

▶ See separate instructions.

OMB No. 1545-0687

2011

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

A [ ] Check box if address changed

B Exempt under section
[X] 501(C)(3)
[ ] 408(e) [ ] 220(e)
[ ] 408A [ ] 530(a)
[ ] 529(a)

C Book value of all assets at end of year
85,601,952.

Print or Type

Name of organization ([ ] Check box if name changed and see instructions.)
ATLANTIC GENERAL HOSPITAL

Number, street, and room or suite no. If a P.O. box, see instructions.
9733 HEALTHWAY DRIVE

City or town, state, and ZIP code
BERLIN, MD 21811

D **Employer identification number** (Employees' trust, see instructions.)
52-1656507

E **Unrelated business activity codes** (See instructions.)
621110

F Group exemption number (See instructions.) ▶

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

H Describe the organization's primary unrelated business activity. ▶ PHYSICIAN BILLING SERVICES

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ [ ] Yes [X] No

If "Yes," enter the name and identifying number of the parent corporation. ▶

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

Part I Unrelated Trade or Business Income		(A) Income	(B) Expenses	(C) Net
1a Gross receipts or sales 191,572. b Less returns and allowances c Balance ▶	1c	191,572.		
2 Cost of goods sold (Schedule A, line 7)	2			
3 Gross profit. Subtract line 2 from line 1c	3	191,572.		191,572.
4a Capital gain net income (attach Schedule D)	4a			
b Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b			
c Capital loss deduction for trusts	4c			
5 Income (loss) from partnerships and S corporations (attach statement)	5			
6 Rent income (Schedule C)	6			
7 Unrelated debt-financed income (Schedule E)	7			
8 Interest, annuities, royalties, and rents from controlled organizations (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	191,572.		191,572.

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	85,179.
16 Repairs and maintenance			16	4,533.
17 Bad debts			17	
18 Interest (attach schedule)			18	
19 Taxes and licenses			19	5,813.
20 Charitable contributions (See instructions for limitation rules.)			20	
21 Depreciation (attach Form 4562)	21	596.		
22 Less depreciation claimed on Schedule A and elsewhere on return	22a		22b	596.
23 Depletion			23	
24 Contributions to deferred compensation plans			24	
25 Employee benefit programs			25	9,870.
26 Excess exempt expenses (Schedule I)			26	
27 Excess readership costs (Schedule J)			27	
28 Other deductions (attach schedule) ATTACHMENT 1			28	37,938.
29 **Total deductions.** Add lines 14 through 28			29	143,929.
30 Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13			30	47,643.
31 Net operating loss deduction (limited to the amount on line 30)			31	46,643.
32 Unrelated business taxable income before specific deduction. Subtract line 31 from line 30			32	1,000.
33 Specific deduction (Generally $1,000, but see line 33 instructions for exceptions.)			33	1,000.
34 **Unrelated business taxable income.** Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32			34	

Part III Tax Computation

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

Part IV Tax and Payments

40 a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	40a			
b	Other credits (see instructions)	40b			
c	General business credit. Attach Form 3800 (see instructions)	40c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	40d			
e	**Total credits.** Add lines 40a through 40d			40e	
41	Subtract line 40e from line 39			41	
42	Other taxes. Check if from: ☐ Form 4255 ☐ Form 8611 ☐ Form 8697 ☐ Form 8866 ☐ Other (attach schedule)			42	
43	**Total tax.** Add lines 41 and 42			43	0
44 a	Payments: A 2010 overpayment credited to 2011	44a			
b	2011 estimated tax payments	44b			
c	Tax deposited with Form 8868	44c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	44d			
e	Backup withholding (see instructions)	44e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	44f			
g	Other credits and payments: ☐ Form 2439 _____ ☐ Form 4136 _____ ☐ Other _____ Total ▶	44g			
45	**Total payments.** Add lines 44a through 44g			45	
46	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐			46	
47	**Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ▶			47	
48	**Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ▶			48	
49	Enter the amount of line 48 you want: **Credited to 2012 estimated tax** ▶ **Refunded** ▶			49	

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

		Yes	No
1	At any time during the 2011 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here ▶ _____		X
2	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If YES, see instructions for other forms the organization may have to file.		X
3	Enter the amount of tax-exempt interest received or accrued during the tax year ▶ $		

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

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					
4 a	Additional section 263A costs (attach schedule)	4a		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes:	No: X
b	Other costs (attach schedule)	4b					
5	**Total.** Add lines 1 through 4b	5					

Sign Here

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 | Date | Title

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

Paid Preparer Use Only

Print/Type preparer's name: TINA C ECKLOFF	Preparer's signature	Date: 05/13/2013	Check ☐ if self-employed; PTIN: P01074058
Firm's name ▶ COHEN, RUTHERFORD + KNIGHT, PC			Firm's EIN ▶ 52-1202280
Firm's address ▶ 6903 ROCKLEDGE DRIVE, SUITE 500 BETHESDA, MD 20817-1800			Phone no. 301-828-1008

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		Total	

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

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

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

	1. Description of debt-financed property	**2.** Gross income from or allocable to debt-financed property	**3.** Deductions directly connected with or allocable to debt-financed property	
			(a) Straight line depreciation (attach schedule)	**(b)** Other deductions (attach schedule)
(1)				
(2)				
(3)				
(4)				

	4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	**5.** Average adjusted basis of or allocable to debt-financed property (attach schedule)	**6.** Column 4 divided by column 5	**7.** Gross income reportable (column 2 x column 6)	**8.** Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)			%		
(2)			%		
(3)			%		
(4)			%		
				Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).

Totals . . . . . ▶

Total dividends-received deductions included in column 8 . . . . . ▶

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 . . . . . ▶

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

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

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

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

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)) ▶						

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)						
(5) Totals from Part I						
Totals, Part II (lines 1-5) ▶	Enter here and on page 1, Part I, line 11, col. (A).	Enter here and on page 1, Part I line 11, col. (B).				Enter here and on page 1, Part II, line 27.

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 ▶			

ATTACHMENT 1

FORM 990T - PART II - LINE 28 - TOTAL OTHER DEDUCTIONS

LEASE RENTALS	5,948.
OTHER	1,464.
PURCHASED SERVICES	24,091.
SUPPLIES	2,236.
UTILITIES	4,199.
PART II - LINE 28 - OTHER DEDUCTIONS	37,938.