Form **8879-EO**

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

For calendar year 2010, or fiscal year beginning 07/01 , 2010, and ending 06/30 , 20 11

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

▶ **See instructions on back.**

OMB No. 1545-1878

2010

Department of the Treasury
Internal Revenue Service

Name of exempt organization

CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number

52-0619000

Name and title of officer

JAMES XINIS, PRESIDENT AND CEO

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

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

1a	**Form 990** check here ▶ [X]	b	**Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	1b 125568979.
2a	**Form 990-EZ** check here ▶ [ ]	b	**Total revenue,** if any (Form 990-EZ, line 9)	2b
3a	**Form 1120-POL** check here ▶ [ ]	b	**Total tax** (Form 1120-POL, line 22)	3b
4a	**Form 990-PF** check here ▶ [ ]	b	**Tax based on investment income** (Form 990-PF, Part VI, line 5)	4b
5a	**Form 8868** check here ▶ [ ]	b	**Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	5b

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2010 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize COHEN, RUTHERFORD + KNIGH to enter my PIN 14232 as my signature

ERO firm name

Enter five numbers, but do not enter all zeros

on the organization's tax year 2010 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 2010 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 ▶ James J Xinis Date ▶ 5/10/12

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. 520515208 17

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2010 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ Date ▶ 05/01/2012

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

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

OMB No. 1545-0047

2010

Open to Public Inspection

A For the 2010 calendar year, or tax year beginning 07/01, **2010, and ending** 06/30, **20** 11

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

C Name of organization
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
100 HOSPITAL ROAD

City or town, state or country, and ZIP + 4
PRINCE FREDERICK, MD 20678

D Employer identification number
52-0619000

E Telephone number
(410) 535-4000

G Gross receipts $ 125,641,578.

F Name and address of principal officer: JAMES XINIS
100 HOSPITAL RD PRINCE FREDERICK, MD 20678

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

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

H(c) Group exemption number ▶

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

J Website: ▶ WWW.CALVERTHOSPITAL.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶ **L** Year of formation: 1918 **M** State of legal domicile: MD

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:
CALVERT MEMORIAL HOSPITAL PROVIDES QUALITY INPATIENT AND AMBULATORY HEALTH CARE TO THE PEOPLE OF SOUTHERN MARYLAND THAT IS ACCESSIBLE, COST-EFFECTIVE AND COMPASSIONATE.

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	19.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	17.
5	Total number of individuals employed in calendar year 2010 (Part V, line 2a)	5	1,215.
6	Total number of volunteers (estimate if necessary)	6	145.
7a	Total gross unrelated business revenue from Part VIII, column (C), line 12	7a	1,900,626.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	1,032,422.	1,763,149.
9	Program service revenue (Part VIII, line 2g)	113,459,935.	120,289,994.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	160,356.	281,629.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,108,110.	3,234,207.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	116,760,823.	125,568,979.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	5,000.
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)	57,183,282.	63,351,052.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24f)	59,650,566.	60,378,117.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	116,833,848.	123,734,169.
19	Revenue less expenses. Subtract line 18 from line 12	-73,025.	1,834,810.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	102,163,097.	107,635,420.
21	Total liabilities (Part X, line 26)	77,807,926.	78,252,994.
22	Net assets or fund balances. Subtract line 21 from line 20	24,355,171.	29,382,426.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date

▶ Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed ▶ ☐	PTIN
TINA C ECKLOFF		05/01/2012		P01074058

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

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

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2010)

JSA
0E1010 1.000

5/1/2012 8:26:27 AM

Part III **Statement of Program Service Accomplishments**
Check if Schedule O contains a response to any question in this Part III . . . . . ☐

1 Briefly describe the organization's mission:
CALVERT MEMORIAL HOSPITAL PROVIDES QUALITY INPATIENT AND AMBULATORY HEALTH CARE TO THE PEOPLE OF SOUTHERN MARYLAND THAT IS ACCESSIBLE, COST-EFFECTIVE AND COMPASSIONATE. CMH WORKS IN PARTNERSHIP WITH THE COMMUNITY TO IMPROVE THE HEALTH STATUS OF ITS MEMBERS.

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

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

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

4a (Code:) (Expenses $ 112,359,195. including grants of $ 5,000.) (Revenue $ 121,623,575.)
ATTACHMENT 1

4b (Code:) (Expenses $ including grants of $) (Revenue $)

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

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

4e Total program service expenses ▶ 112,359,195.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete Schedule B, Schedule of Contributors? (see instructions)	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4		X
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		
6	Did the organization maintain any donor advised funds or any similar funds or accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in term, permanent, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		X
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		X
c	Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		X
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f		X
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI, XII, and XIII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, and program service activities outside the United States? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospitals? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach its audited financial statements to this return? **Note.** Some Form 990 filers that operate one or more hospitals must attach audited financial statements (see instructions)	20b	X	

Part IV Checklist of Required Schedules *(continued)*

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

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

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	**1a**	130		
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**	1,215		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		**2b**	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file*. (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?		**3a**	X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*		**3b**	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		**4a**		X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		**5a**		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		**5b**		X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		**5c**		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible?		**6a**		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		**6b**		
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?		**7a**		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		**7b**		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		**7c**		X
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		**7e**		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		**7f**		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		**7g**		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		**7h**		
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?		**8**		
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?		**9a**		
b	Did the organization make a distribution to a donor, donor advisor, or related person?		**9b**		
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?		**12a**		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?		**13a**		
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?		**14a**		X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*		**14b**		

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

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

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a 19		
b	Enter the number of voting members included in line 1a, above, who are independent	1b 17		
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	Does the organization have members or stockholders?	6		X
7a	Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?	7a		X
b	Are any decisions of the governing body subject to approval by members, stockholders, or other persons?	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	Does the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization?	10b		
11a	Has the organization provided a 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	Does the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Does the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this is done*	12c	X	
13	Does the organization have a written whistleblower policy?	13	X	
14	Does 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," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken 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 ▶

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

☐ Own website ☐ Another's website ☒ Upon request

19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶ ROBERT KERTIS 100 HOSPITAL ROAD PRINCE FREDERICK, MD 20678
410-535-4000

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
ATTACHMENT 3										
(1) CLIFF STEWART DIRECTOR	3.00	X						0.	0.	0.
(2) DEAN SCHLEICHER DIRECTOR	2.00	X						0.	0.	0.
(3) KEVIN BETZ DIRECTOR	2.00	X						0.	0.	0.
(4) GAIL GIBSON SECRETARY	2.00	X		X				0.	0.	0.
(5) EMAD AL BANNA DIRECTOR	10.00	X						56,700.	0.	0.
(6) CHARLES JUDGE DIRECTOR	6.00	X						16,538.	0.	0.
(7) MARY KRUG DIRECTOR	2.00	X						0.	0.	0.
(8) VICTOR CORNELLIER DIRECTOR	2.00	X						0.	0.	0.
(9) KEVIN NIETMANN TREASURER	4.00	X		X				0.	0.	0.
(10) MARSHA PLATER DIRECTOR	2.00	X						6,787.	0.	0.
(11) SALLY SHOWALTER CHAIRPERSON	3.00	X		X				0.	0.	0.
(12) LAURIE UHEREK VICE CHAIRPERSON	10.00	X		X				0.	0.	0.
(13) JAMES XINIS PRESIDENT AND CEO	40.00	X		X				604,730.	0.	261,043.
(14) PETER DALY DIRECTOR	2.00	X						0.	0.	0.
(15) PAMELA LUCAS DIRECTOR	2.00	X						0.	0.	0.
(16) JOHN WEIGEL DIRECTOR	2.00	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(17) CIARAN BROWNE DIRECTOR	6.00	X						0.	0.	0.
(18) ANWAR MUNSHI DIRECTOR	2.00	X						0.	0.	0.
(19) HENRY TRENTMAN DIRECTOR	2.00	X						0.	0.	0.
(20) PATRICIA EDDLEMAN DIRECTOR	4.00	X						0.	0.	0.
(21) BARBARA ESTES DIRECTOR	5.00	X						4,000.	0.	0.
(22) RICHARD FLEMING DIRECTOR	2.00	X						0.	0.	0.
(23) ROBERT KERTIS VP FINANCE	40.00			X				149,551.	0.	11,909.
(24) ROBERT MCWHIRT VP CNE PATIENT CARE SERVICES	40.00				X			162,622.	0.	22,060.
(25) SUSAN DOHONY VP CQO PERFORM IMPROVEMENT	40.00				X			165,719.	0.	42,577.
(26) EDWARD GROGAN VP IT	40.00				X			150,750.	0.	19,074.
(27) ROBERT SCHLAGER VP MEDICAL AFFAIRS	40.00				X			170,927.	0.	23,235.
(28) BARBARA POLAK VP CLINICAL SERVICES	40.00				X			153,167.	0.	27,385.
1b Sub-total ▶								1,641,491.	0.	407,283.
c Total from continuation sheets to Part VII, Section A ATTACHMENT 2 ▶								1,569,835.	0.	100,959.
d Total (add lines 1b and 1c) ▶								3,211,326.	0.	508,242.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 in reportable compensation from the organization ▶ 50

		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.

