### **Return of Organization Exempt From Income Tax**

Department of the Treasury Internal Revenue Service

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

Do not enter Social Security numbers on this form as it may be made public.

▶ Information about Form 990 and its instructions is at www.irs.gov/form990.

16 Open to Public

Inspection

Form **990** (2016)

OMB No. 1545-0047

A	For t	he 201	6 calendar year, or tax year beg	ginning 07	/01 <b>,201</b> 6	6, and endir	ng		0 (	6/30 <b>,20</b> <sub>17</sub>	7					
_			C Name of organization					D Employer	identif	ication number						
В	Check if a	applicable:	THE UNION MEMORIAL H	OSPITAL												
	Add char		Doing Business As MEDSTAR UN	NION MEMORIAL HOS	SPITAL			52-059	9168	5						
	_	e change	Number and street (or P.O. box if mail	is not delivered to street addres	ss)	Room/suite		E Telephone	numbe	er						
	Initia	if return	201 EAST UNIVERSITY	PARKWAY				(410) 772-6721								
	Terr	ninated	City or town, state or province, country		e											
	Ame	nded	BALTIMORE, MD 21218					G Gross rece	iots \$	463,02	9 985					
	retu	ication	F Name and address of principal officer:	BRADLEY CHAMI	BERS			H(a) Is this a g								
ш.	pend	iing	201 EAST UNIVERSITY			1218		subordinat H(b) Are all subo			ļ					
<del></del>	Tax-e	kempt sta			4947(a)(1)		7			st. (see instructions)						
J			WWW.UNIONMEMORIAL.ORG	. ) <b>(</b> (macremo.)	4347 (a)(1)	01   32		H(c) Group exe								
K			ization: X Corporation Trust	Association Other		I Voor o				e of legal domicil	e: MD					
	art I		mmary	Association Other		L rear 0	Tomati	OII. 1034 IV	1 State	s or legal domicil	e. MD					
	1		describe the organization's mission	or most significant setivities	TO BE	7 COMDD	CUCNO	STME HOG	יייי ד כו	עייי דע דע						
a	-								L T 1 F	7T MTTU						
ŭ	REGIONAL SPECIALTY SERVICES OF DISTINCTION AND QUALITY COMMUNITY															
i.	REGIONAL SPECIALTY SERVICES OF DISTINCTION AND QUALITY COMMUNITY  SERVICES, ALL ENHANCED BY CLINICAL EDUCATION & RESEARCH.  Check this box  if the organization discontinued its operations or disposed of more than 25% of its net assets.  Number of voting members of the governing body (Part VI, line 1a) 3															
Š	2		Check this box  if the organization discontinued its operations or disposed of more than 25% of its net assets.  Number of voting members of the governing body (Part VI, line 1a)													
প্র	1 .	Numb	er of voting members of the government	ng body (Part VI, line 1a)		• • • • • •					24.					
es	4	Numb	er of independent voting members of	the governing body (Part	VI, line 1b)				4		15.					
Activities &	5	l otal r	number of individuals employed in ca	alendar year 2016 (Part V, li	ne 2a)				5	2	2,595.					
ć	6	l otal r	number of volunteers (estimate if nece	essary)					6		130.					
	/a	lotali	unrelated business revenue from Part		7a		52,691									
	b	Net un	related business taxable income fron	n Form 990-T, line 34	· · · · · ·	<u> </u>	<del></del>		7b		1,742					
								Prior Year		Current						
ne	8	Contri	butions and grants (Part VIII, line 1h).		COP	Y FOR		2,582,7			7,904					
Revenue	9	Progra	am service revenue (Part VIII, line 2g)		PUBLIC II	USPECTION	4:	37 <b>,</b> 142 <b>,</b> 5		456,49						
Re	10	mvesu	ment income (Fart VIII, column (A), iii	nies 3, 4, and 70)				987 <b>,</b> 9			1,149					
	11		revenue (Part VIII, column (A), lines !					4,045,3		1,39	3,625					
	12		evenue - add lines 8 through 11 (mu				4	44 <b>,</b> 758 <b>,</b> 5	07.	463,02	9,985					
	13		s and similar amounts paid (Part IX, co				0.		0							
	14	Benefi	ts paid to or for members (Part IX, col			0.		0								
es	15	Salarie	es, other compensation, employee be	nefits (Part IX, column (A),	lines 5-10).		20	01,507,2	46.	223,38	0,418					
sua	16a	Profes	sional fundraising fees (Part IX, colum	nn (A), line 11e)					0.		0					
Expenses	b		undraising expenses (Part IX, column													
ш	17		expenses (Part IX, column (A), lines 1		34 <b>,</b> 758 <b>,</b> 2		224,40	4,364								
	18	Total e	expenses. Add lines 13-17 (must equa	al Part IX, column (A), line 2	25)		43	36,265,4	70.	447,78	4,782					
	19	Reven	ue less expenses. Subtract line 18 fro	om line 12				8,493,0	37.	15,24	5,203					
s or							Beginn	ing of Current	Year	End of Ye	ar					
Net Assets Fund Balanc	20	Total a	assets (Part X, line 16)				20	02,424,7	90.	200,73	9,664					
t As	21	Total li	abilities (Part X, line 26)				Į.	59,269,6	27.	57,00	6,308					
S.F.	22	Net as	sets or fund balances. Subtract line 2	21 from line 20			14	43,155,1	63.	143,73	3,356					
Pa			nature Block													
Und	der per	nalties of	f perjury, I declare that I have examined to complete. Declaration of preparer (other that	this return, including accompa	anying schedu	iles and statem	nents, an	d to the best o	of my l	knowledge and b	pelief, it is					
	, 00110	Ct, and c	John place: Cother the	an onicer) is based on an imon	nation of with	cii piepaiei iia	s arry Krit	Jwieuge.	<del>, ,</del>							
O:		<b>.</b>	lat Bry					5/	10/	18						
Sig		<b>7</b> 8	Signature of officer					Date								
Hei	е	_	JOEL BRYAN		VP/TRE	EASURER										
			Type or print name and title													
De!		Print/T	ype preparer's name	Preparer's signature		Date		Check	if F	PTIN						
Paid		JG W	HITE	1 2 Hut	ı	05/09	/201	8 self-emplo	yed	P01498698	3					
	oarer Only	Firm's	name ▶ KPMG LLP	ı	Firm's EIN ▶ 13-5565207											
Jae	Unity	Firm's	address ▶ 1676 INTERNATIO	NAL DRIVE, MCLEA	N, VA 2	2102		Phone no.	703	-286-8000	)					
Mav	the II	RS disc	cuss this return with the preparer show							X Yes	No					

JSA 6E1065 1.000 32068H 2502

For Paperwork Reduction Act Notice, see the separate instructions.

### Form **8868**

(Rev. January 2017)

Department of the Treasury Internal Revenue Service

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

► File a separate application for each return.
► Information about Form 8868 and its instructions is at www.irs.gov/form8868.

OMB No. 1545-1709

Electronic filing (e-file). You can electronically file Form 8868 to request a 6-month automatic extension of time to file any of the forms listed below with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, for which an extension request must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit www.irs.gov/efile, click on Charities & Non-Profits, and click on e-file for Charities and Non-Profits.

File by the due date for filling your return. See instructions.  Enter the Return Code for the return that this application is for (file a separate application for each return)	Automotio	6 Month Extension of Time Only subm	it original	(no conjes needed)								
Name of exempt organization or other filer, see instructions.   Employer identification number, see instructions   Employer identification number (EIN) or print   THE UNION MEMORIAL HOSPITAL   52-0591685   Number, steret, and room or suite no. If a P.O. box see instructions.   Social security number (SSN)   University PARKWAY   City, town or post office, state, and ZIP code. For a foreign address, see instructions.   BALTIMORE, MD 21218   Enter the Return Code for the return that this application is for (file a separate application for each return)   Of I					are) nartnershins	REI	AICs :	and truete				
Type or print Title UNION MEMORIAL HOSPITAL, Number, street, and room or suite no. If a P.O. box, see instructions.  THE UNION MEMORIAL HOSPITAL, Number, street, and room or suite no. If a P.O. box, see instructions.  Social security number (SSN)  201 EAST UNIVERSITY PARKWAY  C101, bown or post office, state, and ZIP code. For a foreign address, see instructions.  BALTIMORE, MD 21218  Enter the Return Code for the return that this application is for (file a separate application for each return).  Application Is For Code SFORM 990 or Form 990-EZ  01 Form 990-T (corporation)  07 Form 990-BL  02 Form 1720 (individual)  03 Form 4720 (individual)  03 Form 4720 (individual)  05 Form 990-T (sec. 401(a) or 408(a) trust)  06 Form 990-T (sec. 401(a) or 408(a) trust)  07 Form 990-T (trust other than above)  08 Form 890-T (sec. 401(a) or 408(a) trust)  09 Form 990-T (sec. 401(a) or 408(a) trust)  10 Form 990-T (sec. 401(a) or 408(a) trust)  10 Form 990-T (sec. 401(a) or 408(a) trust)  11 Form 990-T (sec. 401(a) or 408(a) trust)  11 Form 990-T (sec. 401(a) or 408(a) trust)  12 Form 990-T (sec. 401(a) or 408(a) trust)  13 Form 990-T (sec. 401(a) or 408(a) trust)  14 Form 990-T (sec. 401(a) or 408(a) trust)  15 Form 990-T (sec. 401(a) or 408(a) trust)  16 Form 990-T (sec. 401(a) or 408(a) trust)  17 Form 990-T (sec. 401(a) or 408(a) trust)  18 Form 990-T (sec. 401(a) or 408(a) trust)  19 Form 990-T (sec. 401(a) or 408(a) trust)  10 Form 990-T (sec. 401	•	•			ers), partilerships,	111	VIIO3, 6	and truste				
Name of exempt organization or other filer, see instructions.    Employer identification number (EIN) or THE UNION MEMORIAL HOSPITAL	must use i t	of the to request an extension of time to r	ne meome	tax returns.	Enter filer's identifyin	a nur	nher s	e instructi	ons			
THE UNION MEMORIAL HOSPITAL THE UNION MEMORIAL HOSPITAL THE UNION MEMORIAL HOSPITAL THE UNION MEMORIAL HOSPITAL  Social security number (SSN)  201 EAST UNIVERSITY PARKWAY  COLUMBRITY PARKWAY  Telephone No. ► 410 772-6721 FAX No. ►  If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return enter the organization's return for the organization does not have an office or parket the difference of the group of the group of the group		Name of exempt organization or other filer, see in	structions.	Emple								
THE UNION MEMORIAL HOSPITAL  THE UNION MEMORIAL HOSPITAL  Number, street, and room or suite no. If a P.O. box, see instructions.  201 EAST UNIVERSITY PARKWAY  City, town or post office, state, and ZIP code. For a foreign address, see instructions.  BALTIMORE, MD 21218  Enter the Return Code for the return that this application is for (file a separate application for each return).  O 1  Application  Form 990 or Form 990 return	Type or	Traine of exempt organization of other mer, esemin		Empi	by critication na	moci	(=114)	0.				
File by the date of the filling your control of the property	print	THE INTON MEMORIAL HOSPITAL			52-0591689	5						
due date freture. Second process. The park way continuous continuous continuous. Second process. Second proce	File by the		x see instru	ctions								
Enter the Return Code for the return that this application is for (file a separate application for each return)	due date for		x, 000 mon a	Sucre.	i security number (Sc	) ( PIC						
Enter the Return Code for the return that this application is for (file a separate application for each return).    Application   Return   Code		· ·	a foreign ag	dress see instructions								
Application   Return   Application   Return   Application   Return   Code   Separate application   Return   Code   Separate   Application   Return   Code   Separate   Application   Applicatio	instructions.	tions I										
Application Is For Code Form 990 or Form 990-EZ O1 Form 990-T (corporation) O7 Form 990-BL O2 Form 1041-A O8 Form 4720 (individual) O3 Form 4720 (other than individual) O4 Form 590-F O7 Form 990-F O7 Form 990-T (sec. 401(a) or 408(a) trust) O5 Form 6069 O6 Form 8870 O6 Form 8970 O7 Tole BRYAN  Telephone No. ► 410 772-6721 Fax No. ► If the organization does not have an office or place of business in the United States, check this box If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) Of the whole group, check this box I request an automatic 6-month extension of time until												
Series	Enter the Re	eturn Code for the return that this application	is for (file	a separate application for eac	h return)			. [ 0 ]				
Form 990 or Form 990-EZ  O1 Form 990-T (corporation)  O7 Form 990-B.  O2 Form 1041-A  O8 Form 4720 (individual)  O9 Form 990-PF  O4 Form 5227  O10 Form 990-T (rust other than individual)  O9 Form 990-T (sec. 401(a) or 408(a) trust)  O5 Form 6069  O6 Form 8870  O12  OOE FORM 8870  O12  OOE FORM 890-T (trust other than above)  O6 Form 8870  O12  OOE FORM 890-T (trust other than above)  O6 Form 8870  O12  OOE FORM 8870  O12  OOE FORM 8870  O14  Telephone No. ► 410 772-6721  Fax No. ►  If the organization does not have an office or place of business in the United States, check this box  If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN)  If this is for the whole group, check this box  If this is for the whole group, check this box  If this is a list with the names and EINs of all members the extension is for.  I request an automatic 6-month extension of time until  O5/15, 20 18, to file the exempt organization return for the organization named above. The extension is for the organization's return for:  □ Calendar year 20 or  □ X tax year beginning or 07/01, 20 16, and ending 06/30, 20 17.  If the tax year entered in line 1 is for less than 12 months, check reason: □ Initial return □ Final return  □ Change in accounting period  If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.  If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.  Oce Blance due, Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	Application		Return	Application				Retur	1			
Form 990-BL 02 Form 1041-A 08 Form 4720 (individual) 03 Form 4720 (other than individual) 09 Form 990-PF 04 Form 5227 10 Form 990-T (sec. 401(a) or 408(a) trust) 05 Form 6069 11 Form 990-T (trust other than above) 06 Form 8870 12  JOEL BRYAN 120	Is For		Code	Is For				Code				
Form 4720 (individual)  O3 Form 4720 (other than individual)  O9 Form 990-PF  O4 Form 5227  10 Form 990-T (sec. 401(a) or 408(a) trust)  O5 Form 6069  11 Form 990-T (trust other than above)  O6 Form 8870  12  JOEL BRYAN  Telephone No. ▶ _410_772-6721  Fax No. ▶  If the organization does not have an office or place of business in the United States, check this box  If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN)  If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN)  If this is for the whole group, check this box  If it is for part of the group, check this box  If the organization named and EINs of all members the extension is for.  I request an automatic 6-month extension of time until	Form 990 o	Form 990-EZ	01	Form 990-T (corporation)				07				
Form 990-PF	Form 990-B		02	Form 1041-A				08				
Form 990-T (sec. 401(a) or 408(a) trust)    Form 990-T (trust other than above)   06   Form 8870   12	Form 4720	(individual)	03	Form 4720 (other than indi	vidual)			09				
Form 990-T (trust other than above)    The books are in the care of   10980 GRANTCHESTER WAY COLUMBIA MD 21044	Form 990-PI		04	Form 5227				10				
The books are in the care of ▶ 10980 GRANTCHESTER WAY COLUMBIA MD 21044  Telephone No. ▶ 410 772-6721 Fax No. ▶  If the organization does not have an office or place of business in the United States, check this box ▶  If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) If this is for the whole group, check this box ▶	Form 990-T	(sec. 401(a) or 408(a) trust)	05	Form 6069				11				
Telephone No. ►410772_6721	Form 990-T	(trust other than above)	06	Form 8870				12				
If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.  Bif this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.  Balance due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.  Caution. If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.	<ul> <li>If the orga</li> <li>If this is for the whole a list with the for the for the for the for the formula.</li> </ul>	anization does not have an office or place of lor a Group Return, enter the organization's for a group, check this box \bigsim It a names and EINs of all members the extensionst an automatic 6-month extension of time unorganization named above. The extension is calendar year 20 or tax year beginning 07/0	business ir digit Grown digit	the United States, check this pup Exemption Number (GEN) art of the group, check this bound of the group of the gro	to file the exempt	org.	. If thand at	nis is tach	_			
nonrefundable credits. See instructions.  b If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.  c Balance due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.  3c \$ 0.  Caution. If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.	C	hange in accounting period										
b If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.  c Balance due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.  3c \$ 0.  Caution. If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.									0.			
estimated tax payments made. Include any prior year overpayment allowed as a credit.  balance due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.  caution. If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.			4720 0	6069 enter any refunda	ble credits and	Ja	<u> </u>		-			
c Balance due. Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.  3c \$ 0.  Caution. If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.		• •		·	i	3h	\$		0.			
(Electronic Federal Tax Payment System). See instructions.  Caution. If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.						20	*		<u></u>			
Caution. If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.				ent with the form, it required		30	ŧ		Ω			
nstructions.				t) with this Form 8868, see Form					_			
		a are going to make an electronic funds withdrawar	(allect deb	ty with this rottle occo, see rottl	, 5-55-LO and t om	501	C ()	or paymer	•			
		ct and Panerwork Reduction Act Notice see instr	uctions			Form	8868	(Rev. 1-20	17)			

1793311

		Page 2
P	art III Statement of Program Service Accomplishments	
_	Check if Schedule O contains a response or note to any line in this Part III	X
1	Briefly describe the organization's mission: ATTACHMENT 1	
	ATTACHMENT I	
2	Did the organization undertake any significant program services during the year which were not listed on the	
		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	_
		∐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 measure expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to o	
	the total expenses, and revenue, if any, for each program service reported.	meis
	in tetar expenses, and revenue, it any, for each program early to reported.	
42	a (Code:) (Expenses \$ 341,222,049. including grants of \$ ) (Revenue \$ 453,066,975. )	
74	ATTACHMENT 2	
	ATTACHMENT 2	
	o (Code:) (Expenses \$17,141,419. including grants of \$) (Revenue \$146,650. )	
	MEDSTAR UNION MEMORIAL PROVIDED \$17.1M IN HEALTH PROFESSIONS	
	EDUCATION IN FISCAL YEAR 2017. THIS CATEGORY INCLUDES TRAINING IN	
	GRADUATE MEDICAL EDUCATION, EDUCATION FOR PHYSICIANS, MEDICAL	
	STUDENTS, NURSES, AND OTHER HEALTH PROFESSIONS.	
4c	(Code: ) (Expenses \$ 6,152,041. including grants of \$ ) (Revenue \$ 2,903,100. )	
	MEDSTAR UNION MEMORIAL PROVIDED \$6.1M IN SUBSIDIZED (MISSION	
	DRIVEN) HEALTH SERVICES IN FISCAL YEAR 2017. THESE CRITICAL	
	SERVICES, WHICH ARE DRIVEN BY COMMUNITY NEEDS, OPERATE AT A LOSS.	
	THEY ADDRESS PRIORITIES PRIMARILY THROUGH DISEASE PREVENTION AND	
	IMPROVEMENT OF HEALTH STATUS. SERVICES PROVIDED INCLUDE	
	HOSPITALISTS, AND WOMEN'S AND CHILDREN'S SERVICES.	
	Other program services (Describe in Schedule O.)	
	(Expenses \$ including grants of \$ ) (Revenue \$ )	
4e	Total program service expenses ▶ 364,515,509.	

