Form **8879-EO**

Department of the Treasury
Internal Revenue Service

IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2016, or fiscal year beginning _____, 2016, and ending _____, 20___

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

▶ Information about Form 8879-EO and its instructions is at www.irs.gov/form8879eo.

OMB No 1545-1878

2016

Name of exempt organization

CAPITAL HOSPICE

Employer identification number

54-1920770

Name and title of officer

DAVID SCHWIND
EXECUTIVE VP CFO

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

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

1a Form 990 check here ▶ [X]	b Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	92,274,065.
2a Form 990-EZ check here ▶ [ ]	b Total revenue, if any (Form 990-EZ, line 9)	2b	
3a Form 1120-POL check here ▶ [ ]	b Total tax (Form 1120-POL, line 22)	3b	
4a Form 990-PF check here ▶ [ ]	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b	
5a Form 8868 check here ▶ [ ]	b Balance Due (Form 8868, line 3c)	5b	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2016 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize DIXON HUGHES GOODMAN LLP to enter my PIN 22102
ERO firm name
Enter five numbers, but do not enter all zeros

as my signature on the organization's tax year 2016 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2016 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ _____ Date ▶ 11/14/17

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. 54922222102
do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2016 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature ▶ _____ Date ▶ 11/14/17

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

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

▶ Do not enter social security numbers on this form as it may be made public.

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

OMB No. 1545-0047

2016

Open to Public Inspection

A For the 2016 calendar year, or tax year beginning and ending

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/ terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
CAPITAL HOSPICE
Doing business as CAPITAL CARING

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
2900 TELESTAR COURT

City or town, state or province, country, and ZIP or foreign postal code
FALLS CHURCH, VA 22042

F Name and address of principal officer: MALENE DAVIS
2900 TELESTAR COURT, FALLS CHURCH, VA 22042

D Employer identification number
54-1920770

E Telephone number
703-538-2065

G Gross receipts $ 92,555,796.

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

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

H(c) Group exemption number ▶

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

J Website: ▶ WWW.CAPITALCARING.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1998 M State of legal domicile: VA

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: THE MISSION OF CAPITAL HOSPICE IS TO IMPROVE CARE FOR THOSE FACING LIFE-LIMITING ILLNESSES THROUGH

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

3	Number of voting members of the governing body (Part VI, line 1a)	3	9
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	7
5	Total number of individuals employed in calendar year 2016 (Part V, line 2a)	5	857
6	Total number of volunteers (estimate if necessary)	6	1315
7a	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.

		Prior Year	Current Year
Revenue 8	Contributions and grants (Part VIII, line 1h)	7,855,714.	5,528,902.
9	Program service revenue (Part VIII, line 2g)	86,830,555.	85,835,787.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	17,286.	953,538.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	133,337.	-44,162.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	94,836,892.	92,274,065.
Expenses 13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	21,355.	16,385.
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)	50,562,092.	53,789,198.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 2,057,695.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	38,426,993.	37,371,118.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	89,010,440.	91,176,701.
19	Revenue less expenses. Subtract line 18 from line 12	5,826,452.	1,097,364.

		Beginning of Current Year	End of Year
Net Assets or Fund Balances 20	Total assets (Part X, line 16)	85,191,864.	87,398,840.
21	Total liabilities (Part X, line 26)	14,618,353.	14,754,007.
22	Net assets or fund balances. Subtract line 21 from line 20	70,573,511.	72,644,833.

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

▶ DAVID SCHWIND, EXECUTIVE VP CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
TAMARA VINEYARD		11/14/17		P01775208

Firm's name ▶ DIXON HUGHES GOODMAN LLP Firm's EIN ▶ 56-0747981

Firm's address ▶ 1410 SPRING HILL ROAD, 5TH FLOOR TYSONS, VA 22102 Phone no. 703-970-0400

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

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:
THE MISSION OF CAPITAL HOSPICE IS TO IMPROVE CARE FOR THOSE FACING LIFE-LIMITING ILLNESSES THROUGH DIRECT SUPPORT OF PATIENTS AND THEIR FAMILIES, PUBLIC EDUCATION AND PUBLIC ADVOCACY.

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 $ 66,982,137. including grants of $ 16,385.) (Revenue $ 76,541,586.)
CAPITAL HOSPICE PROVIDES EXPERT MEDICAL, EMOTIONAL, SPIRITUAL AND PRACTICAL CARE AND SUPPORT TO PATIENTS WITH SERIOUS, PROGRESSIVE ILLNESS AND THEIR FAMILIES 24 HOURS A DAY, SEVEN DAYS A WEEK TO PATIENTS WHEREVER THEY LIVE BY QUALIFIED PHYSICIANS, NURSES, NURSES' AIDES, SOCIAL WORKERS, NON-DENOMINATIONAL CHAPLAINS AND OTHER PROFESSIONALS. IT IS THE OBJECTIVE OF CAPITAL HOSPICE TO PROVIDE CARE TO ANYONE MEDICALLY ELIGIBLE, REGARDLESS OF THE PATIENT'S ABILITY TO PAY. CAPITAL HOSPICE PROVIDED SERVICES TO 7,429 PATIENTS DURING 2016 AND HAD 402,464 PATIENT DAYS OF CARE. CAPITAL HOSPICE HAD COSTS RELATED TO SERVICES AND SUPPLIES UNDER ITS CHARITY CARE POLICY OF APPROXIMATELY $3,278,000 IN 2016. IN ADDITION, CAPITAL HOSPICE PROVIDED UNCOMPENSATED CARE, WHERE REIMBURSEMENT FOR SERVICES IS LESS THAN THE ACTUAL COST OF

4b (Code:) (Expenses $ 9,601,281. including grants of $ 0.) (Revenue $ 7,737,902.)
HALQUIST MEMORIAL INPATIENT CENTER AND THE ADLER CENTER FOR CARING PROVIDES CARE FOR OUR HOSPICE PATIENTS THAT NEED CONSTANT MONITORING AND WHOSE PAIN AND SYMPTOMS CAN'T BE ADEQUATELY MANAGED AT HOME. IT IS THE OBJECTIVE OF THE HALQUIST MEMORIAL INPATIENT CENTER AND THE ADLER CENTER FOR CARING TO MAKE OUR PATIENTS AS SYMPTOM FREE AND AS COMFORTABLE AS POSSIBLE. THE HALQUIST MEMORIAL INPATIENT CENTER PROVIDED CARE TO 541 PATIENTS AND HAD 4,643 PATIENT DAYS OF CARE IN 2016. THE ADLER CENTER FOR CARING PROVIDED CARE TO 457 PATIENTS AND HAD 5,214 PATIENT DAYS OF CARE IN 2016. THE CAPITAL CARING CENTER NORTHEAST PROVIDED CARE TO 217 PATIENTS AND HAD 3,240 PATIENT DAYS OF CARE IN 2016.

4c (Code:) (Expenses $ 4,550,911. including grants of $ 0.) (Revenue $ 1,630,236.)
CAPITAL PALLIATIVE CARE CONSULTANTS PROVIDES PHYSICIAN SERVICES TO OUR HOSPICE PATIENTS, AND TO NON-HOSPICE ELIGIBLE PATIENTS WHO ARE IN NEED OF SYMPTOM MANAGEMENT. IT IS THE OBJECTIVE OF CAPITAL PALLIATIVE CARE CONSULTANTS TO PROVIDE PHYSICIAN SERVICES TO ALL PATIENTS IN NEED OF SYMPTOM MANAGEMENT, REGARDLESS OF THE PATIENT'S ABILITY TO PAY. CAPITAL PALLIATIVE CARE CONSULTANTS PROVIDED 20,185 PATIENT VISITS DURING 2016.

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

4e Total program service expenses ▶ 81,134,329.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response 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	1a	136		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	857		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a			X
b	If "Yes," has it filed a Form 990-T for this year? *If "No," to line 3b, provide an explanation in Schedule O*	3b			
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶				
	See instructions for filing requirements for 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?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a		X	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b		X	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?	9a			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

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

Section A. Governing Body and Management

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

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

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

Section C. Disclosure

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

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: ▶

DAVID A SCHWIND - 703-531-1108

2900 TELESTAR COURT, FALLS CHURCH, VA 22042

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) TOM KOUTSOUMPAS	2.00									
CHAIR		X						0.	0.	0.
(2) DAN A. D'AGOSTINO JR.	1.00									
TREASURER		X						0.	0.	0.
(3) VERA DVORAK, MD	1.00									
BOARD MEMBER		X						0.	0.	0.
(4) LORING FLINT, MD	1.00									
BOARD MEMBER		X						0.	0.	0.
(5) TYRONE PITTS	1.00									
BOARD MEMBER		X						0.	0.	0.
(6) SUE HARGREAVES	1.00									
BOARD MEMBER		X						0.	0.	0.
(7) KIM LAREW	1.00									
BOARD MEMBER		X						0.	0.	0.
(8) JEFFREY GODWIN, PHD, MBA, M.DIV	1.00									
BOARD MEMBER		X						0.	0.	0.
(9) MALENE DAVIS	40.00									
PRESIDENT/CEO		X		X				520,296.	0.	27,212.
(10) DAVID SCHWIND	40.00									
EXECUTIVE VP CFO				X				274,198.	0.	32,656.
(11) JAMES CAMERON MUIR, MD	40.00									
EVP QUALITY & ACCESS/ CMO					X			334,212.	0.	37,834.
(12) MICHAEL BYAS-SMITH, MD	40.00									
MEDICAL DIRECTOR						X		351,474.	0.	24,227.
(13) ELIZABETH PHAN, MD	40.00									
HPM PHYSICIAN						X		232,957.	0.	4,727.
(14) JASON SOBEL, MD	40.00									
SENIOR MEDICAL DIRECTOR						X		231,775.	0.	13,178.
(15) JORDAN KEEN, MD	40.00									
HPM PHYSICIAN						X		228,043.	0.	8,318.
(16) ANNE SILAO-SOLOMON MD	40.00									
NBRHD LEAD PHYSICIAN						X		214,773.	0.	21,212.