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 4		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 28

Part VIII Statement of Revenue

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d	454,698.			
	e	Government grants (contributions)	1e	1,308,451.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f				
	g	Noncash contributions included in lines 1a-1f: $					
	h	**Total.** Add lines 1a-1f		1,763,149.			
Program Service Revenue			**Business Code**				
	2a	INPATIENT REVENUE		28,093,976.	28,093,976.		
	b	OUTPATIENT REVENUE		31,419,136.	31,419,136.		
	c	EMERGENCY REVENUE		11,459,937.	11,459,937.		
	d	OTHER PATIENT REVENUE		1,136,600.	1,136,600.		
	e	MEDICARE/MEDICAID REVENUE		48,180,345.	48,180,345.		
	f	All other program service revenue					
	g	**Total.** Add lines 2a-2f		120,289,994.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) ATTACHMENT 5		268,345.			268,345.
	4	Income from investment of tax-exempt bond proceeds		0.			
	5	Royalties		0.			
			(i) Real / (ii) Personal				
	6a	Gross Rents	65,556.				
	b	Less: rental expenses	72,599.				
	c	Rental income or (loss)	-7,043.				
	d	Net rental income or (loss)		-7,043.	-881.	-6,162.	
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	13,284.				
	b	Less: cost or other basis and sales expenses					
	c	Gain or (loss)	13,284.				
	d	Net gain or (loss)		13,284.			13,284.
	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from fundraising events		0.			
	9a	Gross income from gaming activities. See Part IV, line 19	a				
	b	Less: direct expenses	b				
	c	Net income or (loss) from gaming activities		0.			
	10a	Gross sales of inventory, less returns and allowances	a				
	b	Less: cost of goods sold	b				
	c	Net income or (loss) from sales of inventory		0.			
		Miscellaneous Revenue	**Business Code**				
	11a	OTHER REVENUE		659,370.	659,370.		
	b	PHARMACY SALES	446110	9,243.		9,243.	
	c	EMERGENCY PSYCH SERVICES	621400	193,500.		193,500.	
	d	All other revenue	561000	2,379,137.	675,092.	1,704,045.	
	e	**Total.** Add lines 11a-11d		3,241,250.			
	12	**Total revenue.** See instructions		125,568,979.	121,623,575.	1,900,626.	281,629.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns.
All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21	0.			
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22	5,000.	5,000.		
3 Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	2,124,847.		2,124,847.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.			
7 Other salaries and wages	49,745,304.	45,803,173.	3,942,131.	0.
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	2,903,166.	2,569,846.	333,320.	0.
9 Other employee benefits	4,913,032.	4,288,059.	624,973.	0.
10 Payroll taxes	3,664,703.	3,225,076.	439,627.	0.
11 Fees for services (non-employees):				
a Management	472,127.	472,127.	0.	0.
b Legal	183,990.	0.	183,990.	0.
c Accounting	115,772.	0.	115,772.	0.
d Lobbying	0.	0.	0.	0.
e Professional fundraising services. See Part IV, line 17	0.			0.
f Investment management fees	0.	0.	0.	0.
g Other	3,572,534.	3,572,534.	0.	0.
12 Advertising and promotion	181,860.	146,111.	35,749.	0.
13 Office expenses	25,302,700.	24,998,741.	303,959.	0.
14 Information technology	1,760,539.	1,429,159.	331,380.	0.
15 Royalties	0.	0.	0.	0.
16 Occupancy	3,396,954.	3,056,238.	340,716.	0.
17 Travel	144,963.	73,724.	71,239.	0.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.	0.	0.	0.
19 Conferences, conventions, and meetings	158,427.	123,242.	35,185.	0.
20 Interest	2,901,726.	2,901,726.	0.	0.
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	7,211,622.	7,116,632.	94,990.	0.
23 Insurance	1,566,413.	1,537,396.	29,017.	0.
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24f. If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O.)				
a PURCHASED SERVICES	4,742,781.	4,016,323.	726,458.	0.
b BAD DEBT	3,800,476.	3,758,586.	41,890.	0.
c REPAIRS AND MAINTENANCE	2,819,763.	2,744,811.	74,952.	0.
d OTHER	2,041,156.	520,691.	1,520,465.	0.
e K-1 MD ECARE	4,314.	0.	4,314.	0.
f All other expenses				0.
25 **Total functional expenses.** Add lines 1 through 24f	123,734,169.	112,359,195.	11,374,974.	0.
26 **Joint Costs.** Check here ▶ ☐ if following SOP 98-2 (ASC 958-720). Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X Balance Sheet

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	9,149,690.	1	11,759,711.
	2	Savings and temporary cash investments	5,820.	2	53,831.
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	14,221,984.	4	12,498,585.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions)		6	
	7	Notes and loans receivable, net ATCH 6	24,149.	7	14,233.
	8	Inventories for sale or use	2,374,648.	8	2,305,026.
	9	Prepaid expenses and deferred charges ATCH 7	964,074.	9	1,388,923.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 132,547,646.			
	b	Less: accumulated depreciation — 10b: 68,783,983.	62,702,743.	10c	63,763,663.
	11	Investments - publicly traded securities ATCH 8	6,046,239.	11	6,348,816.
	12	Investments - other securities. See Part IV, line 11	2,711,990.	12	4,597,409.
	13	Investments - program-related. See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	3,961,760.	15	4,905,223.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	102,163,097.	16	107,635,420.
Liabilities	17	Accounts payable and accrued expenses	8,355,957.	17	11,766,318.
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	53,755,445.	20	52,982,421.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	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. Complete Part X of Schedule D	15,696,524.	25	13,504,255.
	26	**Total liabilities.** Add lines 17 through 25	77,807,926.	26	78,252,994.
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	24,057,029.	27	29,262,731.
	28	Temporarily restricted net assets	298,142.	28	119,695.
	29	Permanently restricted net assets	0.	29	0.
		Organizations that do not follow SFAS 117, check here ▶ [ ] and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	24,355,171.	33	29,382,426.
	34	Total liabilities and net assets/fund balances	102,163,097.	34	107,635,420.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	125,568,979.
2	Total expenses (must equal Part IX, column (A), line 25)	2	123,734,169.
3	Revenue less expenses. Subtract line 2 from line 1	3	1,834,810.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	24,355,171.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	3,192,445.
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	29,382,426.

Part XII Financial Statements and Reporting

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

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

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization	**Employer identification number**
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY	52-0619000

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2010 (line 6, column (f) divided by line 11, column (f)) . . . . . 14 %

15 Public support percentage from 2009 Schedule A, Part II, line 14 . . . . . 15 %

16a **33 1/3% support test - 2010.** 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 - 2009.** 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 - 2010.** If the organization did not check a box on line 13, 16a or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2009.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organzation meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

JSA

0E1220 1.000

5/1/2012 8:26:27 AM

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2010 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2009 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2010** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2009** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2010.** 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 - 2009.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ▶ ☐

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

Part IV **Supplemental Information.** Complete this part to provide the explanations required by Part II, line 10; Part II, line 17a or 17b; or Part III, line 12. 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," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11, or 12.**

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

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization

CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number

52-0619000

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

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

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

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

b Assets included in Form 990, Part X ▶ $

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

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

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

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

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

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

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

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

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

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

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

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

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

2 Provide the estimated percentage of the year end balance held as:

- a Board designated or quasi-endowment ▶ _____%
- b Permanent endowment ▶ _____%
- c Term endowment ▶ _____%

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

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

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

Part VI **Land, Buildings, and Equipment.** See Form 990, Part X, line 10.