Form 990 (2016)
Part IV Checklist of Required Schedules

Fall	Checklist of Required Schedules		Т.,	T
		Γ	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	ļ	X
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h)			l
	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	ļ	X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors			
	have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If			
	"Yes," complete Schedule D, Part I	6	ļ	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, for escrow or custodial account liability, serve as a			
	custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or			
	debt negotiation services? 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		Х
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.			
а	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	Х	
С	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		Х
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		Х
е	Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	11e	Х	
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 and XII.	12a		Х
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 and XII is optional.	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13		Χ
	Did the organization maintain an office, employees, or agents outside of the United States?	14a		Х
	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		Х
15	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or			
	for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	15		Х
16	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other			
. •	assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	16		Х
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		Х
18	Did the organization report more than \$15,000 total of fundraising event gross income and contributions on	H		
	Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	18		Х
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		Х
	100, complete contents of a trim.	<u>.                                  </u>	L	

Checklist of Required Schedules (continued)

Part IV

#### Yes No Χ 20a Χ b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?..... 20b 21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II . . . . . . . . . . Χ 21 22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on 22 Χ 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 23 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 Χ 24a b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?..... 24b Did the organization maintain an escrow account other than a refunding escrow at any time during the year 24c d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . . 25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit Χ 25a 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? 25b Χ 26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or Χ 26 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, 27 substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled Χ entity or family member of any of these persons? If "Yes," complete Schedule L, Part III........... 27 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 current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV . . . . . . . A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Χ 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 Χ Χ 29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M. . . . 29 30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified 30 Χ 31 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N. 31 Χ 32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," Χ 33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations Χ 33 34 Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, X 34 Χ Did the organization have a controlled entity within the meaning of section 512(b)(13)?.......... If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2 . . . . . Χ 35b 36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable 36 Χ 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, 37 Χ 38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O.

Page 5 Form 990 (2016)

Par	Statements Regarding Other IRS Filings and Tax Compliance			
	Check if Schedule O contains a response or note to any line in this Part V			<del>:</del>
			Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable			
	Enter the humber of Forms vv-28 included in line 1a. Enter -0- in not applicable,			
С	Did the organization comply with backup withholding rules for reportable payments to vendors and	1c	Х	
	reportable gaming (gambling) winnings to prize winners?	- 10	- 23	
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  2,595			
h	Statements, filed for the calendar year ending with or within the year covered by this return $2a = 2,595$ If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b	Х	
D	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			
3 2	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	Х	\$104500000000000000000000000000000000000
	If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation in Schedule O.</i>	3b	X	
	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 FinCEN Form 114, Report of Foreign Bank and Financial Accounts			
	(FBAR).			
5а	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		X
	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b		X
	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			37
	organization solicit any contributions that were not tax deductible as charitable contributions?	6a		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or	e h		
_	gifts were not tax deductible?	6b		
	Organizations that may receive deductible contributions under section 170(c).			
а	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods	7a	9,000,000	Х
h	and services provided to the payor?	7b		
	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was			
٠	required to file Form 8282?	7c		X
d	If "Yes," indicate the number of Forms 8282 filed during the year			
	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e		Х
	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f		X
	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. Did a donor advised fund maintained by the			
	sponsoring organization have excess business holdings at any time during the year?	8	KE9492565	
9	Sponsoring organizations maintaining donor advised funds.	_		
	Did the sponsoring organization make any taxable distributions under section 4966?	9a		
	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b		
	Section 501(c)(7) organizations. Enter: Initiation fees and capital contributions included on Part VIII, line 12			
	militation rees and capital contributions moladed on a dr. vin, into 12 1111111111111111111111111111111111			
	Cross receipts, included on Form 550, Fart VIII, III.6 12, 161 public doc of olds facilities.			
	Section 501(c)(12) organizations. Enter:  Gross income from members or shareholders			
	Gross income from members or shareholders			
b	against amounts due or received from them.)			
12 a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a		
	If "Yes," enter the amount of tax-exempt interest received or accrued during the year			
	Section 501(c)(29) qualified nonprofit health insurance issuers.			
	Is the organization licensed to issue qualified health plans in more than one state?	13a	- Name of the last	and a facility of the second
	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			
	Enter the amount of reserves on hand			•••
	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		

Form 990 (2016) THE UNION MEMORIAL HOSPITAL 52-0591685 Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions. 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. b Enter the number of voting members included in line 1a, above, who are independent . . . . . Did any officer, director, trustee, or key employee have a family relationship or a business relationship with 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? . . Χ 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?..... 5 X 5 Did the organization become aware during the year of a significant diversion of the organization's assets?.... Χ 6 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint Χ 7a b Are any governance decisions of the organization reserved to (or subject to approval by) members, 7b Х Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: 8a Χ Χ 8b 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 . . . . . . . . . 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		Х
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	Χ	
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	Х	
С	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes,"			
•	describe in Schedule O how this was done	12c	Х	
13	Did the organization have a written whistleblower policy?	13	Х	
14	· · · · · · · · · · · · · · · · · · ·	14	X	<u> </u>
	Did the organization have a written document retention and destruction policy?	• •		
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?	4.5	37	
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	Χ	100000000000000000000000000000000000000
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	Χ	

#### Section C. Disclosure List the states with which a copy of this Form 990 is required to be filed ►MD.

	2.01 1.10 010100	***************************************	a 00p) 01 time		.o roquirou	to be mear	
10	Section 6104	roquiree an	organization	to make ite	Forme 100	22 /05 1024	if applied

10	Section 6 104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-1 (Section 501(c)(3)s only
	available for public inspection. Indicate how you made these available. Check all that apply.
	Own website Another's website X Upon request Other (explain in Schedule O)

	Own website		Another's website	X	Upon request		Other (explain in Schedul	e O
--	-------------	--	-------------------	---	--------------	--	---------------------------	-----

State the name, address, and telephone number of the person who possesses the organization's books and records: 20 JOEL BRYAN 10980 GRANTCHESTER WAY COLUMBIA, MD 21044

Form 990 (2016)

6E1042 1.000

JSA

<sup>19</sup> 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.

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

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

#### Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

- 1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.
- List all of the organization's current officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
  - List all of the organization's current key employees, if any. See instructions for definition of "key employee."
- List the organization's five current highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's former officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's former directors or trustees that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

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

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

(A) Name and Title	(B) Average hours per week (list any	box,	unle	Pos heck ss pe	erson	e than o	an	(D) Reportable compensation from	(E) Reportable compensation from related	(F) Estimated amount of other
	hours for related organizations below dotted line)	1 4 5	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	the organization (W-2/1099-MISC)	organizations (W-2/1099-MISC)	compensation from the organization and related organizations
(1)PETER J. SLOANE, M.D.	20.00									
DIRECTOR	20.00	Х						50,045.	0.	4,324.
(2)MICHAEL FIOCCO, M.D.	40.00	25	-	-			-	30,013.		1,021.
DIRECTOR	0.	X						727,293.	0.	14,989.
(3)CYNTHIA WEBB, M.D.	1.00	22					<del>                                     </del>	,2,,233.		21,303.
DIRECTOR	39.00	x						0.	498,107.	32,738.
(4)P. JUSTIN TORTOLANI, M.D.	40.00	21					<u> </u>	0.	130/101.	327.30.
DIRECTOR	0.	Х						1,042,737.	0.	23,100.
(5)CHRISTOPHER D. KEARNEY, M.D.	40.00					ļ		2,010,1011	5.	
DIRECTOR	0.	X						154,396.	146,768.	12,649.
(6)DAVID NASRALLAH, M.D.	40.00									
DIRECTOR	0.	X						363,002.	0.	40,406.
(7)MICHAEL RANDOLPH, M.D.	1.00							•		
DIRECTOR	0.	Х						0.	0.	0.
(8)KENNETH A. SAMET	1.00									
DIRECTOR	39.00	Х						0.	7,675,042.	76,815.
(9)BRADLEY S. CHAMBERS	20.00							· ·		
PRESIDENT/DIRECTOR	20.00	Х		Х				559,724.	559,725.	42,754.
(10)DAVID NORRIS WILLIS	1.00									
DIRECTOR	0.	Х						0.	0.	0.
(11)EBEN D. FINNEY, III	1.00									
DIRECTOR	0.	Х						0.	0.	0.
(12)DERRICK A. ADAMS	1.00									
DIRECTOR	0.	Х						0.	0.	0.
(13)EILEEN AUEN	1.00									
DIRECTOR	0.	Х						0.	0.	0.
(14)NATHAN J. BIEL	1.00									
DIRECTOR	0.	Х						0.	0.	0.

JSA 6E1041 1.000

Form **990** (2016)

V 16-7.17 PAGE 8 32068H 2502 1793311

Part VII Section A. Officers, Directors,	1	y En	plo		, and	HIÇ			
(A) Name and title	(B)  Average hours per week (list any hours for	box,	not ch unles: r and	s pers a dir	ore thar on is bo ector/tru	th an stee)	(D)  Reportable compensation from the	(E)  Reportable compensation from related organizations	(F) Estimated amount o other compensati
	related organizations below dotted line)	Individual trustee or director	Institutional trustee	Officer	employee  Key employee	Former	organization (W-2/1099-MISC)	(W-2/1099-MISC	from the organizatic and related organization
) SAVAS J. KARAS CHAIR	1.00	Х					0.	0	•
) NANCY PERRY DIRECTOR	1.00	Х					0.	0	
) JOHN A. WOLF DIRECTOR	1.00	Х					0.	. 0	
) CHRISTOPHER G. WUNDER DIRECTOR	1.00	Х					0.	0	•
) WILLIAM F. RIENHOFF, IV DIRECTOR	1.00	Х					0.	0	
) PETER R. FENWICK DIRECTOR	1.00	Х					0.	0	
DAWN M. MOTOVIDLAK VICE CHAIR	1.00	Х					0.	0	•
JAMES R. PAQUETTE DIRECTOR	1.00	Х					0.	0	•
CHRISTOPHER P. GIBSON DIRECTOR (AS OF 11/2016)	1.00	Х					0.	0	•
) JEFFREY R. ELKIN DIRECTOR (AS OF 11/2016)	1.00	Х					0.	0	•
DEANA STOUT CHIEF FINANCIAL OFFICER	20.00			Х			207,095.	207,095	. 38,9
Sub-total	Section A					<b>&gt;</b>	2,897,197. 7,087,504.	8,879,642 504,096	. 247,
Total (add lines 1b and 1c)	ot limited to th ion ▶	1 <b>0se I</b> 270	isted	abo	ve) wł	io re			Yes
Did the organization list any former of employee on line 1a? If "Yes," complete Sche For any individual listed on line 1a, is the organization and related organizations individual	edule J for suc sum of rep greater than	<i>h indi</i> ortab \$15	<i>vidua</i> e co 0,00	al . ompe 0?	nsations	 on a s,"	nd other compens	ation from the	3 X
Did any person listed on line 1a receive of for services rendered to the organization? If	or accrue cor	npens	atio	n fro	m an	y un	related organization	n or individual	5
Complete this table for your five highest co compensation from the organization. Repor year.									
(A) Name and business a	address						(B) Description of ser	rvices	(C) Compensation
ITACHMENT 3									
Total number of independent contractors									

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)										
(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	officer and a director/t					an	(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation fron related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
	,	rustee	l trustee		/ee	Highest compensated employee				
( 26) STEPHEN KOENIGSBERG	20.00	-1						124 006	124 006	22 342
VICE PRESIDENT ( 27) SHARON BOTTCHER	20.00				Х			124,086.	124,086	. 22,342.
VICE PRESIDENT	20.00	-			Х			172,915.	172,915	15,647.
( 28) FRANK EBERT, M.D.	40.00	<del> </del>								
PHYSICIAN	0.					Х		1,305,950.	0	. 21,766.
( 29) HENRY BOUCHER, M.D.	40.00									
PHYSICIAN	0.					X		1,117,584.	0	. 23,784.
( 30) ANAND MURTHI, M.D.	40.00							1 110 100		22 002
MEDICAL DIRECTOR	0.					X	<u> </u>	1,110,136.	0	23,003.
( 31) JOHN WANG  CHIEF OF CARDIAC CATH LAB	40.00					X		995,417.	0	. 23,049.
( 32) RICHARD LEVINE	40.00					21		333,417.		23,013.
PHYSICIAN	1 0.					Х		966,519.	0	. 23,071.
(33) JOSEPH SMITH	40.00							· · · · · · · · · · · · · · · · · · ·		
FORMER OFFICER	0.						Χ.	164,996.	0	. 0.
( 34) STUART BELL	40.00									
FORMER OFFICER	0.						Х	693,343.	0	. 22,360.
( 35) CHERYL LUNNEN	40.00	-					X	229,463.	0	. 19,604.
FORMER KEY EMPLOYEE	0.						^	229,403.	0	10,004.
	<del> </del>	1								
1b Sub-total							<b></b>			
c Total from continuation sheets to Part VII, S										
d Total (add lines 1b and 1c)							<b>&gt;</b>	L	0100 000 1	
2 Total number of individuals (including but not reportable compensation from the organizatio		hose i 270		d ai	OOV	e) who	o re	ceived more than	\$100,000 of	
Teportable compensation from the organization		270								Yes No
3 Did the organization list any former office	er directo	or or	tru	iste	e	kev e	mn	lovee or highest	compensated	
employee on line 1a? If "Yes," complete Sched										3 X
4 For any individual listed on line 1a, is the	sum of rec	ortab	le c	om	pen	satio	n ai	nd other compens	sation from the	
organization and related organizations gr	eater than	\$15	0,0	00?	lf	"Yes	i," (	complete Schedu	le J for such	
individual										4 X
5 Did any person listed on line 1a receive or										5 X
for services rendered to the organization? If "Y Section B. Independent Contractors	es, comple	ie Scri	eau	ie J	101	Sucri	per.	SOII	· · · · · · · · · · · · · · · · · · ·	5 1
Complete this table for your five highest com- compensation from the organization. Report of year.	pensated i	ndepe on for	nde the	nt o	conf	tracto lar ye	rs t ar e	hat received more inding with or with	than \$100,000 nin the organizati	of on's tax
(A)							Τ	(B)		(C)
Name and business add	dress						_	Description of se	rvices	Compensation
							1			
							-			
							+			
							+			
2 Total number of independent contractors (in	ncludina hi	ıt not	lim	iter	d to	thos	e li	sted above) who	received	
more than \$100,000 in compensation from the							- "			

Pari	t VII	Statement of Rever Check if Schedule O co		nse or note to a	ny line in this Part	\/III	,	
					(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from ta under sections 512-514
nts	1a	Federated campaigns	1a					
Gra	b	Membership dues	1b					
An An	С	Fundraising events	1c					
ia Gi	đ	Related organizations	1d				45	
Sirr	е	Government grants (contribu	utions) 1e	624,823.				
ner Ter	f	All other contributions, gifts,	grants,					
불품		and similar amounts not include	d above . 1f	2,983,081.				
Contributions, Gifts, Grants and Other Similar Amounts	g	Noncash contributions included		-	3 607 604			
- Re	<u>h</u>	Total. Add lines 1a-1f		Business Code	3,607,904.			
Program Service Revenue	2a	NET PATIENT SERVICE REVEN	NUE	621400	447,700,457.	447,319,875.	380,582.	
Re	b	PHARMACY		900099	7,557,205.	7,557,205.	300,302.	
vice	c	MEANINGFUL USE INCOME		900099	675,595.	675,595.		
Ser	d	OTHER PHYSICIAN REVENUE		900099	564,050.	564,050.		
E	e							
ogra	f	All other program service rev	venue					
4	g	Total. Add lines 2a-2f	<u> </u>	<u> </u>	456,497,307.			
	3	Investment income (inc	cluding dividen	nds, interest,				
		and other similar amounts).		▶	435,494.			435,494
	4	Income from investment of	-	•	0.			
	5	Royalties		1	0.			
			(i) Real	(ii) Personal				
	6a	Gross rents	436,241.					
	b	Less: rental expenses			5 5			
	C	Rental income or (loss)		l				
	_d	Net rental income or (loss).			436,241.			436,241
	7a	Gross amount from sales of	(i) Securities	(ii) Other				
		assets other than inventory	1,065,783.	29,872.				
	b	Less: cost or other basis						
		and sales expenses	1 065 703	29,872.				
		Gain or (loss)			1 005 655			1 005 655
		Gross income from fundra			1,095,655.			1,095,655
une	oa	events (not including \$	iisiiig					
eve		of contributions reported on	line 1c)					
7.		See Part IV, line 18	•	0.				
Other Revenue	b	Less: direct expenses		0.		100		
		Net income or (loss) from fu		<b>.</b>	0.			
	9a	Gross income from gaming	activities.					S 10
		See Part IV, line 19	а	0.	2.00			
	b	Less: direct expenses	b	0.				
	С	Net income or (loss) from ga	aming activities.	<u></u>	0.			
1		Gross sales of inventor						
		returns and allowances		0.				
		Less: cost of goods sold		0.				
-	С	Net income or (loss) from sal  Miscellaneous Revenue		Business Code	0.			
-	4				^=			
1	1a	REBATE INCOME		900099	853,812.			853,812
		PARKING LOT REVENUE	v	900099	415,841.		82,109.	333,732
	-	OPERATING EXPENSE RECOVER		900099	11,063.			11,063
		All other revenue		900099	-323,332. 957,384.			-323,332
		Total revenue. See instruction			463,029,985.	456,116,725.	462,691.	2,842,665.
11.								

