

Form **990**

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Department of the Treasury
Internal Revenue Service

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

2016
Open to Public Inspection

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.

A For the 2016 calendar year, or tax year beginning **JUL 1, 2016** and ending **JUN 30, 2017**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization FULTON COUNTY MEDICAL CENTER		D Employer identification number 23-1401561
	Doing business as		E Telephone number (717) 485-3155
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	
	214 PEACH ORCHARD ROAD		G Gross receipts \$ 52,073,572.
	City or town, state or province, country, and ZIP or foreign postal code MCCONNELLSBURG, PA 17233		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
F Name and address of principal officer: DEBORAH SHUGHART SAME AS C ABOVE		H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			If "No," attach a list. (see instructions)
J Website: WWW.FCMCPA.ORG			H(c) Group exemption number ▶
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		L Year of formation: 1947	M State of legal domicile: PA

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: TO CONTINUOUSLY IMPROVE THE HEALTH OF OUR COMMUNITY		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	13
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	11
	5 Total number of individuals employed in calendar year 2016 (Part V, line 2a)	5	565
	6 Total number of volunteers (estimate if necessary)	6	65
	7 a Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
b Net unrelated business taxable income from Form 990-T, line 34	7b	0.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	233,675.	820,506.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	46,904,710.	46,429,829.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	-477,112.	872,528.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	2,237,030.	2,621,488.
		48,898,303.	50,744,351.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	352,301.	371,442.
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	30,071,991.	30,517,317.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	18,836,157.	19,144,790.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	49,260,449.	50,033,549.	
19 Revenue less expenses. Subtract line 18 from line 12	-362,146.	710,802.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21 Total liabilities (Part X, line 26)	53,286,171.	80,309,137.
	22 Net assets or fund balances. Subtract line 21 from line 20	43,235,783.	68,968,067.
		10,050,388.	11,341,070.

Part II Signature Block

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

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

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: TO CONTINUOUSLY IMPROVE THE HEALTH OF OUR COMMUNITY. WE PERFORM THIS MISSION BY PROVIDING DIAGNOSTIC AND THERAPEUTIC SERVICES IN OUR ACUTE CARE HOSPITAL, MAINTAINING HEALTH AND PROVIDING A HIGHER QUALITY OF LIFE IN OUR COMMUNITY BY OPERATING A NURSING HOME AND A HOME CARE

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? [] Yes [X] No If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? [] Yes [X] No If "Yes," describe these changes on Schedule O.

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

4a (Code:) (Expenses \$ 35,254,142. including grants of \$ 371,442.) (Revenue \$ 39,168,212.) FULTON COUNTY MEDICAL CENTER ("FCMC") PROVIDES INPATIENT, OUTPATIENT, EMERGENCY CARE, SKILLED NURSING, AND HOME HEALTH SERVICES TO ALL WHO NEED THEM, REGARDLESS OF ABILITY TO PAY. EMERGENCY SERVICES ARE PROVIDED 24/7, 365 DAYS A YEAR WITHOUT INQUIRY INTO FINANCIAL MEANS OR INSURANCE STATUS.

ELECTIVE SERVICES ARE PROVIDED WITH FINANCIAL ASSISTANCE OFFERED BASED UPON A STANDARD, AFTER AN OBJECTIVE APPLICATION WITH SUFFICIENT SUPPORTING DOCUMENTATION HAS BEEN EVALUATED. DISCOUNTS AND ALLOWANCES OFFERED UNDER THE MEDICAL CENTER'S FINANCIAL ASSISTANCE PROGRAM TOTALED \$110,677 BASED ON CHARGES FOREGONE DURING THE FISCAL YEAR ENDED JUNE 30, 2017. CONTINUED ON SCHEDULE O.

4b (Code:) (Expenses \$ 2,925,236. including grants of \$ 0.) (Revenue \$ 7,261,617.) FCMC OPERATES A 67-BED HOSPITAL-BASED SKILLED NURSING FACILITY. THE NURSING HOME OFFERS QUALITY CARE IN A FRIENDLY, HOME ENVIRONMENT. THE HOSPITAL-BASED NURSING HOME OFFERS DIRECT AVAILABILITY TO SERVICES SUCH AS LAB, X-RAY, EKG, RESPIRATORY THERAPY, REHAB SERVICES, AND 24-HOUR PHYSICIAN AVAILABILITY FOR EMERGENCIES.

TODAY, FCMC LONG-TERM CARE IS VERY MUCH A VITAL PART OF THE ORGANIZATION. THIS IS THE ONLY NURSING HOME IN FULTON COUNTY. HEALTHCARE HAS DRAMATICALLY CHANGED SINCE 1970 WHEN THE LONG-TERM CARE UNIT WAS BUILT, HOWEVER, THE QUALITY OF CARE, COUPLED WITH THE FAMILY-LIKE ATMOSPHERE, HAS REMAINED UNCHANGED. CONTINUED ON SCHEDULE O.

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

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

4e Total program service expenses 38,179,378.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

	Yes	No
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	X	
22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>		X
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	X	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	X	
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		X
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		X
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		X
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>		X
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>		X
26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i>		X
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>		X
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		X
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	X	
c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>		X
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>		X
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		X
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		X
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>		X
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>		X
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	X	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	X	
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>	X	
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		X
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>		X
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable		
1b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable		
1c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		X
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return		
2b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	X	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?		X
3b	If "Yes," has it filed a Form 990-T for this year? If "No," to line 3b, provide an explanation in Schedule O		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		X
4b	If "Yes," enter the name of the foreign country: See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		X
5b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
5c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		X
6b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	Organizations that may receive deductible contributions under section 170(c).		
7a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		X
7b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
7c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
7d	If "Yes," indicate the number of Forms 8282 filed during the year		
7e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
7f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
7g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
7h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
9	Sponsoring organizations maintaining donor advised funds.		
9a	Did the sponsoring organization make any taxable distributions under section 4966?		
9b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter:		
10a	Initiation fees and capital contributions included on Part VIII, line 12		
10b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities		
11	Section 501(c)(12) organizations. Enter:		
11a	Gross income from members or shareholders		
11b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)		
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?		
12b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year		
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
13a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O.		
13b	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		
13c	Enter the amount of reserves on hand		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		X
14b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O		

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

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

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.		
	1a 13		
b	Enter the number of voting members included in line 1a, above, who are independent		
	1b 11		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		X
6	Did the organization have members or stockholders?		X
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?		X
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?		X
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
a	The governing body?	X	
b	Each committee with authority to act on behalf of the governing body?	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		X

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

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

Section C. Disclosure

- 17** List the states with which a copy of this Form 990 is required to be filed **▶ PA**
- 18** Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
 Own website Another's website Upon request Other (explain in Schedule O)
- 19** Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records: **▶**
DEBORAH SHUGHART, CFO - (717) 485-3155
214 PEACH ORCHARD ROAD, MCCONNELLSBURG, PA 17233

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DENNY L. BUTERBAUGH CHAIR	1.00	X		X				0.	0.	0.
(2) TIMOTHY R. MCGARVEY VICE CHAIR	1.00	X		X				0.	0.	0.
(3) C. O. (SONNY) WEICHT TREASURER	1.00	X		X				0.	0.	0.
(4) PENELOPE SHIVES SECRETARY	1.00	X		X				0.	0.	0.
(5) J. SCOTT ALEXANDER DIRECTOR	1.00	X						0.	0.	0.
(6) MICHAEL L. CRAMPION DIRECTOR	1.00	X						0.	0.	0.
(7) DR. FRANK D'AMELIO DIRECTOR (AS OF 1/2017)/PHYSICIAN	40.00	X					59,580.	0.	8,397.	
(8) WILLIAM C. DOVEY, JR. DIRECTOR	1.00	X						0.	0.	0.
(9) TIMOTHY HANN DIRECTOR	1.00	X						0.	0.	0.
(10) TONYA K. HOUSE DIRECTOR	1.00	X						0.	0.	0.
(11) MARK MELLOTT DIRECTOR (AS OF 1/2017)	1.00	X						0.	0.	0.
(12) C. VIRGINIA PALMER DIRECTOR	1.00	X						0.	0.	0.
(13) DOUGLAS STERN, D.O. CHIEF OF MEDICAL STAFF	40.00	X					588,868.	0.	24,262.	
(14) JAMES A. BOTHELL, SR. DIRECTOR (UNTIL 12/2016)	1.00	X						0.	0.	0.
(15) SANDRA H. LAND DIRECTOR (UNTIL 12/2016)	1.00	X						0.	0.	0.
(16) JASON HAWKINS PRESIDENT/CEO	38.00 2.00			X			210,230.	0.	24,755.	
(17) DEBORAH SHUGHART CFO	38.00 2.00			X			167,693.	0.	22,579.	