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		4,881,046.		4,881,046.
b Buildings		34,594,271.	12,934,838.	21,659,433.
c Leasehold improvements		33,982,440.	14,525,208.	19,457,232.
d Equipment		55,392,476.	40,332,724.	15,059,752.
e Other		3,697,413.	991,213.	2,706,200.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				63,763,663.

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

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

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

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

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

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

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

1. (a) Description of liability	(b) Amount
(1) Federal income taxes	0.
(2) EXECUTIVE 457B 457F PLANS	4,802,753.
(3) ADVANCES FROM THIRD PARTIES	4,054,939.
(4) ACCRUED PENSION COSTS	4,646,563.
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	13,504,255.

2. FIN 48 (ASC 740) Footnote. In Part XIV, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740).

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

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

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

1	Total revenue, gains, and other support per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV.)	2d			
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line **1**:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIV.)	4b			
c	Add lines **4a** and **4b**			4c	
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	

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

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

Part XIV Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

Part XIV Supplemental Information *(continued)*

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number
52-0619000

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing *free* care to low income individuals? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	3a	X	
b	Did the organization use FPG to determine eligibility for providing *discounted* care to low income individuals? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☒ 300% ☐ 350% ☐ 400% ☐ Other _____%	3b	X	
c	If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheets 1 and 2)			3,134,865.		3,134,865.	2.61
b Unreimbursed Medicaid (from Worksheet 3, column a)						
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			3,134,865.		3,134,865.	2.61
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			1,209,590.	18,216.	1,191,374.	.99
f Health professions education (from Worksheet 5)			816,955.		816,955.	.68
g Subsidized health services (from Worksheet 6)			11,176,542.	3,858,738.	7,317,804.	6.10
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)			20,044.		20,044.	.02
j **Total.** Other Benefits			13,223,131.	3,876,954.	9,346,177.	7.79
k **Total.** Add lines 7d and 7j			16,357,996.	3,876,954.	12,481,042.	10.40

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			67,061.	1,073.	65,988.	.06
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			86,775.		86,775.	.07
7 Community health improvement advocacy			53,088.	12,000.	41,088.	.03
8 Workforce development						
9 Other						
10 Total			206,924.	13,073.	193,851.	.16

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

Section A. Bad Debt Expense

			Yes	No
1	Does 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 (at cost) 2 2,587,820.			
3	Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy 3 607,732.			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts in community benefit.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME) 5 33,350,810.			
6	Enter Medicare allowable costs of care relating to payments on line 5 6 32,856,061.			
7	Subtract line 6 from line 5. This is the surplus (or shortfall) 7 494,749.			
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	Does 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**

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

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, measured by total revenue per facility, from largest to smallest)

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

Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1 CALVERT MEMORIAL HOSPITAL OF CALVERT	CO								SKILLED NURSING FAC
100 HOSPITAL ROAD									URGENT CARE CENTERS
PRINCE FREDERICK MD 20678	X	X					X		FAMILY PRACTICE CLIN
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of Hospital Facility: CALVERT MEMORIAL HOSPITAL OF CALVERT CO

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

			Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)				
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1		
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	☐ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☐ How data was obtained			
e	☐ The health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☐ The process for consulting with persons representing the community's interests			
i	☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j	☐ Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 __ __			
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5	Did the hospital facility make its Needs Assessment widely available to the public?	5		
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a	☐ Hospital facility's website			
b	☐ Available upon request from the hospital facility			
c	☐ Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a	☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b	☐ Execution of the implementation strategy			
c	☐ Participation in the development of a community-wide community benefit plan			
d	☐ Participation in the execution of a community-wide community benefit plan			
e	☐ Inclusion of a community benefit section in operational plans			
f	☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g	☐ Prioritization of health needs in its community			
h	☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	☐ Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8		
9	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care to low income individuals?	9		
	If "Yes," indicate the FPG family income limit for eligibility for free care: __ __ __ %			

Part V **Facility Information** *(continued)* CALVERT MEMORIAL HOSPITAL OF CALVERT CO

			Yes	No
10	Used FPG to determine eligibility for providing *discounted* care to low income individuals?	10		
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: _ _ _ %			
11	Explained the basis for calculating amounts charged to patients?	11		
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	☐ Income level			
b	☐ Asset level			
c	☐ Medical indigency			
d	☐ Insurance status			
e	☐ Uninsured discount			
f	☐ Medicaid/Medicare			
g	☐ State regulation			
h	☐ Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12		
13	Included measures to publicize the policy within the community served by the hospital facility?	13		
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☐ The policy was posted on the hospital facility's website			
b	☐ The policy was attached to billing invoices			
c	☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	☐ The policy was posted in the hospital facility's admissions offices			
e	☐ The policy was provided, in writing, to patients on admission to the hospital facility			
f	☐ The policy was available on request			
g	☐ Other (describe in Part VI)			

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14		
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☐ Other actions (describe in Part VI)			
16	Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year?	16		
	If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☐ Other actions (describe in Part VI)			
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply):			
a	☐ Notified patients of the financial assistance policy on admission			
b	☐ Notified patients of the financial assistance policy prior to discharge			
c	☐ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	☐ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e	☐ Other (describe in Part VI)			

Part V Facility Information *(continued)* CALVERT MEMORIAL HOSPITAL OF CALVERT CO

Policy Relating to Emergency Medical Care

			Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	18		
	If "No," indicate the reasons why (check all that apply):			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility did not have a policy relating to emergency medical care			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d	☐ Other (describe in Part VI)			

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):			
a	☐ The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b	☐ The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c	☐ The hospital facility used the Medicare rate for those services			
d	☐ Other (describe in Part VI)			
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?	20		
	If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient?	21		
	If "Yes," explain in Part VI.			

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

Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, measured by total revenue per facility, from largest to smallest)

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

Name and address	Type of Facility (describe)
1 CALVERT PHYSICIAN ASSOCIATES LLC 100 HOSPITAL RD PRINCE FREDERICK MD 20678	PHYSICIAN PRACTICE
2	
3	
4	
5	
6	
7	
8	
9	
10	

5/1/2012 8:26:27 AM

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

PART I, LINE 3C

N/A

PART I, LINE 5A AND 5B

CALVERT MEMORIAL HOSPITAL OFFERS FREE OR DISCOUNTED CARE TO PATIENTS WHO ARE UNABLE TO PAY FOR THEIR SERVICES AND MEET THE ELIGIBILITY CRITERIA REGARDLESS OF THE AMOUNT BUDGETED FOR FINANCIAL ASSISTANCE IN THE HOSPITAL'S ANNUAL OPERATING PLAN.

PART I, LINE 6A

N/A

PART I, LINE 7A, COLUMN D

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

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

UNIQUE ALL PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

PART I, LINE 7B, COLUMNS C, D, E AND F

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

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

HOSPITALS THROUGH THE RATE SETTING SYSTEM.

PART I, LINE 7F, COLUMN C AND D

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

PART I, LINE 7G

THE HOSPITAL PORTION OF THE MARYLAND MEDICAID ASSESSMENT FOR CMH FOR THE 2010 TAX YEAR WAS $301,642.

SUBSIDIZED HEALTH SERVICES INCLUDE THE FOLLOWING NON-PHYSICIAN CLINICS:

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

WOMAN'S WELLNESS CENTER, DUNKIRK URGENT CARE, GYN-ONCOLOGY CLINIC,

PEDIATRIC ORTHOPEDIC CLINIC, SOLOMONS URGENT CARE AND SPINE CLINIC. COSTS

ATTRIBUTABLE TO THE CLINICS TOTALED $1,223,980. THESE SERVICES WOULD

LIKELY NOT BE UNDERTAKEN IN THE COMMUNITY IF NOT PROVIDED FOR CALVERT

MEMORIAL HOSPITAL. AS A RESULT CALVERT MEMORIAL HOSPITAL HAS IDENTIFIED A

COMMUINITY NEED OF THESE SERVICES.