### Part IX Statement of Functional Expenses

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

	Check if Schedule O contains a response or note to any line in this Part IX							
	not include amounts reported on lines 6b, 7b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses			
1	Grants and other assistance to domestic organizations							
	and domestic governments. See Part IV, line 21	0.						
2	Grants and other assistance to domestic							
	individuals. See Part IV, line 22	0.	<u></u>					
3	Grants and other assistance to foreign							
	organizations, foreign governments, and foreign	_						
	individuals. See Part IV, lines 15 and 16	0.						
4	Benefits paid to or for members	0.						
5	Compensation of current officers, directors,	2 556 605	2 224 226	0.61 7.00				
	trustees, and key employees	3,556,625.	3,294,826.	261,799.				
6	Compensation not included above, to disqualified							
	persons (as defined under section 4958(f)(1)) and	164 006	150 051	10 145				
	persons described in section 4958(c)(3)(B)	164,996.	152,851.	12,145.				
7	Other salaries and wages	187,451,189.	173,653,102.	13,798,087.				
8	Pension plan accruals and contributions (include	2 010 746	2 602 050	206 206				
	section 401(k) and 403(b) employer contributions)	2,810,746.	2,603,850.	206,896.				
9	Other employee benefits	18,732,719.	17,353,823.	1,378,896.				
10	Payroll taxes	10,664,143.	9,750,126.	914,017.				
11	Fees for services (non-employees):	40,428,213.	760 005	39,658,228.				
	Management	4,121.	769,985.	4,121.				
	Legal	4,121.		4,121.				
	Accounting	0.						
	Lobbying	0.						
	Professional fundraising services. See Part IV, line 17.	0.			/			
	f Investment management fees	0.						
ç	Other. (If line 11g amount exceeds 10% of line 25, column	41,704,008.	36,802,170.	4,901,838.				
42	(A) amount, list line 11g expenses on Schedule O.)	358,410.	25,502.	332,908.				
13	Advertising and promotion	3,071,528.	2,881,648.	188,491.	1,389.			
14	Information technology	0.	, , , , , , , , , , , , , , , , , , , ,					
15	Royalties	0.						
16	Occupancy	2,712,133.	2,437,539.	274,020.	574.			
17		524,054.	451,657.	72,397.				
18	Payments of travel or entertainment expenses							
	for any federal, state, or local public officials	0.						
19	Conferences, conventions, and meetings	216,170.	187,285.	28,885.				
	Interest	2,757,580.		2,757,580.				
21	Payments to affiliates	0.						
22	Depreciation, depletion, and amortization	17,184,317.	7,427,099.	9,754,909.	2,309.			
23	Insurance	6,870,459.	997,932.	5,872,527.				
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.)							
а	MEDICAL / SURGICAL SUPPLIES	57,807,694.	58,032,529.	-224,835.				
b	IMPLANTS/PROSTHESES	27,546,111.	27,514,583.	31,528.				
	MAINTENANCE	7,211,553.	6,784,775.	426,778.				
d	UTILITIES	5,157,472.	4,698,491.	458,577.	404.			
e	All other expenses	10,850,541.	8,695,736.	2,152,818.	1,987.			
	Total functional expenses. Add lines 1 through 24e	447,784,782.	364,515,509.	83,262,610.	6,663.			
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							
JSA	following SOP 98-2 (ASC 958-720)	0.			Form <b>990</b> (2016)			

JSA 6E1052 1.000

Form 990 (2016) Page **11** 

### Part X Balance Sheet

ran		Check if Schedule O contains a response or note to any line in this P	art X. ,		
			(A) Beginning of year		(B) End of year
	1	Cash - non-interest-bearing	168,085.	1	4,115
	2	Savings and temporary cash investments	0.	2	0
	3	Pledges and grants receivable, net	968,283.	3	1,334,948
	4	Accounts receivable, net	55,715,293.	4	50,931,985
	5	Loans and other receivables from current and former officers, directors,			
		trustees, key employees, and highest compensated employees.			
		Complete Part II of Schedule L	0.	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0.	6	0
ets	7	Notes and loans receivable, net	8,392.		0
ssets	8	Inventories for sale or use	6,843,571.		7,329,863
⋖	9	Prepaid expenses and deferred charges	1,600,906.	<del></del>	1,002,987
1		Land, buildings, and equipment: cost or	1,000,300.	-	1,002,307
'	· o u	other basis. Complete Part VI of Schedule D   10a   352,723,157.			,
	h	Less: accumulated depreciation	74,002,500.	100	73,367,906
1	1	Investments - publicly traded securities		11	0
- 1	2	Investments - other securities. See Part IV, line 11	58,750,354.		
- 1	3	Investments - program-related. See Part IV, line 11		<b></b>	00,224,412
- 1	4		0.		0
	5	Intangible assets	4,367,406.		543,448
- 1	6	Total assets. Add lines 1 through 15 (must equal line 34)	202,424,790.		200,739,664
_	7	Accounts payable and accrued expenses.	31,384,658.		27,641,411
- 1	8		1,287,087.		2,408,219
	9	Grants payable	19,667.	19	2,408,219
- 1	20	Deferred revenue	15,007.		2,318,111
2		Tax-exempt bond liabilities		21	0
		Loans and other payables to current and former officers, directors,	υ.	21	U
		trustees, key employees, highest compensated employees, and			
5			0	20	
		disqualified persons. Complete Part II of Schedule L	0.	22	0
		Secured mortgages and notes payable to unrelated third parties		23	0
	4 5	Unsecured notes and loans payable to unrelated third parties	U.	24	0
2	0	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X			
		, ,	26,578,215.	0.5	24 420 567
2	c	of Schedule D	59,269,627.		24,438,567. 57,006,308.
		Organizations that follow SFAS 117 (ASC 958), check here > X and	39,269,627.	20	37,000,306
3		complete lines 27 through 29, and lines 33 and 34.			
2 2	7	Unrestricted net assets	112,173,641.	27	109,639,777.
2	8	Temporarily restricted net assets	4,619,267.	28	7,786,256.
2	9	Permanently restricted net assets	26,362,255.	29	26,307,323.
5		Organizations that do not follow SFAS 117 (ASC 958), check here and complete lines 30 through 34.			
3 3	0	Capital stock or trust principal, or current funds		30	
3	1	Paid-in or capital surplus, or land, building, or equipment fund		31	
3	2	Retained earnings, endowment, accumulated income, or other funds		32	
Siasser sans	3	Total net assets or fund balances	143,155,163.	33	143,733,356.
3	4	Total liabilities and net assets/fund balances.	202,424,790.	34	200,739,664.
	•	The state of the s	-02,123,100.	J-T	Form <b>990</b> (2016

Form 990 (2016) Page 12 **Reconciliation of Net Assets** Part XI Check if Schedule O contains a response or note to any line in this Part XI. . . . . . 463,029,985. 1 447,784,782. 2 2 15,245,203. 3 3 143, 155, 163. 4 Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) . . . . . 4 5,609,852. 5 5 6 0. 6 0. 7 7 0. 8 8 9 -20,276,862. Other changes in net assets or fund balances (explain in Schedule O) . . . . . . . 9 Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 143,733,356. Part XII **Financial Statements and Reporting** Χ Check if Schedule O contains a response or note to any line in this Part XII . . No Yes 1 Accounting method used to prepare the Form 990: Cash X Accrual If the organization changed its method of accounting from a prior year or checked "Other," explain in Χ 2a Were the organization's financial statements compiled or reviewed by an independent accountant?..... 2a If "Yes." check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: Consolidated basis Separate basis Both consolidated and separate basis 2b Χ If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: X Consolidated basis Separate basis Both consolidated and separate basis c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight Χ 2c of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.

3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in

Χ

За

3b

#### **SCHEDULE A**

(Form 990 or 990-EZ)

## **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.

OMB No. 1545-0047

Department of the Treasury Internal Revenue Service Name of the organization

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

Employer identification number

TH	ΕU	NION MEMORIAL HOSPI	TAL				52-05916	85
Pa	rt I	Reason for Public Cha	arity Status (All o	organizations must o	complet	te this pa	art.) See instructions	S.
The	org	anization is not a private for			-	-	-	
1		A church, convention of ch						
2		A school described in sect	ion 170(b)(1)(A)(ii	). (Attach Schedule E	(Form 9	90 or 990	D-EZ).)	
3	Χ	A hospital or a cooperative	hospital service o	organization described	in section	on 170(b)	)(1)(A)(iii).	
4		A medical research organi	zation operated in	conjunction with a ho	spital de	escribed i	n section 170(b)(1)(A	)(iii). Enter the
		hospital's name, city, and s	tate:					
5		An organization operated	for the benefit of	a college or universi	ty owne	d or ope	erated by a governme	ental unit described in
		section 170(b)(1)(A)(iv). (0	Complete Part II.)					
6		A federal, state, or local go	overnment or gove	rnmental unit describe	ed in sec	tion 170	(b)(1)(A)(v).	
7		An organization that norm	ally receives a sul	bstantial part of its su	apport fr	om a go	vernmental unit or fr	om the general public
		described in section 170(b	)(1)(A)(vi). (Comp	lete Part II.)				
8		A community trust describe	ed in <b>section 170(I</b>	b)(1)(A)(vi). (Complete	e Part II.)	)		
9		An agricultural research or	ganization describ	ed in section 170(b)(1	)(A)(ix)	operated	d in conjunction with a	land-grant college
		or university or a non-land-	grant college of a	griculture (see instruc	tions). E	nter the	name, city, and state c	of the college or
		university:						
10 11		An organization that norma receipts from activities rela support from gross investn acquired by the organization organized	ated to its exempt to nent income and u on after June 30, 1	functions - subject to inrelated business tax 975. See <mark>section 509</mark>	certain e able ince (a)(2). (0	exceptior ome (les Complete	ns, and (2) no more tha s section 511 tax) from e Part III.)	n 331/3 % of its
12		An organization organized	•	•	-			carny out the numbers
		of one or more publicly su	•	•				
		Check the box in lines 12a						
а		Type I. A supporting org	•		• •	• •	•	
<u> </u>	L	the supported organization	•		•			
		supporting organization.	•			ajonty of		oco or the
b	Г	Type II. A supporting org				n with its	supported organizati	on(s) by having
_	-	control or management of	•				.,	
		organization(s). You must		-		.о ролоол	io mar control of mar	ago mo oapportoa
С	Г	Type III functionally inte			ated in c	onnectio	n with and functiona	lly integrated with
Ū	<b>L</b>	its supported organization						ny magnatoa man,
d		Type III non-functionally		-				ted organization(s)
~	L	that is not functionally into			-		, ,	- ' '
		requirement (see instruct						a an alterniveness
е	Г	Check this box if the orga						II Type III
٠	L	functionally integrated, or					**	n, rype m
f	En	ter the number of supported						
g		ovide the following information						
		lame of supported organization	(ii) EIN	(iii) Type of organization	(iv) Is the	organization	(v) Amount of monetary	(vi) Amount of
	• •		, ,	(described on lines 1-10	listed in yo	ur governing	support (see	other support (see
				above (see instructions))	Yes	ment?	instructions)	instructions)
						.,,0		
(A)								
<b>(D)</b>								
(B)								
(C)								
					ļ			
(D)								
/E\								
(E)								
Tota	ai							

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

Schedule A (Form 990 or 990-EZ) 2016

Schedule A	(Form 990 or 990-EZ) 2016						ra
Part II	Support Schedule for Organ (Complete only if you checked Part III. If the organization fails	d the box on l	line 5, 7, or 8	of Part I or if t	he organizatio	n failed to qua	
Section	A. Public Support						
Calendar	year (or fiscal year beginning in)	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(a) 2016	(f) Total

Calendar year (or fiscal year beginning in) ▶ (e) 2012 (b) 2013 (c) 2014 (d) 2015 (e) 2016 (f) Total membership feas received. (Do not include any "unusual grants.")  3. The value of sances or facilities for the organization's benefit and either paid to or expended on its behalf in.  3. The value of sances or facilities for the organization without charge.  4. Total Add lines 1 through 3.  5. The portion of total contributions by each person (other than the organization without charge).  4. Total Add lines 1 through 3.  5. The portion of total contributions by each person (other than the organization included on line 11 that exceeds 2% of the amount shown on line 11, column (f) .  6. Public aupport. Subtract line 6 from line 4.  8. Gross income from interest dividends, payments received on accurates losins, rents, royaltes and income from similar sources.  9. Net income from unrelated activities, etc. (see instructions).  11. Total support. Add lines 7 through 10.  12. Gross receipts from related activities, etc. (see instructions).  13. Flest five years. If the Form 890 is for the organization (in) the business is regularly carried on .  14. Total support percentage for 2016 (line 6, column (f) divided by line 11, column (f)).  15. Public support percentage from 2015 Schedule A, Part II, line 14.  16. Section B. Computation of Public Support Percentage.  17. Public support percentage from 2015 Schedule A, Part II, line 14.  18. Salta% support test - 2015. If the organization did not check the box on line 13, and line 14 is 331/3% or more, check this box and stop here. The organization medities as a publicly supported organization.  18. Total support percentage from 2015 Schedule A, Part II, line 14.  19. Salta% support test - 2015. If the organization did not check a box on line 13, fia, or 16b, and line 14 is 10% or more, and if the organization medities as a publicly supported organization.  19. Total support percentage from 2015 Schedule A, Part II, line 14.  19. Total support percentage from 2015 Schedule	Sec	tion A. Public Support				***************************************		
membership fees received. (Do not include any "unusual grants.").  2	Cale	ndar year (or fiscal year beginning in)	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
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 lines if from line 4.  Section B. Total Support  Calendar year (or fiscal year beginning in) ►  (a) 2012 (b) 2013 (c) 2014 (d) 2015 (e) 2016 (f) Total  7 Amounts from line 4.  8 Organ incorne from interest dividends, press, organization and incorne from similar sources.  9 Net income from unrelated business activities, whether or not the business is regularly carried on.  10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI).  11 Total support. Add lines 7 through 10.  12 Gross receipts from related activities, etc. (see instructions)  13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.  Section C. Computation of Public Support Percentage  14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f)).  15 Public support percentage form 2015 Schedule A. Part II, line 14.  16 331rs% support test - 2016. If the organization did not check the box on line 13, and line 14 is 331rs% or more, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization qualifies as a publicly supported organization qualifies as a publicly supported organization qualifies as a publ	1	membership fees received. (Do not						
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 to the organization) included by each person (other than a governmental unit to the organization) included by each person (other than a governmental unit to the organization) included by each person (other than a governmental unit to the organization of the anount shown on line 11, column (f).  8 Public support. Subtract line 5 from line 4.  8 Gross income from interest, dividends, payments received on securities loans, rents, royaltes and income from similar sources.  9 Net income from unrelated business activities, whether or not the business is regularly carried on 1.  10 Other income. Do not include gain or less from the sale of capital assets (Explain in Part VI.).  11 Total support. Add lines 7 through 10.  12 Gross receipts from related activities, etc. (see instructions).  13 First five years. If the Form 990 is for the organizations first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.  9 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f)).  14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f)).  15 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f)).  16 331/3 % support test - 2016. If the organization did not check a box on line 13, and line 14 is 331/3 % or more, check this box and stop here. The organization qualifies as a publicly supported organization.  17 a 10%-facts-and-circumstances test - 2016. If the organization did not check a box on line 13, 16a, 6b, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization.  15 10 0% or more	2	organization's benefit and either paid						
5 The portion of total contributions by each person (other than a governmental unit publicly supported organization included on the support of the amount shown on the support of the amount shown on the support. Subtract line 5 from line 4.  Section B. Total Support  7 Amounts from line 4.  8 Gross income from interest, dividends, payments received on securities loans, supported organization received on securities loans, such supports 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 (cisplain in Part VI).  11 Total support. Add lines 7 through 10.  12 Gross receipts from related activities, etc. (see instructions).  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  8 Public support percentage for 2015 (Schedule A. Part II, line 14.  15 Public support percentage for 2016 (filme 6, column (f)) divided by line 11, column (f)).  14 Public support percentage for 2016 (filme 6, column (f)) divided by line 11, column (f)).  15 Public support percentage for 2015 Schedule A. Part II, line 14.  16 33/13 % support test - 2016. If the organization qualifies as a publicly supported organization.  17 10%-facts-and-circumstances test - 2016. If the organization did not check a box on line 13, 16a, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test, the Kh this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test, the organization qualifies as a publicly supported organization.  10 Private foundation. If the organization meets the "facts-and-circumstances" test. The organization qualifies	3	furnished by a governmental unit to the organization without charge						
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) 2012 (b) 2013 (c) 2014 (d) 2015 (e) 2016 (f) Total 7.  Amounts from line 4.  8 Gross income from interest, dividends, prements received on securities loans, reprise received on securities loans, reprise, 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 gein or loss from the sale of capital assets (Explain in Part VI).  11 Total support. Add lines 7 through 10.  12 Gross receipts from related activities, etc. (see instructions)  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  14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	4	Total. Add lines 1 through 3						
Section B. Total Support  Calendar year (or fiscal year beginning in)   (a) 2012 (b) 2013 (c) 2014 (d) 2015 (e) 2016 (f) Total  7 Amounts from line 4	5	each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount		1. A. S.				
Calendar year (or fiscal year beginning in)    (a) 2012 (b) 2013 (c) 2014 (d) 2015 (e) 2016 (f) Total  Amounts from line 4  Cross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources.  Perform the sale of capital assets (Explain in Part VI)  Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI)  Total support. Add lines 7 through 10  Gross receipts from related activities, etc. (see instructions)  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  Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))  18 Private founds and stop here. The organization qualifies as a publicly supported organization.	6	Public support. Subtract line 5 from line 4.						
7 Amounts from line 4	Sec	tion B. Total Support						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources.  9 Net income from unrelated business activities, whether or not the business is regularly carried on  10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI).  11 Total support. Add lines 7 through 10  12 Gross receipts from related activities, etc. (see instructions)  13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.  Section C. Computation of Public Support Percentage  14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	Cale	ndar year (or fiscal year beginning in) 🕨	(a) 2012	<b>(b)</b> 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
payments received on securities loans, rents, royalties and income from similar sources.  9 Net income from unrelated business activities, whether or not the business activities, whether or not the business is regularly carried on  10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI)  11 Total support. Add lines 7 through 10  12 Gross receipts from related activities, etc. (see instructions)	7	Amounts from line 4						
activities, whether or not the business is regularly carried on	8	payments received on securities loans, rents, royalties and income from similar						
loss from the sale of capital assets (Explain in Part VI.)  11 Total support. Add lines 7 through 10.  12 Gross receipts from related activities, etc. (see instructions)  13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.  Section C. Computation of Public Support Percentage  14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	9	activities, whether or not the business						
12 Gross receipts from related activities, etc. (see instructions)  13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here  Section C. Computation of Public Support Percentage  14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	10	loss from the sale of capital assets	<u>, , , , , , , , , , , , , , , , , , , </u>		***************************************			
First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here  Section C. Computation of Public Support Percentage  14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	11							
Section C. Computation of Public Support Percentage  14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	12	Gross receipts from related activities, etc. (s	ee instructions)				12	
Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))		organization, check this box and stop here						
Public support percentage from 2015 Schedule A, Part II, line 14	Sec			-T			7	
331/3% support test - 2016. If the organization did not check the box on line 13, and line 14 is 331/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization	14	Public support percentage for 2016 (lin	ne 6, column (f)	) divided by line	11, column (f))		14	
this box and stop here. The organization qualifies as a publicly supported organization		Public support percentage from 2015	Schedule A, Pa	art II, line 14			15	
b 331/3% support test - 2015. If the organization did not check a box on line 13 or 16a, and line 15 is 331/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization	16a							
check this box and stop here. The organization qualifies as a publicly supported organization		this box and stop here. The organization	on qualifies as a	a publicly suppor	rted organizatio	n		▶ □
17a 10%-facts-and-circumstances test - 2016. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization.  b 10%-facts-and-circumstances test - 2015. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization.  Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see	b	331/3% support test - 2015. If the o	rganization did	not check a b	ox on line 13 o	or 16a, and line	e 15 is 331/3%	or more,
10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization								
Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	17a	10%-facts-and-circumstances test - 2	.016. If the org	ganization did n	ot check a box	on line 13, 16	a, or 16b, and I	ine 14 is
b 10%-facts-and-circumstances test - 2015. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here.  Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization.  Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see		10% or more, and if the organization	meets the "fac	cts-and-circums	tances" test, ch	neck this box a	nd <b>stop here.</b> E	xplain in
<ul> <li>b 10%-facts-and-circumstances test - 2015. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization</li></ul>		Part VI how the organization meets t	he "facts-and-c	circumstances" te	est. The organi	zation qualifies	as a publicly s	upported
15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here</b> .  Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization								▶ □
Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	b	10%-facts-and-circumstances test - 2	015. If the org	ganization did n	ot check a box	on line 13, 16	a, 16b, or 17a,	and line
Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		15 is 10% or more, and if the orga	nization meets	s the "facts-and	d-circumstances	" test, check t	his box and <b>st</b>	op here.
Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see								
Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see		supported organization						▶ □
instructions	18	Private foundation. If the organization	did not check a	a box on line 13	, 16a, 16b, 17a	, or 17b, check	this box and see	;
		instructions		<u></u> <u>.</u>				<b>&gt;</b> L

Schedule A (Form 990 or 990-EZ) 2016

Schedule A (Form 990 or 990-EZ) 2016 Page 3

#### Part III

Support Schedule for Organizations Described in Section 509(a)(2)
(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Sec	ction A. Public Support						
Cale	endar year (or fiscal year beginning in) 🕨	(a) 2012	<b>(b)</b> 2013	(c) 2014	(d) 2015	(e) 2016	(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						
7	organization's benefit and either paid						
	to or expended on its behalf						
5	The value of services or facilities						
3							
	furnished by a governmental unit to the						
_	organization without charge						
6	Total. Add lines 1 through 5						
/ a	Amounts included on lines 1, 2, and 3						
b	received from disqualified persons  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						
	Add lines 7a and 7b						
8	Public support. (Subtract line 7c from						
	line 6.)		<u>L</u>			<b>!</b>	
	tion B. Total Support	(a) 2012	<b>(b)</b> 2013	(c) 2014	(d) 2015	(=) 2016	(D. Tatal
	ndar year (or fiscal year beginning in)	(a) 2012	(b) 2013	(6) 2014	(a) 2015	(e) 2016	(f) Total
9 10 a	Amounts from line 6						
104	payments received on securities loans,						
	rents, royalties and income from similar						
	sources						
a	Unrelated business taxable income (less						
	section 511 taxes) from businesses						
	acquired after June 30, 1975						<u>.</u>
С	Add lines 10a and 10b						
11	Net income from unrelated business						
	activities not included in line 10b, whether or not the business is regularly						
	carried on						
12	Other income. Do not include gain or						
	loss from the sale of capital assets						
	(Explain in Part VI.)						
13	Total support. (Add lines 9, 10c, 11,	I					
	and 12.)						
14	First five years. If the Form 990 is fo						
	organization, check this box and stop here.					<del></del>	▶
Sec	tion C. Computation of Public Supp	<del></del>					·
15	Public support percentage for 2016 (line 8,					15	%%
16	Public support percentage from 2015 Scheo					16	%
Sec	tion D. Computation of Investment					_	
17	Investment income percentage for 2016 (line					17	%%
18	Investment income percentage from 2015 S					18	%%
19 a	331/3% support tests - 2016. If the orga						
	17 is not more than 331/3 %, check this						
b	331/3% support tests - 2015. If the organ	nization did not	check a box on l	ine 14 or line 19	a, and line 16 is	more than 331/3	3 %, and
	line 18 is not more than 331/3%, check to	this box and <b>st</b>	op here. The or	ganization qualifie	es as a publicly	supported organi	zation 🕨 🔣
20	Private foundation If the organization d	id not check	a how on line "	14 10a or 10b	check this bo	y and see instr	uctions 🛌

Schedule A (Form 990 or 990-EZ) 2016

#### **Supporting Organizations** Part IV

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

Section A. All Support	ing Organizations
------------------------	-------------------

Sect	on A. All Supporting Organizations		Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.	1	165	NO
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in <b>Part VI</b> when and how the organization made the determination.	3b		
С	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in <b>Part VI</b> what controls the organization put in place to ensure such use.	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes," and if you checked 12a or 12b in Part I, answer (b) and (c) below.	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.	4b	:	-
С	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in <b>Part VI</b> what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.	4c	-	
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in <b>Part VI</b> , including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).	5a		
b	Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
С	Substitutions only. Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to			
	anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited			
	by one or more of its supported organizations, or (iii) other supporting organizations that also support or			
	benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI.	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in <b>Part VI</b> .	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in <b>Part VI.</b>	9b		
С	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in <b>Part VI.</b>	9c		
10 a		10a		
b	Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to			

Schedule A (Form 990 or 990-EZ) 2016

determine whether the organization had excess business holdings.)