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) JEFFREY MANDAK, M.D. CARDIOLOGIST	40.00					X	510,771.	0.	26,200.	
(19) MERRILL MCKENZIE, M.D. ER PHYSICIAN	40.00					X	398,391.	0.	22,169.	
(20) GERALD CELESTINE, M.D. ER PHYSICIAN	40.00					X	342,278.	0.	23,423.	
(21) ALBERT IGUCHI, M.D. ER PHYSICIAN	40.00					X	337,999.	0.	22,229.	
(22) WILLIAM MILROTH, M.D. PHYSICIAN	40.00					X	325,000.	0.	3,012.	
1b Sub-total							2,940,810.	0.	177,026.	
c Total from continuation sheets to Part VII, Section A							0.	0.	0.	
d Total (add lines 1b and 1c)							2,940,810.	0.	177,026.	

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

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ARLINGTON ORTHRO GROUP 805 SIR THOMAS COURT, HARRISBURG, PA 17109	DOCTORS	352,000.
ECKERT SEAMANS CHARIN PO BOX 643187, PITTSBURG, PA 15264-3187	LEGAL SERVICES	176,854.
ARMEN ARAKELIAN 42 LAWRENCE LANE, LEXINGTON, MA 02421	IT SPECIALIST	104,168.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization **3**

Part VIII Statement of Revenue

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

			(A)	(B)	(C)	(D)	
			Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d	613,837.				
	e Government grants (contributions)	1e	86,972.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	119,697.				
	g Noncash contributions included in lines 1a-1f: \$		17,000.				
	h Total. Add lines 1a-1f		820,506.				
Program Service Revenue	2 a NET PATIENT SERVICE REVENUE	Business Code	621110	39,168,212.	39,168,212.		
	b NET RESIDENT SERVICE REVENUE		623000	7,261,617.	7,261,617.		
	c						
	d						
	e						
	f All other program service revenue						
	g Total. Add lines 2a-2f			46,429,829.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			762,363.		762,363.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real	81,199.				
		(ii) Personal					
		b Less: rental expenses		293,865.			
		c Rental income or (loss)		-212,666.			
	d Net rental income or (loss)			-212,666.		-212,666.	
	7 a Gross amount from sales of assets other than inventory	(i) Securities	1,116,134.				
		(ii) Other		26,000.			
		b Less: cost or other basis and sales expenses		1,012,841.	19,128.		
		c Gain or (loss)		103,293.	6,872.		
	d Net gain or (loss)			110,165.		110,165.	
	8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a	9,611.				
		b Less: direct expenses		3,387.			
c Net income or (loss) from fundraising events				6,224.		6,224.	
9 a Gross income from gaming activities. See Part IV, line 19	a						
	b Less: direct expenses						
	c Net income or (loss) from gaming activities						
10 a Gross sales of inventory, less returns and allowances	a						
	b Less: cost of goods sold						
	c Net income or (loss) from sales of inventory						
Miscellaneous Revenue		Business Code					
11 a 340B		900099	2,109,679.			2,109,679.	
b CONTRACTS		900099	234,004.			234,004.	
c CAFETERIA		900099	143,525.			143,525.	
d All other revenue		900099	340,722.			340,722.	
e Total. Add lines 11a-11d			2,827,930.				
12 Total revenue. See instructions.			50,744,351.	46,429,829.	0.	3,494,016.	

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	371,442.	371,442.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	1,122,660.	651,802.	470,858.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	21,695,199.	16,613,746.	5,081,453.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	2,389,207.	1,814,489.	574,718.	
9 Other employee benefits	3,516,156.	2,692,070.	824,086.	
10 Payroll taxes	1,794,095.	1,359,918.	434,177.	
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch. O.)	5,226,763.	2,921,763.	2,305,000.	
12 Advertising and promotion	255,578.	23,075.	232,503.	
13 Office expenses	367,535.	6,156.	361,379.	
14 Information technology	7,823.		7,823.	
15 Royalties				
16 Occupancy	759,614.	86,013.	673,601.	
17 Travel	118,476.	88,989.	29,487.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	116,863.	25,529.	91,334.	
20 Interest	1,103,913.	1,103,913.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	2,697,995.	2,697,995.		
23 Insurance	377,528.	45,603.	331,925.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a BAD DEBT EXPENSE	2,966,440.	2,966,440.		
b PHARMACEUTICALS	1,978,046.	1,976,534.	1,512.	
c MEDICAL SUPPLIES	1,935,151.	1,921,966.	13,185.	
d DIETARY SUPPLIES	344,495.	344,495.		
e All other expenses	888,570.	467,440.	421,130.	
25 Total functional expenses. Add lines 1 through 24e	50,033,549.	38,179,378.	11,854,171.	0.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

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

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	5,757,561.	1	9,145,188.
	2 Savings and temporary cash investments	129,603.	2	
	3 Pledges and grants receivable, net	628,401.	3	118,202.
	4 Accounts receivable, net	8,423,426.	4	7,515,987.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	427,453.	8	396,233.
	9 Prepaid expenses and deferred charges	896,043.	9	905,459.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 59,281,693.		
	b Less: accumulated depreciation	10b 26,603,588.	22,840,853.	10c 32,678,105.
	11 Investments - publicly traded securities	7,804,098.	11	8,387,166.
	12 Investments - other securities. See Part IV, line 11		12	
	13 Investments - program-related. See Part IV, line 11		13	
	14 Intangible assets	162,979.	14	162,979.
	15 Other assets. See Part IV, line 11	6,215,754.	15	20,999,818.
16 Total assets. Add lines 1 through 15 (must equal line 34)	53,286,171.	16	80,309,137.	
Liabilities	17 Accounts payable and accrued expenses	5,387,237.	17	7,141,614.
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities	25,740,000.	20	48,397,839.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties	869,924.	23	454,214.
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	11,238,622.	25	12,974,400.
	26 Total liabilities. Add lines 17 through 25	43,235,783.	26	68,968,067.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	9,034,496.	27	10,250,930.
	28 Temporarily restricted net assets		28	1,711.
	29 Permanently restricted net assets	1,015,892.	29	1,088,429.
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
33 Total net assets or fund balances	10,050,388.	33	11,341,070.	
34 Total liabilities and net assets/fund balances	53,286,171.	34	80,309,137.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	50,744,351.
2	Total expenses (must equal Part IX, column (A), line 25)	2	50,033,549.
3	Revenue less expenses. Subtract line 2 from line 1	3	710,802.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	10,050,388.
5	Net unrealized gains (losses) on investments	5	180,367.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	-16,089.
9	Other changes in net assets or fund balances (explain in Schedule O)	9	415,602.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	11,341,070.

Part XII Financial Statements and Reporting

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

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2012	(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 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2015 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2016. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 33 1/3% support test - 2015. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 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		<input type="checkbox"/>
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		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2012	(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 organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2015 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2016 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2015 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2016. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

b 33 1/3% support tests - 2015. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

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

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions	
9 Distributable amount for 2016 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2016	(iii) Distributable Amount for 2016
1 Distributable amount for 2016 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2016 (reasonable cause required- explain in Part VI). See instructions			
3 Excess distributions carryover, if any, to 2016:			
a			
b			
c From 2013			
d From 2014			
e From 2015			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2016 distributable amount			
i Carryover from 2011 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2016 from Section D, line 7: \$			
a 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 Part VI. See instructions			
7 Excess distributions carryover to 2017. Add lines 3j and 4c			
8 Breakdown of line 7:			
a			
b Excess from 2013			
c Excess from 2014			
d Excess from 2015			
e Excess from 2016			

Schedule B

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

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2016

Name of the organization

FULTON COUNTY MEDICAL CENTER

Employer identification number

23-1401561

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

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

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

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

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2016)

Name of organization FULTON COUNTY MEDICAL CENTER	Employer identification number 23-1401561
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Part I Contributors (See instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	<hr/> <hr/> <hr/>	\$ <u>613,837.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	<hr/> <hr/> <hr/>	\$ <u>17,000.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
3	<hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	<hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	<hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	<hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization FULTON COUNTY MEDICAL CENTER	Employer identification number 23-1401561
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Part II Noncash Property (See instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions)	(d) Date received
2	DONATED MATERIALS, LABOR, AND EQUIPMENT FOR THE GREENHOUSE <hr/> <hr/> <hr/>	\$ 17,000.	01/31/17
	<hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/>	\$ _____	_____

Name of organization FULTON COUNTY MEDICAL CENTER	Employer identification number 23-1401561
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Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this info. once.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

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

SCHEDULE D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2016 Open to Public Inspection

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

Name of the organization: FULTON COUNTY MEDICAL CENTER; Employer identification number: 23-1401561

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

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

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

Form for Part II Conservation Easements. Includes checkboxes for various purposes (land for public use, natural habitat, open space, historic area, historic structure), a table for lines 2a-2d (Total number, acreage, certified historic structures, acquired after 8/17/06), and questions 3-9 regarding monitoring, expenses, and reporting.

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

Form for Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Includes questions 1a and 1b regarding reporting requirements, and question 2 regarding amounts for works of art held for financial gain.