PART I, LINE 7, COLUMN F

BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A), BUT

SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN -

$3,564,490.

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 VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

PART II

CALVERT MEMORIAL HOSPITAL (CMH) IS RECOGNIZED AS A LEADER IN THE PROVISION OF HEALTH CARE IN THE LOCAL AREA. IT PARTNERS WITH MANY ORGANIZATIONS AND AGENCIES TO EXPAND THE REACH FOR IMPROVING THE HEALTH OF ITS COMMUNITY. ACTIVITIES INCLUDE:

DEVELOPING AND LEADING A HEALTH MINISTRY TEAM PROGRAM WITH 15 LOCAL AREA CHURCHES.

SUPPORTING STAFF PARTICIPATION ON LOCAL AREA BOARDS, COALITIONS AND COLLABORATIVES, SUCH AS THE UNITED WAY OF CALVERT COUNTY, HOSPICE OF CALVERT COUNTY, MARYLAND RURAL HEALTH ASSOCIATION, THE OFFICE ON AGING, SOUTHERN MARYLAND COMMUNITY NETWORK, CALVERT COUNTY ORAL HEALTH COALITION, TRI-COUNTY COUNCIL, EMS COUNCIL, MARYLAND PERINATAL PATIENT SAFETY COLLABORATIVE, COMPTROLLER'S ADVISORY BOARD AND THE CALVERT CANCER COALITION.

LEADER WITH CALVERT COUNTY HEALTHCARE CAREER PARTNERSHIP - COORDINATING

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

MEETINGS, ANNUAL EXPO AND STUDENT MENTORSHIPS. PURPOSE IS TO EXPOSE MORE

STUDENTS TO A VARIETY OF HEALTH CAREER OPPORTUNITIES WITH THE GOAL TO

ATTRACT THEM TO FUTURE CAREERS IN HEALTHCARE.

CHAIR OF THE CALVERT COUNTY IMPROVED PREGNANCY OUTCOME PROGRAM THAT IS A

PARTNERSHIP WITH PHYSICIANS, THE LOCAL HEALTH DEPARTMENT, CHILD CARE

PROVIDERS AND CMH THAT PERFORMS CASE REVIEWS OF DELIVERIES WITH POTENTIAL

POOR OUTCOME TO IDENTIFY TRENDS. THESE TRENDS THEN SERVE AS A GUIDE FOR

PROGRAM AND SERVICE DEVELOPMENT. TWO AREAS OF RECENT ATTENTION HAVE BEEN

SAFE SLEEP EDUCATION FOR PARENTS AND IDENTIFICATION OF EARLY LABOR AND

ACTION PLAN FOR THE MATERNITY PATIENT.

CALVERT COUNTY NUCLEAR POWER PLANT DISASTER PREPAREDNESS IS AN ONGOING

PROGRAM FOR CMH SINCE CMH IS THE DESIGNATED RECEIVING HOSPITAL FOR

ACCIDENTS OR EMERGENCIES. CMH PROVIDES SALARIES AND TRAVEL EXPENSES FOR

EMERGENCY DEPARTMENT STAFF TO TRAIN OFFSITE FOR SUCH EMERGENCIES. IT ALSO

DRILLS AT LEAST ANNUALLY WITH THE COUNTY, THE POWER PLANT AND FEMA ON

ACCIDENT MANAGEMENT. THE HOSPITAL HAS A PART OF ITS EMERGENCY DEPARTMENT

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

A DECONTAMINATION UNIT THAT IS FULLY EQUIPPED AND AVAILABLE 24/7 FOR HANDLING PATIENTS NEEDING THIS PROCEDURE.

THESE ARE JUST A FEW OF CMH'S COMMUNITY BUILDING ACTIVITIES. IMPROVING THE HEALTH OF THE COMMUNITY IS A PRIORITY AREA FOR THE HOSPITAL AND THEREFORE DRIVES MANY OF OUR STRATEGIC PLANS.

PART III, LINE 4

THE FINANCIAL STATEMENTS FOR CALVERT MEMORIAL HOSPITAL DO NOT CONTAIN A FOOTNOTE REGARDING BAD DEBT EXPENSE. BAD DEBT EXPENSE IS CLASSIFIED AS AN OPERATING EXPENSE, "PROVISION FOR UNCOLLECTIBLE ACCOUNTS," IN THE HOSPITAL'S STATEMENT OF OPERATIONS.

THE AMOUNT REPORTED ON PART III, LINE 2 WAS DETERMINED BY TAKING CHARGES WRITTEN OFF TO BAD DEBT IN FY 2011 LESS BAD DEBT RECOVERIES AND ANY DISCOUNTS THAT WERE APPLIED TO ACCOUNTS THAT HAD BEEN WRITTEN OFF AS BAD DEBT. THE COST TO CHARGE RATIO, AS CALCULATED IN WORKSHEET 2 WAS USED TO CALCULATE THE COST OF THE ORGANIZATION'S BAD DEBT EXPENSE.

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

THE AMOUNT REPORTED ON PART III, LINE 3 WAS ESTIMATED UTILIZING ACTUAL DATA FROM SIX MONTHS IN FY 2012 WHEN CALVERT MEMORIAL HOSPITAL IMPLEMENTED A "PRESUMPTIVE CHARITY" PROCESS TO IDENTIFY PATIENTS WHO WOULD LIKELY QUALIFY FOR FINANCIAL ASSISTANCE IF SUFFICIENT INFORMATION HAD BEEN AVAILABLE. THE PROCESS THAT WAS IMPLEMENTED TO IDENTIFY "PRESUMPTIVE CHARITY" PATIENTS WHO OTHERWISE WOULD BE WRITTEN OFF TO BAD DEBT INCLUDES THE REVIEW OF SEVERAL DOCUMENTS SUBMITTED BY PATIENTS, THE ACCEPTANCE OF NEED BASED GOVERNMENT OR COMMUNITY ASSISTANCE THAT PROVES THE PATIENT'S PROBABLE ELIGIBILITY, AND THE UTILIZATION OF SOFTWARE THAT EXAMINES SEVERAL FINANCIAL FACTORS AND PLACES THEM IN AN ALGORITHYM TO DETERMINE THEIR PROBABILITY TO MEET CMH'S 100% LEVEL OF FINANCIAL ASSISTANCE IN FY 2011.

PART III, LINE 8

THE COSTING SOURCE IS THE MEDICARE COST REPORT AND THE METHODOLOGY IS MEDICARE ALLOWABLE COST TO MEDICARE REVENUES RECEIVED.

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

PART III, LINE 9B

AS STATED IN CALVERT MEMORIAL HOSPITAL'S FINANCIAL ASSISTANCE POLICY,

PART V, SECTION G:

CALVERT MEMORIAL HOSPITAL HAS DEVELOPED POLICIES AND PROCEDURES FOR

INTERNAL AND EXTERNAL COLLECTION PRACTICES THAT TAKE INTO ACCOUNT THE

EXTENT TO WHICH THE PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE, A

PATIENT'S GOOD FAITH EFFORT TO APPLY FOR A GOVERNMENTAL PROGRAM OR FOR

FINANCIAL ASSISTANCE FROM CALVERT MEMORIAL HOSPITAL, AND A PATIENT'S GOOD

FAITH EFFORT TO COMPLY WITH HIS OR HER PAYMENT AGREEMENTS WITH CALVERT

MEMORIAL HOSPITAL. FOR PATIENTS WHO ARE COOPERATING WITH APPLYING AND

QUALIFYING FOR EITHER MEDICAL ASSISTANCE OR FINANCIAL ASSISTANCE, CALVERT

MEMORIAL HOSPITAL WILL NOT SEND UNPAID BILLS TO OUTSIDE COLLECTION

AGENCIES AND WILL CEASE ALL COLLECTION ACTIVITIES.