	THE UNION MEMORIAL HOSPITAL 52-059	1685		
24,000,000	lle A (Form 990 or 990-EZ) 2016			Page 5
Part	Supporting Organizations (continued)			,
			Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?			
а	, , , , , , , , , , , , , , , , , , , ,			
	below, the governing body of a supported organization?	11a		
	A family member of a person described in (a) above?	11b	ļ	
	A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in Part VI.	11c		l
Sect	on B. Type i Supporting Organizations		V	N.
			res	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to			
	regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the		۱.	
	tax year? If "No," describe in <b>Part VI</b> how the supported organization(s) effectively operated, supervised, or			
	controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported			
	organizations and what conditions or restrictions, if any, applied to such powers during the tax year.			
		1		
2	Did the organization operate for the benefit of any supported organization other than the supported			
	organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in <b>Part</b> VI how providing such benefit carried out the purposes of the supported organization(s) that operated,			
	supervised, or controlled the supporting organization.			
Secti	on C. Type II Supporting Organizations	2		L
	on o. Typo ii oupporting organizations		Vos	No
4	Mara a majority of the arrangeding's dispetage or trustees device the tay year the arranged the dispetage		163	140
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? If "No," describe in <b>Part VI</b> how control			
	or management of the supporting organization was vested in the same persons that controlled or managed			
	the supported organization(s).	1		
Secti	on D. All Type III Supporting Organizations			
			Yes	Nο
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the		103	140
	organization's tax year, (i) a written notice describing the type and amount of support provided during the prior			
	tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously			
	provided?	1		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported	'-		
_	organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in <b>Part VI</b> how			
	the organization maintained a close and continuous working relationship with the supported organization(s).	2		
3	By reason of the relationship described in (2), did the organization's supported organizations have a	-		
3	significant voice in the organization's investment policies and in directing the use of the organization's			
	income or assets at all times during the tax year? If "Yes," describe in <b>Part VI</b> the role the organization's			
	supported organizations played in this regard.	3		
Secti	on E. Type III Functionally Integrated Supporting Organizations	131		
1	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see in		one)	
а	The organization satisfied the Activities Test. Complete line 2 below.	,a a a a	<i>5113<sub>)</sub></i> .	
b	The organization is the parent of each of its supported organizations. Complete line 3 below.			
C	The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see	instruc	ctions)	
		Г	Yes	No
2	Activities Test. Answer (a) and (b) below.			
а	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of			
	the supported organization(s) to which the organization was responsive? If "Yes," then in <b>Part VI identify</b>			
	those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined			
	that these activities constituted substantially all of its activities.	2a		
-				
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more			
	of the organization's supported organization(s) would have been engaged in? If "Yes," explain in <b>Part VI</b> the reasons for the organization's position that its supported organization(s) would have engaged in these			
	activities but for the organization's involvement.	2b	İ	
	•	20		
3	Parent of Supported Organizations. <i>Answer (a) and (b) below.</i>			
а	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>	2-		
h.		3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in <b>Part VI</b> the role played by the organization in this regard.	3b		
	or the supported Signification in 100, accombs in 1 are 11 the 10th played by the organization in this regard.	100		

Schedule A (Form 990 or 990-EZ) 2016

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organ			
1 Check here if the organization satisfied the Integral Part Test as a qualifying instructions. All other Type III non-functionally integrated supporting organization.			
Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	1		
2 Recoveries of prior-year distributions	2		
3 Other gross income (see instructions)	3		
4 Add lines 1 through 3.	4		
5 Depreciation and depletion	5		
6 Portion of operating expenses paid or incurred for production or			
collection of gross income or for management, conservation, or			
maintenance of property held for production of income (see instructions)	6		
7 Other expenses (see instructions)	7		
8 Adjusted Net Income (subtract lines 5, 6, and 7 from line 4).	8		
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see	,5		5
instructions for short tax year or assets held for part of year):	4.		
a Average monthly value of securities	1a		
b Average monthly cash balances	1b		
c Fair market value of other non-exempt-use assets	1c		
d Total (add lines 1a, 1b, and 1c)	1d		
e Discount claimed for blockage or other	535	egy a magaga a agail a saw	
factors (explain in detail in <b>Part VI</b> ):	-		Beer Ver
2 Acquisition indebtedness applicable to non-exempt-use assets	2		
3 Subtract line 2 from line 1d.	3		
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount,			
see instructions).	4		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6 Multiply line 5 by .035.	6		
7 Recoveries of prior-year distributions	7		
8 Minimum Asset Amount (add line 7 to line 6)	8		
Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1	รูปเรียก ที่สู่ <u>ของค่องส่วน</u> ของเราะ เรื่องสารและของ เก	
2 Enter 85% of line 1.	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3.	4		
5 Income tax imposed in prior year	5		
6 Distributable Amount. Subtract line 5 from line 4, unless subject to			
emergency temporary reduction (see instructions).	6		
7 Check here if the current year is the organization's first as a non-functionall	v inted	rated Type III supporting	organization (see
instructions).	, -	, ,, ,,	,

Schedule A (Form 990 or 990-EZ) 2016

Part		Supporting Organizat	tions (continuea)	
Sect	ion D - Distributions			Current Year
1	Amounts paid to supported organizations to accomplish e			
2	Amounts paid to perform activity that directly furthers exer	mpt purposes of support	ed	
	organizations, in excess of income from activity			
3	Administrative expenses paid to accomplish exempt purpo	oses of supported organiz	zations	
4	Amounts paid to acquire exempt-use assets			
5	Qualified set-aside amounts (prior IRS approval required)			
6	Other distributions (describe in Part VI). See instructions.			
7	Total annual distributions. Add lines 1 through 6.			
8	Distributions to attentive supported organizations to which	the organization is resp	onsive	
	(provide details in Part VI). See instructions.			
9	Distributable amount for 2016 from Section C, line 6			
10	Line 8 amount divided by Line 9 amount	Т		
	Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2016	(iii) Distributable Amount for 2016
1	Distributable amount for 2016 from Section C, line 6			
	Underdistributions, if any, for years prior to 2016			
2	(reasonable cause required-explain in Part VI). See			
	instructions.			
3	Excess distributions carryover, if any, to 2016:			
а		*		
b				
С	From 2013			
d	From 2014			
е	From 2015			
f	Total of lines 3a through e			
g	Applied to underdistributions of prior years			
	Applied to 2016 distributable amount			
<u>i</u>	Carryover from 2011 not applied (see instructions)			
<u>į</u>	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2016 from			
	Section D, line 7: \$			
<u>а</u>	Applied to underdistributions of prior years			
b	Applied to 2016 distributable amount			
C	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2016, if			
	any. Subtract lines 3g and 4a from line 2. For result			
-	greater than zero, explain in Part VI. See instructions.			
6	Remaining underdistributions for 2016. Subtract lines 3h			
	and 4b from line 1. For result greater than zero, explain in			
7	Part VI. See instructions.			
7	Excess distributions carry over to 2017. Add lines 3j			
8	and 4c. Breakdown of line 7:			
	DICANUOWII OI IIIIC 1.			
a b	Excess from 2013			
C	Excess from 2014			
d	Excess from 2015			
a e	Excess from 2016			
	LA0633 HUIII ZUTU, . , ,		0-1 : :	A /Form 000 or 000 F7) 2040

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

#### Schedule B

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

#### **Schedule of Contributors**

► Attach to Form 990, Form 990-EZ, or Form 990-PF.

2M16

OMB No. 1545-0047

Department of the Treasury
Internal Revenue Service

| Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at www.irs.gov/form990.

Name of the organization Employer identification number THE UNION MEMORIAL HOSPITAL 52-0591685 Organization type (check one): Filers of: Section: X 501(c)(3 Form 990 or 990-EZ ) (enter number) organization 4947(a)(1) nonexempt charitable trust not treated as a private foundation 527 political organization Form 990-PF 501(c)(3) exempt private foundation 4947(a)(1) nonexempt charitable trust treated as a private foundation 501(c)(3) taxable private foundation Check if your organization is covered by the General Rule or a Special Rule. Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions. General Rule For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions. Special Rules For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of (1) \$5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II. For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III. For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions exclusively for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an exclusively religious, charitable, etc., purpose. Don't complete any of the parts unless the General Rule applies to this organization because it received nonexclusively religious, charitable, etc., contributions 

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

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

Schedule B (Form 990, 990-EZ, or 990-PF) (2016)

Employer identification number 52-0591685

Part I Contributors (See instructions). Use duplicate copies of Part I if additional space is needed.			eeded.
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		\$ \$ 825,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
2		\$\$.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
3		\$\$.	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
4		\$\$	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
5_		\$\$	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
6		\$37,000.	Person Payroll Noncash  (Complete Part II for noncash contributions.)

Employer identification number 52-0591685

Part I Contributors (See instructions). Use duplicate copies of Part I if additional space is needed.			
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7		\$35,000.	Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
8		\$\$.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
9		\$\$	Person Payroll Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
10		\$\$.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
11		\$\$	Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
12		\$\$	Person Payroll Noncash (Complete Part II for noncash contributions.)

Employer identification number 52-0591685

			52-0591685
Part I	Contributors (See instructions). Use duplicate copi	es of Part I if additional space is ne	eeded.
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13		\$\$	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
14		\$\$	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
15		\$\$	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
16		\$\$	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
17		\$\$	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
18		\$\$	Person Payroll Noncash (Complete Part II for noncash contributions.)

Employer identification number 52-0591685

Part I	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		\$\$.	Person X Payroll Noncash (Complete Part II for noncash contributions.)	
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution	
20		\$12,530.	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)	
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution	
21		\$12,500.	Person Payroll Noncash (Complete Part II for noncash contributions.)	
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution	
22_		\$11,000.	Person Payroll Noncash  (Complete Part II for noncash contributions.)	
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution	
23		\$10,750.	Person Payroll Noncash (Complete Part II for noncash contributions.)	
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution	
24		\$10,000.	Person Payroll Noncash  (Complete Part II for noncash contributions.)	

Employer identification number

			52-0591685
Part I	Contributors (See instructions). Use duplicate cop	ies of Part I if additional space is n	eeded.
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25		\$\$.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
26_		\$\$_ 10,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
27		\$\$	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
28		\$\$	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
29		\$\$	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
30		\$\$.	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)

Employer identification number 52-0591685

Part I	Contributors (See instructions). Use duplicate copie	es of Part I if additional space is n	eeded.
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31		<b>\$</b> \$	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
32		<b>\$</b> \$	Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
33		\$\$	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
34		\$	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
35		<b>\$</b> \$	Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
36		<b>\$</b> \$	Person Payroll Noncash  (Complete Part II for noncash contributions.)

Employer identification number 52-0591685

Part I Contributors (See instructions). Use duplicate copies of Part I if additional space is needed.			eeded.
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
37		\$ 5,865.	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
38		\$\$.	Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
39		\$\$	Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
40_		\$\$,	Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
41		\$\$	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
42		\$\$.	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)

Employer identification number 52-0591685

Part I	Contributors (See instructions). Use duplicate copi	es of Part I if additional space is n	eeded.
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
43		\$ 5,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
44		\$\$	Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
45_		\$5,000.	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
46_		\$ 5,000.	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
47		\$\$	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
48		\$5,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)

Employer identification number 52-0591685

Part I	Contributors (See instructions). Use duplicate copies of Part I if additional space is needed.		
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
49		\$\$	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
50		\$\$	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
51		\$\$,000.	Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
52		\$\$,000.	Person  Payroll  Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
_ 53_		\$\$,000.	Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
54		\$5,000.	Person Payroll Noncash  (Complete Part II for noncash contributions.)

PAGE 32

Employer identification number 52-0591685

Part I	Contributors (See instructions). Use duplicate copies of Part I if additional space is needed.		
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
55		\$5,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
56		\$5,000.	Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
57		\$5,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
58		\$5,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
59		\$ 5,000.	Person X Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
60		\$5,000.	Person X Payroll Noncash  (Complete Part II for noncash contributions.)

Employer identification number 52-0591685

Part I	Contributors (See instructions). Use duplicate cop	ies of Part I if additional space is n	eeded.
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
61		\$\$.	Person Payroll Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
62		\$\$.	Person Payroll Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
63		\$\$	Person Payroll Noncash  (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
			Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
			Person Payroll Noncash (Complete Part II for noncash contributions.)
(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
		\$	Person Payroll Noncash (Complete Part II for noncash contributions.)

Employer identification number 52-0591685

### Part II Noncash Property (See instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions)	(d) Date received
61	SECURITIES		
		<b>\$</b>	VAR
a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions)	(d) Date received
62	SECURITIES		
		<b>\$</b> \$.	VAR
a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions)	(d) Date received
63	SECURITIES		
		\$\$	VAR
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
		\$	

Schedule B (Form 990, 990-EZ, or 990-PF) (2016)

Name of organization THE UNION MEMORIAL HOSPITAL

Employer identification number 52-0591685

th co U	0) that total more than \$1,000 for the following line entry. For organization on tributions of \$1,000 or less for the seduplicate copies of Part III if additional and the seduplicate copies.	ons completing Part III, year. (Enter this infor	enter the total	
(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	d ZIP + 4	Relation	nship 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) Transfe  Transferee's name, address, and ZIP + 4			nship 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		Relation	ship of transferor to transferee
(a) No. from Part I	(b) Purpose of gift	(c) Use of g	ift	(d) Description of how gift is held
-	(e) Transfer of gift			
-	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
-				

Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or

JSA 6E1255 1.000

Schedule B (Form 990, 990-EZ, or 990-PF) (2016)

V 16-7.17 1793311 PAGE 36 32068H 2502

### **SCHEDULE D** (Form 990)

Supplemental Financial Statements

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

► Attach to Form 990.

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

OMB No. 1545-0047 Open to Public Inspection

Department of the Treasury Internal Revenue Service Name of the organization

Employer identification number

TH	E UNION MEMORIAL HOSPITAL		52-0591685
Pa	art I Organizations Maintaining Donor Adv	ised Funds or Other Similar Funds or	Accounts.
	Complete if the organization answered	"Yes" on Form 990, Part IV, line 6.	
		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		
5	Did the organization inform all donors and donor	advisors in writing that the assets held	in donor advised
	funds are the organization's property, subject to the	e organization's exclusive legal control?	Yes No
6	Did the organization inform all grantees, donors, a	and donor advisors in writing that grant fu	nds can be used
	only for charitable purposes and not for the bene	fit of the donor or donor advisor, or for ar	ny other purpose
	conferring impermissible private benefit?	<u> </u>	Yes No
Pá	rt II Conservation Easements.		
	Complete if the organization answered		
1	Purpose(s) of conservation easements held by the	organization (check all that apply).	
	Preservation of land for public use (e.g., rec	reation or education) Preservation o	of a historically important land area
	Protection of natural habitat	Preservation o	of a certified historic structure
	Preservation of open space		
2	Complete lines 2a through 2d if the organization he	eld a qualified conservation contribution in	
	easement on the last day of the tax year.		Held at the End of the Tax Year
а	Total number of conservation easements		2a
b	Total acreage restricted by conservation easements	T T T T T T T T T T T T T T T T T T T	2b
С	Number of conservation easements on a certified		2c
d	Number of conservation easements included in (c		
	historic structure listed in the National Register		2d
3	Number of conservation easements modified, tran	isferred, released, extinguished, or termina	ated by the organization during the
	tax year >		
4	Number of states where property subject to conse		
5	Does the organization have a written policy reg		
^	violations, and enforcement of the conservation ea		
6	Staff and volunteer hours devoted to monitoring, inspec	ting, handling of violations, and enforcing cons	servation easements during the year
7	Amount of expenses incurred in monitoring, inspect	ting handling of violations and enforcing as	near vation against during the year
′	S	ing, nationing of violations, and emorcing co	inservation easements during the year
8	Does each conservation easement reported on line 2	2(d) above eatisfy the requirements of section	on 170(h)(4)(R)(i)
Ü	and section 170(h)(4)(B)(ii)?	• •	
9	In Part XIII, describe how the organization reports		
•	balance sheet, and include, if applicable, the text of		·
	organization's accounting for conservation easeme		
Pa	rt III Organizations Maintaining Collections	of Art, Historical Treasures, or Other	Similar Assets.
	Complete if the organization answered	"Yes" on Form 990, Part IV, line 8.	
1a	If the organization elected, as permitted under SF works of art, historical treasures, or other similar	FAS 116 (ASC 958), not to report in its re	evenue statement and balance sheet
	works of art, historical treasures, or other similar	er assets held for public exhibition, educ	ation, or research in furtherance of
	public service, provide, in Part XIII, the text of the fo		
b	If the organization elected, as permitted under sworks of art, historical treasures, or other similar		
	public service, provide the following amounts relati		ation, or research in futilierance or
	(i) Revenue included in Form 990, Part VIII, line 1		<b>&gt;</b> \$
	(ii) Assets included in Form 990, Part X		
2	If the organization received or held works of ar		
	following amounts required to be reported under S	FAS 116 (ASC 958) relating to these items:	:
а	Revenue included in Form 990, Part VIII, line 1	· · · · · · · · · · · · · · · · · · ·	
h	Assets included in Form 990 Part X		<b>&gt;</b> ¢