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

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

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

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

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

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

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		556,178.		556,178.
b Buildings		16,110,115.	7,054,480.	9,055,635.
c Leasehold improvements				
d Equipment		26,161,679.	16,591,958.	9,569,721.
e Other		16,453,721.	2,957,150.	13,496,571.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				32,678,105.

Part VII Investments - Other Securities.

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

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

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) DEBT SERVICE FUND	18,003,221.
(2) ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	1,451,684.
(3) DUE FROM AFFILIATES	100,000.
(4) BENEFICIAL INTEREST IN PERPETUAL TRUST	1,088,429.
(5) INVESTMENT IN CHART	356,484.
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	20,999,818.

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) PENSION PLAN LIABILITY	12,974,400.
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	12,974,400.

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

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

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

1	Total revenue, gains, and other support per audited financial statements	1	48,667,745.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains (losses) on investments	2a	180,367.
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIII.)	2d	-2,550,838.
e	Add lines 2a through 2d	2e	-2,370,471.
3	Subtract line 2e from line 1	3	51,038,216.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	-293,865.
c	Add lines 4a and 4b	4c	-293,865.
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)	5	50,744,351.

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

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

1	Total expenses and losses per audited financial statements	1	47,360,974.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIII.)	2d	293,865.
e	Add lines 2a through 2d	2e	293,865.
3	Subtract line 2e from line 1	3	47,067,109.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII.)	4b	2,966,440.
c	Add lines 4a and 4b	4c	2,966,440.
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)	5	50,033,549.

Part XIII Supplemental Information.

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

PART X, LINE 2:

THE CORPORATION ACCOUNTS FOR UNCERTAINTY IN INCOME TAXES USING A RECOGNITION THRESHOLD OF MORE-LIKELY-THAN-NOT TO BE SUSTAINED UPON EXAMINATION BY THE APPROPRIATE TAXING AUTHORITY. MEASUREMENT OF THE TAX UNCERTAINTY OCCURS IF THE RECOGNITION THRESHOLD HAS BEEN MET. MANAGEMENT HAS DETERMINED THAT THERE WERE NO TAX UNCERTAINTIES THAT MET THE RECOGNITION THRESHOLD IN 2017 AND 2016.

THE CORPORATION'S POLICY IS TO RECOGNIZE INTEREST RELATED TO UNRECOGNIZED TAX BENEFITS IN INTEREST EXPENSE AND PENALTIES IN OPERATING EXPENSES.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

Part XIII Supplemental Information *(continued)*

VALUATION GAIN ON PERMANENTLY RESTRICTED NET ASSETS	72,537.
PENSION LIABILITY ADJUSTMENT	343,065.
BAD DEBT EXPENSES NETTED TO REVENUES ON THE FINANCIAL STATEMENTS	-2,966,440.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	-2,550,838.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

RENTAL EXPENSES	-293,865.
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PART XII, LINE 2D - OTHER ADJUSTMENTS:

RENTAL EXPENSES	293,865.
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PART XII, LINE 4B - OTHER ADJUSTMENTS:

BAD DEBT EXPENSES NETTED TO REVENUES ON THE FINANCIAL STATEMENTS	2,966,440.
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**SCHEDULE H
(Form 990)**

Department of the Treasury
Internal Revenue Service

Hospitals

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
- ▶ Attach to Form 990.
- ▶ Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2016

Open to Public Inspection

Name of the organization **FULTON COUNTY MEDICAL CENTER** Employer identification number **23-1401561**

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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

7 Financial Assistance and Certain Other Community Benefits at Cost

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			59,092.		59,092.	.13%
b Medicaid (from Worksheet 3, column a)			9064799.	8710164.	354,635.	.75%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			9123891.	8710164.	413,727.	.88%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			93,171.	19,623.	73,548.	.16%
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)			7416842.	4039313.	3377529.	7.18%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits			7510013.	4058936.	3451077.	7.34%
k Total. Add lines 7d and 7j			16633904.	12769100.	3864804.	8.22%

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 FULTON COUNTY MEDICAL CENTER

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

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		X
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	X	
7 Did the hospital facility make its CHNA report widely available to the public?	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.FCMCPA.ORG/COMMUNITY-RESOURCES</u>		
b <input type="checkbox"/> Other website (list url):		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a If "Yes," (list url): <u>WWW.FCMCPA.ORG/COMMUNITY-RESOURCES</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group FULTON COUNTY MEDICAL CENTER

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	X	
If "Yes," indicate the eligibility criteria explained in the FAP:		
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>100</u> % and FPG family income limit for eligibility for discounted care of <u>200</u> %		
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input checked="" type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	X	
15 Explained the method for applying for financial assistance?	X	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.FCMCPA.ORG/FINANCIAL-ASSISTANCE</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>WWW.FCMCPA.ORG/FINANCIAL-ASSISTANCE</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j <input checked="" type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group FULTON COUNTY MEDICAL CENTER

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?		X
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs		
b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
d <input checked="" type="checkbox"/> Made presumptive eligibility determinations		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group FULTON COUNTY MEDICAL CENTER

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

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 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.

FULTON COUNTY MEDICAL CENTER:

PART V, SECTION B, LINE 5: REPRESENTATIVES FROM FULTON COUNTY FAMILY

PARTNERSHIP (FCFP), FULTON INDUSTRIAL DEVELOPMENT ASSOCIATION (FIDA),

FULTON COUNTY SERVICES FOR CHILDREN AND HEALTH SERVICES (FCSCHS), MENTAL

HEALTH ASSOCIATION OF FRANKLIN AND FULTON COUNTIES (MHAFF), TRI-STATE

COMMUNITY HEALTH CENTER (TRI-STATE), AND STRATEGY SOLUTIONS, INC. WORKED

COLLABORATIVELY TO GUIDE AND CONDUCT THE COMMUNITY HEALTH NEEDS

ASSESSMENT. A STEERING COMMITTEE MADE UP OF SENIOR REPRESENTATIVES OF

FCMC, AS WELL AS REPRESENTATIVES FROM LOCAL HEALTH DEPARTMENTS, LEADING

HEALTH AND SOCIAL SERVICE ORGANIZATIONS AND COUNTY GOVERNMENT PROVIDED

ADDITIONAL INPUT. THE COMBINED EXPERTISE, INPUT AND KNOWLEDGE OF THE

MEMBERS OF THE STEERING COMMITTEE WAS VITAL TO THE PROJECT. TO GUIDE THIS

ASSESSMENT, THE HOSPITAL'S LEADERSHIP TEAM FORMED A STEERING COMMITTEE

THAT CONSISTED OF HOSPITAL AND COMMUNITY AGENCIES WHO REPRESENTED THE

BROAD INTERESTS OF THE LOCAL REGION. THESE INCLUDED REPRESENTATIVES WHO

UNDERSTOOD THE NEEDS AND ISSUES RELATED TO VARIOUS UNDERREPRESENTED GROUPS

INCLUDING MEDICALLY UNDERSERVED POPULATIONS, LOW-INCOME PERSONS, MINORITY

GROUPS, AND THOSE WITH CHRONIC DISEASE AND MENTAL HEALTH NEEDS,

INDIVIDUALS WITH EXPERTISE IN PUBLIC HEALTH, AND INTERNAL PROGRAM

MANAGERS. THE FCMC STEERING COMMITTEE MET THREE TIMES BETWEEN FEBRUARY

2015 AND SEPTEMBER 2015 TO PROVIDE GUIDANCE ON THE VARIOUS COMPONENTS OF

THE CHNA.

FULTON COUNTY MEDICAL CENTER:

PART V, SECTION B, LINE 6B: THE FULTON COUNTY MEDICAL CENTER (FCMC)

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.

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WAS DEVELOPED WITH COLLABORATION FROM FULTON COUNTY FAMILY PARTNERSHIP (FCFP), FULTON INDUSTRIAL DEVELOPMENT ASSOCIATION (FIDA), FULTON COUNTY SERVICES FOR CHILDREN AND HEALTH SERVICES (FCSCHS), MENTAL HEALTH ASSOCIATION OF FRANKLIN AND FULTON COUNTIES (MHAFF), TRI-STATE COMMUNITY HEALTH CENTER (TRI-STATE), AND STRATEGY SOLUTIONS, INC. (SSI), THE CONSULTING GROUP ENGAGED BY FCMC TO ASSIST WITH THE ASSESSMENT.

FULTON COUNTY MEDICAL CENTER:

PART V, SECTION B, LINE 7D: FCMC PUBLICALLY REPORTED THE CHNA AT THE FULTON COUNTY PARTNERSHIP MEETING THAT MEETS MONTHLY. IT IS COMPRISED OF MEMBERS OF THE HEALTH AND HUMAN SERVICES COMMUNITIES OF FRANKLIN, FULTON & BEDFORD COUNTIES.