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			
1b Sub-total ▶								2,387,728.	0.	169,364.
c Total from continuation sheets to Part VII, Section A ▶								0.	0.	0.
d Total (add lines 1b and 1c) ▶								2,387,728.	0.	169,364.

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 ▶ 39

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
NMS HEALTHCARE OF HYATTSVILLE 4922 LASALLE ROAD, HYATTSVILLE, MD 20782	NURSING HOME SERVICE	3,230,332.
WILBEA MEDICAL EQUIPMENT P.O. BOX 3449, HARKER HEIGHTS, TX 76548	MEDICAL EQUIPMENT RENTAL	2,575,898.
WOODBINE REHAB & HEALTHCARE 2729 KING STREET, ALEXANDRIA, VA 22302	NURSING HOME SERVICE	726,290.
POTOMAC FALLS HEALTH & REHAB, 46531 HARRY BIRD HIGHWAY, STERLING, VA 20164	NURSING HOME SERVICE	680,414.
CORAM ALTERNATE SITE SERVICES P.O. BOX 74798, CHICAGO, IL 60694	IV THERAPY	677,727.

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 ▶ 32

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c	242,798.				
	d Related organizations	1d					
	e Government grants (contributions)	1e	53,827.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	5,232,277.				
	g Noncash contributions included in lines 1a-1f: $ 53,881.						
	h Total. Add lines 1a-1f			5,528,902.			
Program Service Revenue		Business Code					
	2a PATIENT SERVICES			85,835,787.	85,835,787.		
	b						
	c						
	d						
	e						
	f All other program service revenue						
	g Total. Add lines 2a-2f			85,835,787.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			635,780.			635,780.
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
		(i) Real	(ii) Personal				
	6a Gross rents						
	b Less: rental expenses						
	c Rental income or (loss)						
	d Net rental income or (loss)						
		(i) Securities	(ii) Other				
	7a Gross amount from sales of assets other than inventory	317,758.					
	b Less: cost or other basis and sales expenses	0.					
	c Gain or (loss)	317,758.					
	d Net gain or (loss)			317,758.			317,758.
	8a Gross income from fundraising events (not including $ 242,798. of contributions reported on line 1c). See Part IV, line 18	a	163,632.				
	b Less: direct expenses	b	281,731.				
	c Net income or (loss) from fundraising events			-118,099.			-118,099.
	9a Gross income from gaming activities. See Part IV, line 19	a					
	b Less: direct expenses	b					
	c Net income or (loss) from gaming activities						
	10a Gross sales of inventory, less returns and allowances	a					
	b Less: cost of goods sold	b					
	c Net income or (loss) from sales of inventory						
	Miscellaneous Revenue	Business Code					
	11a MISCELLANEOUS	541700		66,263.	66,263.		
	b FOOD SERVICE REVENUE			7,674.	7,674.		
	c						
	d All other revenue						
	e Total. Add lines 11a-11d			73,937.			
	12 Total revenue. See instructions.			92,274,065.	85,909,724.	0.	835,439.

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	16,385.	16,385.		
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	1,391,798.	671,709.	690,529.	29,560.
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	43,778,910.	40,154,415.	2,679,212.	945,283.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,114,116.	1,006,959.	83,113.	24,044.
9 Other employee benefits	4,192,276.	3,789,057.	312,744.	90,475.
10 Payroll taxes	3,312,098.	2,993,536.	247,083.	71,479.
11 Fees for services (non-employees):				
a Management				
b Legal	263,233.	12,815.	250,129.	289.
c Accounting	72,149.	1,349.	70,800.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	142,948.		142,948.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	15,187,546.	13,539,246.	1,491,035.	157,265.
12 Advertising and promotion	280,842.	74,674.	190,746.	15,422.
13 Office expenses	2,080,265.	1,307,676.	566,278.	206,311.
14 Information technology	2,148,498.	1,957,990.	92,139.	98,369.
15 Royalties				
16 Occupancy	2,304,563.	1,729,713.	275,323.	299,527.
17 Travel	1,495,818.	1,156,703.	296,945.	42,170.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	45,403.	13,423.	31,619.	361.
20 Interest	492,058.	6,180.	442,146.	43,732.
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	1,860,729.	1,729,238.	106,479.	25,012.
23 Insurance	311,419.	292,513.	12,292.	6,614.
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	7,903,243.	7,903,230.	5.	8.
b BAD DEBT	2,670,061.	2,670,061.		
c OTHER	112,343.	107,457.	3,112.	1,774.
d				
e All other expenses				
25 **Total functional expenses.** Add lines 1 through 24e	91,176,701.	81,134,329.	7,984,677.	2,057,695.
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		1	0.
	2	Savings and temporary cash investments	18,242,661.	2	8,325,311.
	3	Pledges and grants receivable, net	384.	3	75,847.
	4	Accounts receivable, net	7,776,696.	4	18,458,506.
	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	18,322.	8	57,428.
	9	Prepaid expenses and deferred charges	487,177.	9	536,018.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 43,015,834.			
	b	Less: accumulated depreciation — 10b: 13,844,063.	30,094,853.	10c	29,171,771.
	11	Investments - publicly traded securities	16,411,618.	11	18,086,477.
	12	Investments - other securities. See Part IV, line 11	7,962,318.	12	7,201,395.
	13	Investments - program-related. See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	4,197,835.	15	5,486,087.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	85,191,864.	16	87,398,840.
Liabilities	17	Accounts payable and accrued expenses	6,268,806.	17	7,335,597.
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	6,190,000.	20	5,603,716.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	2,159,547.	25	1,814,694.
	26	**Total liabilities.** Add lines 17 through 25	14,618,353.	26	14,754,007.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	63,587,534.	27	65,112,468.
	28	Temporarily restricted net assets	2,273,759.	28	2,467,927.
	29	Permanently restricted net assets	4,712,218.	29	5,064,438.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	70,573,511.	33	72,644,833.
	34	Total liabilities and net assets/fund balances	85,191,864.	34	87,398,840.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	92,274,065.
2	Total expenses (must equal Part IX, column (A), line 25)	2	91,176,701.
3	Revenue less expenses. Subtract line 2 from line 1	3	1,097,364.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	70,573,511.
5	Net unrealized gains (losses) on investments	5	712,849.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	261,109.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	72,644,833.

Part XII Financial Statements and Reporting

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

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

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ Attach to Form 990 or Form 990-EZ.

▶ Information about Schedule A (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

CAPITAL HOSPICE

Employer identification number

54-1920770

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

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

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

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)

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

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

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

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

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

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

9 ☐ An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____

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

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

12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**

b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

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

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

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 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** ..... ▶ ☐

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 ..... ▶ ☐

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 ..... ▶ ☐

17a **10% -facts-and-circumstances test - 2016.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

b **10% -facts-and-circumstances test - 2015.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

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

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

(Complete only if you checked the box on line 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? *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.*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? *If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below.*	3a		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? *If "Yes," describe in Part VI when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in Part VI what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes," and if you checked 12a or 12b in Part I, answer (b) and (c) below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.*	4b		
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)? *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.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in 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).*	5a		
b	**Type I or Type II only.** Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? *If "Yes," provide detail in Part VI.*	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	8		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? *If "Yes," provide detail in Part VI.*	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in Part VI.*	9b		
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? *If "Yes," provide detail in Part VI.*	9c		
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)? *If "Yes," answer 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)*	10b		

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?	11a		
b	A family member of a person described in (a) above?	11b		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in Part VI.*	11c		

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? *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.*	1		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.*	2		

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)? *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).*	1		

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?	1		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? *If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).*	2		
3	By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? *If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.*	3		

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 ☐ The organization satisfied the Activities Test. *Complete line 2 below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete line 3 below.*

c ☐ The organization supported a governmental entity. *Describe in Part VI how you supported a government entity (see instructions).*

			Yes	No
2	Activities Test. *Answer (a) and (b) below.*			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *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.*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in 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.*	2b		
3	Parent of Supported Organizations. *Answer (a) and (b) below.*			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in Part VI.*	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? *If "Yes," describe in Part VI the role played by the organization in this regard.*	3b		

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			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 ☐ 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			

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

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

OMB No. 1545-0047

2016
Open to Public Inspection

Name of the organization
CAPITAL HOSPICE

Employer identification number
54-1920770

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements.

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

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

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

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

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

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

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

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

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

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

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

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

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

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

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

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

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

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

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

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

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

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

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII ☐

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	20,259,672.	20,749,609.	32,544,708.	29,332,201.	24,892,384.
b Contributions	294,136.	224,100.	355,135.	1,195,004.	3,293,566.
c Net investment earnings, gains, and losses	1,560,942.	-432,750.	1,321,461.	2,314,142.	1,513,143.
d Grants or scholarships					
e Other expenditures for facilities and programs	99,966.	135,501.	13,327,940.	168,058.	247,019.
f Administrative expenses	142,948.	145,786.	143,755.	128,581.	119,873.
g End of year balance	21,871,836.	20,259,672.	20,749,609.	32,544,708.	29,332,201.