chedule D (Form 990) 2016 Page 2

	rt    Organizations Maintaini	na Collections o	f Art Historica	l Troseuros or	Other Similar Ass	ete (continued)
3	Using the organization's acquisition		otner records, cr	eck any of the to	nowing that are a sig	nificant use of its
	collection items (check all that app	oly):	. — .			
а	Public exhibition		<del></del>	an or exchange pro	=	
b	Scholarly research		e Otl	ner		
С	Preservation for future gene	erations				
4	Provide a description of the orga	nization's collection	s and explain ho	w they further the	organization's exemp	ot purpose in Part
	XIII.					
5	During the year, did the organization	on solicit or receive	donations of art, I	nistorical treasures,	or other similar	
	assets to be sold to raise funds rat	her than to be maint	ained as part of t	ne organization's co	ollection?	Yes No
Pai	rt IV Escrow and Custodial A	rrangements.	***************************************			
	Complete if the organiza		s" on Form 990	, Part IV, line 9, o	r reported an amour	nt on Form
	990, Part X, line 21.				•	
1a	Is the organization an agent, truste	ee. custodian or oth	er intermediary fo	or contributions or c	other assets not	
٠	included on Form 990, Part X?		-			Yes No
b	If "Yes," explain the arrangement i					
b	ii res, explain the arrangement	iir i art XIII and Com	piete me ronowing	table.	Amount	
_	Designing halance			-	Amount	
C	Beginning balance					
d	Additions during the year					
е	Distributions during the year					
f	Ending balance					
2a	Did the organization include an am					Yes No
	If "Yes," explain the arrangement i	n Part XIII. Check h	ere if the explana	tion has been provid	ied on Part XIII	
Par	t V Endowment Funds.					
	Complete if the organization	tion answered "Ye	s" on Form 990	Part IV, line 10.		
		(a) Current year	(b) Prior year	(c) Two years ba	ck (d) Three years back	(e) Four years back
1a	Beginning of year balance					
h	Contributions					
0	Net investment earnings, gains,					
C	and losses					
_1						
d	Grants or scholarships	<del></del>				
е	Other expenditures for facilities					
	and programs					
f	Administrative expenses					
g	End of year balance					
2	Provide the estimated percentage			1g, column (a)) held	d as:	
а	Board designated or quasi-endown		%			
b	Permanent endowment					
С	Temporarily restricted endowment	<b>&gt;</b> %				
	The percentages on lines 2a, 2b, a	and 2c should equal	100%.			
3 a	Are there endowment funds not in	the possession of t	he organization tl	at are held and ad	Iministered for the	
	organization by:					Yes No
	(i) unrelated organizations					3a(i)
	(ii) related organizations					3a(ii)
b	If "Yes" on line 3a(ii), are the relate	ed organizations liste	ed as required on s	Schedule R?		3b
4	Describe in Part XIII the intended u	•	•			<u> </u>
Par	+ VI Land Buildings, and Equ	inment.				
18.10	Complete if the organiza	tion answered "Ye	s" on Form 990	, Part IV, line 11a	a. See Form 990, Pa	rt X, line 10.
	Description of property					d) Book value
1a	Land		itment)		depreciation	1,925,817.
	Land		·	,925,817.	152 006	
b	Buildings			,130,635. 103		22,677,549.
C	Leasehold improvements				,365,704.	786,374.
d	Equipment			,079,214. 173		44,762,939.
е	Other				,220,187.	3,215,227.
Tota	I. Add lines 1a through 1e. (Column	(d) must equal Fori	n 990, Part X, coll	ımn (B), line 10c.)	▶	73,367,906.

Part VII Investments - Other Securities.  Complete if the organization answered "	Yes" on Form 990,	Part IV, line 11b. See Form 990, Part X, line 12
(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) RESTRICTED INVESTMENT FUNDS	33,076,785.	FMV
(B) GREATER CHES SURGERY CTR	188,039.	FMV
(C) BOARD DESIGNATED	32,959,588.	FMV
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.)	66,224,412.	
Part VIII Investments - Program Related.  Complete if the organization answered ""		Part IV, line 11c. See Form 990, Part X, line 13
(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 13.) ▶		
Part IX Other Assets.  Complete if the organization answered "	Yes" on Form 990,	Part IV, line 11d. See Form 990, Part X, line 15
(a) Descr	ription	(b) Book value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line	: 15.)	
Part X Other Liabilities.		
Complete if the organization answered "\ line 25.	Yes" on Form 990,	Part IV, line 11e or 11f. See Form 990, Part X,
1. (a) Description of liability	(b) Book value	
(1) Federal income taxes		
(2) ADVANCES FROM 3RD PARTY PAYORS	11,361,0	84.
(3) GBR LIABILITY	507,1	70.
(4) CREDIT BALANCE PATIENT A/R	2,441,0	96.
(5) STOCK OPTION PLAN	426,0	41.
(6) WORKERS COMPENSATION	2,337,0	· · · · · · · · · · · · · · · · · · ·
(7) INTERCOMPANY PAYABLES	1,415,4	
(8) UCC POOL LIABILITY	516,6	
(9) OTHER LIABILITIES	5,433,9	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)		

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII JSA 6E1270 1.000 32068H 2502

Schedule D (Form 990) 2016

Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶

Part >	Reconciliation of Revenue per Audited Financial Statements With Revenue per Retur Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.	n.
1	Total revenue, gains, and other support per audited financial statements	1
	Amounts included on line 1 but not on Form 990, Part VIII, line 12:	
	Net unrealized gains (losses) on investments 2a	
	Donated services and use of facilities	
	Recoveries of prior year grants	
	Other (Describe in Part XIII.)	]
	Add lines 2a through 2d	2e
	Subtract line 2e from line 1	3
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:	
а	Investment expenses not included on Form 990, Part VIII, line 7b 4a	
b	Other (Describe in Part XIII.)	_
	Add lines 4a and 4b	4c
	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)	5
Part >	Reconciliation of Expenses per Audited Financial Statements With Expenses per Reto Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.	urn.
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:	
	Donated services and use of facilities	
b	Prior year adjustments	
	Other losses	
d	Other (Describe in Part XIII.)	4 _
	Add lines 2a through 2d	
3	Subtract line 2e from line 1	3
	Amounts included on Form 990, Part IX, line 25, but not on line 1:	
а	Investment expenses not included on Form 990, Part VIII, line 7b 4a	
	Other (Describe in Part XIII.)	4
	Add lines 4a and 4b	
	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)	5
	XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional informable 5	mation.

JSA

### Part XIII Supplemental Information (continued)

FIN 48 FOOTNOTE

SCHEDULE D, PART X

INCOME TAXES ARE ACCOUNTED FOR UNDER THE ASSET AND LIABILITY METHOD.

DEFERRED TAX ASSETS AND LIABILITIES ARE RECOGNIZED FOR THE FUTURE TAX

CONSEQUENCES ATTRIBUTABLE TO DIFFERENCES BETWEEN THE FINANCIAL STATEMENT

CARRYING AMOUNTS OF EXISTING ASSETS AND LIABILITIES AND THEIR RESPECTIVE

TAX BASES AND OPERATING LOSS AND TAX CREDIT CARRYFORWARDS. DEFERRED TAX

ASSETS AND LIABILITIES ARE MEASURED USING ENACTED TAX RATES EXPECTED TO

APPLY TO TAXABLE INCOME IN THE YEARS IN WHICH THOSE TEMPORARY DIFFERENCES

ARE EXPECTED TO BE RECOVERED OR SETTLED. THE EFFECT ON DEFERRED TAX

ASSETS AND LIABILITIES OF A CHANGE IN TAX RATES IS RECOGNIZED IN THE

PERIOD THAT INCLUDES THE ENACTMENT DATE. ANY CHANGES TO THE VALUATION

ALLOWANCE ON THE DEFERRED TAX ASSET ARE REFLECTED IN THE YEAR OF CHANGE.

THE CORPORATION ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH

THE FASB ACCOUNTING STANDARDS CODIFICATION (ASC) TOPIC 740, INCOME TAXES.

THERE WAS NO LIABILITY RECORDED FOR UNCERTAIN TAX POSITIONS AS OF JUNE

30, 2017.

### SCHEDULE H (Form 990)

# **Hospitals**

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

Open to Public Inspection

OMB No. 1545-0047

Department of the Treasury Internal Revenue Service

► Attach to Form 990. ▶ Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization Employer identification number THE UNION MEMORIAL HOSPITAL 52-0591685 Financial Assistance and Certain Other Community Benefits at Cost Yes No Χ 1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . . . . Χ 1b b If "Yes," was it a written policy?....... 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. X Applied uniformly to all hospital facilities Applied uniformly to most hospital facilities Generally tailored to individual hospital facilities Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing Χ free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: 3a X 200% \_\_\_ Other % 150% b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," Χ 3b 350% X 400% Other 250% 300% c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?............ X Χ 5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? 5a Χ 5b b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . . . . . . . . . . . . . c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or Χ 5c Χ 6a X 6b Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H. Financial Assistance and Certain Other Community Benefits at Cost (a) Number of activities or programs (optional) (c) Total community benefit expense (d) Direct offsetting (e) Net community benefit expense Financial Assistance and (b) Persons (f) Percent revenue Means-Tested Government served of total (optional) Programs a Financial Assistance at cost 4,398,013. 4,398,013. 98 (from Worksheet 1) . . . . Medicaid (from Worksheet 3. column a) . . . . . . . . Costs of other means-tested government programs (from Worksheet 3, column b) Total Financial Assistance and Means-Tested Government 4,398,013. 4,398,013. .98 Other Benefits e Community health improvement services and community benefit 290,866. 1,155,023. 1,445,889. .25 operations (from Worksheet 4) f Health professions education 17,141,419. 146,650. 16,994,769. 3.75 (from Worksheet 5) . . . . g Subsidized health services (from 6,152,041. 2,903,100. .73 3,248,941 Worksheet 6) . . . . . . . . . 1,905,252. 1,905,252. .43 h Research (from Worksheet 7) Cash and in-kind contributions for community benefit (from Worksheet 8) 68,989. 68,989. .02

i Total. Other Benefits . . . .

Total, Add lines 7d and 7i.

5.18

3,340,616.

3,340,616.

1793311

26,713,590.

31,111,603.

23,372,974.

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
		184,871.		184,871.	.04
		26,386.		26,386.	.01
		4,016.		4,016.	
		215,273.		215,273.	.05
	activities or programs (optional)	activities or programs (optional) (optional)	activities or programs (optional)  Served (optional)  184,871.	activities or programs (optional)  184,871.  26,386. 4,016.	activities or programs (optional)   184,871.   184,871.   184,871.   26,386.   4,016.   4,016.   215,273.   215,273.

Г	Bau Debt, Medicare, & Conection Fractices			
Sed	ction A. Bad Debt Expense		Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association			
	Statement No. 15?,	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the			
	methodology used by the organization to estimate this amount			
3	Enter the estimated amount of the organization's bad debt expense attributable to			
	patients eligible under the organization's financial assistance policy. Explain in Part VI			
	the methodology used by the organization to estimate this amount and the rationale,			
	if any, for including this portion of bad debt as community benefit			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt			
	expense or the page number on which this footnote is contained in the attached financial statements.			
Sec	tion B. Medicare			
5	Enter total revenue received from Medicare (including DSH and IME)			
6	Enter Medicare allowable costs of care relating to payments on line 5 6			
7	Subtract line 6 from line 5. This is the surplus (or shortfall)			
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 X Cost to charge ratio Other			
Sec	tion C. Collection Practices			
9a	Did the organization have a written debt collection policy during the tax year?	9a	Х	
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	Х	
Pa	rt IV Management Companies and Joint Ventures (owned 10% or more by officers directors trustees key employees and physicians	- see ins	structions	5)

activity of entity profit % or stock ownership % employees; profit % or stock ownership % or	Part IV Wanagement Compa	INIES and Joint Ventures (owned 10% or more by	officers, directors, trustees, key	employees, and physicians -	see instructions)
5       6         6       7         8       9         10       9         11       11         12       9	(a) Name of entity		profit % or stock	trustees, or key employees' profit %	(e) Physicians' profit % or stock ownership %
5       6         6       7         8       9         10       9         11       11         12       9	1				
5       6         6       7         8       9         10       9         11       11         12       9	2				
5       6         6       7         8       9         10       9         11       11         12       9	_ 3				
6 7	4				
7 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	5				
9 10	6				
9 10	7				
10       11       12	8				
11 12	9				
12	10				
12	11				
	12				
	13				

Schedule H (Form 990) 2016 Page 3

Part V Facility Information	,									
Section A. Hospital Facilities (list in order of size, from largest to smallest - see instructions) How many hospital facilities did the organization operate during the tax year?  Name, address, primary website address, and state license	Ę	Ge	오	Tea	Ω	Re	Ę	ER-other		
(list in order of size, from largest to smallest - see instructions)	ense	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	윷		
How many hospital facilities did the organization operate during	b h	al m	n's	ng h	acc	- C-	hou	4		
the tax year?1	osp	edic	hos	osp	ess	acili	S.			
Name, address, primary website address, and state license	ta	<u>a</u> &	pital	ital	hos	₹				
number (and if a group return, the name and EIN of the		Sur			pita					Facility
subordinate hospital organization that operates the hospital		gica			_					reporting
facility)		=							Other (describe)	group
1 UNION MEMORIAL HOSPITAL										
201 EAST UNIVERSITY PARKWAY										
BALTIMORE MD 21218	1									
	Х	Х		Х			Х			
3										
2										
3										
4										
5										
6										
7										
8										
9										
10										
						'				

### Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group UNION MEMORIAL HOSPITAL Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):  $\underline{1}$ Yes No Community Health Needs Assessment Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the 1 Χ Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C . . . . . . . . . . . . . Χ 2 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a Χ 3 If "Yes," indicate what the CHNA report describes (check all that apply): X A definition of the community served by the hospital facility X Demographics of the community X Existing health care facilities and resources within the community that are available to respond to the C health needs of the community d How data was obtained X The significant health needs of the community |X| Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups X The process for identifying and prioritizing community health needs and services to meet the g community health needs | X | The process for consulting with persons representing the community's interests h X The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) \_\_\_ Other (describe in Section C) j Indicate the tax year the hospital facility last conducted a CHNA: 20 14 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted . . . . . . . . . 5 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other 6a Χ b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," Χ 6b If "Yes," indicate how the CHNA report was made widely available (check all that apply): X Hospital facility's website (list url): WWW.MEDSTARUNIONMEMORIAL.ORG b Other website (list url): Made a paper copy available for public inspection without charge at the hospital facility С Other (describe in Section C) Did the hospital facility adopt an implementation strategy to meet the significant community health needs 8 X identified through its most recently conducted CHNA? If "No," skip to line 11 . . . . . . . . . 9 Indicate the tax year the hospital facility last adopted an implementation strategy: 2014 Χ 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . 10 If "Yes," (list url): WWW.MEDSTARUNIONMEMORIAL.ORG b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?..... 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed. 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a Χ 12a b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . . . . . . c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

JSA 6E1287 1.000

# Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facilit	y or letter of facility	reporting group	UNION	MEMORIAL	HOSPITAL
--------------------------	-------------------------	-----------------	-------	----------	----------

				Yes	No
	Did tl	ne hospital facility have in place during the tax year a written financial assistance policy that:			
13		ined eligibility criteria for financial assistance, and whether such assistance included free or discounted care? s," indicate the eligibility criteria explained in the FAP:	13	X	
	a X	Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.0000 %			
		and FPG family income limit for eligibility for discounted care of 400.0000 %			
	b X	Income level other than FPG (describe in Section C)			
	c X	Asset level			
	d X	Medical indigency			
1	e X	Insurance status			
1	f X	Underinsurance status			
!	g X	Residency			
i	h	Other (describe in Section C)			
14		ined the basis for calculating amounts charged to patients?	14	Х	
15		ined the method for applying for financial assistance?	15	Х	
		es," indicate how the hospital facility's FAP or FAP application form (including accompanying ctions) explained the method for applying for financial assistance (check all that apply):			
;	a X	Described the information the hospital facility may require an individual to provide as part of his or her application			
	b X	Described the supporting documentation the hospital facility may require an individual to submit as part			
		of his or her application			
	X	Provided the contact information of hospital facility staff who can provide an individual with information			
		about the FAP and FAP application process			
(	d X	Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
	e 🔲	Other (describe in Section C)			
16	Was	widely publicized within the community served by the hospital facility?	16	Х	
	If "Ye	s," indicate how the hospital facility publicized the policy (check all that apply):			
	a X	The FAP was widely available on a website (list url): WWW. MEDSTARUNIONMEMORIAL.ORG			
1		The FAP application form was widely available on a website (list url): WWW. MEDSTARUNIONMEMORIA	₽.OR	G	
(	: X	A plain language summary of the FAP was widely available on a website (list url): WWW.MEDSTARUNION.	иемо	RIAI	.ORG
(	i X	The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
(	X	The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
1	X	A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
	x X	Individuals were notified about the FAP by being offered a paper copy of the plain language summary of			
•	,	the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
ı	1 X	Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	X	The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j		Other (describe in Section C)			

Schedule H (Form 990) 2016

PAGE 46

Schedule H (Form 990) 2016

Part	V	Facility Information (continued)			
		Collections			
Nam	e of I	nospital facility or letter of facility reporting group UNION MEMORIAL HOSPITAL			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written				No
	fina	ncial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party			
		y take upon nonpayment?	17	X	Hamanoonionionio
18		ck all of the following actions against an individual that were permitted under the hospital facility's			
		cies during the tax year before making reasonable efforts to determine the individual's eligibility under the			
	faci	lity's FAP:			
а	_	Reporting to credit agency(ies)			
b		Selling an individual's debt to another party			
С	L	Deferring, denying, or requiring a payment before providing medically necessary care due to			
		nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	_	Actions that require a legal or judicial process			
е	<u> </u>	Other similar actions (describe in Section C)			
f	X	The second secon			
19		the hospital facility or other authorized party perform any of the following actions during the tax year			
		ore making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	62565555555	X
	IT "Y	'es," check all actions in which the hospital facility or a third party engaged:			
a		Reporting to credit agency(ies)			
b	-	Selling an individual's debt to another party			
С	L_	Deferring, denying, or requiring a payment before providing medically necessary care due to			
		nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	-	Actions that require a legal or judicial process			
e		Other similar actions (describe in Section C)			
20		cate which efforts the hospital facility or other authorized party made before initiating any of the actions liste	d (wi	nethe	∍r or
_	X	checked) in line 19 (check all that apply):			
а		t revised a written netice about appearing Eer b (Extraordinary concentration) and a plain language st	ımma	ry of	the
<b>L</b>	X	FAP at least 30 days before initiating those ECAs			
b c	X	made a reasonable entire to drainy notiny individuals about the FAI and FAI application process			
d	X	The desired and dempisite the approximations			
e	1	Other (describe in Section C)			
f		None of these efforts were made			
	Rela	ating to Emergency Medical Care			
21	Did	the hospital facility have in place during the tax year a written policy relating to emergency medical care			
		required the hospital facility to provide, without discrimination, care for emergency medical conditions to			
		viduals regardless of their eligibility under the hospital facility's financial assistance policy?	21	Х	
	If_"N	o," indicate why:			
а		The hospital facility did not provide care for any emergency medical conditions			
b		The hospital facility's policy was not in writing			
С		The hospital facility limited who was eligible to receive care for emergency medical conditions (describe			
		in Section C)			
d		Other (describe in Section C)			

Part	V Facility Information (continued)			
Charg	es to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)			
Name	e of hospital facility or letter of facility reporting group UNION MEMORIAL HOSPITAL			
	, 1 <b>33</b> 1		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
а	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period			
b	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
С	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period			
d	X The hospital facility used a prospective Medicare or Medicaid method			
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?  If "Yes," explain in Section C.	23		Х
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	24		X

### Part V Facility Information (continued)

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

CHNA INPUT

PART V, SECTION B, LINE 5

HOSPITAL LEAD

ROLE DESCRIPTION

THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) HOSPITAL LEAD SERVES AS THE COORDINATOR OF ALL ASPECTS OF THE COMMUNITY HEALTH ASSESSMENT PROCESS.