FULTON COUNTY MEDICAL CENTER:

PART V, SECTION B, LINE 11: AFTER ALL PRIMARY (COMMUNITY SURVEY, STAKEHOLDER INTERVIEWS AND FOCUS GROUPS) AND SECONDARY DATA WERE REVIEWED AND ANALYZED BY THE STEERING COMMITTEE DURING A MEETING ON SEPTEMBER 15, 2015, THE DATA SUGGESTED A TOTAL OF 85 DISTINCT ISSUES, NEEDS AND POSSIBLE PRIORITY AREAS FOR POTENTIAL INTERVENTION BY FCMC. MEMBERS OF THE FCMC CHNA COLLABORATION WORK GROUP MET ON OCTOBER 22, 2015 TO REVIEW THE FINAL PRIORITIES SELECTED BY THE FCMC STEERING COMMITTEE. USING THE METHODOLOGY OF LOOKING AT THE FOUR PRIORITIZATION CRITERIA OF (I) ACCOUNTABLE ROLE OF THE HOSPITAL, (II) MAGNITUDE OF THE PROBLEM, (III) IMPACT ON OTHER HEALTH OUTCOMES AND (IV) CAPACITY (SYSTEMS AND RESOURCES) TO IMPLEMENT

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.

EVIDENCE-BASED SOLUTIONS, ALONG WITH THE RANK ORDER OF THE FINAL PRIORITIES SELECTED BY THE FCMC STEERING COMMITTEE, THE FOLLOWING TOP TWENTY PRIORITIES ARE CONSIDERED THE MOST SIGNIFICANT.

1. CHRONIC DISEASE: DIABETES
2. CHRONIC DISEASE: CARDIOVASCULAR DISEASE (HEART DISEASE, CHOLESTEROL, ETC.)
3. CHRONIC DISEASE: OBESITY
4. CHRONIC DISEASE: HYPERTENSION/CARDIAC
5. CHRONIC DISEASE: CONGESTIVE HEART FAILURE
6. PHYSICAL ACTIVITY/NUTRITION: LACK OF PHYSICAL ACTIVITY
7. TOBACCO USE: SMOKING
8. PHYSICAL ACTIVITY/NUTRITION: EATING HABITS/ACCESS TO HEALTHY FOODS
9. ACCESS TO QUALITY HEALTH SERVICES: ACCESS TO BEHAVIORAL/MENTAL HEALTH SERVICES
10. ACCESS TO QUALITY HEALTH SERVICES: AFFORDABILITY OF HEALTH CARE/INSURANCE COSTS/COPAYS
11. PHYSICAL ACTIVITY/NUTRITION: SEDENTARY LIFESTYLE
12. TOBACCO USE: CHEWING TOBACCO, SNUFF, SNUS
13. ACCESS TO QUALITY HEALTH SERVICES: ACCESS TO PRIMARY CARE SERVICES
14. HEALTHY MOTHERS, BABIES & CHILDREN: CHILDHOOD OBESITY
15. TOBACCO USE: YOUTH SMOKING/CHEWING
16. CHRONIC DISEASE: COPD/CHRONIC BRONCHITIS
17. MENTAL HEALTH/SUBSTANCE ABUSE: ALCOHOL ABUSE
18. MENTAL HEALTH/SUBSTANCE ABUSE: DEPRESSION
19. ACCESS TO QUALITY HEALTH SERVICES: WOMEN'S HEALTH
20. MENTAL HEALTH/SUBSTANCE ABUSE: PRESCRIPTION DRUG MISUSE/ABUSE

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.

THE IMPLEMENTATION STRATEGIES SELECTED BY FCMC AND ITS COMMUNITY PARTNERS WILL ADDRESS THE MOST SIGNIFICANT NEEDS THROUGH A VARIETY OF IMPLEMENTATION STRATEGIES FOCUSING ON (4) MAIN GOALS.

1. IMPROVE CHRONIC DISEASE PREVENTION, ACCESS TO CARE AND CARE MANAGEMENT IN COLLABORATION WITH TSCHC AND OTHER COMMUNITY PROVIDER
2. IMPROVE ACCESS AND CARE COORDINATION FOR THE UNDERSERVED IN FULTON COUNTY
3. DEVELOP A FULL CONTINUUM OF AGING SERVICES TO MEET THE NEEDS OF OLDER PERSONS IN FULTON COUNTY
4. IMPROVE THE QUALITY OF THE LIFE FOR THE FAMILIES OF FULTON COUNTY.

THE FCMC CHNA DID NOT ADDRESS THE HIGH NUMBER OF ACCIDENTS AND RELATED DEATHS AND INJURIES - BOTH MOTOR VEHICLE AND NON-TRANSPORT. FCMC DID NOT FEEL THAT THEY WOULD HAVE ENOUGH DATA OR EXPERTISE TO TAKE ON THIS PRIORITY AT THIS TIME OR HAVE THE FINANCIAL RESOURCES. FCMC DID NOT HAVE ANYONE IN THE CORE TEAM OR ADVISORY PANELS THAT COULD ADDRESS THESE ISSUES. FCMC RANKED THE PRIORITIES AND DETERMINED THAT THIS ONE WAS NOT A HIGH PRIORITY AT THIS TIME.

FULTON COUNTY MEDICAL CENTER

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

WWW.FCMCPA.ORG/FINANCIAL-ASSISTANCE

FULTON COUNTY MEDICAL CENTER:

Part V Facility Information *(continued)*

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

PART V, SECTION B, LINE 16J: BILLING STATEMENTS INCLUDE A NOTICE ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE AND HOW TO OBTAIN INFORMATION.

Multiple horizontal lines for providing supplemental information.

Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 3C:

PATIENTS WITH NO HEALTH INSURANCE, PRIVATE OR EMPLOYER-SPONSORED INSURANCE, OR VIA GOVERNMENTAL PROGRAMS, ARE AUTOMATICALLY ELIGIBLE FOR A FINANCIAL ASSISTANCE DISCOUNT IN THE FOLLOWING AMOUNTS:

INPATIENT SERVICES - 30%

OUTPATIENT SERVICES - 40%

HOME HEALTH SERVICES - 20%

SWING BED SERVICES - 30%

ADDITIONAL FINANCIAL ASSISTANCE MAY BE MADE AVAILABLE TO THE PATIENT BASED ON A SLIDING FEE SCALE, IN ACCORDANCE WITH FINANCIAL NEED, AS DETERMINED BY REFERENCING FEDERAL POVERTY LEVELS (FPL) IN EFFECT AT THE TIME OF THE DETERMINATION. IN GENERAL, PEOPLE WHOSE HOUSEHOLD INCOME IS BELOW 200 PERCENT OF THE FEDERAL POVERTY LEVEL ARE ELIGIBLE FOR FINANCIAL ASSISTANCE. FAMILIES OR INDIVIDUALS WITH HIGHER INCOMES MAY QUALIFY ON A CASE-BY-CASE BASIS.

Part VI Supplemental Information

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PART I, LINE 7:

CHARITY CARE WAS CONVERTED TO COST ON LINE 7A BASED ON AN OVERALL
COST-TO-CHARGE RATIO ADDRESSING ALL PATIENT SEGMENTS. UNREIMBURSED
MEDICAID ON LINE 7B WAS CALCULATED USING THE COST-TO-CHARGE RATIO DERIVED
FROM WORKSHEET 2. COMMUNITY HEALTH IMPROVEMENT SERVICES, LINE 7E ARE
REPORTED FROM THE COMMUNITY BENEFIT'S ANNUAL BOARD REPORT. LINE 7G WAS
DETERMINED USING THE MEDICARE COST REPORT.

PART I, LINE 7G:

SUBSIDIZED HEALTH SERVICES INCLUDED IN FISCAL YEAR 2016 WERE: EMERGENCY
ROOM AND HOME HEALTH

PART I, LN 7 COL(F):

THE AMOUNT OF BAD DEBT EXPENSE REMOVED FROM THE DENOMINATOR OF THE
CALCULATIONS WAS \$2,966,440.

PART I, LINE 6A:

FULTON COUNTY MEDICAL CENTER'S (FCMC) 990 FILING IS AVAILABLE TO THE

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PUBLIC UPON REQUEST. A SUMMARY OF FCMC'S COMMUNITY BENEFIT IS DESCRIBED
IN FCMC'S ANNUAL REPORT. THE ANNUAL REPORT IS AVAILABLE TO THE PUBLIC
DURING THE ANNUAL MEETING, AT THE HOSPITAL, AS WELL AS ON THE HOSPITAL
WEBSITE.

PART II, COMMUNITY BUILDING ACTIVITIES:

PART II, LINE 8:

THE AMOUNT REPORTED REPRESENTS THE EXPENSE RELATED TO RECRUITING
HEALTHCARE PROFESSIONALS AND MANAGEMENT POSITIONS TO THE HOSPITAL.

PART III, LINE 2:

PRIOR TO ANY ACCOUNT BEING CLASSIFIED AS BAD DEBT, ALL PAYMENTS ARE
APPLIED INCLUDING CONTRACTUAL ALLOWANCES AND DISCOUNTS, AND EVERY EFFORT
IS MADE WITH THE PATIENT IN AN ATTEMPT TO COLLECT THE OUTSTANDING BALANCE.
ACCOUNTS PLACED IN COLLECTION FOR A YEAR WITH NO PAYMENT BEING RECEIVED
WITHIN 120 DAYS ARE WRITTEN OFF TO BAD DEBT. IF A PAYMENT IS RECEIVED ON
AN AMOUNT PREVIOUSLY WRITTEN OFF TO BAD DEBT, THE AMOUNT WOULD REDUCE BAD

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DEBT EXPENSE.