ADDITIONALLY, EVEN R

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

NEEDS ASSESSMENT

PART VI, LINE 2

CALVERT MEMORIAL HOSPITAL (CMH) USES A VARIETY OF RESOURCES TO IDENTIFY THE HEALTH NEEDS OF ITS COMMUNITY.

AS STATED IN 2010'S COMMUNITY BENEFIT REPORT NARRATIVE, BETWEEN JULY 2007AND NOVEMBER 2007, CMH IN COLLABORATION WITH THE CALVERT COUNTY COMMUNITY HEALTH IMPROVEMENT ROUNDTABLE COMPLETED A COMPREHENSIVE COMMUNITY HEALTH ASSESSMENT. THIS IS DONE BY THE ROUNDTABLE APPROXIMATELY EVERY FIVE YEARS AND TAKES ABOUT ONE YEAR TO COMPLETE. ON A QUARTERLY BASIS, ROUNDTABLE PARTNERS PROVIDE AN ACTION PLAN UPDATE. DATA FOR A COMMUNITY HEALTH ASSESSMENT INTERIM REPORT WAS OBTAINED FOR FY 2011 AND IS CURRENTLY BEING COMPILED. THE ROUNDTABLE MEMBERSHIP IS REPRESENTATIVE OF THE MAJOR COMMUNITY PARTNERS FOR HEALTH AND HUMAN SERVICES AND INCLUDES THE LEADERSHIP FROM THE CALVERT COUNTY HEALTH DEPARTMENT, CALVERT COUNTY PUBLIC SCHOOLS, CALVERT COUNTY OFFICE ON AGING, CALVERT COUNTY OF COMMUNITY RESOURCES, THE CALVERT COUNTY DEPARTMENT OF SOCIAL SERVICES, CALVERT HOSPICE, CALVERT ALLIANCE AGAINST DRUG ABUSE, THE

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

CALVERT COUNTY TRAFFIC SAFETY COUNCIL AND THE ARC OF SOUTHERN MD WITH CMH AS THE PRIMARY FACILITATOR OF THE ROUNDTABLE. THE PURPOSE OF THE ASSESSMENT WAS TO DETERMINE THE CURRENT STATUS OF COMMUNITY HEALTH IN THE COUNTY, TO PROJECT FUTURE NEEDS AND TO IDENTIFY AREAS WHERE THEIR GAPS IN SERVICES. THE ASSESSMENT CONSISTED OF TWO COMPONENTS: THE FIRST BEING THE COLLECTION OF DATA ON THE HEALTH STATUS OF THE COUNTY AS AVAILABLE THROUGH LOCAL, STATE AND NATIONAL DATA SOURCES. IT ALSO CONSISTED OF PERSONAL INTERVIEWS WITH KEY LEADERS IN THE COMMUNITY IN ORDER TO GATHER INFORMATION ON THEIR PERCEPTION OF THE HEALTH OF THIS COMMUNITY. THESE LEADERS INCLUDED A COUNTY COMMISSIONER, THE SUPERINTENDENT OF SCHOOLS, THE COUNTY HEALTH OFFICER, A LEADING CLERGY REPRESENTATIVE FROM A MINORITY CHURCH, THE DIRECTOR OF AGING SERVICES AT THE OFFICE ON AGING AND THE CEO OF CMH. THE SECOND PHASE WAS THE DEVELOPMENT OF A PUBLIC COMMUNITY SURVEY DESIGNED TO DETERMINE RESIDENT'S VIEWS ABOUT THEIR HEALTH AND THE LOCAL HEALTH CARE SYSTEM. IT UTILIZED FACE-TO FACE METHODS, ONLINE AVAILABILITY AND A PAPER SYSTEM. THE SURVEY WAS DISTRIBUTED BY COMMUNITY AGENCIES SUCH AS THE UNITED WAY, THE LOCAL INTERAGENCY COUNCIL, LOCAL CHURCHES AND EMPLOYERS AS WELL AS AT A

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

COMMUNITY HEALTH FORUM AT THE COLLEGE OF SOUTHERN MARYLAND. A TOTAL OF

1,418 SURVEYS WERE RETURNED TO CMH.

IN OCTOBER 2007, THE COMMUNITY HEALTH IMPROVEMENT ROUNDTABLE HELD A

COMMUNITY HEALTH FORUM AT THE COLLEGE OF SOUTHERN MARYLAND, CALVERT

COUNTY CAMPUS. IT CONSISTED OF A PANEL PRESENTATION BY THE COUNTY'S

HEALTH OFFICER, A PRIVATE PHYSICIAN AND THE HOSPITAL'S PRESIDENT WITH A

QUESTION AND ANSWER PERIOD AFTERWARDS. APPROXIMATELY 50 PEOPLE ATTENDED

THIS FORUM.

IN THE FALL OF 2007, THE COMMUNITY WELLNESS DEPARTMENT OF CMH SURVEYED

ITS FAITH-BASED MINISTRY COUNCIL FOR THEIR CONCERNS AND PERCEPTIONS

REGARDING THE HEALTH OF THE COMMUNITY AND WHAT RECOMMENDATIONS THEY HAD

FOR CMH TO ADDRESS IN FUTURE PLANNING.

IN JANUARY 2008, CMH'S 2004 MEDICAL STAFF DEVELOPMENT PLAN WAS UPDATED.

THIS PROCESS IS COMPLETED EVERY 4 YEARS. APPLYING VERY SPECIFIC

QUANTITATIVE ANALYSIS ALONG WITH QUALITATIVE MEDICAL STAFF INPUT, THE

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

STUDY SHOWED THE NEED FOR A SIGNIFICANT NUMBER OF PRIMARY CARE PHYSICIANS

AS WELL AS MEDICAL AND SURGICAL SUB-SPECIALTIES.

IN THE SPRING OF 2008, CMH'S BOARD OF DIRECTORS INITIATED A STRATEGIC

PLANNING PROCESS FOR THE YEARS 2009-2012. THE PURPOSE OF THE PLAN IS TO

AMALGAMATE AND SYNTHESIZE THE ESSENTIAL FINDINGS AND RECOMMENDATIONS OF

KEY STUDIES AND TO PRESENT A "ROLL-UP" OF RECOMMENDED ACTIONS THAT REMAIN

TO BE IMPLEMENTED. THE PLAN WAS COMPLETED IN FY 2009 AND SERVES AS A

GUIDE FOR SERVICE DEVELOPMENT, IMPLEMENTATION AND CONTINUATION.

THE LOCAL HEALTH DEPARTMENT IS INTEGRAL TO THE ASSESSMENT AND PLANNING OF

HEALTH CARE SERVICES AT CMH. THROUGH ACTIVE PARTICIPATION ON THE

COMMUNITY HEALTH ROUNDTABLE AND OTHER COLLABORATIVE EFFORTS THE HOSPITAL

AND THE HEALTH DEPARTMENT WORK CLOSELY TO IMPROVE THE HEALTH OF THE

COMMUNITY. FOR EXAMPLE, BOTH THE COUNTY HEALTH OFFICER AND THE HOSPITAL'S

CEO PRESENTED THE RESULTS OF THE COMMUNITY HEALTH ASSESSMENT TO THE

COUNTY COMMISSIONER'S AT THEIR MEETING ON DECEMBER 16, 2008.