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

NAME OF HOSPITAL LEAD: JAMES BLOOM

EXECUTIVE SPONSOR

ROLE DESCRIPTION

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

Schedule H (Form 990) 2016 Page **8** 

### Part V Facility Information (continued)

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

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

ADVISORY TASK FORCE

ROLE DESCRIPTION

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

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

### NOTE:

THE ATF SHOULD BE A COMBINATION OF COMMUNITY REPRESENTATIVES AND STAFF.

COMMUNITY REPRESENTATIVES SHOULD MAKEUP AT LEAST 50% OF TOTAL

PARTICIPANTS.

NAME TITLE/AFFILIATION WITH NAME OF ORGANIZATION

HOSPITAL

JAMES BLOOM FINANCIAL ANALYST MEDSTAR UNION MEMORIAL

HOSPITAL

BRAD CHAMBERS PRESIDENT & SVP MSH MEDSTAR UNION MEMORIAL

HOSPITAL

### Facility Information (continued)

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

SAVAS KARAS

BOARD MEMBER

MEDSTAR UNION MEMORIAL

HOSPITAL

DERRICK ADAMS

BOARD MEMBER

MEDSTAR UNION MEMORIAL

HOSPITAL

SARAH FAWCETT

REGIONAL VP OF PHILANTHROPY

MEDSTAR UNION MEMORIAL

LEE

HOSPITAL, GUILFORD

RESIDENT

GLENDA

EXECUTIVE DIRECTOR

SHEPHERD'S CLINIC & JOY

SKULETICH

WELLNESS CENTER

LISA GHINGER

EXECUTIVE DIRECTOR

HAMPDEN FAMILY CENTER

ALICE ANN

COMMUNITY LEADER

GUILFORD RESIDENT

FINNERTY

NICHOLE BATTLE CHIEF EXECUTIVE OFFICER

GOVANS ECUMENICAL

DEVELOPMENT CORPORATION

IMPLEMENTATION STRATEGIES

PART V, SECTION B, LINE 8

THE IMPLEMENTATION STRATEGIES SERVE AS A ROADMAP FOR HOW COMMUNITY

BENEFIT RESOURCES WILL BE ALLOCATED AND DEPLOYED. MEDSTAR'S HOSPITAL WILL

BE ABLE TO MEASURE OUR CONTRIBUTION TO IMPROVING THE HEALTH OF

UNDERSERVED AND VULNERABLE POPULATIONS IN THE REGIONS WE SERVE.

THREE-YEAR IMPLEMENTATION STRATEGIES WITH MEASURABLE OBJECTIVES WERE

DEVELOPED FOR EACH HOSPITAL'S COMMUNITY BENEFIT SERVICE AREA - A SPECIFIC

COMMUNITY OR TARGET POPULATION OF FOCUS. PRIORITIES WERE BASED ON

COMMUNITY NEED AS DETERMINED BY QUANTITATIVE DATA AND COMMUNITY INPUT, AS

### Part V Facility Information (continued)

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

WELL AS ON HOSPITAL EXPERTISE, RESOURCES, STRENGTHS OF EXISTING

PROGRAMMING AND PARTNERSHIPS, AND ALIGNMENT WITH NATIONAL, STATE, AND

LOCAL HEALTH GOALS. THE MEDSTAR HEALTH CORPORATE COMMUNITY HEALTH

DEPARTMENT WILL PROVIDE SYSTEM-WIDE COORDINATION AND OVERSIGHT OF

COMMUNITY BENEFIT PROGRAMMING.

HOSPITAL ADVISORY TASK FORCES CONVENE AT LEAST ANNUALLY TO MONITOR

PROGRESS OF STRATEGY EXECUTION AND TO PROVIDE ONGOING RECOMMENDATIONS

RELATED TO OUTCOMES ACHIEVEMENT, PROGRAM DEVELOPMENT, PARTNERSHIP

APPROACHES, AND OVERALL IMPLEMENTATION IMPROVEMENT.

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

## Part V Facility Information (continued)

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

low many non-hospital health care facilities did the org	ganization operate during the tax year?
Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
0	

### Supplemental Information Part VI

Provide the following information.

1 Required descriptions. Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and

THE UNION MEMORIAL HOSPITAL

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

CHARITY CARE AT COST

PART I, LINE 7A

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

UNREIMBURSED MEDICAID

PART I, LINE 7B

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

Provide the following information.

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

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

BAD DEBT

PART III, LINES 2 & 4

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

Schedule H (Form 990) 2016 Page 10

### Part VI Supplemental Information

Provide the following information.

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

SELF PAY AMOUNTS ARE COLLECTIBLE IN DETERMINING REVENUE RECOGNITION.

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

### MEDICARE

PART III, LINE 8

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL

PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES

COST REVIEW COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING

PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME

AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S

UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED

CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO

BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. AS SUCH,

Provide the following information.

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

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

PART III, LINE 9B

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

NEEDS ASSESSMENT

PART VI, LINE 2

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

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

Provide the following information.

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

LEADERSHIP, CLINICAL EDUCATORS AND BOARD MEMBERS. THE ATF REVIEWED

QUANTITATIVE AND QUALITATIVE COMMUNITY HEALTH DATA, AS WELL AS LOCAL,

REGIONAL AND NATIONAL HEALTH GOALS.

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

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

Schedule H (Form 990) 2016 Page **10** 

### Part VI Supplemental Information

Provide the following information.

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

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

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

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

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

Schedule H (Form 990) 2016

JSA

THE UNION MEMORIAL HOSPITAL

### Supplemental Information Part VI

Provide the following information.

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

NECESSARY HOSPITAL SERVICES. MEDSTAR HEALTH AND ITS HEALTHCARE FACILITIES WILL:

- TREAT ALL PATIENTS EQUITABLY, WITH DIGNITY, WITH RESPECT AND WITH COMPASSION.
- SERVE THE EMERGENCY HEALTH CARE NEEDS OF EVERYONE WHO PRESENTS AT OUR FACILITIES REGARDLESS OF A PATIENT'S ABILITY TO PAY FOR CARE.
- ASSIST THOSE PATIENTS WHO ARE ADMITTED THROUGH OUR ADMISSIONS PROCESS FOR NON-URGENT, MEDICALLY NECESSARY CARE WHO CANNOT PAY FOR PART OF ALL OF THE CARE THEY RECEIVE.
- BALANCE NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH BROADER FISCAL RESPONSIBILITIES IN ORDER TO KEEP ITS HOSPITALS' DOORS OPEN FOR ALL WHO MAY NEED CARE IN THE COMMUNITY.

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

Schedule H (Form 990) 2016

JSA

32068H 2502

### Part VI Supplemental Information

Provide the following information.

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

ELIGIBILITY, MEDSTAR HEALTH'S FACILITIES ASSISTS UNINSURED PATIENTS WHO

RESIDE WITHIN THE COMMUNITIES WE SERVE IN ONE OR MORE OF THE FOLLOWING

WAYS:

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

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

Provide the following information.

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

INFORMATION TO PATIENTS AS REQUIRED BY THIS POLICY AND APPLICABLE REGULATIONS AND MAKES A COPY OF THE POLICY AVAILABLE TO ALL PATIENTS. ADDITIONALLY, THE MARYLAND PATIENT INFORMATION SHEET/MEDSTAR'S PATIENT INFORMATION SHEET IS PROVIDED TO INPATIENTS ON ADMISSION AND AT TIME OF FINAL ACCOUNT BILLING.

MEDSTAR HEALTH BELIEVES THAT ITS PATIENTS HAVE PERSONAL RESPONSIBILITIES RELATED TO THE FINANCIAL ASPECTS OF THEIR HEALTHCARE NEEDS. THE CHARITY CARE, FINANCIAL ASSISTANCE, AND PERIODIC PAYMENT PLANS AVAILABLE UNDER THIS POLICY ARE NOT BE AVAILABLE TO THOSE PATIENTS WHO FAIL TO FULFILL THEIR RESPONSIBILITIES. FOR PURPOSES OF THIS POLICY, PATIENT RESPONSIBILITIES INCLUDE:

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

Schedule H (Form 990) 2016

JSA

Provide the following information.

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

AVAILABILITY OF FINANCIAL ASSISTANCE.

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

UNINSURED PATIENTS OF MEDSTAR HEALTH'S FACILITIES MAY BE ELIGIBLE FOR CHARITY CARE OR SLIDING-SCALE FINANCIAL ASSISTANCE UNDER THIS POLICY. THE

Provide the following information.

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

FINANCIAL COUNSELORS AND FINANCIAL SERVICES STAFF WILL DETERMINE

ELIGIBILITY FOR CHARITY CARE AND SLIDING-SCALE FINANCIAL ASSISTANCE BASED

ON REVIEW OF INCOME FOR THE PATIENT AND THEIR FAMILY (HOUSEHOLD), OTHER

FINANCIAL RESOURCES AVAILABLE TO THE PATIENT'S FAMILY, FAMILY SIZE, AND

THE EXTENT OF THE MEDICAL COSTS TO BE INCURRED BY THE PATIENT.

COMMUNITY INFORMATION

PART VI, LINE 4

GEOGRAPHIC:

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

DEMOGRAPHICS:

MEDSTAR UNION MEMORIAL HOSPITAL IS LOCATED IN ZIP CODE 21218 WITH 21211

TO THE WEST AND 21213 TO THE EAST; THUS, THE HOSPITAL IS DIRECTLY

SURROUNDED BY THE CBSA. THESE THREE ZIP CODES ACCOUNT FOR 40.8% OF THE

Provide the following information.

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

ADMISSIONS TO THE HOSPITAL. NEIGHBORHOODS WITHIN THE CBSA INCLUDE

MEDFIELD/HAMPDEN/WOODBERRY/REMINGTON, GREATER CHARLES VILLAGE/BARCLAY,

WAVERLIES, MIDWAY/COLDSTREAM, AND BELAIR-EDISON. ACCORDING TO THE UNITED

STATES CENSUS BUREAU, THERE ARE 99,880 RESIDENTS CURRENTLY LIVING WITHIN

THE CBSA, 15% OF THE ENTIRE POPULATION OF BALTIMORE CITY. IT IS A

RELATIVELY DIVERSE POPULATION, WITH 64% BLACK/AFRICAN AMERICAN, 29%

WHITE, 3.8% ASIAN, AND 0.6% OTHER. APPROXIMATELY 2% OF RESIDENTS ARE OF

HISPANIC ORIGIN. THE VAST MAJORITY OF THE POPULATION (81%) IS OVER THE

AGE OF 18. AVERAGE MEDIAN HOUSEHOLD INCOME ACROSS THE CBSA IS \$43,256 PER

YEAR, JUST SLIGHTLY ABOVE THE CITY MEDIAN.

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

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

### Part VI Supplemental Information

Provide the following information.

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

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

ADDITIONALLY, AN ASSORTMENT OF SUBSIDIZED HEALTH SERVICES ARE PROVIDED.

THESE SERVICES OPERATE AT A NEGATIVE MARGIN BUT ARE NEEDED FOR THE

COMMUNITY. EXAMPLES INCLUDE RENAL SERVICES, PSYCHIATRY AND PEDIATRIC

CARE. SERVICES ARE AVAILABLE 24 HOURS PER DAY, 7 DAYS PER WEEK.

1793311

Provide the following information.

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

AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

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

STATE FILING OF COMMUNITY BENEFIT REPORT

PART VI, LINE 7

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

### **SCHEDULE J** (Form 990)

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

Complete if the organization answered "Yes" on Form 990, Part IV, line 23.

► Attach to Form 990.

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

OMB No. 1545-0047 Open to Public

Department of the Treasury Internal Revenue Service Name of the organization

THE UNION MEMORIAL HOSPITAL

Inspection Employer identification number

52-0591685

Par	Questions Regarding Compensation			
			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form			
	990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	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			
	Discretionary spending account  Personal services (such as, maid, chauffeur, chef)			
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment			
-	or reimbursement or provision of all of the expenses described above? If "No," complete Part III to		3.7	
_	explain	1b	X	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all			
	directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line		X	
	1a?	2	^	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the			
	organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	X Compensation committee X Written employment contract			
	X Independent compensation consultant X Compensation survey or study			
	X Form 990 of other organizations X Approval by the board or compensation committee			
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
а	Receive a severance payment or change-of-control payment?	4a	Х	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b		Х
С	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		Х
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any			
	compensation contingent on the revenues of:			
а	The organization?	5a		X
b	Any related organization?	5b	***************************************	X
	If "Yes" on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any			
	compensation contingent on the net earnings of:			
а	The organization?	6a		X
b	Any related organization?	6b		X
	If "Yes" on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed	,		Х
	payments not described on lines 5 and 6? If "Yes," describe in Part III.	7		
8	Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe			
		8		Х
9	in Part III	U		21
J	Regulations section 53.4958-6(c)?	9		

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

Schedule J (Form 990) 2016

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

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

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

	Γ	(B) Breakdown of W-2	f W-2 and/or 1099-MISC compensation	C compensation	(C) Retirement and	(D) Nontaxable	(E) Total of columns	(E) Compensation
(A) Name and Title		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable	other deferred compensation	benefits	(B)(i)-(D)	in column (B) reported as deferred on prior
				compensation				
MICHAEL FIOCCO, M.D.	ε	702,293.	25,000.	0.	0	14,989.	742,282.	0.
1DIRECTOR	(ii)	0.	0.	0.	0	0		0
CYNTHIA WEBB, M.D.	ε	0.	0.	0.	0.	0.	0.	0
2DIRECTOR	(ii)	498,107.	0	0.	17,595.	15,143.	530,845.	0.
STIN TORTOLANI, M.	ε	992,993.	49,744.	0.	5	, 15	65,83	0
3DIRECTOR	€	0	0	0	0			0
OPHER D. KEARNEY,	€	154,396.	0	0	11,897.	752.	167,045.	0
	<b>(E)</b>	146,768.	0.	0.	0.	0	146,768.	0.
DAVID NASRALLAH, M.D.	Ξ	363,002.	0	0.	25,628.	14,778.	403,408.	0.
	Ξ	0.	0.	0	0.	0	0	0.
EBERT, M.D.	€	1,305,950.	0	0	6,809.	14,957.	1,327,716.	0.
Z	€	0	0.	0	0	0	0	0
HENRY BOUCHER, M.D.	Ξ	962,553.	155,031.	0.	8,651.	15,133.	1,141,368.	0.
	Ξ	0.	0.	0	0	0	0	0.
ANAND MURTHI, M.D.	Ξ	1,019,762.	90,374.	0.	7,950.	15,053.	1,133,139.	0.
ECTOR	€	0.	.0	0.	0	0	0	0
STEPHEN KOENIGSBERG	Ξ	101,977.	22,109.	0	5,379.	5,792.	135,257.	0
DENT	€	101,977.	22,109.	0.	5,378.	5,793.	135,257.	0.
SHARON BOTTCHER	ε	137,436.	35,479.	0.	7,382.	441.	180,738.	0
ENT	Ξ	137,436.	35,479.	.0	7,382.	442.	180,739.	0.
KENNETH A. SAMET	ε	0	.0	0	.0	0	0	0.
	€	1,739,872.	3,775,374.	2,159,796.	47,768.	29,047.	7,751,857.	0.
BRADLEY S. CHAMBERS	Ξ	290,742.	268,982.	0.	9,626.	11,751.	581,101.	0
/DIRECTOR	€	290,743.	268,982.	0.	9,625.	11,752.	581,102.	0.
JOSEPH SMITH	Ξ	6,018.	0.	158,978.	0.	0	164,996.	0.
ICER	Ξ	0.	0.	.0	0.	0.	0	0.
T	Ξ	413,892.	279,451.	0.	7,950.	14,410.	715,703.	0.
TCER	Ξ	.0	0.	0.	.0	0	0	0.
	Ξ	197,089.	32,374.	0.	12,948.	6,656.	249,067.	0.
EY EMPLOYEE	€	0.	0.	0.	0	0	0	0.
·	ε	- 1	67,322.	.0	12,080.	7,413.	226,588.	0.
16CHIEF FINANCIAL OFFICER	€	139,773.	67,322.	0.	12,080.	7,414.	226,589.	0.
							Sch	Schedule J (Form 990) 2016

V 16-7.17

52-0591685

Schedule J (Form 990) 2016

Page 2

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

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

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

		(B) Breakdown of W-2	f W-2 and/or 1099-MISC compensation	3C compensation	(C) Retirement and	(D) Nontaxable	(F) Total of columns	(F) Compensation
(A) Name and Title		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	other deferred compensation	benefits	(B)(l)-(D)	in column (B) reported as deferred on prior Form 990
JOHN WANG	ε	900,417.	.000,26	0	7,950.	15,099.	1,018,466.	0.
4CHIEF OF CARDIAC CATH LAB	€	.0	.0	0	.0	0	0	0.
RICHARD LEVINE	€	966,519.	0	.0	7,950.	15,121.	.065,686	0
2PHYSICIAN	(E)	.0	0	.0	0.	0	0	0.
	Θ							
က	€							
	€							
4	€							
	€							
5	€							
	€							
9	<u> </u>						•	
	ε							
7	€							
	ε							
8	(II)							
	Θ							
6	€							
	<u>(i)</u>							
10	Œ							
	Θ							
11	<u>(ii)</u>							
	€							
12	Ξ							
	€							
13	<b>(E)</b>							
	Ξ							
14	(ii)							
	Ξ							
15	(ii)							
	Ξ							
16	(ii)							
							Sch	Schedule J (Form 990) 2016

6E12911.000 32068H 2502

V 16-7.17

1793311

Schedule J (Form 990) 2016

Page 3

# Part III Supplemental Information

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

SOCIAL CLUB DUES

SCHEDULE J, PART I, LINE 1

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

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

BUSINESS PURPOSES, AND HELPED THE ORGANIZATION FURTHER ITS EXEMPT

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

SEVERANCE PAYMENTS

SCHEDULE J, PART I, LINE 4A

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

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

MR. SMITH

SUPPLEMENTAL RETIREMENT PLAN

SCHEDULE J, PART III

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

REPRESENTING BENEFITS RECEIVED FROM EXECUTIVE RETIREMENT PLANS THAT ARE

COMPRISED OF TARGET BENEFITS DETERMINED ANNUALLY BASED ON COMPENSATION

AND YEARS OF SERVICE AND LONG-TERM RETENTION ARRANGEMENTS.

JSA

PAGE 71

Schedule J (Form 990) 2016

Page 3

# Part III Supplemental Information

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

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

HOSPITAL.