PART III, LINE 3:

FCMC DOES NOT REFUSE SERVICE TO PATIENTS THAT GENERATE BAD DEBT. THE ESTIMATED AMOUNT OF ORGANIZATION'S BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S CHARITY CARE POLICY IS CALCULATED BASED ON AN ESTIMATE OF CHARITY CARE ACCOUNTS COMPARED TO TOTAL BAD DEBT ACCOUNTS.

PART III, LINE 4:

THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IS BASED ON HISTORICAL LOSSES AND AN ANALYSIS OF CURRENTLY OUTSTANDING AMOUNTS FOR ITS MAJOR PAYER SOURCES. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYER SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS AND RESIDENTS WHO HAVE THIRD-PARTY COVERAGE, THE MEDICAL CENTER ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY (FOR EXAMPLE, FOR EXPECTED

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UNCOLLECTABLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYER HAS NOT YET PAID). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS AND RESIDENTS (WHICH INCLUDES BOTH PATIENTS AND RESIDENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND PAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE MEDICAL CENTER RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS AND RESIDENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

PART III, LINE 8:

MEDICARE SERVICES ARE PROVIDED TO THE ELDERLY WHICH ARE CONSIDERED TO BE A CHARITABLE CLASS. AS SUCH, WE BELIEVE THE SHORTFALL SHOULD BE CONSIDERED AS A COMMUNITY BENEFIT.

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PART III, LINE 9B:

PATIENTS APPLYING FOR CHARITY CARE OR FINANCIAL ASSISTANCE, OR PATIENTS WHO ARE KNOWN TO QUALIFY FOR FREE OR DISCOUNTED CARE WILL BE PROCESSED AS SUCH BEFORE COLLECTION EFFORTS START. ONCE A DETERMINATION IS MADE ON ELIGIBILITY, ANY PERSONAL PORTION DUE IS SUBJECT TO THE SAME COLLECTION POLICY AS OTHER ACCOUNTS. IF THE PATIENT DOES NOT HAVE A THIRD PARTY INSURANCE COVERAGE, THEY WILL BE INFORMED OF THE FREE CARE PROGRAM. ELIGIBILITY WILL BE DETERMINED USING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES INCOME POVERTY GUIDELINES CATEGORY B WITH NO SLIDING SCALE. PATIENTS/GUARANTORS WHO HAVE NOT MET ARRANGEMENTS TO PAY OFF THEIR ACCOUNTS WITHIN THE ALLOTTED TIME WILL BE FORWARDED TO THE HOSPITAL'S COLLECTION AGENCY. ALL ACCOUNTS WILL BE REVIEWED BY THE FINANCIAL ADVOCATE PRIOR TO AGENCY REFERRAL.

PART VI, LINE 2:

HEALTH CARE NEEDS FOR FCMC HAVE BEEN ASSESSED USING BOTH INTERNAL AND EXTERNAL MEANS. INTERNALLY RECOMMENDATIONS ARE RECEIVED FROM STAFF AND

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PHYSICIANS (BOTH HOSPITAL-BASED AND VISITING) OF POTENTIAL SERVICES PATIENTS MAY BE REQUESTING. OUR CUSTOMER SERVICE REPRESENTATIVES AT FCMC ALSO RECEIVE RECOMMENDATIONS FROM PATIENTS. THE RECOMMENDATIONS FROM PATIENTS MAY COME VIA COMPLIMENTS OR COMPLAINTS RECEIVED AS WELL AS PATIENT SURVEYS THAT ARE UTILIZED THROUGH THE HOSPITAL AS PART OF OUR QUALITY PROGRAM. IN ADDITION, DURING THE DEVELOPMENT OF THE STRATEGIC PLAN CURRENT AND FUTURE SERVICES ARE DISCUSSED THAT WILL BENEFIT THE COMMUNITY.

PART VI, LINE 3:

THE FCMC POSTS INFORMATION ABOUT THE FINANCIAL ASSISTANCE PROGRAM AND DISCOUNTS AT THE ADMISSIONS AREAS, EMERGENCY ROOM WAITING AREAS, AND FINANCIAL ADVOCATE'S OFFICE. THE INFORMATION IS INCLUDED IN THE INPATIENT AND OUTPATIENT SURGERY PATIENT PACKETS. THE FINANCIAL ADVOCATE DISCUSSES WITH THE PATIENT THE AVAILABILITY OF FINANCIAL ASSISTANCE AS WELL AS VARIOUS GOVERNMENT BENEFITS SUCH AS MEDICAID, AND ASSISTS THE PATIENT WITH QUALIFICATION FOR SUCH PROGRAMS, WHERE APPLICABLE. IN ADDITION, PATIENT INVOICES FOR FCMC INCLUDE A NUMBER TO CALL FOR HELP IN APPLYING FOR FINANCIAL ASSISTANCE. THE FINANCIAL ASSISTANCE APPLICATION IS ON THE BACK

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OF THE PATIENT INVOICE AS WELL. WHEN COLLECTION TELEPHONE CALLS ARE MADE TO PATIENTS WITH OUTSTANDING BALANCES THEY ARE REMINDED OF OUR FINANCIAL ASSISTANCE PROGRAM.

PART VI, LINE 4:

THE FCMC IS IN FULTON COUNTY PENNSYLVANIA. THIS COUNTY IS IN RURAL SOUTH CENTRAL PENNSYLVANIA AND HAD AN ESTIMATED POPULATION IN 2016 OF 14,640 WITH 10.6% OF THE POPULATION BELOW THE POVERTY LEVEL (US CENSUS). THE FCMC IS THE ONLY MEDICAL FACILITY IN THE COUNTY. THE CLOSEST HOSPITAL IS 19 MILES AWAY AND PATIENTS WOULD HAVE TO TRAVEL OVER MOUNTAINOUS RURAL TERRAIN. THE FCMC IS A CRITICAL ACCESS HOSPITAL WITH OVER 50% OF ITS REVENUES RECEIVED FROM THE MEDICARE AND MEDICAID PROGRAMS.

PART VI, LINE 5:

FCMC'S BOARD IS COMPRISED OF CITIZENS FROM THE COMMUNITIES AND SERVICE AREAS THAT BENEFIT FROM FCMC'S SERVICES. FCMC IS THE ONLY HOSPITAL AND SKILLED NURSING HOME IN THIS RURAL SERVICE AREA. IN ADDITION FCMC OFFERS HOME HEALTH SERVICES AND A SPECIALTY SERVICES CLINIC WHERE PHYSICIAN

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SPECIALISTS FROM OTHER GEOGRAPHICAL AREAS SEE PATIENTS. THIS ALLOWS RESIDENTS OF THE SURROUNDING AREAS TO RECEIVE MEDICAL CARE FROM MEDICAL PROFESSIONALS CLOSE TO HOME. PATIENTS WHO COME TO THE EMERGENCY ROOM ARE NOT DENIED TREATMENT BASED ON THE ABILITY TO PAY. FCMC OFFERS FINANCIAL ASSISTANCE DISCOUNTS AND CHARITY CARE FOR THOSE PATIENTS WHO HAVE LIMITED OR NO MEANS TO PAY THEIR MEDICAL BILL. TO MEET THE NEEDS OF OUR COMMUNITY, THE HOSPITAL EXTENDS PRIVILEGES TO LICENSED MEDICAL STAFF. MEMBERS OF THE MEDICAL CENTER STAFF VISIT THE LOCAL SCHOOLS AND PARTICIPATE IN HEALTH FAIRS IN THE AREA TO REMIND CHILDREN OF HEALTHY HABITS THEY SHOULD PRACTICE. IN ADDITION, SEVERAL COMMUNITY HEALTH FAIRS ARE HELD SUCH AS A WOMEN'S HEALTH FAIR AND A HEALTH HUNTER'S HEALTH FAIR. SUPPORT GROUPS SUCH AS ALZHEIMER'S SUPPORT GROUP, SMOKING CESSATION, AND AA ARE ALSO OFFERED TO THE COMMUNITY.

AS A CRITICAL ACCESS HOSPITAL AND RURAL HEALTHCARE PROVIDER, FCMC PROVIDES AN OPPORTUNITY TO ASSIST IN THE EDUCATION OF FUTURE HEALTH CARE WORKERS. LAKE ERIE COLLEGE OF OSTEOPATHIC MEDICINE (LECOM) MEDICAL STUDENTS ROTATE TO FCMC AS PART OF THEIR EDUCATION. IN ADDITION HIGH SCHOOL STUDENTS HAVE

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THE OPPORTUNITY TO VOLUNTEER WITHIN THE FACILITY OR JOB SHADOW A
PROFESSIONAL AT THE HOSPITAL.