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

a Board designated or quasi-endowment ▶ 66.00 %
b Permanent endowment ▶ 23.00 %
c Temporarily restricted endowment ▶ 11.00 %

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)		X
(ii) related organizations	3a(ii)		X
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		3,415,980.		3,415,980.
b Buildings		27,779,728.	6,068,398.	21,711,330.
c Leasehold improvements		480,664.	128,099.	352,565.
d Equipment		10,499,639.	7,620,058.	2,879,581.
e Other		839,823.	27,508.	812,315.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ▶				29,171,771.

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) US GOVERNMENT SECURITIES	432,025.	END-OF-YEAR MARKET VALUE
(B) CD'S AND MONEY MARKET		
(C) FUNDS	5,947,776.	END-OF-YEAR MARKET VALUE
(D) CORPORATE DEBT SECURITIES	105,974.	END-OF-YEAR MARKET VALUE
(E) CASH AND CASH EQUIVALENTS	715,620.	END-OF-YEAR MARKET VALUE
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	7,201,395.	

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) RESTRICTED CASH	2,365,972.
(2) BENEFICIAL INT REMAIN TRUST	126,308.
(3) OTHER RECEIVABLES	243,807.
(4) LOAN RECEIVABLE	2,750,000.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	5,486,087.

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) CHARITABLE GIFT ANNUITIES	299,284.
(3) CAPITAL LEASE OBLIGATION	243,618.
(4) INTEREST RATE SWAP LIABILITY	1,271,792.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	1,814,694.

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 [X]

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	93,125,698.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains (losses) on investments	2a	712,850.		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d	281,731.		
e	Add lines 2a through 2d			2e	994,581.
3	Subtract line 2e from line 1			3	92,131,117.
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	142,948.		
b	Other (Describe in Part XIII.)	4b			
c	Add lines 4a and 4b			4c	142,948.
5	Total revenue. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 12.)*			5	92,274,065.

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	91,315,484.
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	281,731.		
e	Add lines 2a through 2d			2e	281,731.
3	Subtract line 2e from line 1			3	91,033,753.
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	142,948.		
b	Other (Describe in Part XIII.)	4b			
c	Add lines 4a and 4b			4c	142,948.
5	Total expenses. Add lines 3 and 4c. *(This must equal Form 990, Part I, line 18.)*			5	91,176,701.

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 V, LINE 4:

CAPITAL HOSPICE INTENDS TO INVEST ITS PERMANENTLY RESTRICTED ENDOWMENT FUNDS UNTIL THEY REACH FIVE MILLION DOLLARS AT WHICH TIME, WITH THE BOARD OF TRUSTEES APPROVAL, EIGHTY PERCENT OF ANY EARNINGS WOULD BE USED TO SUPPORT ONGOING OPERATIONS AND TWENTY PERCENT WOULD BE ADDED TO THE FUND. TEMPORARILY RESTRICTED FUNDS ARE USED AS INTENDED. THE LARGEST TEMPORARILY RESTRICTED FUND AT THE BEGINNING OF THE YEAR WAS USED DURING THE YEAR TO PAY FOR THE CONSTRUCTION OF A HOSPICE INPATIENT UNIT IN ADLER, VIRGINIA.THE BOARD DESIGNATED RESTRICTED FUNDS ARE TO BE USED FOR ANY EMERGENCY OR NEW SERVICE THAT THE BOARD APPROVES.

PART X, LINE 2:

Part XIII Supplemental Information *(continued)*

THE HOSPICE WAS RECOGNIZED AS A PUBLIC CHARITY GENERALLY EXEMPT FROM FEDERAL INCOME TAXATION UNDER 501(C)(3) OF THE INTERNAL REVENUE CODE PURSUANT TO A DETERMINATION LETTER ISSUED BY THE IRS IN APRIL 1998. THE HOSPICE IS ENTITLED TO RELY ON THIS DETERMINATION AS LONG AS THERE ARE NO SUBSTANTIAL CHANGES IN ITS CHARACTER, PURPOSES, OR OPERATIONS. MANAGEMENT HAS CONCLUDED THAT THERE HAVE BEEN NO SUCH CHANGES AND THEREFORE THE HOSPICE'S STATUS AS A PUBLIC CHARITY EXEMPT FROM FEDERAL INCOME TAXATION REMAINS IN EFFECT. THE STATES IN WHICH THE HOSPICE OPERATES ALSO PROVIDE GENERAL EXEMPTION FROM STATE INCOME TAXATION FOR ORGANIZATIONS THAT ARE EXEMPT FROM FEDERAL INCOME TAXATION. HOWEVER, THE HOSPICE IS SUBJECT TO BOTH FEDERAL AND STATE INCOME TAXATION AT CORPORATE TAX RATES ON ITS UNRELATED BUSINESS INCOME. EXEMPTION FROM OTHER STATE TAXES, SUCH AS REAL AND PERSONAL PROPERTY TAXES, IS SEPARATELY DETERMINED. THE OPERATIONS OF CPCC IS INCLUDED IN THE HOSPICE'S FILING.

THE HOSPICE DID NOT HAVE MATERIAL UNRECOGNIZED TAX BENEFITS DURING THE PERIODS PRESENTED. FOR TAX PERIODS WITH RESPECT TO WHICH THE HOSPICE DID NOT RECOGNIZE ANY UNRELATED BUSINESS INCOME, THE HOSPICE WAS NOT REQUIRED TO FILE ANY INCOME TAX RETURNS.

CURRENT ACCOUNTING STANDARDS DEFINE THE THRESHOLD FOR RECOGNIZING UNCERTAIN INCOME TAX RETURN POSITIONS IN THE FINANCIAL STATEMENTS AS "MORE LIKELY THAN NOT" THAT THE POSITION IS SUSTAINABLE, BASED ON ITS TECHNICAL MERITS, AND ALSO PROVIDE GUIDANCE ON THE MEASUREMENT, CLASSIFICATION AND DISCLOSURE OF TAX RETURN POSITIONS IN THE FINANCIAL STATEMENTS. MANAGEMENT BELIEVES THERE IS NO IMPACT ON THE HOSPICE'S ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS RELATED TO UNCERTAIN INCOME TAX POSITIONS.

Part XIII Supplemental Information *(continued)*

PART XI, LINE 2D - OTHER ADJUSTMENTS:

SPECIAL EVENTS EXPENSE	281,731.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

SPECIAL EVENTS EXPENSE	281,731.

SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

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

▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule G (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

CAPITAL HOSPICE

Employer identification number

54-1920770

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

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

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

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

b If "Yes," list the 10 highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions? Yes	(iii) No	(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col. (i)	(vi) Amount paid to (or retained by) organization
Total ▶						

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

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

		(a) Event #1 HOSPICE COMES TO WAS (event type)	(b) Event #2 GALA (event type)	(c) Other events NONE (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	60,250.	346,180.		406,430.
	2 Less: Contributions	29,578.	213,220.		242,798.
	3 Gross income (line 1 minus line 2)	30,672.	132,960.		163,632.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes		5,223.		5,223.
	6 Rent/facility costs	6,000.	2,878.		8,878.
	7 Food and beverages	19,204.	126,620.		145,824.
	8 Entertainment	11,468.	6,340.		17,808.
	9 Other direct expenses	9,339.	94,659.		103,998.
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				281,731.
	11 Net income summary. Subtract line 10 from line 3, column (d) ▶				-118,099.

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

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

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

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

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

13 Indicate the percentage of gaming activity conducted in:

a The organization's facility 13a %

b An outside facility 13b %

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

Name ▶

Address ▶

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

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

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

Name ▶

Address ▶

16 Gaming manager information:

Name ▶

Gaming manager compensation ▶ $ _____

Description of services provided ▶

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

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

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

Part IV **Supplemental Information.** Provide the explanations required by Part I, line 2b, columns (iii) and (v); and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional information. See instructions

Part IV **Supplemental Information** *(continued)*

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
CAPITAL HOSPICE

Employer identification number
54-1920770

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	X	
b	If "Yes," was it a written policy?	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☒ 300% ☐ 350% ☐ 400% ☐ Other _____ %	X	
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"?	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a	Did the organization prepare a community benefit report during the tax year?		X
b	If "Yes," did the organization make it available to the public?		