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

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

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

Schedule J (Form 990) 2016

V 16-7.17

Page 3

Part III Supplemental Information

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

Schedule J (Form 990) 2016

6E1505 2.000 32068H 2502

### **SCHEDULE L**

# **Transactions With Interested Persons**

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

OMB No. 1545-0047

Open To Public Inspection

Department of the Treasury Internal Revenue Service

►Attach to Form 990 or Form 990-EZ. ▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

Name of the organization

Employer identification number

THE	UNION MEMORIAL	HOSPITAL							52 <b>-</b>	0591	685				
Par		Transactions organization a	(section 501 answered "Ye	(c)(3 es" oı	), sect 1 Form	ion 501(c)(4 n 990, Part I'	), and V, line	501(c)(29) organi 25a or 25b, or For	zations m 990-	only). EZ, P	art V,	line 4	0b.		
	( - )		(b) Relatio	nship	between	disqualified pers	son and	(-) P	!	-64			(d)	Сопесь	2d?
1	(a) Name of disqualified	person	` '	•	organiz			(c) Des	cription	of trans	action		Y	es N	0
(1)														1	
(2)														T	
(3)															
(4)															
(5)															
(6)															
3	Enter the amount of tunder section 4958. Enter the amount of ta												-		
Par		organization a	inswered "Ye	es" or				ine 38a or Form 99	00, Pari	t IV, lin	ie 26;	or if th	ne		
(a)	Name of interested person	(b) Relationship with organization	(c) Purpose of Ioan	fror	an to or n the ization?	(e) Origin principal am		(f) Balance due	(g) In	default?	by bo	proved pard or nittee?	(i) W agreer		
				То	From				Yes	No	Yes	No	Yes	No	
(1)															
(2)															
(3)															
(4)															
(5)															
(6)															
(7)															
(8)															
(9)															
(10)															
			<i></i> .	<u> </u>		<u> </u>	▶	\$							
Par	Grants or Assis Complete if the	organization a	nswered "Ye	es" or	Form	990, Part IV	,	7.							
(a)	Name of interested person		p between intere the organization		:) Amou	nt of assistance		(d) Type of assistance		(e)	Purpos	se of ass	sistance	<del></del>	
(1)															_
(2)															_
(3)															_
(4)															_
(5)															_
(6)															_
(7)															_
(8)															_
(9)															_

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

Schedule L (Form 990 or 990-EZ) 2016

Schedule L (Form 990 or 990-EZ) 2016

Page 2

## Part IV Business Transactions Involving Interested Persons.

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

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

## Part V Supplemental Information

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

BUSINESS TRANSACTION INVOLVING INTERESTED PERSONS

SCHEDULE L, PART IV

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

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

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

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

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

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

Page 2

# Part IV Business Transactions Involving Interested Persons.

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

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

### Part V **Supplemental Information**

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

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

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

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

32068H 2502

1793311

# **Noncash Contributions**

► Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.

Attach to Form 990.

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

OMB No. 1545-0047

2016

Open To Public

Inspection

Department of the Treasury Internal Revenue Service Name of the organization

THE UNION MEMORIAL HOSPITAL

Employer identification number

52-0591685

Pai	t Types of Property			<b>,</b>				
		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	Method of noncash cont			
1	Art - Works of art							
2	Art - Historical treasures							
3	Art - Fractional interests	· · · · · · · · · · · · · · · · · · ·						
4	Books and publications							
5	Clothing and household							
	goods							
6	Cars and other vehicles							
7	Boats and planes							
8	Intellectual property							
9	Securities - Publicly traded	Х	5.	33,288.	FMV			
10	Securities - Closely held stock							
11	Securities - Partnership, LLC,							
	or trust interests							
12	Securities - Miscellaneous							
13	Qualified conservation							
	contribution - Historic							
	structures							
14	Qualified conservation							
	contribution - Other							
15	Real estate - Residential							
16	Real estate - Commercial							
17	Real estate - Other							
18	Collectibles							
19	Food inventory							
20	Drugs and medical supplies							
21	Taxidermy			· · · · · · · · · · · · · · · · · · ·				
22	Historical artifacts							
23	Scientific specimens							
24	Archeological artifacts							
25	Other ►()							
26	Other ►()							
27	Other ►()							
28	Other ►(							
29	Number of Forms 8283 received	by the ora	anization during the tax ve	ear for contributions for				
	which the organization completed F				29			
	willow and organization completed t	onn ozoo,	a.c.v, bonco roknowody				Yes	No
30a	During the year, did the organizati	on receive	by contribution any proper	ty reported in Part I lines	s 1 through		1 1 1	
	28, that it must hold for at least th			= *	- 1		i 1	: 
	to be used for exempt purposes for					30a		Х
b	If "Yes," describe the arrangement in		oranig portoa					
31	Does the organization have a		ance policy that require	s the review of any r	nonstandard		,	
٠.	contributions?			•	1	31	X	
32a	Does the organization hire or use							
u	contributions?		<del>-</del>		1	32a		Х
h	If "Yes," describe in Part II.		• • • • • • • • • • • • • • • • • • • •					
	If the organization didn't report an a	amount in c	olumn (c) for a type of pror	nerty for which column (a)	is checked			
-	describe in Part II	annount in C	oranini (c) for a type or brot	serty for without column (a)	is circoneu,			

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

Schedule M (Form 990) (2016)

Page 2

Part II

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

Schedule M (Form 990) (2016)

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

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

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

Attach to Form 990 or 990-EZ.

2016
Open to Public Inspection

OMB No. 1545-0047

Department of the Treasury Internal Revenue Service

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

Name of the organization

Employer identification number

52-0591685

ORGANIZATION MEMBERS

THE UNION MEMORIAL HOSPITAL

PART VI, LINE 6

THE ORGANIZATION IS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC.,

A TAX-EXEMPT MARYLAND NON-STOCK CORPORATION. MEDSTAR HEALTH, INC., OR ONE

OF ITS AFFILIATES AND SUBSIDIARIES, IS THE SOLE MEMBER OF THE

ORGANIZATION.

DESCRIPTION OF MEMBERS

PART VI, LINE 7A

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT

MARYLAND NON-STOCK CORPORATION, THE ORGANIZATION MAY RECOMMEND PERSON(S)

FOR MEMBERSHIP ON THE ORGANIZATION'S GOVERNING BODY. ANY SUCH

RECOMMENDATION BY THE ORGANIZATION IS SUBJECT TO APPROVAL BY THE

GOVERNANCE COMMITTEE OF THE BOARD OF DIRECTORS OF MEDSTAR HEALTH, INC.

THE BOARD OF MEDSTAR HEALTH, INC. HAS DELEGATED CERTAIN APPROVAL

AUTHORITY TO THE GOVERNANCE COMMITTEE AND THE PRESIDENT & CEO OF MEDSTAR

HEALTH, INC.

DECISIONS OF GOVERNING BODY

PART VII, LINE 7B

AS AN AFFILIATE AND SUBSIDIARY OF MEDSTAR HEALTH, INC., A TAX-EXEMPT

MARYLAND NON-STOCK CORPORATION, THE BYLAWS OF THE ORGANIZATION ARE

SUBJECT TO CERTAIN RESERVED POWERS, WHICH PROVIDE THAT THE SOLE MEMBER OF

THE ORGANIZATION MUST APPROVE CERTAIN DECISIONS, INCLUDING BUT NOT

Employer identification number 52-0591685

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

PROCESS FOR REVIEWING FORM 990

PART VI, LINE 11B

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

CONFLICT OF INTEREST POLICY

PART VI, LINE 12C

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

ANNUAL DISCLOSURES - ALL OFFICERS, DIRECTORS, AND SENIOR MANAGERS

ALL OFFICERS, DIRECTORS AND SENIOR MANAGERS ARE REQUIRED, NOT LESS THAN ANNUALLY, TO COMPLETE A SURVEY OF QUESTIONS CONCERNING ANY TRANSACTIONS OR RELATIONSHIPS WHICH WOULD OR COULD REPRESENT A CONFLICT OF INTEREST.

SUCH DISCLOSURES (IF ANY) ARE REVIEWED BY THE GOVERNANCE COMMITTEE OF THE MEDSTAR HEALTH BOARD OF DIRECTORS WHICH DETERMINES HOW THE MATTER SHOULD BE RESOLVED.

EXECUTIVE COMPENSATION PROCESS

PART VI, LINE 15

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

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

1793311

Employer identification number 52-0591685

ORGANIZATIONS"). WHERE APPROPRIATE, ADDITIONAL INDUSTRY DATA IS

CONSIDERED (GENERAL BUSINESS AND/OR TAXABLE HEALTHCARE) FOR SELECTED

POSITIONS THAT CAN BE RECRUITED FROM OR POTENTIALLY LOST TO THESE

INDUSTRIES (E.G., INFORMATION TECHNOLOGY, FINANCE, ETC.).

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

FINANCIAL STATEMENTS AVAILABILITY

PART VI, LINE 19

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

FINANCIAL STATEMENTS AND REPORTING

PART XII, LINE 2C

Name of the organization
THE UNION MEMORIAL HOSPITAL

Employer identification number 52-0591685

THE UNION MEMORIAL HOSPITAL IS PART OF THE MEDSTAR HEALTH, INC. AUDIT AND SUBJECT TO OVERSIGHT BY THE AUDIT COMMITTEE OF THE MEDSTAR BOARD.

OTHER CHANGES IN NET ASSETS

PART XI, LINE 9

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

ATTACHMENT 1

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

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

ATTACHMENT 2

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

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

Name of the organization
THE UNION MEMORIAL HOSPITAL

Employer identification number 52-0591685

ATTACHMENT 2 (CONT'D)

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

ATTACHMENT 3

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

NAME AND ADDRESS

DESCRIPTION OF SERVICES

COMPENSATION

PARKWAY ANESTHESIOLOGISTS 201 E UNIVERSITY PARKWAY

PHYSICIAN SERVICES

12,516,000.

SAN DIEGO, CA 92130

Name of the organization

THE UNION MEMORIAL HOSPITAL

Employer identification number
52-0591685

ATTACHMENT 3 (CONT'D)

990, PART VII- COMPENSATION OF THE FIVE HIGHEST	PAID IND. CONTRACTORS	
NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
BALTIMORE, MD 21218		
CROTHALL SVCS GROUP 13028 COLLECTIONS CENTER DRIVE CHICAGO, IL 60693	ENVIRONMENTAL SVCS	4,377,655.
GREATER CHESAPEAKE ORTHO ASSOC 201 E UNIVERSITY PARKWAY BALTIMORE, MD 21218	MEDICAL SERVICES	3,946,554.
MORRISON MANAGEMENT SPECIALIST 4721 MORRISON DRIVE MOBILE, AL 36609	FOOD SERVICES	3,846,802.
AMN HEALTHCARE INC 12400 HIGH BLUFF DRIVE	STAFFING SERVICES	2,802,900.

Related Organizations and Unrelated Partnerships

► Attach to Form 990.

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

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

OMB No. 1545-0047 Open to Public 2016

Employer identification number Inspection

52-0591685

THE UNION MEMORIAL HOSPITAL

Name of the organization Department of the Treasury Internal Revenue Service

Partl

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) MEDSTAR HEALTH ANESTHESIA SERVICES D LLC 20-5909921					
201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218	HEALTH SVCS	MS	5,210,618.	-187,661. N/A	N/A
(2) BALTIMORE/WASHINGTON PATHOLOGY GROUP LLC 52-2242146					
201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218	HEALTH SVCS	MD	0	0.	0. N/A
(3) UNION MEMORIAL IMAGING, LLC					
201 EAST UNIVERSITY PARKWAY BALTIMORE, MD 21218	HEALTH SVCS	MD	893,912.	0	0. N/A
(4)					
(5)					
(9)					

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

(a) Name, address, and EIN of related organization	alated 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?	(b)(13)
							Yes	No
(1) CHURCH HOME CORPORATION	23-7374724							
10980 GRANTCHESTER WAY	COLUMBIA, MD 21044	MEDICAL FUND	MD	501(C)(3)	PF	N/A	×	
(2) FRANKLIN SQUARE HOSPITAL CENTER, INC.	ic. 52-0608007				The second secon			
9000 FRANKLIN SQUARE DRIVE	BALTIMORE, MD 21237	HOSPITAL	MD	501(C)(3)	n	N/A	×	
(3) HARBOR HOSPITAL, INC.	52-0491660							
3001 SOUTH HANOVER STREET	BALTIMORE, MD 21225	HOSPITAL	MD	501(C)(3)	n	N/A	×	
(4) MEDSTAR HEALTH, INC.	52-2087445		-					
10980 GRANTCHESTER WAY	COLUMBIA, MD 21044	MEDICAL SVCS	MD	501(C)(3)	12C III	N/A		×
(5) MONTGOMERY GENERAL HOSPITAL	52-0646893							
18101 PRINCE PHILIP DRIVE	OLNEY, MD 20832	HOSPITAL	MD	501(C)(3)	m	N/A	×	
(6) THE GOOD SAMARITAN HOSPITAL OF MARYLAND,	LAND, 52-0591607							
5601 LOCH RAVEN BLVD	BALTIMORE, MD 21239	HOSPITAL	MD	501(C)(3)	m	N/A	×	
(7) MEDSTAR HEALTH RESEARCH INSTITUTE	52-6056274							
108 IRVING STREET NW	WASHINGTON, DC 20010	HOSPITAL	DC	501(C)(3)	ላ	N/A	×	
For Paperwork Reduction Act Notice, see the Instructions for Form 990.	he Instructions for Form 990.					Schedule F	Schedule R (Form 990) 2016	) 2016

V 16-7.17

Name of the organization Department of the Treasury Internal Revenue Service

THE UNION MEMORIAL HOSPITAL

Part I

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37. Related Organizations and Unrelated Partnerships

► Attach to Form 990

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

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

Open to Public

OMB No. 1545-0047

Employer identification number

Inspection

52-0591685

	Name, address, and E	(a) Name, address, and EIN (if applicable) of disregarded entity	0_	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling	rolling
(1)								(min)	
(2)								***************************************	
(3)									
(4)					The state of the s				
(5)									-
(9)									
		100 mm m							
Part II	Identification of Relatec	Identification of Related Tax-Exempt Organizations. Cone or more related tax-exempt organizations during the	ions. Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had ring the tax year.	anization answe	red "Yes" on Fo	rm 990, Part IV,	line 34 because i	it had	
	(a)		(q)	(0)	(p)	(a)	<b>£</b> )	(6)	
	Name, address, and EIN of related organization	f related organization	Primary activity	Legal domicile (state or foreign country)	Exempt Code section	Public charity status (if section 501(c)(3))	trolling y	Section 512(b)(13) controlled entity?	2(b)(13) Iled
								Yes	No
(1) THE A	(1) THE MEDSTAR-GEORGETOWN MEDICAL CENTER,	NTER, I 52-2218584							
HOPSI	HOPSITAL ADMIN, 1 MAIN BLDG	WASHINGTON, DC 20007	HOSPITAL	DC	501(C)(3)	3	N/A	×	

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

(7) CHURCH HOME AND HOSPITAL OF THE CITY OF

10980 GRANTCHESTER WAY

4061 POWDERMILL ROAD, SUITE 21 (6) MEDSTAR SURGERY CENTER, INC.

6E1307 1.000 32068H 2502

1793311

PAGE

87

Schedule R (Form 990) 2016

 $\bowtie$ 

N/A

×

N/A

III

12C

501(C)(3)

MD

MEDICAL SVCS

501(C)(3)

20

HOSPITAL

52-1272129

(2) WASHINGTON HOSPITAL CENTER CORPORATION

WASHINGTON, DC 20010

52-1542230

COLUMBIA, MD 21044

52-1132992

(4) MEDSTAR AMBULATORY SERVICES, INC.

(5) BAY LIFE SERVICES, INC. 10980 GRANTCHESTER WAY

10980 GRANTCHESTER WAY

(3) HH MEDSTAR HEALTH, INC.

110 IRVING STREET NW

10980 GRANTCHESTER WAY

COLUMBIA, MD 21044

 $\bowtie$ 

N/A

III

12C

501(C)(3)

MD

ADMIN SVCS

×

N/A

501(C)(3)

MENTAL HEALTH | MD

 $\bowtie$ 

N/A

10

501(C)(3)

МD

MEDICAL SVCS

52-1061679

CALVERTON, MD 20705

52-1496539

COLUMBIA, MD 21044

52-0591600

COLUMBIA, MD 21044

N/A

12A

501(C)(3)

MD

MEDICAL FUND

Name of the organization Department of the Treasury Internal Revenue Service

THE UNION MEMORIAL HOSPITAL

Part

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37. Related Organizations and Unrelated Partnerships

▶ Attach to Form 990.

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

OMB No. 1545-0047

Open to Public Inspection

Employer identification number

52-0591685

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling
(1)					
(2)					
(3)					
(4)					
(5)					
(9)					

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

(a) Name, address, and EIN of related organization	lated 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?	(b)(13)
							Yes	No
(1) FRANKLIN SQUARE HOSPITAL CENTER FOUNDATI	NDATI 52-2329546							
9000 FRANKLIN SQUARE DRIVE	BALTIMORE, MD 21237	FOUNDATION	MD	501(C)(3)	7	N/A	×	
(2) GOOD SAMARITAN HOSPITAL FOUNDATION, INC.	INC. 52-2307122							
5601 LOCH RAVEN BLVD	BALTIMORE, MD 21239	FOUNDATION	MD	501(C)(3)	12A I	N/A	×	
(3) GOOD SAMARITAN NURSING CENTER, INC.	52-1672866							
5601 LOCH RAVEN BLVD	BALTIMORE, MD 21239	MEDICAL SVCS	MD	501(C)(3)	10	N/A	×	
(4) GS HOUSING, INC.	52-1481656	-						
5601 LOCH RAVEN BLVD	BALTIMORE, MD 21239	ELDER HOUSING	MD	501(C)(3)	10	N/A	×	
(5) GS PROPERTIES, INC.	52-1429853							
5601 LOCH RAVEN BLVD	BALTIMORE, MD 21239	ADMIN SVCS	MD	501(C)(3)	12A I	N/A	×	
(6) HARBOR HOSPITAL FOUNDATION, INC.	52-1284532							
3001 SOUTH HANOVER STREET	BALTIMORE, MD 21225	FOUNDATION	MD	501(C)(3)	12A I	N/A	×	
(7) MEDSTAR HEALTH INFUSION, INC.	52-1980510							
4061 POWDERMILL ROAD, SUITE 21	CALVERTON, MD 20705	MEDICAL SVCS	MD	501 (C) (3)	10	N/A	X	

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

1793311

Schedule R (Form 990) 2016

Department of the Treasury Internal Revenue Service

Part I

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.

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

OMB No. 1545-0047 Open to Public

52-0591685

Employer identification number

THE UNION MEMORIAL HOSPITAL Name of the organization

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

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

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

(a) Name, address, and EIN of related organization	elated 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?
T T T T T T T T T T T T T T T T T T T							Yes No
(1) MEDSTAR HEALTH VISITING NURSES ASSOCIATI	CIATI 53-0196597						
4061 POWDERMILL ROAD	CALVERTON, MD 20705	MEDICAL SVCS	MD	501(C)(3)	10	N/A	×
(2) MEDSTAR VNA HEALTHCARE	52-1458516						
4061 POWDERMILL ROAD, SUITE 21	CALVERTON, MD 20705	MEDICAL SVCS	MD	501(C)(3)	10	N/A	×
(3) MGH COMMUNITY HEALTH, INC.	52-1372467						
18101 PRINCE PHILIP DRIVE	OLNEY, MD 20832	MEDICAL SVCS	MD	501(C)(3)	10	N/A	×
(4) MGH HEALTH FOUNDATION, INC.	52-1129959						
18101 PRINCE PHILIP DRIVE	OLNEY, MD 20832	FOUNDATION	MD	501(C)(3)	7	N/A	×
(5) MGH HEALTH SERVICES, INC.	52-1366812		The state of the s				
18101 PRINCE PHILIP DRIVE	OLNEY, MD 20832	FOUNDATION	MD	501(C)(3)	12B II	N/A	×
(6) MGH WOMEN'S BOARD	52-6039600						
18101 PRINCE PHILIP DRIVE	OLNEY, MD 20832	FOUNDATION	MD	501(C)(3)	12C III	N/A	×
(7) NATIONAL REHABILITATION HOSPITAL	52-1369749						
102 IRVING STREET NW	WASHINGTON, DC 20010	HOSPITAL	DC	501(C)(3)	ന	N/A	×

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

6E1307 1.000 32068H 2502

Schedule R (Form 990) 2016

Name of the organization Department of the Treasury Internal Revenue Service

THE UNION MEMORIAL HOSPITAL

Partl

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37. Related Organizations and Unrelated Partnerships

▶ Attach to Form 990.