STAFF MEMBERS OF FCMC PROVIDE EDUCATION TO SCHOOLS, SENIOR CENTERS AND
OTHER AREA GROUPS REGARDING CHRONIC DISEASE EDUCATION AND PREVENTION. IN
ADDITION, SEVERAL COMMUNITY HEALTH FAIRS ARE HELD EACH YEAR, SUCH AS GO
RED DAY FOR WOMEN, NATIONAL NUTRITION CELEBRATION, DIABETES FORUM, LADIES
NIGHT OUT, AND HEALTHY SPORTSMAN. FCMC OFFERS SIX DIFFERENT SUPPORT GROUPS
TO THE COMMUNITY INCLUDING ALCOHOLICS ANONYMOUS, NARCOTICS ANONYMOUS,
ALZHEIMER'S AWARENESS, DIABETES, BREAST FEEDING AND SMOKING CESSATION.
FCMC ALSO HOSTS FIVE DIFFERENT EXERCISE CLASSES FOR FREE OR A REDUCED
COST. THEY INCLUDE: PILATES, YOGA, ZUMBA, TAI CHI AND LOW-IMPACT EXERCISE.
THE CLASSES ARE HELD ON THE FCMC CAMPUS AND THE LOCAL COMMUNITY CENTER.

FCMC PROVIDES NUMEROUS SCREENINGS IN THE COMMUNITY TO ADDRESS THE GOALS OF
THE IMPLEMENTATION STRATEGY. FCMC FOCUSES ON HEART HEALTH IN FEBRUARY BY
HOSTING A LUNCHEON WITH CARDIOLOGISTS WHO SPEAK ON RELEVANT TOPICS AND
PREVENTATIVE MEDICINE AND FREE SCREENINGS IN THE MAIN LOBBY OF FCMC.

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IN APRIL 2017 AFTER A 10 YEAR HIATUS THE DIABETES EDUCATION PROGRAM HOSTED A ONE-DAY FORUM ON DIABETES. THE FORUM CONSISTED OF A1-C SCREENINGS, EDUCATION AND SPECIAL SPEAKERS. OVER 40 PEOPLE ATTENDED.

LATE SPRING TIME LENDS ITSELF TO HEALTH FAIRS IN THE FOUR FULTON COUNTY SCHOOLS AS WELL AS TWO IN SOUTHERN HUNTINGDON WITH THE HELP OF TRISTATE COMMUNITY HEALTH CENTER AND FULTON COUNTY FAMILY PARTNERSHIP. THE PARTNERS DEVELOP THE TOPICS FROM THE PAYS (PENNSYLVANIA AREA YOUTH SURVEY) DATA TO COME UP WITH TOPICS TO ADDRESS. IN 2017 IT WAS HEALTHY NINJA WARRIOR THEME WHERE FCMC, ALONG WITH TRISTATE COMMUNITY HEALTH CENTER AND TRUE NORTH WELLNESS, WORKED ON COMBATTING BULLYING, DEPRESSION AND EXERCISE AND HYGIENE. 778 STUDENTS WERE SERVED DURING OUR 2017 SCHOOL HEALTH FAIRS.

ALSO FOR THE FOURTH YEAR IN A ROW, FCMC HAS OFFERED AN AFTERSCHOOL PROGRAM FOR GIRLS, GIRLS ON THE MOVE. THE SESSIONS EXPANDED IN 2016 TO ALL THREE SCHOOL DISTRICTS AS WELL AS FANNETT METAL AND SOUTHERN HUNTINGDON. IT IS RUN BY THE FULTON COUNTY FAMILY PARTNERSHIP. THE PROGRAM PROMOTES HEALTHY

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EATING, LIFESTYLES AND GOOD SELF-ESTEEM AS WELL AS TEAM BUILDING.

SUMMER SETS THE STAGE FOR THE ANNUAL KICK OFF YOUR DRUG FREE SUMMER. IN JUNE, FCMC CONTINUED WITH THE NINJA WARRIOR THEME AND PROVIDED A PLETHORA OF EVENTS RANGING FROM FACE PAINTING TO TIMED OBSTACLE COURSE, ALL WHILE GETTING OUT A DRUG FREE MESSAGE. VENDORS ON THE CAMPUS PROVIDE A SERIES OF INFORMATIONAL TABLES AND FUN ACTIVITIES FOR KIDS AND PARENTS. THE SAFE ENVIRONMENT ALLOWS PARENTS TO BRING THEIR CHILDREN TO THE FUN ACTIVITIES WHILE LEARNING ABOUT PROGRAM AND SERVICES FROM OVER 25 VENDORS AVAILABLE TO THEM IN THE COMMUNITY. OVER 300 MEN WOMEN AND CHILDREN ATTENDED THE EVENTS. THE SHERIFF'S OFFICE ALSO PROVIDES A DRUG COLLECTION BOOTH TO TURN IN OUT DATED, UNWANTED NARCOTICS.

JUNE ALSO SAW A NEW SUPPORT GROUP COME TO FRUITION. LYME DISEASE SUPPORT GROUP BEGAN WITH AN AWARENESS CAMPAIGN DURING THE LOCAL STRAWBERRY FESTIVAL.

FCMC ALSO TEAMED UP WITH MCCONNELLSBURG VOLUNTEER FIRE COMPANY TO PROVIDE

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FREE CPR TRAINING TO THE CENTRAL FULTON SCHOOL DISTRICT STAFF. THERE WERE OVER 170 TRAINED DURING THE EVENTS IN JUNE 2017.

2017 CONTINUED THE FARMERS MARKET SET UP ON THE CAMPUS TO COMBAT THE ISSUES OF HEALTHY FOOD CHOICES. THE MARKET IS HELD EVERY FRIDAY FROM JUNE THROUGH OCTOBER. THE MARKET OFFERS RESIDENTS HEALTHY FOOD CHOICES AS WELL AS EDUCATION.

IN OCTOBER, FCMC FOCUSES ON BREAST CANCER AWARENESS. WITH THE HELP OF ALL THE LOCAL SCHOOLS, FCMC HOSTED PINK OUT GAMES IN SOCCER, BASKETBALL, VOLLEYBALL, HOCKEY AND BASEBALL. ALL SPORTING EVENTS INCLUDED ONE GAME OF EDUCATIONAL MATERIALS AS WELL AS MESSAGING THROUGH THE GAMES. TEAMS WERE GIVEN FREE PINK WARM UP SHIRTS TO RAISE AWARENESS. ALSO DURING THE MONTH, WOMEN RECEIVE A FREE PINK CARNATION FOR RECEIVING THEIR MAMMOGRAM. FCMC TOUCHED THOUSANDS OF COMMUNITY MEMBERS DURING THESE EVENTS. THE PROGRAM WAS ESTABLISHED TO RAISE FUNDS FOR FREE/REDUCED MAMMOGRAMS FOR WOMEN, AS WELL AS BRING RECOGNITION TO THE NEWEST TECHNOLOGY IN THE RADIOLOGY DEPARTMENT, THE 3D MAMMOGRAM MACHINE.

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.

FCMC CONTINUED THE PART-TIME POSITION IN SEPTEMBER 2017 AS A BREAST HEALTH ADVOCATE (BHA) TO HELP PATIENTS NAVIGATE THROUGH THE SERVICES FOR FREE MAMMOGRAMS. THE BHA ALSO PROMOTE EDUCATION TO THE COMMUNITY AND PHYSICIAN OFFICES ON THE BENEFITS OF MAMMOGRAMS AND POTENTIAL RISK FACTORS. THEY ARE RESPONSIBLE FOR THE "PINK OUT" GAMES AT THE LOCAL SCHOOLS AS WELL AS SUPPORT GROUP AND EDUCATION TO COMMUNITY MEMBERS.

FCMC UTILIZES THE HEALTHY COMMUNITY INSTITUTE SOFTWARE TO RESEARCH PROMISING PRACTICES AND EVIDENCE BASED PROGRAMS. THE SOFTWARE IS HOUSED ON OUR WEBSITE AT [HTTP://FCMCPA.ORG/COMMUNITY](http://fcmcpa.org/community). IT IS A VALUABLE TOOL FOR NOT ONLY FCMC, BUT OUR PARTNERS, SO THEY CAN ACCESS OUR GOALS AND MONITOR THE HEALTH OF OUR COMMUNITY.

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

PA

**SCHEDULE I
(Form 990)**

Department of the Treasury
Internal Revenue Service

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2016

**Open to Public
Inspection**

Name of the organization **FULTON COUNTY MEDICAL CENTER** Employer identification number **23-1401561**

Part I General Information on Grants and Assistance

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

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

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
THE FULTON COUNTY MEDICAL CENTER FOUNDATION - 214 PEACH ORCHARD ROAD - MCCONNELLSBURG, PA 17233	51-0674514	501(C)(3)	371,442.	0.	CASH		FINANCIAL SUPPORT TO AFFILIATE

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

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

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

Schedule I (Form 990) (2016)

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

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

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

PART I, LINE 2:

THE ORGANIZATION'S ONLY DONATION WAS TO THE FULTON COUNTY MEDICAL CENTER FOUNDATION, A RELATED ORGANIZATION. THROUGH THIS RELATIONSHIP, THE ORGANIZATION IS ABLE TO OBTAIN INFORMATION ON HOW THE FUNDS ARE SPENT AND IS ABLE TO MAKE SURE THE FUNDS ARE SPENT PROPERLY.