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			3249137.	0.	3249137.	3.56%
b Medicaid (from Worksheet 3, column a)			13266946.	13812313.	-545,367.	.00%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			16516083.	13812313.	2703770.	3.56%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			740.	1,407.	-667.	.00%
f Health professions education (from Worksheet 5)			221,321.	5,009.	216,312.	.24%
g Subsidized health services (from Worksheet 6)			8951945.	5632000.	3319945.	3.64%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			16,385.		16,385.	.02%
j **Total.** Other Benefits			9190391.	5638416.	3551975.	3.90%
k **Total.** Add lines 7d and 7j			25706474.	19450729.	6255745.	7.46%

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

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development						
9	Other						
10	Total						

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2 2,564,635.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	57,986,456.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	62,489,637.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-4,503,181.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☐ Cost to charge ratio ☒ Other		

Section C. Collection Practices

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

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

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

Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	Gen. medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 CAPITAL HOSPICE HALQUIST MEMORIAL CENT 4715 N 15TH STREET ARLINGTON, VA 22205-2640	X								HOSPICE IMPATIENT CENTER	

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 CAPITAL HOSPICE HALQUIST MEMORIAL 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?	1	X	
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	[X] Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 13			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		X
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		X
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): WWW.CAPITALCARING.ORG			
b	[ ] Other website (list url):			
c	[ ] Made a paper copy available for public inspection without charge at the hospital facility			
d	[X] Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 13			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): WWW.CAPITALCARING.ORG			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group CAPITAL HOSPICE HALQUIST MEMORIAL 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?	13	X	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 300 %			
b	[X] Income level other than FPG (describe in Section C)			
c	[X] Asset level			
d	[X] Medical indigency			
e	[X] Insurance status			
f	[X] Underinsurance status			
g	[ ] Residency			
h	[X] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	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	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[X] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[ ] The FAP was widely available on a website (list url):			
b	[ ] The FAP application form was widely available on a website (list url):			
c	[ ] A plain language summary of the FAP was widely available on a website (list url):			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	[X] Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	[ ] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[ ] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	[ ] Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group CAPITAL HOSPICE HALQUIST MEMORIAL 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?	17	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	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
f	☒ 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?	19		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
20	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	☐ 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	☒ Made a reasonable effort to orally notify individuals about the FAP and FAP application process			
c	☒ Processed incomplete and complete FAP applications			
d	☐ Made presumptive eligibility determinations			
e	☐ Other (describe in Section C)			
f	☐ 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?	21		X
	If "No," indicate why:			
a	☒ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ 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 CAPITAL HOSPICE HALQUIST MEMORIAL 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 ☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b ☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c ☐	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 ☐	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.

PART V, SECTION A:

SCHEDULE H, PART V, QUESTION 22:

THE HOSPITAL FACILITY DETERMINES THE MAXIMUM AMOUNTS THAT CAN BE CHARGED TO FINANCIAL ASSISTANCE ELIGIBLE INDIVIDUALS (THAT DO NOT QUALIFY FOR FREE CARE) FOR EMERGENCY OR OTHER MEDICALLY NECESSARY CARE THROUGH THE USE OF A SLIDING FEE SCHEDULE FOR FINANCIAL ASSISTANCE PATIENTS. THE SLIDING SCALE BEGINS AT A LEVEL BELOW THE RATES BILLED TO MEDICARE OR ANY COMMERCIAL INSURERS FOR SUCH CARE FOR PATIENTS THAT HAVE FAMILY ANNUAL INCOME OF 300% OF THE FEDERAL POVERTY GUIDELINES AND GOES DOWN TO 25% OF FULL CHARGES (APPROXIMATELY 35-40% OF MEDICARE RATES) FOR PATIENTS THAT HAVE FAMILY ANNUAL INCOME OF 225% OF THE FEDERAL POVERTY GUIDELINES.

CAPITAL HOSPICE HALQUIST MEMORIAL CENTER:

PART V, SECTION B, LINE 3J: THE HALQUIST MEMORIAL INPATIENT CENTER WAS LICENSED IN 1981 AS ONE OF THE FIRST HOSPICE INPATIENT CENTERS IN THE UNITED STATES AND THE FIRST IN THE STATE OF VIRGINIA. AS SUCH, THE STATE OF VIRGINIA HAD NO CATEGORY FOR LICENSURE THAT WOULD FIT THE FACILITY AND THEREFORE LICENSED THE UNIT AS A GENERAL HOSPITAL. AS A HOSPICE INPATIENT CENTER, THE FACILITY HAS NO EMERGENCY ROOM, OUTPATIENT CENTER, LABS, OR OTHER DIAGNOSTIC SERVICES AS WOULD A GENERAL HOSPITAL. IT SERVES ONLY CAPITAL HOSPICE PATIENTS REQUIRING ACUTE SYMPTOM MANAGEMENT OR PATIENTS IN THEIR FINAL DAYS OF A TERMINAL ILLNESS WHO CAN NO LONGER BE SERVED AT HOME. THE UNIT HAS 15 BEDS AND REPRESENTS ON AVERAGE ONLY 13 OF THE MORE THAN 1100 PATIENTS THAT ARE TREATED BY CAPITAL HOSPICE ON A DAILY BASIS. AS A RESULT, THE COMMUNITY HEALTH NEEDS ASSESSMENT IS NOT APPLICABLE TO HOSPICE INPATIENT BEDS. IN STATES OTHER THAN VIRGINIA, UNITS LIKE HALQUIST

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.

ARE LICENSED AS HOSPICE CENTERS AND ARE NOT SUBJECT TO EITHER THE COMMUNITY HEALTH NEEDS ASSESSMENT OR THE H SCHEDULES. IT IS FOR THIS REASON THAT SUCH AN ASSESSMENT WAS NOT PERFORMED IN 2016. SIMILARLY, MEDICARE HAS RECOGNIZED THAT OUR UNIT IS NOT ACTUALLY A HOSPITAL AND HAS NOT REQUIRED US TO COMPLY WITH MANY OF THE REPORTING REQUIREMENT APPLICABLE TO HOSPITALS.

CAPITAL HOSPICE HALQUIST MEMORIAL CENTER:

PART V, SECTION B, LINE 5: THE HOSPITAL FACILITY RECEIVED INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE HOSPITAL FACILITY, INCLUDING THOSE WITH SPECIAL KNOWLEDGE OR EXPERTISE IN PUBLIC HEALTH, AS WELL AS LEADERS AND REPRESENTATIVES OF MEDICALLY UNDERSERVED, LOW INCOME, AND MINORITY POPULATIONS, AND POPULATIONS WITH CHRONIC DISEASE NEEDS. IN PARTICULAR, A SURVEY WAS DEVELOPED BY THE ORGANIZATION, WHICH WAS ADMINISTERED TO LEADERS AND REPRESENTATIVES FROM ORGANIZATIONS ACROSS THE COMMUNITY, INCLUDING: UNIVERSITY OF MARYLAND PREVENTION RESEARCH CENTER, GEORGE WASHINGTON UNIVERSITY HOSPITAL, PROVIDENCE HOSPITAL, DIMENSIONS HEALTHCARE SYSTEM, LIVINRITE HOME HEALTH, AARP DEPARTMENT OF AGING, THE DC OFFICE ON AGING, HEAVEN SENT LLC, MORNINGSIDE HOUSE OF LAUREL, N STREET VILLAGE, SEABURY RESOURCES FOR AGING, AND THE RESIDENCES AT THOMAS CIRCLE.

CAPITAL HOSPICE HALQUIST MEMORIAL CENTER:

PART V, SECTION B, LINE 7D: THE HALQUIST MEMORIAL INPATIENT CENTER WAS LICENSED IN 1981 AS ONE OF THE FIRST HOSPICE INPATIENT CENTERS IN THE

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.

UNITED STATES AND THE FIRST IN THE STATE OF VIRGINIA. AS SUCH, THE STATE OF VIRGINIA HAD NO CATEGORY FOR LICENSURE THAT WOULD FIT THE FACILITY AND THEREFORE LICENSED THE UNIT AS A GENERAL HOSPITAL. AS A HOSPICE INPATIENT CENTER, THE FACILITY HAS NO EMERGENCY ROOM, OUTPATIENT CENTER, LABS, OR OTHER DIAGNOSTIC SERVICES AS WOULD A GENERAL HOSPITAL. IT SERVES ONLY CAPITAL HOSPICE PATIENTS REQUIRING ACUTE SYMPTOM MANAGEMENT OR PATIENTS IN THEIR FINAL DAYS OF A TERMINAL ILLNESS WHO CAN NO LONGER BE SERVED AT HOME. THE UNIT HAS 15 BEDS AND REPRESENTS ON AVERAGE ONLY 13 OF THE MORE THAN 1100 PATIENTS THAT ARE TREATED BY CAPITAL HOSPICE ON A DAILY BASIS. AS A RESULT, THE COMMUNITY HEALTH NEEDS ASSESSMENT IS NOT APPLICABLE TO HOSPICE INPATIENT BEDS. IN STATES OTHER THAN VIRGINIA, UNITS LIKE HALQUIST ARE LICENSED AS HOSPICE CENTERS AND ARE NOT SUBJECT TO EITHER THE COMMUNITY HEALTH NEEDS ASSESSMENT OR THE H SCHEDULES. IT IS FOR THIS REASON THAT SUCH AN ASSESSMENT WAS NOT PERFORMED IN 2016. SIMILARLY, MEDICARE HAS RECOGNIZED THAT OUR UNIT IS NOT ACTUALLY A HOSPITAL AND HAS NOT REQUIRED US TO COMPLY WITH MANY OF THE REPORTING REQUIREMENT APPLICABLE TO HOSPITALS.