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

NOTIFICATION ABOUT THE AVAILABILITY OF FINANCIAL ASSISTANCE FROM CALVERT MEMORIAL HOSPITAL INCLUDES A CONTACT NUMBER AND IS DISSEMINATED BY CALVERT MEMORIAL HOSPITAL BY VARIOUS MEANS, WHICH INCLUDES, BUT IS NOT LIMITED TO, THE PUBLICATION OF NOTICES IN PATIENT BILLS AND BY POSTING NOTICES IN THE EMERGENCY DEPARTMENT, URGENT CARE CENTERS, ADMITTING AND REGISTRATION DEPARTMENTS, AND PATIENT FINANCIAL SERVICES OFFICES. INFORMATION IS ALSO INCLUDED ON THE HOSPITAL'S WEBSITE AND IN THE PATIENT HANDBOOK. IN ADDITION, NOTIFICATION OF THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM IS ALSO PROVIDED TO EACH PATIENT THROUGH AN INFORMATION SHEET PROVIDED TO EACH PATIENT AT THE TIME OF REGISTRATION. SUCH INFORMATION IS PROVIDED IN THE PRIMARY LANGUAGES SPOKEN BY THE POPULATION SERVICED BY CALVERT MEMORIAL HOSPITAL. REFERRAL OF PATIENTS FOR FINANCIAL ASSISTANCE MAY BE MADE BY ANY MEMBER OF THE CALVERT MEMORIAL HOSPITAL STAFF OR MEDICAL STAFF, INCLUDING PHYSICIANS, NURSES, FINANCIAL COUNSELORS, SOCIAL WORKERS, CASE MANAGERS, AND CHAPLAINS. A REQUEST FOR FINANCIAL ASSISTANCE MAY BE MADE BY THE PATIENT OR A FAMILY

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

MEMBER, CLOSE FRIEND, OR ASSOCIATE OF THE PATIENT, SUBJECT TO APPLICABLE

PRIVACY LAWS.

COMMUNITY INFORMATION

PART VI, LINE 4

CALVERT MEMORIAL HOSPITAL (CMH) IS THE SOLE HOSPITAL PROVIDER IN CALVERT

COUNTY, MARYLAND. CALVERT COUNTY IS LOCATED IN SOUTHERN MARYLAND AND IS

ESSENTIALLY A PENINSULA BORDERED ON THE EAST BY THE CHESAPEAKE BAY AND ON

THE WEST BY THE PATUXENT RIVER. WITH A LONG AND SKINNY TOPOGRAPHY, THE

COUNTY'S "SPINE" IS MARYLAND ROUTES 2/4 RUNNING FROM DUNKIRK IN THE NORTH

TO SOLOMONS ISLAND IN THE SOUTH FOR APPROXIMATELY 45 MILES. THIS

TOPOGRAPHY PRESENTS CHALLENGES TO BOTH TRANSPORTATION AND SERVICE

DELIVERY THAT ARE UNIQUE TO CALVERT COUNTY. IN RESPONSE TO THIS UNIQUE

TOPOGRAPHY, CMH'S STRATEGIC GOAL IS TO ENSURE ACCESS TO PRIMARY CARE

SERVICES WITHIN A 15 MINUTE DRIVE FROM ANY COUNTY LOCATION AND SPECIALTY

CARE WITHIN 30 MINUTES. IN ADDITION, CMH'S SECONDARY MARKET AREA INCLUDES

THE SURROUNDING AREAS OF SOUTHERN PRINCE GEORGES AND ANNE ARUNDEL

COUNTIES, ST MARY'S COUNTY ON ITS SOUTHERN BORDER AND CHARLES COUNTY ON

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

ITS WESTERN BORDER.

CALVERT COUNTY IS IN THE OUTER RING OF SUBURBAN WASHINGTON, D.C.

POPULATION ESTIMATES FROM THE U.S. CENSUS BUREAU FOR 2010 IS 88,737.

POPULATION DENSITY INCREASED IN THE COUNTY FROM 346.5 TO 412 PEOPLE PER

SQUARE MILE OVER THE PERIOD OF 2000-2009. POPULATION PROJECTIONS ARE FOR

CALVERT TO CONTINUE TO GROW TO 99,350 PEOPLE IN 2020. THE FUTURE IS

PROJECTED TO BRING SMALL GROWTH IN POPULATION OF YOUNG PEOPLE, LARGE

INCREASES (ON A PERCENTAGE BASIS) OF THE ELDERLY, AND MODEST GROWTH IN

TOTAL NUMBER OF HOUSEHOLDS AND IN SIZE OF THE LABOR FORCE. CALVERT

COUNTY'S ESTIMATED MEDIAN HOUSEHOLD INCOME WAS $89,289 IN 2009. DESPITE

ITS RELATIVE HIGH INCOME LEVEL, CALVERT COUNTY IS HOME TO POCKETS OF

PEOPLE WHO LIVE IN POVERTY. US CENSUS AMERICAN COMMUNITY SURVEY DATA

INDICATED THAT INDIVIDUALS AND FAMILIES LIVING BELOW THE POVERTY LEVEL

WERE 5.5% OF THE POPULATION.

THE AGE DISTRIBUTION OF THOSE LIVING BELOW THE POVERTY LEVEL REVEALS THE

FOLLOWING:

UNDER AGE 18 35.9%

AGE 18-64 49.1%

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

AGE 65+ 15.0%

THE COMMUNITY HEALTH STATUS REPORT FROM DHHS INDICATES THAT THERE ARE 9207 UNINSURED INDIVIDUALS UNDER AGE 65 IN CALVERT COUNTY. IT ALSO REPORTS THAT THERE ARE 8,311 MEDICARE BENEFICIARIES AND 8,887 MEDICAID BENEFICIARIES. FINANCIAL ANALYSIS OF FY2011 FOR CALVERT MEMORIAL HOSPITAL REVEALS THAT 5.2% OF GROSS REVENUE IS FROM SELF-PAY OR UNINSURED PATIENTS, 12.3% OF GROSS REVENUE IS FROM MEDICAID RECIPIENTS AND 37.1% IS FROM MEDICARE RECIPIENTS. IN 2009, MARYLAND VITAL STATISTICS REPORT THAT CALVERT COUNTY'S CRUDE DEATH RATE FOR ALL CAUSES OF DEATH IS 656.9 PER 100,000 PEOPLE WHICH IS BELOW THE STATE AVERAGE OF 767.8 DEATHS PER 100,000 PEOPLE. HEART DISEASE, CANCER, CEREBROVASCULAR DISEASE AND CHRONIC LOWER RESPIRATORY DISEASE ARE THE LEADING CAUSES OF DEATH IN CALVERT. DEATH FROM HEART DISEASE, CANCERS AND CHRONIC LOWER RESPIRATORY DISEASE IN CALVERT COUNTY IS HIGHER THAN THE MARYLAND STATE AVERAGE.

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

THE HOSPITAL IS GOVERNED BY A COMMUNITY BOARD COMPRISED OF CIVIC LEADERS THROUGHOUT CALVERT COUNTY WHO ARE COMMITTED TO AND REPRESENT THE HEALTHCARE NEEDS OF THE COMMUNITY. THE HOSPITAL EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS FOR ALL OF ITS DEPARTMENTS. ALL FINANCIAL SURPLUSES THE HOSPITAL GENERATES ARE USED EXCLUSIVELY TO FURTHER THE CHARITABLE PURPOSES OF THE ORGANIZATION.

AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

CALVERT MEMORIAL HOSPITAL IS PART OF AN AFFILIATED HEALTH CARE SYSTEM THAT COOPERATES IN PROVIDING HEALTHCARE SERVICES TO ITS COMMUNITY. THE HOSPITAL, AS A SOLE COMMUNITY PROVIDER, PROVIDES ESSENTIAL HEALTH CARE SERVICES SUCH AS OBSTETRICS, PSYCHIATRY (INPATIENT AND OUTPATIENT), EMERGENCY SERVICES, URGENT CARE AND LONG-TERM CARE THAT OTHERWISE WOULD NOT BE PROVIDED WITHIN CALVERT COUNTY DUE TO THEIR UNPROFITABLE NATURE (HIGH COST SERVICES WITH LOW REIMBURSEMENT), OR WOULD NEED TO BE PROVIDED

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

BY ANOTHER TAX-EXEMPT ORGANIZATION OR THE GOVERNMENT. ADDITIONALLY, THE HOSPITAL PROVIDED $3,134,865 IN CHARITY CARE, AT COST, TO PATIENTS THAT QUALIFIED FOR FINANCIAL ASSISTANCE. THE HOSPITAL IS THE SOLE MEMBER AND EMPLOYER OF A PHYSICIAN GROUP, CALVERT PHYSICIAN ASSOCIATES LLC, WHICH PROVIDES PRIMARY AND SPECIALTY CARE SERVICES TO THE COMMUNITY. THE PROVISION OF THESE PHYSICIAN SERVICES TO THE COMMUNITY MEETS AN IDENTIFIED COMMUNITY NEED. FURTHERMORE, THE HOSPITAL IS A PARTNER IN A PARTNERSHIP BETWEEN THE LOCAL HEALTH DEPARTMENT, LOCAL PHYSICIANS AND THE HOSPITAL ("CALVERT HEALTHCARE SOLUTIONS") THAT PROVIDES PRIMARY CARE SERVICES TO PATIENTS WHO ARE UNINSURED. AMOUNG THE CHARITY CARE SERVICES, THE HOSPITAL PROVIDED $263,081 OF FREE HEALTH CARE SERVICES FOR CALVERT HEALTHCARE SOLUTIONS PATIENTS.