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

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.

2016

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization

FULTON COUNTY MEDICAL CENTER

Employer identification number

23-1401561

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|--|---|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (such as, maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- | | |
|--|---|
| <input checked="" type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment?
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
- c** Participate in, or receive payment from, an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
- b** Any related organization?
- If "Yes" on line 5a or 5b, describe in Part III.

6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization?
- b** Any related organization?
- If "Yes" on line 6a or 6b, describe in Part III.

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

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

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

Schedule J (Form 990) 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.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) DOUGLAS STERN, D.O. CHIEF OF MEDICAL STAFF	(i)	588,868.	0.	0.	1,980.	22,282.	613,130.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) JASON HAWKINS PRESIDENT/CEO	(i)	210,230.	0.	0.	3,600.	21,155.	234,985.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) DEBORAH SHUGHART CFO	(i)	151,932.	15,761.	0.	1,620.	20,959.	190,272.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) JEFFREY MANDAK, M.D. CARDIOLOGIST	(i)	510,771.	0.	0.	1,980.	24,220.	536,971.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) MERRILL MCKENZIE, M.D. ER PHYSICIAN	(i)	378,544.	0.	19,847.	2,460.	19,709.	420,560.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) GERALD CELESTINE, M.D. ER PHYSICIAN	(i)	342,278.	0.	0.	2,268.	21,155.	365,701.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) ALBERT IGUCHI, M.D. ER PHYSICIAN	(i)	337,999.	0.	0.	2,520.	19,709.	360,228.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) WILLIAM MILROTH, M.D. PHYSICIAN	(i)	325,000.	0.	0.	1,980.	1,032.	328,012.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

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

PART I, LINE 7:

CERTAIN OFFICERS ARE ELIGIBLE FOR BONUS PAYMENTS BASED ON PERFORMANCE
FACTORS. THE OFFICERS ARE EVALUATED BY THE PRESIDENT/CEO AND/OR THE BOARD
IN DETERMINING BONUS PAYMENTS.

Supplemental Information on Tax-Exempt Bonds

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

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

Name of the organization **FULTON COUNTY MEDICAL CENTER** Employer identification number **23-1401561**

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	FULTON COUNTY INDUSTRIAL DEVELOPMENT AUTHORITY	23-2299855	36024LAL3	05/15/16	25740000.	SEE PART VI		X		X		X
B	FULTON COUNTY INDUSTRIAL DEVELOPMENT AUTHORITY	23-2299855	36024LAN9	09/15/16	21590000.	SEE PART VI		X		X		X
C												
D												

	A	B	C	D
1 Amount of bonds retired	50,000.			
2 Amount of bonds legally defeased				
3 Total proceeds of issue	25,740,000.	21,590,000.		
4 Gross proceeds in reserve funds	1,886,028.	1,956,228.		
5 Capitalized interest from proceeds	1,261,701.	815,622.		
6 Proceeds in refunding escrows				
7 Issuance costs from proceeds	629,579.	731,093.		
8 Credit enhancement from proceeds				
9 Working capital expenditures from proceeds				
10 Capital expenditures from proceeds				
11 Other spent proceeds	21,963,470.			
12 Other unspent proceeds		18,092,666.		
13 Year of substantial completion	2016			
	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?		X		X
15 Were the bonds issued as part of an advance refunding issue?	X			X
16 Has the final allocation of proceeds been made?		X		X
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X	

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

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X				
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X		X				
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government00 %		.00 %		%		%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government00 %		.00 %		%		%
6 Total of lines 4 and 500 %		.00 %		%		%
7 Does the bond issue meet the private security or payment test?		X		X				
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of		%		%		%		%
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X					

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

SCHEDULE K, PART I, BOND ISSUES:

BOND NUMBER 1:

(A) ISSUER NAME: FULTON COUNTY INDUSTRIAL DEVELOPMENT AUTHORITY
 (C) CUSIP NUMBER: 36024LAL3, 36024LAM1, 36024LAK5
 (F) DESCRIPTION OF PURPOSE: REFUND SERIES 2006 & 2009 BONDS

BOND NUMBER 2:

(A) ISSUER NAME : FULTON COUNTY INDUSTRIAL DEVELOPMENT AUTHORITY
 (C) CUSIP NUMBER: 36024LAN9, 36024LAP4
 (F) DESCRIPTION OF PURPOSE: FINANCE THE CONSTRUCTION, IMPROVEMENT, AND EQUIPPING OF CERTAIN HOSPITAL FACILITIES, INCLUDING AN APPROXIMATELY 60,000 SQUARE FOOT TWO-STORY ADDITION TO THE MEDICAL CENTER'S EXISTING FACILITY, FOR THE PRIMARY PURPOSE OF PROVIDING PHYSICIAN OFFICES FOR PATIENT CARE, A SPECIALTY CLINIC (ACCOMODATING ORTHOPEDICS, UROLOGY, OB/GYN AND ENT PRACTICES) BEHAVIORAL HEALTH, CARDIOLOGY AND PULMONOLOGY, ADMINSTRATIVE OFFICES, A GIFT SHOP AND CAFE AND A PHARMACY, AND AN EXPANSION OF THE PARKING LOT; FUND A DEBT SERVICE RESERVE FUND RELATING TO THE BONDS; FUND INTEREST ON THE BONDS THROUGH JULY 1, 2018; AND PAY CERTAIN EXPENSES INCURRED IN CONNECTION WITH THE AUTHORIZATION AND ISSUANCE OF THE BONDS.

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
DEANN HAWKINS	SEE PART V	112,606.	SEE PART V		X
TODD ALEXANDER	SEE PART V	49,902.	SEE		X

Part V Supplemental Information

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

SCHEDULE L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: DEANN HAWKINS

(B) RELATIONSHIP WITH ORGANIZATION: MRS. HAWKINS IS THE WIFE OF JASON HAWKINS WHO IS THE CEO OF THE MEDICAL CENTER.

(C) AMOUNT OF TRANSACTION: \$112,606

(D) DESCRIPTION OF TRANSACTION: MRS. HAWKINS IS AN EMPLOYEE OF THE MEDICAL CENTER. THE AMOUNT OF THE TRANSACTION REPRESENTS HER ANNUAL SALARY.

(E) SHARING OF ORGANIZATIONS REVENUES: NO

(A) NAME OF PERSON: TODD ALEXANDER

(B) RELATIONSHIP WITH ORGANIZATION: MR. ALEXANDER IS THE OWNER OF ALEXANDER FINANCIAL GROUP WHICH MANAGES THE HOSPITAL'S BENEFIT PLANS, AND HE IS THE BROTHER OF SCOTT ALEXANDER WHO IS A MEMBER OF THE BOARD OF DIRECTORS OF THE MEDICAL CENTER.

(C) AMOUNT OF TRANSACTION: \$49,902

(D) DESCRIPTION OF TRANSACTION: THE AMOUNT THE HOSPITAL PAID TO ALEXANDER FINANCIAL GROUP FOR MANAGEMENT OF THEIR PLANS DURING THE YEAR.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2016

Open to Public
Inspection

Name of the organization

FULTON COUNTY MEDICAL CENTER

Employer identification number

23-1401561

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

PROGRAM, OFFERING ACCESS TO CARE THROUGH A MULTI-SPECIALTY CLINIC,
WORKING WITH OTHER PROVIDERS AND AGENCIES TO PROMOTE WELLNESS IN OUR
COMMUNITY, AND PROVIDING SERVICES REGARDLESS OF THE ABILITY TO PAY.

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

THE AMOUNT OF THE DISCOUNT IS DETERMINED BY THE TYPE OF SERVICE
RECEIVED SUCH AS INPATIENT, OUTPATIENT, ETC. INTEREST-FREE PAYMENT
PLANS ARE MADE AVAILABLE FOR PATIENTS WHO CANNOT PAY IN FULL AT THE
TIME OF SERVICE.

DURING FISCAL YEAR 2017:

- FCMC OPENED THE ORBISONIA REHABILITATION OFFICE - OCCUPATIONAL
THERAPY WAS THE FIRST SERVICE OFFERED.
- OFFERED NEW EXERCISE CLASSES FOR COMMUNITY HEALTH AND WELLNESS.
- BROKE GROUND FOR THE NEW CAM BUILDING.
- EXPANDED SERVICES IN REHAB AND CARDIOLOGY IN ORBISONIA.
- RECEIVED NUCLEAR MEDICINE ACCREDITATION.
- BUILT A GREENHOUSE FOR LONG-TERM-CARE RESIDENTS.
- UPGRADED MAMMOGRAM SERVICES AND ADDED GYNECOLOGIC ONCOLOGY SERVICES.