CAPITAL HOSPICE HALQUIST MEMORIAL CENTER:

PART V, SECTION B, LINE 11: IN THE COMMUNITY HEALTH NEEDS ASSESSMENT THAT WAS CONDUCTED IN 2013, THE AREAS OF GREATEST CONCERN TO SURVEY RESPONDENTS WERE IN THE AREAS OF ALZHEIMER'S DISEASE, GENERAL AGING, AND MENTAL ILLNESS. AS A HOSPICE INPATIENT CENTER, THE HALQUIST MEMORIAL INPATIENT CENTER CARES FOR PATIENTS WITH SHORT TERM SYMPTOM MANAGEMENT ISSUES ASSOCIATED WITH A TERMINAL DIAGNOSIS AND FOR PATIENTS REQUIRING INPATIENT CARE DURING THE LAST DAYS OF THEIR TERMINAL ILLNESS. AS SUCH, ONLY 2% OF

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 PATIENTS CARED FOR AT HALQUIST IN 2015 SUFFERED FROM MENTAL DISORDERS AS THEIR PRIMARY DIAGNOSIS. NONETHELESS, MORE THAN 80% OF THE PATIENTS THAT CAPITAL CARING SERVES ARE OVER 65 YEARS OF AGE. AS A RESULT, A SIGNIFICANT PORTION OF OUR COMMUNITY OUTREACH AND EDUCATION EFFORTS ARE CENTERED ON THE NEEDS OF THE ELDERLY. THE HALQUIST MEMORIAL INPATIENT CENTER IS LOCATED IN OUR ARLINGTON, VA. REGION. IN 2015 CLASSES WERE HELD AT THE LOCAL ARLINGTON ACUTE CARE HOSPITAL ON DEMENTIA AND DELIRIUM IN THE ELDERLY AND A SIMILAR CLASS WAS HELD AT A LOCAL SCHOOL OF NURSING. IN ADDITION, CLASSES WERE HELD AT LOCAL NURSING HOMES AND ASSISTED LIVING FACILITIES. WORKSHOPS WERE ALSO HELD FOR LOCAL CLERGY AND FAITH COMMUNITY LEADERS AS THESE INDIVIDUALS OFTEN SERVE AS THE PRIMARY SOURCE OF HEALTH INFORMATION AND ADVICE FOR MANY INDIVIDUALS. AS THE RATE OF ALZHEIMER'S DISEASE AND DEMENTIA CONTINUE TO GROW WITHIN OUR COMMUNITIES, WE CONTINUE TO EXPAND OUR OFFERINGS TO THE COMMUNITY ON THESE ISSUES.

CAPITAL HOSPICE HALQUIST MEMORIAL CENTER:

PART V, SECTION B, LINE 13H: THE HOSPITAL FACILITY DETERMINES THE MAXIMUM AMOUNTS THAT CAN BE CHARGED TO FINANCIAL ASSISTANCE ELIGIBLE INDIVIDUALS (THAT DO NOT QUALIFY FOR FREE CARE) FOR EMERGENCY OR OTHER MEDICALLY NECESSARY CARE THROUGH THE USE OF A SLIDING FEE SCHEDULE FOR FINANCIAL ASSISTANCE PATIENTS. THE SLIDING SCALE BEGINS AT A LEVEL BELOW THE RATES BILLED TO MEDICARE OR ANY COMMERCIAL INSURERS FOR SUCH CARE FOR PATIENTS THAT HAVE FAMILY ANNUAL INCOME OF 300% OF THE FEDERAL POVERTY GUIDELINES AND GOES DOWN TO 25% OF FULL CHARGES (APPROXIMATELY 35-40% OF MEDICARE RATES) FOR PATIENTS THAT HAVE FAMILY ANNUAL INCOME OF 225% OF THE FEDERAL POVERTY GUIDELINES. IN ADDITION, THE HOSPITAL FACILITY PROVIDES A 20%

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.

DISCOUNT TO ALL UNINSURED PATIENTS THAT HAVE FAMILY ANNUAL INCOME UP TO 400% OF THE FEDERAL POVERTY GUIDELINES AND DO NOT QUALIFY UNDER THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY. IF THE UNINSURED PATIENT IS DEEMED TO BE MEDICALLY INDIGENT, THEN THE HOSPITAL FACILITY WILL PROVIDE A GREATER DISCOUNT.

CAPITAL HOSPICE HALQUIST MEMORIAL CENTER:

PART V, SECTION B, LINE 18E: THE HOSPITAL FACILITY MAKES REASONABLE EFFORTS TO DETERMINE A PATIENT'S ELIGIBILITY UNDER THE FINANCIAL ASSISTANCE POLICY BEFORE TURNING OVER THE UNPAID ACCOUNT TO A COLLECTION AGENCY FOR ATTEMPTED RECOVERY (NO OTHER 3RD PARTY COLLECTION ACTIVITY OR EXTRAORDINARY COLLECTION ACTIONS ARE UNDERTAKEN BY THE ORGANIZATION). THE HOSPITAL FACILITY VISITS EACH PATIENT BEFORE THE PATIENT IS ADMITTED TO THE FACILITY. AS PART OF THAT VISIT ANY INSURANCE COVERAGE OR ELIGIBILITY FOR MEDICAID IS DISCUSSED. IF IT IS APPARENT THAT INSURANCE COVERAGE OR MEDICAID COVERAGE IS NOT AVAILABLE, OR IS LIMITED, THEN THE FACILITY ENCOURAGES THE PATIENT TO APPLY FOR ITS FINANCIAL ASSISTANCE POLICY. IF THE PATIENT DOES NOT APPLY FOR FINANCIAL ASSISTANCE AT THAT TIME, THE FACILITY CONTINUES TO NOTIFY THE PATIENT OF THE EXISTENCE OF ITS FINANCIAL ASSISTANCE POLICY UPON ADMISSION TO THE FACILITY AND WITH EACH BILL THAT IS SENT TO THE PATIENT. ADDITIONALLY, THE EXISTENCE OF THE FINANCIAL ASSISTANCE POLICY WAS POSTED ON THE HOSPITAL FACILITY'S WEBSITE AND IS MADE AVAILABLE UPON REQUEST.

CAPITAL HOSPICE HALQUIST MEMORIAL 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 21C: THE HOSPITAL FACILITY SOLELY PROVIDES HOSPICE AND PALLIATIVE CARE. AS A RESULT, THE HOSPITAL FACILITY DOES NOT PROVIDE ANY EMERGENCY CARE SERVICES.

Part V Facility Information *(continued)*

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

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

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

	Name and address	Type of Facility (describe)
1	CAPITAL HOSPICE 2900 TELESTAR COURT FALLS CHURCH, VA 22042-1206	HOSPICE OFFICE
2	CAPITAL HOSPICE 5845 RICHMOND HIGHWAY SUITE 150 ALEXANDRIA, VA 22303-1868	HOSPICE OFFICE
3	CAPITAL HOSPICE 950 NORTH GLEBE ROAD SUITE 500 ARLINGTON, VA 22203-4183	HOSPICE OFFICE
4	CAPITAL HOSPICE 50 F STREET NW SUITE 3300 WASHINGTON, DC 20001-1565	HOSPICE OFFICE
5	CAPITAL HOSPICE 1801 MCCORMICK DRIVE SUITE 180 LARGO, MD 20774-5345	HOSPICE OFFICE
6	CAPITAL HOSPICE 4501 EMPIRE COURT FREDERICKSBURG, VA 22408-1949	HOSPICE OFFICE
7	CAPITAL HOSPICE ADLER CENTER FOR CARI 24419 MILLSTREAM DRIVE ALDIE, VA 20105-5837	HOSPICE OFFICE
8	CPCC ALEXANDRIA CLINIC 4660 KENMORE AVENUE SUITE 1018 ALEXANDRIA, VA 22304-1306	PALLIATIVE CARE CLINIC
9	HALQUIST MEMORIAL INPATIENT CENTER 4715 NORTH 15TH STREET ARLINGTON, VA 22205-2640	PALLIATIVE CARE CLINIC
10	CPCC PROSPERITY CLINIC 8503 ARLINGTON BLVD SUITE 400 FAIRFAX, VA 22031	PALLIATIVE CARE CLINIC

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

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

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

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

Name and address	Type of Facility (describe)
11 CPCC LEESBURG CLINIC 44035 RIVERSIDE PARKWAY SUITE 300 LEESBURG, VA 20176	PALLIATIVE CARE CLINIC
12 CPCC DC CLINIC 110 IRVING STREET NW WASHINGTON, DC 20010	PALLIATIVE CARE CLINIC
13 CPCC FREDERICKSBURG CLINIC 4501 EMPIRE COURT FREDERICKSBURG, VA 22408-1949	PALLIATIVE CARE CLINIC
14 CAPITAL HOSPICE CTR FOR PAIN & PALLIA 24419 MILLSTREAM DRIVE ALDIE, DC 20105-5837	PALLIATIVE CARE CLINIC

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:

IN ADDITION TO USING THE FEDERAL POVERTY GUIDELINES TO DETERMINE ELIGIBILITY UNDER THE FINANCIAL ASSISTANCE POLICY, THE ORGANIZATION WILL, ON A CASE BY CASE DETERMINATION, ASSESS A PATIENT'S LIQUID ASSETS. THE PATIENT'S LIQUID ASSETS WILL BE ASSESSED IF THE PATIENT HAS HIGH MEDICAL DEBT OUTSTANDING.

PART I, LINE 7:

THE COSTING METHODOLOGY USED TO CALCULATE AMOUNTS REPORTED IN LINE 7 WAS A COST-TO-CHARGE RATIO DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES.

PART I, LINE 7G:

CAPITAL HOSPICE UNDERTAKES SEVERAL PROGRAMS AT A SIGNIFICANT LOSS IN ORDER TO MEET IDENTIFIED NEEDS IN THE COMMUNITY. FIRST, CAPITAL HOSPICE OPERATES A 15 BED INPATIENT UNIT FOR TREATMENT OF HOSPICE PATIENTS THAT NEED CONSTANT MONITORING BUT WHOSE PAIN AND SYMPTOMS CANNOT BE ADEQUATELY TREATED AT HOME. THE REIMBURSEMENT FOR THIS PROGRAM, PRIMARILY FROM

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.