Part VI Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

STATE FILING OF COMMUNITY BENEFIT REPORT

MD,

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

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

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number
52-0619000

Part I Questions Regarding Compensation

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

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

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

Note. The sum of columns (B)(i)-(iii) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a.

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JAMES XINIS	(i)	378,019.	94,261.	132,450.	260,123.	920.	865,773.	
	(ii)	0.	0.	0.	0.	0.	0.	
2 ROBERT KERTIS	(i)	144,551.	5,000.	0.	8,823.	3,086.	161,460.	
	(ii)	0.	0.	0.	0.	0.	0.	
3 ROBERT MCWHIRT	(i)	153,152.	9,248.	222.	14,446.	7,614.	184,682.	
	(ii)	0.	0.	0.	0.	0.	0.	
4 SUSAN DOHONY	(i)	152,630.	12,625.	464.	37,270.	5,307.	208,296.	
	(ii)	0.	0.	0.	0.	0.	0.	
5 EDWARD GROGAN	(i)	140,283.	10,467.	0.	10,751.	8,323.	169,824.	
	(ii)	0.	0.	0.	0.	0.	0.	
6 ROBERT SCHLAGER	(i)	162,677.	8,250.	0.	16,668.	6,567.	194,162.	
	(ii)	0.	0.	0.	0.	0.	0.	
7 SEYED ALI MOHAMMADI	(i)	290,057.	6,900.	0.	16,581.	5,263.	318,801.	
	(ii)	0.	0.	0.	0.	0.	0.	
8 MARA DAIDONE	(i)	298,720.	90,947.	6,629.	17,024.	5,263.	418,583.	
	(ii)	0.	0.	0.	0.	0.	0.	
9 FAISAL BHINDER	(i)	364,554.	0.	0.	17,740.	5,263.	387,557.	
	(ii)	0.	0.	0.	0.	0.	0.	
10 APARAJITA MAHATA	(i)	235,810.	0.	28,200.	17,736.	5,263.	287,009.	
	(ii)	0.	0.	0.	0.	0.	0.	
11 SEBLE GABRE-MADHIN	(i)	248,018.	0.	0.	5,093.	5,733.	258,844.	
	(ii)	0.	0.	0.	0.	0.	0.	
12 BARBARA POLAK	(i)	144,346.	8,821.	0.	21,357.	6,028.	180,552.	
	(ii)	0.	0.	0.	0.	0.	0.	
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

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

NONQUALIFIED RETIREMENT PAYMENT

PART I, LINE 4

THE FOLLOWING EMPLOYEES CONTRIBUTED TO (EMPLOYEE AND EMPLOYER PORTION)

THE ORGANIZATION'S 457(F) DEFERRED COMPENSATION PLAN:

JAMES XINIS $219,255

ROBERT KERTIS $5,815

ROBERT SCHLAGER $6,532

BARBARA POLAK $5,840

BENEFITS

PART I LINE 1A

THE PRESIDENT/CEO RECEIVED THE FOLLOWING BENEFITS: TRAVEL FOR COMPANIONS

HEALTH OR SOCIAL CLUB DUES OR INITIATION FEES. THE SOCIAL CLUB DUES WERE

REFLECTED ON HIS W-2.

SCHEDULE K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information on Schedule O (Form 990).**

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

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number
52-0619000

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled Financing	
							Yes	No	Yes	No	Yes	No
A	MD HELATH & HIGHER EDUCATIONAL FAC AUTHORITY	52-0936091	574127SP1	07/01/2004	32,925,000.	ACQUIRE, RENOVATE AND CONSTRUC		X		X		X
B												
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	290,000.			
2	Amount of bonds legally defeased				
3	Total proceeds of issue	34,646,470.			
4	Gross proceeds in reserve funds	1,846,339.			
5	Capitalized interest from proceeds	3,639,436.			
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	260,239.			
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds	762,919.			
10	Capital expenditures from proceeds	28,195,347.			
11	Other spent proceeds				
12	Other unspent proceeds				
13	Year of substantial completion	2008			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X						
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		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X						
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 Are there any research agreements that may result in private business use of bond-financed property?		X						
c Does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts or research agreements relating to the financed property?		X						
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 ▶	0.0000 %		%		%		%	
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 ▶	0.0000 %		%		%		%	
6 Total of lines 4 and 5	0.0000 %		%		%		%	
7 Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?	X							

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has a Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate, been filed with respect to the bond issue?		X						
2 Is the bond issue a variable rate issue?		X						
3a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X						
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								
4a Were gross proceeds invested in a GIC?	X							
b Name of provider	MORGAN STANLEY							
c Term of GIC	2.200							
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?		X						
5 Were any gross proceeds invested beyond an available temporary period?		X						
6 Did the bond issue qualify for an exception to rebate?		X						

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

DIFFERENCE BETWEEN PART I, COLUMN E AND PART II, LINE 3
DIFFERENCE IS DUE TO INVESTMENT EARNINGS.

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**
▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

OMB No. 1545-0047

2010

Open To Public Inspection

Name of the organization
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number
52-0619000

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Description of transaction	(c) Corrected? Yes	No
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

2 Enter the amount of tax imposed on the organization managers or disqualified persons during the year under section 4958 . . . . . ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 26, or Form 990-EZ, Part V, line 38a.

(a) Name of interested person and purpose	(b) Loan to or from the organization? To	From	(c) Original principal amount	(d) Balance due	(e) In default? Yes	No	(f) Approved by board or committee? Yes	No	(g) Written agreement? Yes	No
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
Total . . . . . ▶ $										

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount and type of assistance
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues? Yes	(e) Sharing of organization's revenues? No
(1) JAMES XINIS	DIRECTOR AND OFFICER	3,714,400.	CAREFIRST TRANSACTIONS (ON BD)		X
(2) JAMES XINIS	DIRECTOR AND OFFICER	22,028,800.	CAREFIRST TRANSACTIONS (ON BD)		X
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

SCHEDULE L, PART IV

CMH PAID CAREFIRST BLUE CROSS $3,714,400 IN HEALTH INSURANCE PREMIUMS.

CMH RECEIVED $22,028,800 IN INSURANCE PAYMENTS FOR PATIENTS WITH BLUE

CROSS HEALTH INSURANCE (ANY BC PLAN).

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.

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization: CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number: 52-0619000

DESCRIPTION OF 990 REVIEW PROCESS

PART VI, LINE 11

THE FORM 990 IS REVIEWED BY THE AUDIT COMMITTEE OF THE CALVERT HEALTH SYSTEM, INC. BOARD OF DIRECTORS AFTER COMPLETION AND PRIOR TO SUBMISSION TO THE IRS. THE DOCUMENT IS DELIVERED TO THE COMMITTEE MEMBERS PRIOR TO THE COMMITTEE MEETING SO THAT THEY CAN REVIEW THE INFORMATION AND RESPOND TO OR QUESTION ANY OR ALL OF THE DATA. THE CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER ARE PRESENT AT THE AUDIT COMMITTEE MEETING.

PRIOR TO SUBMISSION TO THE IRS, A COPY OF THE FINAL FORM 990 IS POSTED ON THE ORGANIZATION'S INTRANET WEB SITE UNDER THE BOARD OF DIRECTORS PORTAL WHICH IS PASSWORD-PROTECTED. ALL BOARD MEMBERS ARE NOTIFIED BY EMAIL THAT THE FORM 990 HAS BEEN POSTED ON THE INTRANET AND IS AVAILABLE FOR REVIEW.