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

IF THE FACILITY DID NOT EXIST, FAMILIES WOULD HAVE TO TRAVEL OVER
MOUNTAINOUS TERRAIN TO RECEIVE LONG-TERM CARE SERVICES. WHILE THE
FACILITY ACCEPTS ALL MAJOR INSURANCES, PRIVATE PAY, MEDICARE, AND
MEDICAID, THE MAJORITY OF THE PATIENTS (APPROXIMATELY 70%) HAVE MEDICAL

Name of the organization

FULTON COUNTY MEDICAL CENTER

Employer identification number

23-1401561

ASSISTANCE.

FORM 990, PART VI, SECTION A, LINE 1:

THE EXECUTIVE COMMITTEE SHALL CONSIST OF THE BOARD OFFICERS AND EACH OF THE COMMITTEE CHARIPERSONS. THE PRESIDENT/CEO SHALL BE AN EX-OFFICIO, NON-VOTING MEMBER OF THE EXECUTIVE COMMITTEE. THE CHAIRPERSON OF THE BOARD SHALL ACT AS THE CHAIRPERSON OF THE EXECUTIVE COMMITTEE. FROM TIME TO TIME, THE EXECUTIVE COMMITTEE SHALL HAVE AND MAY EXERCISE, ALL OF THE POWERS OF THE BOARD OF DIRECTORS TO TRANSACT THE REGULAR BUSINESS OF THE MEDICAL CENTER TO THE EXTENT PERMITTED BY LAW, PROVIDED ANY ACTION TAKEN SHALL NOT CONFLICT WITH THE POLICIES AND EXPRESS WISHES OF THE BOARD OF DIRECTORS, AND IT SHALL REPORT ITS ACTIONS AT THE NEXT BOARD MEETING. THE COMMITTEE MAY ALSO ENSURE THAT THE BOARD OF DIRECTORS COMPLETES AN ANNUAL SELF-EVALUATION OF THE BOARD'S PERFORMANCE. THE COMMITTEE MAY ARRANGE FOR A REGULAR PROGRAM ON CONTINUING EDUCATION FOR ALL MEMBERS OF THE BOARD, AND ASSURE THAT A PROPER ORIENTATION PROGRAM IS PROVIDED FOR ALL NEW BOARD MEMBERS.

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

FULTON COUNTY MEDICAL CENTER HAS A CPA FIRM PREPARE ITS FORM 990. THE RETURN IS COMPLETED IN DRAFT FORM AND REVIEWED BY THE CFO AND PRESENTED TO THE FINANCE COMMITTEE. THE RETURN IS ALSO PROVIDED TO THE FULL GOVERNING BOARD BEFORE FILING WITH THE IRS.

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

A CONFLICT OF INTEREST FORM IS COMPLETED ANNUALLY BY ALL OFFICERS, DIRECTORS, AND KEY EMPLOYEES. ANY POSSIBLE CONFLICT OF INTEREST ON THE PART OF A DIRECTOR MUST BE DISCLOSED TO THE BOARD. THE FORMS ARE REVIEWED BY THE

Name of the organization

FULTON COUNTY MEDICAL CENTER

Employer identification number

23-1401561

PRESIDENT/CEO. WHEN ANY INTEREST BECOMES A MATTER OF BOARD ACTION, THE DIRECTOR IS NOT TO VOTE OR USE PERSONAL INFLUENCE ON THE MATTER, AND IS NOT COUNTED IN THE QUORUM FOR A MEETING AT WHICH BOARD ACTION IS TO BE TAKEN ON THE INTEREST. THE DIRECTOR MAY, HOWEVER, BRIEFLY STATE A POSITION ON THE MATTER AND ANSWER PERTINENT QUESTIONS OF BOARD MEMBERS. THE MINUTES OF ALL ACTIONS TAKEN ON SUCH MATTERS CLEARLY REFLECT THAT THESE REQUIREMENTS HAVE BEEN MET. IT IS THE OBLIGATION OF EACH BOARD MEMBER TO ACT IN THE BEST INTEREST OF THE MEDICAL CENTER. ALL BOARD INFORMATION IS CONFIDENTIAL, AND IS NOT TO BE USED OR DISCUSSED OTHER THAN FOR APPROPRIATE MEDICAL CENTER BUSINESS. FAILURE OF A DIRECTOR TO MAINTAIN THE CONFIDENTIALITY OF BOARD INFORMATION IS GROUNDS FOR REMOVAL.

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

THE BOARD OF DIRECTORS SERVES AS A COMPENSATION COMMITTEE AND REVIEWS AND ADJUSTS THE COMPENSATION OF THE PRESIDENT/CEO BASED ON EVALUATIONS AND COMPARABILITY DATA. THE HUMAN RESOURCES DEPARTMENT CONDUCTS A SURVEY TO GATHER COMPARABILITY DATA AND GIVES THIS INFORMATION TO THE BOARD OF DIRECTORS WHEN IT IS REQUESTED. THE PROCESS IS DOCUMENTED AND WAS LAST COMPLETED IN DECEMBER 2016.

THE CFO RECEIVES COST OF LIVING ADJUSTMENTS AS APPROVED THROUGH THE BUDGET PROCESS BY THE BOARD OF DIRECTORS EACH YEAR. THE PRESIDENT/CEO, IN COLLABORATION WITH THE HR DEPARTMENT, REVIEWS AND ADJUSTS THE COMPENSATION OF THE CFO BASED ON PERFORMANCE AND COMPARABILITY DATA. IF NEEDED, THE HR DEPARTMENT CONDUCTS A SURVEY TO GATHER COMPARABILITY DATA AND GIVES THIS INFORMATION TO THE PRESIDENT/CEO WHEN IT IS REQUESTED. THIS INFORMATION IS SHARED WITH THE BOARD OF DIRECTORS FOR INFORMATIONAL PURPOSES. THE PROCESS WAS LAST COMPLETED FOR FISCAL YEAR 2014.

Name of the organization FULTON COUNTY MEDICAL CENTER	Employer identification number 23-1401561
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FORM 990, PART VI, SECTION C, LINE 19:

THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE UPON REQUEST. THE DOCUMENTS ARE ALSO AVAILABLE AT THE ANNUAL MEETING WHICH IS OPEN TO THE GENERAL PUBLIC.

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

PURCHASED SERVICES:

PROGRAM SERVICE EXPENSES	1,458,318.
MANAGEMENT AND GENERAL EXPENSES	1,784,919.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	3,243,237.

PROFESSIONAL FEES:

PROGRAM SERVICE EXPENSES	1,109,383.
MANAGEMENT AND GENERAL EXPENSES	520,081.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	1,629,464.

CONTRACTED SERVICES:

PROGRAM SERVICE EXPENSES	354,062.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	354,062.

TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	5,226,763.
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FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

VALUATION GAIN ON PERMANENTLY RESTRICTED NET ASSETS	72,537.
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**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

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

OMB No. 1545-0047

2016

Open to Public Inspection

Name of the organization **FULTON COUNTY MEDICAL CENTER** Employer identification number **23-1401561**

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
THE FULTON COUNTY MEDICAL CENTER FOUNDATION - 51-0674514, 214 PEACH ORCHARD ROAD, MCCONNELLSBURG, PA 17233	FUNDRAISING	PENNSYLVANIA	501(C)(3)	LINE 7	FULTON COUNTY MEDICAL CENTER	X	

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

Schedule R (Form 990) 2016

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No

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

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) THE FULTON COUNTY MEDICAL CENTER FOUNDATION	B	371,442	CASH
(2) THE FULTON COUNTY MEDICAL CENTER FOUNDATION	C	613,837	CASH
(3)			
(4)			
(5)			
(6)			

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

Department of the Treasury
Internal Revenue Service

▶ **File a separate application for each return.**

▶ **Information about Form 8868 and its instructions is at www.irs.gov/form8868 .**

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.

Automatic 6-Month Extension of Time. Only submit original (no copies needed).

All corporations required to file an income tax return other than Form 990-T (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

	Enter filer's identifying number	
Type or print	Name of exempt organization or other filer, see instructions. FULTON COUNTY MEDICAL CENTER	Employer identification number (EIN) or 23-1401561
File by the due date for filing your return. See instructions.	Number, street, and room or suite no. If a P.O. box, see instructions. 214 PEACH ORCHARD ROAD	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. MCCONNELLSBURG, PA 17233	

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

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

DEBORAH SHUGHART, CFO

• The books are in the care of ▶ **214 PEACH ORCHARD ROAD - MCCONNELLSBURG, PA 17233**
Telephone No. ▶ **(717) 485-3155** Fax No. ▶ _____

- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.

1 I request an automatic 6-month extension of time until **MAY 15, 2018**, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

- ▶ calendar year _____ or
- ▶ tax year beginning **JUL 1, 2016**, and ending **JUN 30, 2017**.

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

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

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