MEDICAID AND MEDICARE, IS SIGNIFICANTLY LESS THAN THE COST TO OPERATE. IN ADDITION, CAPITAL HOSPICE PROVIDES CONTINUOUS CARE SERVICES FOR HOSPICE PATIENTS THAT NEED MONITORING, BUT WHO CAN REMAIN AT HOME. THE ORGANIZATION PROVIDES SUCH CONTINUOUS HOME CARE SERVICES PRIMARILY TO MEDICARE PATIENTS ANND IS REIMBURSED SIGNIFICANTLY LESS THAN COST.

PART I, LN 7 COL(F):

THE BAD DEBT EXPENSE REPORTED IN THE ORGANIZATIONS AUDITED FINANCIAL STATEMENT IS $2,564,635, WHICH WAS REMOVED FROM TOTAL EXPENSES TO DETERMINE THE PERCENTAGES OF TOTAL EXPENSES.

PART III, LINE 4:

WE DO NOT HAVE A BAD DEBT FOOTNOTE IN OUR FINANCIAL STATEMENTS. THE FOOTNOTE TITLED "PATIENT ACCOUNTS RECEIVABLE" STATES, "PATIENT ACCOUNTS RECEIVABLE INCLUDE BILLINGS TO MEDICARE, MEDICAID (COMMONWEALTH OF VIRGINIA, DISTRICT OF COLUMBIA AND MARYLAND MEDICAL ASSISTANCE), BLUE CROSS (BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA, CAREFIRST AND ANTHEM), TRICARE, COMMERCIAL INSURERS, AND SELF PAYING PATIENTS.

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.

PATIENT ACCOUNTS RECEIVABLE ARE SHOWN NET OF ALLOWANCES FOR UNCOLLECTIBLE ACCOUNTS, WHICH IS ESTIMATED BY MANAGEMENT BASED ON HISTORICAL COLLECTION ACTIVITIES. WE DO NOT INCLUDE ANY OF THE BAD DEBT AS A COMMUNITY BENEFIT. THE ORGANIZATION DOES NOT BELIEVE THAT ANY OF THE BAD DEBT IS ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANZATIONS FINANCIAL ASSISTANCE POLICY.

PART III, LINE 8:

THE COSTING SOURCE IS THE MEDICARE COST REPORT AND THE METHODOLOGY IS MEDICARE ALLOCABLE COSTS TO MEDICARE REVENUE RECEIVED.

PART III, LINE 9B:

THE ORGANIZATION PROVIDES FINANCIAL ASSISTANCE TO ALL PATIENTS THAT QUALIFY UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY. THE ORGANIZATION DOES NOT MAKE ANY ATTEMPT TO COLLECT FROM SUCH PATIENTS, IF WE BECOME AWARE THAT A PATIENT THAT WAS NOT INITIALLY IDENTIFIED AS QUALIFYING FOR FINANCIAL ASSISTANCE DOES IN FACT QUALIFY FOR FINANCIAL ASSISTANCE, THEN THE PATIENT RECEIVES FINANCIAL ASSISTANCE AND ALL COLLECTION EFFORTS (IF COMMENCED) ARE STOPPED IMMEDIATELY. PATIENTS

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.

DETERMINED TO BE FULLY ELIGIBLE FOR FINANCIAL ASSISTANCE SUBSEQUENT TO THE DATE OF SERVICE MAY BE ELIGIBLE FOR A REFUND OF PAYMENTS MADE IF IT IS DETERMINED THAT THE PATIENT WAS ELIGIBLE FOR FINANCIAL ASSISTANCE AT THE TIME OF SERVICE.

PART VI, LINE 2:

ANALYSIS RELATED TO THE NEEDS OF THE COMMUNITY IS AN INTERGRAL PART OF CAPITAL HOSPICE'S STRATEGIC PLANNING PROCESS. EMPIRICAL DATA IS COLLECTED BY: *REFERRAL CENTER STAFF (WHICH FACILITATES ADMISSION INTO OUR PROGRAM); *ACCESS STAFF, WHO INTERACT DIRECTLY WITH THE HOSPITALS, CLINICS, NURSING HOMES, ASSISTED LIVING FACILITIES AND PHYSICIAN PRACTICES THAT SERVE AS THE MAIN SOURCE OF REFERRALS INTO OUR CARE; UTREACH STAFF, WHO INTERACT DIRECTLY WITH MUNICIPAL AGENCIES, FAITH COMMUNITIES AND COMMUNITY ORGANZIATIONS; *EDUCATION STAFF, WHO INTERACT WITH LOCAL UNIVERSITIES, AND *PUBLIC RELATIONS STAFF ARE PRESENT AT COMMUNITY HEALTH FAIRS AND OTHER PUBLIC EVENTS. *ADDITIONALLY, CAPITAL HOSPICE MONITORS AND ANALYZES GOVERNMENT-PROVIDED STATISTICS TO COMPARE THE NUMBER OF DEATHS SERVED BY HOSPICE TO THE TOTAL NUMBER OF DEATHS IN OUR SERVICE AREA TO REVEAL WHERE

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.

SERVICES ARE UNDER-UTILIZED.

PART VI, LINE 3:

ALL PATIENTS RECEIVE AN ADMISSION VISIT BEFORE BEING ADMITTED INTO OUR HOSPICE CARE. AS PART OF THAT VISIT ANY INSURANCE COVERAGE IS VERIFIED. IF THE PATIENT HAS NO, OR LIMITED INSURANCE COVERAGE, THEN WE INQUIRE AS TO THE PATIENT'S ABILITY TO BE COVERED BY MEDICAID. IF IT IS APPARENT THAT NO MEDICAID COVERAGE IS AVAILABLE THEN THE PATIENT IS ENCOURAGED TO COMPLETE THE FINANCIAL ASSISTANCE APPLICATION FORM. BASED ON THE INFORMATION OBTAINED FROM THE FINANCIAL ASSISTANCE FORM THEN FINANCIAL ASSISTANCE IS GRANTED. IF THE PATIENT DOES NOT APPLY FOR FINANCIAL ASSISTANCE AT THE TIME OF THE ADMISSION VISIT, THE FACILITY CONTINUES TO NOTIFY THE PATIENT OF THE EXISTENCE OF ITS FINANCIAL ASSISTANCE POLICY UPON ADMISSION TO THE FACILITY AND WITH THE BILL THAT IS SENT TO THE PATIENT. ADDITIONALLY, THE EXISTENCE OF THE FINANCIAL ASSISTANCE POLICY IS POSTED ON THE HOSPITAL FACILITY'S WEBSITE AND IS MADE AVAILABLE UPON REQUEST.

PART VI, LINE 4:

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.

CAPITAL HOSPICE SERVES AN ETHNIC, RACIAL, RELIGIOUS AND CULTURALLY DIVERSE REGION THAT ENCOMPASSES MUCH OF TWO STATES (VIRGINIA AND MARYLAND) AND THE DISTRICT OF COLUMBIA. COMMUNITIES SPAN THE SPECTRUM FROM URBAN/INNER CITY (DC) TO SUBURBAN (PRINCE GEORGE'S COUNTY, MD., FAIRFAX COUNTY, VA) TO RURAL (FAUQUIER COUNTY AND PARTS OF LOUDOUN COUNTY, VA). THE SOCIO-ECONOMIC COMPOSITION OF THE COMMUNITIES WE SERVE IS EQUALLY DIVERSE, RANGING FROM THE INDIGENT HOMELESS TO THE LOW-MODERATE INCOME TO ONE OF THE MOST AFFLUENT COUNTIES IN THE UNITED STATES. OUR SERVICE AREA ALSO IS HOME TO A VERY LARGE INTERNATIONAL COMMUNITY WITH A MULTITUDE OF LANGUAGES, TRADITIONS AND VALUES.

PART VI, LINE 5:
REGARDLESS OF THE VENUE OR CIRCUMSTANCE, CAPITAL HOSPICE STAFF AND VOLUNTEERS MAKE CLEAR THAT LACK OF INSURANCE OR RESOURCES TO PAY FOR OUR SERVICES IS NOT A BARRIER TO RECEIVING CARE. THAT ALSO IS CLEARLY STATED IN OUR LITERATURE AND OUR WEBSITE. ADDITIONALLY, CAPITAL HOSPICE PROVIDES GRIEF AND LOSS SERVICES (SEMINARS, WORKSHOPS, SUPPORT GROUPS) THROUGHOUT OUR SERVICE AREA, OFFERED AT NO CHARGE; THIS INCLUDES AN ANNUAL SUMMER

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.

WEEKEND CAMP FOR GRIEVING CHILDREN, TEENS AND ADULTS. ATTENDING/REFERRING PHYSICIANS FROM THE COMMUNITY ARE ENCOURAGED TO PARTICIPATE IN OR FOLLOW THEIR PATIENTS' CARE. PHYSICIANS SEEKING BOARD CERTIFICATION IN THE MEDICAL SUB-SPECIALTY OF PALLIATIVE MEDICINE CAN APPLY FOR THE PHYSICIAN FELLOWSHIP PROGRAM CAPITAL HOSPICE OFFERS JOINTLY WITH THE NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER. HOSPICE PARTNERS WITH AREA HOSPITALS, NURSING HOMES AND PHYSICIAN PRACTICES TO PROVIDE FACILITY CLINICS FOR PALLIATIVE CARE CONSULTATIONS REQUESTED BY COMMUNITY PHYSICIANS. COMMUNITY ADVISORY BOARDS ARE UTILIZED TO DEVELOP STRATEGIES TO INCREASE AWARENESS OF CAPITAL HOSPICE SERVICES WITHIN THEIR RESPECTIVE COMMUNITIES. CAMINANDO JUNTOS IS AN OUTREACH PROGRAM DEDICATED TO RAISING AWARENESS OF THE AVAILABILITY OF CAPITAL HOSPICE SERVICES WITHIN THE LATINO COMMUNITY. CAPITAL HOSPICE STAFF REGULARLY CONDUCT TEACHING/TRAINING SESSIONS TO IMPROVE CARE PROVIDED JOINTLY WITH NURSING HOMES, HOSPITALS AND ASSISTED LIVING FACILITIES. THESE ARE OFFERED AT OUR PARTNERS' FACILITIES FOR NO CHARGE. CAPITAL HOSPICE REGULARLY OFFERS PALLIATIVE CARE GRAND ROUNDS AND JOSEFINO MAGNO PALLIATIVE CARE CONFERENCE SERIES AS INSTRUCTIONAL SESSIONS FOR COMMUNITY PHYSICIANS AND OTHER

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.