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

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

Open to Public

OMB No. 1545-0047

Inspection Employer identification number

52-0591685

	(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)						
(2)						
(3)						
(4)						
(2)			777			
(9)						
Part	Identification of Related Tax-Exempt Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had	ıe organization ansv	rered "Yes" on For	rm 990, Part IV,	line 34 because	it had

r nad	(g) Section 512/b)(13)
line 34 because I	(J)
orm 990, Part IV,	(e)
ed "Yes" on Fo	(p)
anization answer	(b) (c) (d) (f) (f)
<b>ations.</b> Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had during the tax year.	(b)
one or more related tax-exempt Organizations. Consider the constant of the con	(a) Mame address and EN of colored accommending
Part II	

(a) Name, address, and EIN of related organization	ed 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?	(b)(13) ed ?
							Yes	N <sub>o</sub>
(1) NRH REGIONAL REHAB AT OLNEY, INC.	52-2310902							
18101 PRINCE PHILIP DRIVE	OLNEY, MD 20832	MEDICAL SVCS	MD	501(C)(3)	8	N/A	×	
(2) SUBURBAN / NRH MEDICAL REHABILITATION, I	, г 52-1931151					***************************************		
102 IRVING STREET NW	WASHINGTON, DC 20010	MEDICAL SVCS	DC	501(C)(3)	೮	N/A	×	
(3) THE THOMAS O'NEIL CATHOLIC HEALTH CARE F	EF 52-1104382							
5601 LOCH RAVEN BLVD	BALTIMORE, MD 21239	FOUNDATION	MD	501(C)(3)	12D IIII	N/A	×	
(4) VNA, INC.	52-1332411					-		
4061 POWDERMILL ROAD, SUITE 21	CALVERTON, MD 20705	ADMIN SVCS	MD	501(C)(3)	12A I	N/A	×	
(5) WHC FOUNDATION, INC.	52-1791670		***************************************	TOTAL CONTRACTOR OF THE PARTY O				
110 IRVING STREET NW	WASHINGTON, DC 20010	FOUNDATION	DC	501(C)(3)	7	N/A	×	
(6) WOODBOURNE WOODS, INC.	52-2299070	The state of the s						
5601 LOCH RAVEN BLVD	BALTIMORE, MD 21239	ELDER HOUSING	MD	501(C)(3)	10	N/A	×	
(7) HOSPICE OF ST. MARY'S, INC.	52-2153926							
PO BOX 527	LEONARDTOWN, MD 20650	SUPPORT ORG	MD	501(C)(3)	12A I	N/A	×	
For Paperwork Reduction Act Notice, see the Instructions for Form 990.	Instructions for Form 990.					Schedule	Schedule R (Form 990) 2016	0) 2016

6E1307 1.000 32068H 2502

THE UNION MEMORIAL HOSPITAL

Name of the organization Department of the Treasury Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047	2016	Open to Public

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

Employer identification number 52-0591685

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

1

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

(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?	12(b)(13) olled
THE PROPERTY OF THE PROPERTY O							Yes	2
(1) ST. MARY'S HOSPITAL OF ST. MARY'S COUNTY 52-(	52-0619006							
25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650	20650	HOSPITAL	MD	501(C)(3)	r	N/A	×	
(2) ST. MARY'S HOSPITAL FOUNDATION, INC. 52-	52-1051368	To the state of th						
PO BOX 527 LEONARDTOWN, MD 20650	20650	SUPPORT ORG	MD	501(C)(3)	12A I	N/A	×	
(3) MEDSTAR SOUTHERN MD HOSPITAL CENTER 46-(	46-0726303	mayoo gaaraa aa a						
7503 SURRATTS ROAD CLINTON, MD 20735	35	HOSPITAL	MD	501(C)(3)	<u>ش</u>	N/A	×	
(4) MEDSTAR HEALTH INC AND AFFILIATES MASTER 46-7	46-7454613							
10980 GRANTCHESTER WAY COLUMBIA, MD 21044	044	RET. TRUST	MD	501(A)	N/A	N/A	×	
(5)								
(9)	The second secon							
(7)								* Commission of the Commission
For Paperwork Reduction Act Notice, see the Instructions for Form 990.	огт 990.					Schedule R (Form 990) 2016	(Form 95	30) 2016

6Е1307 1.000 32068H 2502

1793311

PAGE 91

Page 2

Schedule R (Form 990) 2016

- Regert Identification of Related Organizations Taxable as a Partnership Complete if the organization answered "Yes" on Form 990, Part IV, line 34

Part III	because it had one or more related organizations treated as a partnership during the tax year.	more related orga	nization	s treated as a p	e as a rature sind complete in the organizations treated as a partnership during the tax year.	organization al etax year.	iswered res		990, Part IV, II	ine 34	
S S	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?	(k) Percentage ownership
								Yes No		Yes No	
(1) MEDST?	(1) MEDSTAR SHAH MSO 46-2700536										named in the second
10980	10980 GRANTCHESTER WAY COLUMBI	MGMT SVCS	MD	N/A	N/A						
(2) 22590	(2) 22590 SHADY COURT, LLC										
22590	22590 SHADY COURT CALIFORNIA,	REAL ESTATE	MD	N/A	N/A						
(3) 24035	(3) 24035 THREE NOTCH ROAD, LLC										
24035	24035 THREE NOTCH ROAD, LLC HO REAL ESTATE	REAL ESTATE	MD	N/A	N/A						
(4) 37767	(4) 37767 MARKET DRIVE, LLC										
37767	37767 MARKET DRIVE, LLC CHARLO	REAL ESTATE	MD	N/A	N/A						
(5) 26840	(5) 26840 POINT LOOKOUT ROAD, ILC										
26840	26840 POINT LOOKOUT ROAD LEONA	REAL ESTATE	MD	N/A	N/A			-			
(6) GREATI	(6) GREATER CHESAPEAKE SURGERY CEN										
1212 3	1212 YORK ROAD, STE B100 LUTHE	SURGERY CENTER	MD	N/A	N/A						
(7) MONTEC	(7) MONTGOMERY COMMUNITY MAGNETIC										
4110 7	4110 ASPEN HILL ROAD, SUITE 20 MRI SCREENING	MRI SCREENING	MD	N/A	N/A						

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

				,				
(a) Name, address, and ElN of related organization	(b) Primary activity	(c) Legal domícile	(d)  Direct controlling	(e) Type of entity	(f) Share of total	(g) (h) (i) Share of Percentage Section	(h) Percentage	(i) Section
		(state or foreign country)	entity	(C corp, S corp, or trust)	income	end-of-year assets	ownership	512(b)(13) controlled entity?
								Yes No
(1) MEDSTAR PHARMACIES, INC. 52-1513056								
10980 GRANTCHESTER WAY COLUMBIA, MD 21044	DRUG SALES	QW	N/A	C CORP				
(2) EXTENCARE, INC. 52-1556228								
10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SERVICES	MD	N/A	C CORP				
(3) HELIX RESOURCES MANAGEMENT, INC. 52-1913070								
10980 GRANTCHESTER WAY COLUMBIA, MD 21044	ADMIN SERVICE	Œ	N/A	C CORP				
(4) HELLXCARE MEDICAL GROUP, LLC 52-1955580								
10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SERVICES	MD	N/A	C CORP				
(5) HELIXCARE PROPERTIES, LLC 52-1966695	Adams							
10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MEDICAL SERVICES	Ø	N/A	C CORP				
(6) PARKWAY VENTURES, INC. 52-1893569								
10980 GRANTCHESTER WAY COLUMBIA, MD 21044	HOLDING COMPANY	MD	N/A	C CORP				
(7) PHYSICIANS ADMINISTRATIVE SERVICES, INC. 23-7042074								
10980 GRANTCHESTER WAY COLUMBIA, MD 21044	BILLING SERVICES	MD	N/A	C CORP				
JSA						Schedule R (Form 990) 2016	(Form 99	0) 2016

JSA 6E1308 1.000

Page 2

Schedule R (Form 990) 2016

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

	50 5055.0		ם מסמנטם מס מ	and a second of the second and a second and	י ומא אסים י					
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign	(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 affocations?	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?	(k) Percentage ownership
							Yes No	· .	Yes No	
(1) PHYSIOTHERAPY ASSOCIATES NRH R										
4714 GETTYSBURG ROAD MECHANICS	PHYSIOTHERAPY	PA	N/A	N/A						
(2) FRANKLIN SQUARE MEDICAL CENTER										
101 EAST STATE STREET KENNETT	NURSING HOME	PA	N/A	N/A						
(3) PHYSICIAN IMAGING OF WASHINGTO								THE PARTY OF THE P		The same same same same same same same sam
840 CRESCENT CENTRE DR, STE 20	RADIOLOGY SVCS	ΝŢ	N/A	N/A						
(4) FRANKLIN IMAGING, LLC 52-15886										
7253 AMBASSADOR RD. BALTIMORE,	IMAGING	MD	N/A	N/A						
(5)										
(9)										
(2)									ž.	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicite	(d) Direct controlling	(e) Tvpe of entity	(f) Share of total	(g) Share of	(h) Percentade	(i) Section
	•	(state or foreign country)	entity	(C corp, S corp, or trust)	income	end-of-year assets ownership controlled controlled entity?	ownership	512(b)(13) controlled
								Yes No
(1) MEDSTAR FAMILY CHOICE, INC. 52-1995521								
10980 GRANTCHESTER WAY COLUMBIA, MD 21044	MANAGED CARE	MD	N/A	C CORP				
(2) MEDSTAR ENTERPRISES, INC. 52-2139841								
4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	ADMIN SERVICES	MD	N/A	C CORP				
(3) SITEL, INC. 90-0753340								
10980 GRANTCHESTER WAY COLUMBIA, MD 21044	EDUCATIONAL SVCS	MD	N/A	C CORP				
(4) STAR BILLING, INC. 52-1850113					ANTINCALALATA A.			
4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	BILLING SERVICES	MD	N/A	C CORP				
(5) WASHINGTON RISK NETWORK MANAGEMENT, INC. 52-2132677								
4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SERVICES	MD	N/A	C CORP				
(6) WASHINGTON HOSPITAL CENTER PHYSICIAN HOS 52-1931000								
100 IRVING STREET NW WASHINGTON, DC 20010	MEDICAL SERVICES	MD	N/A	C CORP				
(7) MEDSTAR PHYSICIAN PARTNERS, INC. 52-2030809								
4061 POWDERMILL ROAD, SUITE 210 CALVERTON, MD 20705	MEDICAL SERVICES	MD	N/A	C CORP			••	
JSA BELANB A DOD						Schedule R (Form 990) 2016	(Form 99	0) 2016

JSA 6E1308 1.000

PAGE 93

1793311 V 16-7.17 32068Н 2502

52-0591685

Page 2

Schedule R (Form 990) 2016

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

(a) Name, address, and EIN of	(b) Primary activity	(c) Legal	(d) Direct controlling		(f) Share of total	<u>_</u> _	(h) Disproportionats	(i) Code V - UBI	(i) General or P	(k) Percentage
		domicile (state or foreign	entity	income (related, unrelated, excluded from tax under	income		allocations?	amount in box 20 of Schedule K-1 (Form 1065)	managing partner?	ownership
		country)		sections 512-514)			Yes No		Yes No	
								***************************************		
				The state of the s						
										***************************************

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

(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) (h) Share of Percentage Section end-of-year assets ownership controlled entity?	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?
								Yes No
(1) FRANKLIN SQUARE DRIVE LAND CONDO ASSOCIA 76-0756352								
10980 GRANTCHESTER WAY COLUMBIA, MD 21044	CONDO OWNER ASSOC	QW.	N/A	C CORP				
(2) MGH DIVERSIFIED SERVICES, INC. 52-1943602								
18101 PRINCE PHILIP DRIVE OLNEY, MD 20832	MEDICAL SERVICES	MD	N/A	C CORP				
(3) ST. MARY'S HEALTH ALLIANCE, INC. 52-1930331								
25500 POINT LOOKOUT ROAD LEONARDTOWN, MD 20650	MEDICAL SERVICES	MD	N/A	C CORP				
(4) GREENSPRING FINANCIAL INSURANCE LIMITED 98-0188617								
23 LIME TREE BAY AVENUE, PO BOX 1051 , GRAND CAYMAN CJ KY1	INSURANCE	MD	N/A	C CORP				
(5) ST MARY'S CONDO ASSN 27-3377216								
25500 POINT LOOKOUT RD LEONARDTOWN, MD 20650	CONDOMINIUMS	MD	N/A	C CORP				
(6) MEDSTAR HEALTH MASTER RETIREMENT TRUST 99-999999								
102 SOUTH CHURCH ST., GRAND CAYMAN, CJ KY1-1002	INVESTMENTS	ÇŢ	N/A	C CORP				
(7) MEDSTAR HEALTH, INC INVESTMENT FUND I 98-1310273								
102 SOUTH CHURCH ST., GRAND CAYMAN, CJ KY1-1002	INVESTMENTS	ÇĴ	N/A	C CORP				
JSA RE1308 1 000						Schedule R (Form 990) 2016	Rorm 99	0) 2016

6E1308 1.000

Schedule R (Form 990) 2016

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

Motor Complete line 4 is any positive in listed in Death 11 111 - 107 (241) - 11-11-1			
Note: Complete mile in any entity is listed in Parts II, III, or 10 of this schedule.  1. During the fax year did the organization engage in any of the following transactions with one or more related engaging listed in Dodg II N.O.		م المالية	Yes No
a Receipt of (ii) interest, (iii) annuities, (iiii) royalties, or (iv) rent from a controlled entity	siated Olyanizations iis	ied iii rails ii-iv?	× ×
b Gift, grant, or capital contribution to related organization(s)			
c Gift, grant, or capital contribution from related organization(s)			
d Loans or loan guarantees to or for related organization(s)			
e Loans or loan guarantees by related organization(s)			
			1f
			1g
h Purchase of assets from related organization(s).			
Exchange or assets with related organization(s).			
J rease of racinities, equipment, of other assets to related organization(s).			
k Lease of facilities, equipment, or other assets from related organization(s)			× ×
l Performance of services or membership or fundraising solicitations for related organization(s)			
m Performance of services or membership or fundraising solicitations by related organization(s)			1m ×
			1n X
o Sharing of paid employees with related organization(s)			10 ×
n Reimhursement naid to related organization(s) for concess			
d Reimbursement haid by related organization(s) for expenses			7 dt
			v bl
r Other transfer of cash or property to related organization(s)			1r ×
(0			
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	is line, including cove	red relationships and trans	action thresholds.
(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) CHURCH HOME&HOSPITAL OF THE CITY OF BALTIMORE	Д.	322.001	FMV
12) HH MEDSTAR HEALTH INC			
III TUTI NUT CITIL IIII	2	64,489.	FMV
(3) MEDSTAR HEALTH RESEARCH INSTITUTE	Ø	4,394,231.	FMV
(4) WASHINGTON HOSPITAL CENTER CORPORATION	0	1,177,975.	FMV
(5)			
(9)			
JSA 6E1309 1.000		Sch	Schedule R (Form 990) 2016

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

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

		•	•								
(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?	(f) Share of total income	(g) Share of end-of-year assets	- 0 =	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	General Manage	or Percentage ownership	tage
(5)							r es No		se	02	
(2)											
			T THE THE THE THE THE THE THE THE THE TH		The second secon			***************************************			
(3)											
(4)											
(5)											
(9)											
(7)											
(8)											
107											
(6)											
(10)											
(11)											
(4.5)											
(12)											
(13)											
(14)											
(15)										1	
(16)											
JSA 6E1310 1,000								Sc	hedule R	Schedule R (Form 990) 2016	2016

V 16-7.17

Schedule R (Form 990) 2016

Page 5

Part VII Supplemental Information
Provide additional information for responses to questions on Schedule R. See instructions.

# Cumulative e-File History 2016

Federal

Tax Return

**Return Type** 

32068H

990

Taxpayer

The Union Memorial Hospital

**Submitted Date** 

2018-05-11 09:21:42

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

Status

Accepted

Submission ID

54028020181315000015

# Form **8879-EO**

# IRS e-file Signature Authorization for an Exempt Organization

OMB	No.	1545-1878
-----	-----	-----------

Department of the T	For calendar year 2016, or fiscal year beginning <u>∪ /</u> <b>▶</b> Do not send to t	he IRS. Keep for your records.	30 , 20 1 /	2016
Department of the Treasury Internal Revenue Service	▶ Information about Form 8879-EO an		<del></del>	
Name of exempt organization			1 ' '	fication number
THE UNION MED Name and title of officer	MORIAL HOSPITAL		52-059	1685
	ICE PRESIDENT/TREASUER			
Part I Type of Ro	eturn and Return Information (Whole D	ollars Only)		
check the box on line fleave line 1b, 2b, 3b, 4	k here b Total revenue, if any neck here b Total tax (Form k here b Tax based on investm	nt on that line for the return be o not enter -0-). But, if you ente	eing filed with this for ered -0- on the return the 12) 1b 2b 3b tVI, line 5). 4b	rm was blank, then n, then enter -0- on
Part II Declaration	on and Signature Authorization of Offi	cer		
are true, correct, and corganization's electronito send the organization the transmission, (b) the authorize the U.S. Treafinancial institution accoreturn, and the financia Agent at 1-888-353-45 involved in the process resolve issues related to	ctronic return and accompanying schedule omplete. I further declare that the amount c return. I consent to allow my intermediate n's return to the IRS and to receive from the e reason for any delay in processing the resury and its designated Financial Agent to bunt indicated in the tax preparation softwal institution to debit the entry to this accour 7 no later than 2 business days prior to thing of the electronic payment of taxes to reo the payment. I have selected a personal applicable, the organization's consent to e	in Part I above is the amount slesservice provider, transmitter, IRS (a) an acknowledgement of turn or refund, and (c) the date of initiate an electronic funds with the for payment of the organizate. To revoke a payment, I must be payment (settlement) date. I ceive confidential information nidentification number (PIN) as not transmitted.	nown on the copy of toor electronic return of receipt or reason of any refund. If applidrawal (direct debit) ion's federal taxes of contact the U.S. Trealso authorize the firecessary to answer	he riginator (ERO) for rejection of icable, I entry to the wed on this asury Financial nancial institutions inquiries and
Officer's PIN: check or	ne box only			
X I authorize KF	MG LLP ERO firm name	to enter my PIN	2 1 2 1 8 Enter five numbers, but do not enter all zeros	as my signature
being filed with	tion's tax year 2016 electronically filed retu a state agency(ies) regulating charities as by PIN on the return's disclosure consent so	part of the IRS Fed/State prog		
If I have indicat	the organization, I will enter my PIN as my ed within this return that a copy of the return the program, I will enter my PIN on the return that a copy of the return that a co	n is being filed with a state age		
Officer's signature	bel bon	Date	5/10/18	
Part III Certificati	on and Authentication			
	your six-digit electronic filing identification by your five-digit self-selected PIN.	5	4 0 2 8 0 3 do not enter al	2 2 1 0 2 I zeros
ndicated above. I confi	numeric entry is my PIN, which is my signa om that I am submitting this return in accorded IRS <i>e-file</i> Providers for Business Returns	dance with the requirements of		
RO's signature	S. H. Wite	Date ►	5/9/2018	
	ERO Must Retain This Do Not Submit This Form To th	Form - See Instructions le IRS Unless Requested To	Do So	
or Panerwork Reduct	ion Act Notice see back of form		·	m 8879-FO (2016)

For Paperwork Reduction Act Notice, see back of form.

Form 8879-EO (2016)

JSA 6E1676 1.000