PROFESSIONAL HEALTH CARE PROVIDERS; PARTICIPATES IN AND OFFERS "VIEWING SITES" TO THE COMMUNITY FOR THE ANNUAL HOSPICE FOUNDATION OF AMERICA EDUCATIONAL TELECONFERENCE. MORE THAN A MAJORITY OF CAPITAL HOSPICE'S GOVERNING BODY IS COMPRISED OF INDEPENDENT PERSONS WHO RESIDE IN THE ORGANIZATION'S PRIMARY SERVICE AREA. CAPITAL HOSPICE HAS AN OPEN MEDICAL STAFF POLICY, PURSUANT TO WHICH ALL QUALIFIED PHYSICIANS MAY BECOME MEMBERS OF THE MEDICAL STAFF. ANY SURPLUS FUNDS EARNED BY CAPITAL HOSPICE ARE USED TO IMPROVE PATIENT CARE AND PROVIDE FURTHER COMMUNITY BENEFIT.

PART VI, LINE 6:

CAPITAL HOSPICE IS NOT PART OF AN AFFILIATED GROUP.

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
CAPITAL HOSPICE

Employer identification number
54-1920770

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
HOSPICE SUPPORT OF FAUQUIER COUNTY 42 NORTH FIFTH STREET WARRENTON, VA 20186	52-1250964	501(C)(3)	5,000.	0.			SUPPORT FOR HOSPICE CARE
WEST VIRGINIANS FOR AFFORDABLE HEALTH CARE - P.O. BOX 948 - CHARLESTON, WV 25323	20-3919052	501(C)(3)	5,000.	0.			SUPPORT AFFORDABLE HEALTHCARE

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

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

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 HOSPICE DOES NOT HAVE A FORMAL POLICY FOR MONITORING THE USE OF FUNDS WITHIN THE UNITED STATES BY HOSPICE SUPPORT OF FAUQUIER COUNTY SINCE FOR MANY YEARS THE HOSPICE HAS BEEN PARTNERS IN CARE WITH HOSPICE SUPPORT OF FAUQUIER COUNTY IN SEVERAL KEY FACILITIES LOCATED THROUGHOUT FAUQUIER COUNTY.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2016

Open to Public Inspection

Name of the organization

CAPITAL HOSPICE

Employer identification number

54-1920770

Part I Questions Regarding Compensation

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

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) MALENE DAVIS	(i)	371,164.	128,809.	20,323.	10,524.	16,688.	547,508.	0.
PRESIDENT/CEO	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) DAVID SCHWIND	(i)	228,224.	43,652.	2,322.	8,730.	23,926.	306,854.	0.
EXECUTIVE VP CFO	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) JAMES CAMERON MUIR, MD	(i)	277,165.	55,805.	1,242.	18,000.	19,834.	372,046.	0.
EVP QUALITY & ACCESS/ CMO	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) MICHAEL BYAS-SMITH, MD	(i)	350,675.	541.	258.	9,261.	14,966.	375,701.	0.
MEDICAL DIRECTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) ELIZABETH PHAN, MD	(i)	178,459.	54,450.	48.	1,981.	2,746.	237,684.	0.
HPM PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) JASON SOBEL, MD	(i)	161,046.	70,669.	60.	1,300.	11,878.	244,953.	0.
SENIOR MEDICAL DIRECTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) JORDAN KEEN, MD	(i)	178,459.	49,536.	48.	2,185.	6,133.	236,361.	0.
HPM PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) ANNE SILAO-SOLOMON MD	(i)	171,482.	43,237.	54.	5,704.	15,508.	235,985.	0.
NBRHD LEAD PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(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 6:

IF THE ORGANIZATION REACHES ITS BUDGETED AMOUNT OF NET INCOME FROM OPERATIONS FOR THE YEAR THEN ALL EMPLOYEES ARE ELIGIBLE FOR A BONUS, WHICH IS BASED UPON CERTAIN KEY METRICS THAT ARE UNRELATED TO NET INCOME.

SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

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.

OMB No. 1545-0047
2016
Open to Public Inspection

Name of the organization: CAPITAL HOSPICE

Employer identification number: 54-1920770

Part I Bond Issues SEE PART VI FOR COLUMN (F) CONTINUATIONS

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased Yes	(g) Defeased No	(h) On behalf of issuer Yes	(h) On behalf of issuer No	(i) Pooled financing Yes	(i) Pooled financing No
A	FAIRFAX COUNTY ECONOMIC DEVELOPMENT AUTHORITY	91-1910090	30382YAA8	01/29/09	7,200,000.	PURCHASE AND RENOVATION OF A F		X		X		X
B												
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	1,420,000.			
2	Amount of bonds legally defeased				
3	Total proceeds of issue	7,200,000.			
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	225,106.			
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	6,794,894.			
11	Other spent proceeds				
12	Other unspent proceeds				
13	Year of substantial completion	2009			

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

Part III Private Business Use

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D 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						
2	Are there any lease arrangements that may result in private business use of bond-financed property?		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						
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						
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	%		%		%		%	
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	%		%		%		%	
6 Total of lines 4 and 5	%		%		%		%	
7 Does the bond issue meet the private security or payment test?		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						
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						

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						
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X						
b Exception to rebate?		X						
c No rebate due?	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							
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X							
b Name of provider	BB&T							
c Term of hedge	10.0000000							
d Was the hedge superintegrated?		X						
e Was the hedge terminated?		X						

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						
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						
7 Has the organization established written procedures to monitor the requirements of section 148?		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						

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

SCHEDULE K, PART I, BOND ISSUES:
(A) ISSUER NAME: FAIRFAX COUNTY ECONOMIC DEVELOPMENT AUTHORITY
(F) DESCRIPTION OF PURPOSE: PURCHASE AND RENOVATION OF A FACILITY

PART IV, LINE 2C
ALL OF THE PROCEEDS OF THE TAX-EXEMPT BOND ISSUANCE WERE SPENT IMMEDIATELY UPON RECEIPT: $225,106 FOR ISSUANCE COSTS AND $6,974,894 TO PURCHASE THE ORGANIZATION'S PRIMARY FACILITY (THE TAX EXEMPT BOND ISSUE'S GOVERNMENTAL PURPOSE). AS A RESULT, NONE OF THE SALE PROCEEDS OF THE TAX-EXEMPT BOND ISSUANCE WERE USED TO MAKE HIGHER YIELDING INVESTMENTS FOR NONPURPOSE INVESTMENTS. IN ADDITION, THERE ARE NOT REPLACEMENT PROCEEDS WITH RESPECT TO THIS TAX-EXEMPT BOND ISSUANCE, AS THERE IS NOT A DIRECT NEXUS BETWEEN ANY OF THE ORGANIZATION'S FUNDS AND THE BOND ISSUE OR THE GOVERNMENTAL PURPOSE OF THE ISSUE. BASED UPON THE FOREGOING, THE ORGANIZATION WAS ABLE TO DETERMINE THAT THERE WAS NO REBATABLE ARBITRAGE WITH RESPECT TO THE TAX-EXEMPT BOND ISSUANCE AS OF JUNE 30, 2017.

PART IV, LINE 7
THE ORGANIZATION HAS ONLY UNDERTAKEN ONE TAX-EXEMPT BOND ISSUANCE, WHICH IS THE $7,200,000 VARIABLE INTEREST FAIRFAX COUNTY ECONOMIC DEVELOPMENT AUTHORITY BONDS ISSUED ON JANUARY 29, 2009 THAT IS REPORTED IN PART I. ALL OF THE PROCEEDS OF THIS TAX-EXEMPT BOND ISSUANCE WERE SPENT IMMEDIATELY UPON RECEIPT: $225,106 FOR ISSUANCE COSTS AND

SEE PART VI SUPPLEMENTAL INFORMATION SHEET

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

$6,974,894 TO PURCHASE THE ORGANIZATION'S PRIMARY FACILITY (THE TAX EXEMPT BOND ISSUE'S GOVERNMENTAL PURPOSE). AS A RESULT, NONE OF THE PROCEEDS OF THE TAX-EXEMPT BOND ISSUANCE WERE USED TO MAKE HIGHER YIELDING INVESTMENTS FOR NONPURPOSE INVESTMENTS, WHICH ARE REGULATED UNDER SECTION 148 OF THE INTERNAL REVENUE CODE. SINCE THE ORGANIZATION HAS NOT USED THE PROCEEDS FROM ANY TAX-EXEMPT BOND ISSUANCE TO MAKE HIGHER YIELDING INVESTMENTS OF NONPURPOSE INVESTMENTS, THE ORGANIZATION HAS NOT YET ESTABLISHED WRITTEN PROCEDURES TO MONITOR THE REQUIREMENTS OF SECTION 148.

SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶ Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
▶ Attach to Form 990.
▶ Information about Schedule M (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2016

Open To Public Inspection

Name of the organization: CAPITAL HOSPICE

Employer identification number: 54-1920770

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art - Works of art	X	1	1,200.	FMV
2	Art - Historical treasures				
3	Art - Fractional interests				
4	Books and publications	X		350.	FMV
5	Clothing and household goods	X		6,525.	FMV
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities - Publicly traded	X	4	5,428.	FMV
10	Securities - Closely held stock				
11	Securities - Partnership, LLC, or trust interests				
12	Securities - Miscellaneous				
13	Qualified conservation contribution - Historic structures				
14	Qualified conservation contribution - Other				
15	Real estate - Residential				
16	Real estate - Commercial				
17	Real estate - Other				
18	Collectibles				
19	Food inventory	X	20	2,808.	FMV
20	Drugs and medical supplies				
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ (MISCELLANEOUS)	X	40	20,095.	FMV
26	Other ▶ (VARIOUS TICKE)	X	4	14,225.	FMV
27	Other ▶ (GIFT CERTIFIC)	X	16	3,250.	FMV
28	Other ▶ ( )				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement 29

			Yes	No
30a	During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period?	30a		X
b	If "Yes," describe the arrangement in Part II.			
31	Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?	31		X
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?	32a	X	
b	If "Yes," describe in Part II.			
33	If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.			

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

SCHEDULE M, LINE 32B:

THE FIRM CHARLES SCHWAB WAS USED TO SELL ANY STOCK GIFTS.

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

CAPITAL HOSPICE

Employer identification number

54-1920770

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

DIRECT SUPPORT OF PATIENTS AND THEIR FAMILIES, PUBLIC EDUCATION AND ADVOCACY.

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

CARE PROVIDED, OF APPROXIMATELY $4,758,000.

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

THE 990 FOR CAPITAL HOSPICE IS REVIEWED BY THE CONTROLLER AND THE EXECUTIVE VICE PRESIDENT/CHIEF FINANCIAL OFFICER, WHO WILL SIGN THE RETURN WHEN IT IS FINALIZED. NEXT THE 990 IS SENT TO ALL THE MEMBERS OF THE BOARD OF TRUSTEES INCLUDING THE PRESIDENT OF CAPITAL HOSPICE FOR THEIR REVIEW AND TO SOLICIT ANY COMMENTS OR QUESTIONS. THE AUDIT COMMITTEE OF THE BOARD MEETS TO REVIEW AND DISCUSS THE FORM 990 IN DETAIL. THIS MEETING IS OPEN TO ALL BOARD MEMBERS INCLUDING THE COMPENSATION AND OTHER COMMITTEE CHAIRS. AFTER THE FORM 990 HAS BEEN REVIEWED BY THE BOARD AND ANY COMMENTS OR QUESTIONS FROM BOARD MEMBERS HAVE BEEN RESPONDED TO, THE FORM 990 WILL BE FINALIZED, SIGNED AND FILED.

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

ALL BOARD MEMBERS, OFFICERS AND KEY MANAGERS ARE REQUIRED TO REPORT ANY REAL OR POTENTIAL OR PERCEIVED CONFLICT OF INTEREST INVOLVING THEM OR ANOTHER PERSON BY PROMPTLY FILING A WRITTEN DISCLOSURE STATEMENT WITH THE PRESIDENT OR CHAIR OF THE BOARD OF TRUSTEES. THE PRESIDENT WILL REVIEW ALL SUCH STATEMENTS AND THE ANNUAL DISCLOSURE STATEMENTS AND DISCUSS WITH THE CHAIR OF THE BOARD ANY POTENTIAL CONFLICTS OF INTEREST. IF THE PRESIDENT

Name of the organization: CAPITAL HOSPICE

Employer identification number: 54-1920770

AND THE CHAIR OF THE BOARD DETERMINE THAT A POTENTIAL CONFLICT EXISTS, THEN THE BOARD SHALL INFORM THE PERSON OF THE BASIS FOR SUCH BELIEF AND ALLOW THE PERSON TO EXPLAIN AND DISCLOSE. FOR ANY TRANSACTION/ARRANGEMENT DISCUSSED DURING A BOARD MEETING FOR WHICH A CONFLICT OF INTEREST IS DEEMED TO EXIST, THE AFFECTED BOARD MEMBER SHALL NOT BE COUNTED IN DETERMINING THE QUOROM FOR THE MEETING BUT SHALL BE PERMITTED TO BRIEFLY STATE HIS POSITION ON THE MATTER AND ANSWER PERTINENT QUESTIONS OF OTHER BOARD MEMBERS BEFORE VACATING THE GOVERNING BOARD. THE BOARD MEMBER SHALL LEAVE THE GOVERNING BOARD AND A MAJORITY OF THE REMAINING BOARD MEMBERS SHALL DETERMINE WHETHER TO UNDERTAKE SUCH TRANSACTION/ARRANGEMENT. IF THE BOARD DECIDES THAT A PERSON HAS FAILED TO DISCLOSE A CONFLICT OF INTEREST, THE BOARD SHALL TAKE CORRECTIVE ACTION.

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

THE INDEPENDENT COMPENSATION COMMITTEE OF CAPITAL HOSPICE HAS ENGAGED TOWERS WATSON, AN INDEPENDENT CONSULTING GROUP, EXPERIENCED IN THIS WORK, TO CONDUCT A SURVEY TO GATHER COMPARABLE, VALID MARKET DATA OF EXECUTIVE COMPENSATION FROM BOTH TAX-EXEMPT AND FOR-PROFIT EMPLOYERS, OF SIMILAR SIZE AND COMPARABLE SCOPE FOR THE CEO AND OTHER KEY PERSONNEL. THE REPORT WAS REVIEWED AND APPROVED BY THE INDEPENDENT COMPENSATION COMMITTEE AFTER THOROUGH DISCUSSION OF THE DATA, IT SOURCES AND THE FINDINGS. CAPITAL HOSPICE, AS SUBJECT TO INTERMEDIATE SANCTIONS UNDER INTERNAL REVENUE CODE (IRC) SECTION 4958, CONSIDERS THAT THE INTERMEDIATE SANCTIONS MARKET BENCHMARKING METHODOLOGY FOR DISQUALIFIED INDIVIDUALS, CONDUCTED BY TOWERS WATSON, HAS PROVIDED A VALID AND ROBUST MEANS OF DETERMINING MARKET BASED COMPENSATION COMPETITIVENESS. CAPITAL HOSPICE HAS APPOINTED AN INDEPENDENT COMPENSATION COMMITTEE TO REVIEW AND APPROVE (WITH CONTEMPORANEOUS SUBSTANTIATION OF THE DELIBERATION AND DECISION) THE COMPENSATION FOR OTHER

Name of the organization: CAPITAL HOSPICE

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OFFICERS AND KEY EMPLOYEES OF CAPITAL HOSPICE. THE REVIEW IS DONE IN CONJUNCTION WITH INDEPENDENT MARKET REVIEW AND FINDINGS PRESENTED FROM TOWERS WATSON.

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

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

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

PHYSICIAN SERVICES:

PROGRAM SERVICE EXPENSES	185,899.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	185,899.

CONTRACT SERVICES NURSING HOME:

PROGRAM SERVICE EXPENSES	11,057,634.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	11,057,634.

CONTRACT SERVICES LABOR:

PROGRAM SERVICE EXPENSES	112,743.
MANAGEMENT AND GENERAL EXPENSES	87,171.
FUNDRAISING EXPENSES	1,295.
TOTAL EXPENSES	201,209.

CONTRACT SERVICES CONSULTANTS:

Name of the organization: CAPITAL HOSPICE

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PROGRAM SERVICE EXPENSES	559,545.
MANAGEMENT AND GENERAL EXPENSES	869,008.
FUNDRAISING EXPENSES	155,083.
TOTAL EXPENSES	1,583,636.
CONTRACT SERVICES INPATIENT:	
PROGRAM SERVICE EXPENSES	653,813.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	653,813.
CONTRACT SERVICES OTHER PATIENT RELATED:	
PROGRAM SERVICE EXPENSES	695,935.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	695,935.
CONTRACT SERVICES OTHER:	
PROGRAM SERVICE EXPENSES	273,677.
MANAGEMENT AND GENERAL EXPENSES	534,856.
FUNDRAISING EXPENSES	887.
TOTAL EXPENSES	809,420.
TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	15,187,546.
FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:	
UNREALIZED GAIN ON INTEREST RATE SWAP	261,109.
FORM 990, PART XII, LINE 2C:	

Name of the organization: CAPITAL HOSPICE

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THE PROCESS HAS NOT CHANGED FROM THE PRIOR YEARS.

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.

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Open to Public Inspection

Name of the organization: CAPITAL HOSPICE

Employer identification number: 54-1920770

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
CAPITAL PALLIATIVE CARE CONSULTANTS - 52-2361003, 2900 TELESTAR CT, FALLS CHURCH, VA 22042	PALLIATIVE	MARYLAND	958,166.	4,563,893.	CAPITAL HOSPICE

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	(g) No

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

Schedule R (Form 990) 2016

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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? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

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	(i) 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.

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

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

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

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

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

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

Schedule R (Form 990) 2016

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Part VII Supplemental Information.

Provide additional information for responses to questions on Schedule R. See instructions.