CONFLICTS MONITORING AND ENFORCEMENT

PART VI, LINE 12C

CALVERT HEALTH SYSTEM, INC. AND SUBSIDIARIES (THE HEALTH SYSTEM) HAVE A CONFLICT OF INTEREST PROCESS. AT ITS CORE ARE THREE DISTINCT POLICIES; ONE EACH FOR THE BOARD OF DIRECTORS, MEDICAL STAFF, AND ALL EMPLOYEES AND ASSOCIATES OF THE HEALTH SYSTEM. THESE POLICIES REQUIRE ALL ORGANIZATIONAL LEADERSHIP, AS WELL AS RANK AND FILE ASSOCIATES IN KEY POSITIONS OR WITH RELATIONSHIPS WITH OUTSIDE PARTIES THAT DO BUSINESS WITH THE HEALTH SYSTEM, TO DISCLOSE ANY ACTUAL OR POTENTIAL CONFLICT OF

Name of the organization: CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number: 52-0619000

INTEREST. ANNUAL DISCLOSURES ARE REQUIRED AND DOCUMENTED WITH A FURTHER REQUIREMENT TO PROMPTLY SUPPLEMENT WHEN AN ACTUAL OR POTENTIAL CONFLICT IS DISCOVERED OR CREATED. THE HEALTH SYSTEM REQUIRES THAT THESE POLICIES BE CONSTRUED BROADLY TO AVOID THE APPEARANCE OF IMPROPER ACTIVITY AND REQUIRES DISCLOSURE AND RESOLUTION OF POTENTIAL CONFLICTS AS WELL. THE PROCESS IS OVERSEEN BY THE CHIEF COMPLIANCE OFFICER OF THE HEALTH SYSTEM WHO HAS ACCESS TO EXTERNAL RESOURCES, INCLUDING OUTSIDE COUNSEL. REMEDIES RANGE FROM DISCLOSURE AND MONITORING FOR THE MOST ATTENUATED POTENTIAL CONFLICTS TO RESIGNATION/TERMINATION FOR UNRESOLVABLE CONFLICTS.

PROCESS FOR DETERMINING COMPENSATION

PART VI, LINE 15

THE ORGANIZATION UTILIZES AN INDEPENDENT COMPENSATION CONSULTANT, A WRITTEN EMPLOYMENT CONTRACT, A COMPENSATION SURVEY OR STUDY, APPROVAL BY BOARD/COMPENSATION COMMITTEE AND CONTEMPORANEOUS WRITTEN SUBSTANTIATION OF THE DECISION-MAKING PROCESS TO DETERMINE COMPENSATION OF THE CEO.

DOCUMENT AVAILABILITY

PART VI, LINE 19

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

AUDITED FINANCIAL STATEMENTS

PART XI LINE 2B

THE ORGANIZATIONS FINANCIAL STATEMENTS ARE AUDITED BY AN INDEPENDENT

Name of the organization: CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number: 52-0619000

ACCOUNTING FIRM AS PART OF THE CONSOLIDATED AUDIT OF THE HEALTH SYSTEM.

OTHER CHANGES TO NET ASSETS

PART XI, LINE 5

BOOK/TAX DIFFERENCE K-1 CPHHA	$ 275,867
BOOK/TAX DIFFERENCE K-1 MD ECARE	(6)
NET ASSETS RELEASED	(512,632)
PENSION RELATED CHANGES	3,431,020
UNREALIZED LOSS	(1,804)
TOTAL	$3,192,445

BUSINESS RELATIONSHIPS

PART VI, SECTION A, LINE 2

NAMES	RELATIONSHIP	RELATED ENTITY
JOHN WEIGEL	PARTNER	CALVERT INTERNAL MEDICINE GROUP
CHARLES JUDGE	PARTNER	CALVERT INTERNAL MEDICINE GROUP

ATTACHMENT 1

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

CALVERT MEMORIAL HOSPITAL'S MISSION IS FOR THE CHARITABLE PURPOSE OF PROVIDING QUALITY INPATIENT AND AMBULATORY HEALTH CARE SERVICES TO THE CITIZENS OF SOUTHERN MARYLAND THAT IS ACCESSIBLE, COST EFFECTIVE AND COMPASSIONATE. THE HOSPITAL WORKS IN PARTNERSHIP WITH THE COMMUNITY TO IMPROVE THE HEALTH STATUS OF ITS MEMBERS. THE HOSPITAL PROVIDES MEDICAL SERVICES TO PATIENTS REGARDLESS OF

Name of the organization
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number
52-0619000

ATTACHMENT 1 (CONT'D)

RACE, CREED, SEX, NATIONAL ORIGIN, HANDICAP, AGE OR ABILITY TO PAY. IN FY 2011, THE HOSPITAL SERVED 8,814 INPATIENTS, 123,968 OUTPATIENTS AND PROVIDED 40,458 EMERGENCY ROOM VISITS. IN ADDITION TO THE INPATIENTS SERVED, THE HOSPITAL ALSO TREATED 963 MEDICAL OBSERVATION PATIENTS. FOR 2011, THE HOSPITAL FILED WITH THE STATE OF MARYLAND A COMMUNITY BENEFIT REPORT THAT DOCUMENTED $13,857,990 IN COMMUNITY BENEFIT PROVIDED BY CALVERT MEMORIAL HOSPITAL. THE COMMUNITY BENEFIT REPORT IS AVAILABLE UPON REQUEST. ALL FINANCIAL SURPLUSES THE HOSPITAL GENERATES ARE USED EXCLUSIVELY TO FURTHER THE CHARITABLE PURPOSES OF THE ORGANIZATION. THE HOSPITAL IS GOVERNED BY A COMMUNITY BOARD COMPRISED OF CIVIC LEADERS THROUGHOUT CALVERT COUNTY WHO ARE COMMITTED TO AND REPRESENT THE HEALTHCARE NEEDS OF THE COMMUNITY. THE HOSPITAL IN FY 2011 PROVIDED $3,134,865 IN CHARITY CARE, AT COST, TO RESIDENTS WHO WERE UNABLE TO PAY FOR THOSE SERVICES AND MET ELIGIBILITY CRITERIA. THE HOSPITAL, AS A SOLE COMMUNITY PROVIDER, PROVIDES ESSENTIAL HEALTHCARE SERVICES SUCH AS OBSTETRICS, PSYCHIATRY (BOTH INPATIENT AND OUTPATIENT), EMERGENCY SERVICES, URGENT CARE AND LONG-TERM CARE THAT OTHERWISE WOULD NOT BE PROVIDED WITHIN CALVERT COUNTY OR WOULD HAVE TO BE PROVIDED BY THE GOVERNMENT. MANY OF THESE SERVICES BY THEIR NATURE ARE UNPROFITABLE SERVICES DUE TO THEIR HIGH COST AND LOW REIMBURSEMENT. THESE SERVICES WOULD NOT BE PROVIDED IF THE HOSPITAL DID NOT STEP IN TO PROVIDE THEM. AMOUNG THE CHARITY CARE SERVICES PROVIDED, IN FY 2011, THE HOSPITAL PROVIDED $263,081 OF FREE HEALTH SERVICES FOR CALVERT HEALTHCARE

Name of the organization: CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number: 52-0619000

ATTACHMENT 1 (CONT'D)

SOLUTIONS PATIENTS. CALVERT HEALTHCARE SOLUTIONS IS A PARTNERSHIP BETWEEN THE LOCAL HEALTH DEPARTMENT, LOCAL PHYSICIANS AND THE HOSPITAL THAT PROVIDES PRIMARY CARE SERVICES TO PATIENTS WHO ARE UNINSURED.

ATTACHMENT 2

PART VII - CONTINUATION OF OFFICERS, DIRECTORS, TRUSTEES, KEY EMPLOYEES AND HIGHEST COMPENSATED EMPLOYEES

(1)=IND.TRUSTEE/DIR. (2)=INS.TRUSTEE (3)=OFFICER (4)=KEY EMP. (5)=HIGHEST COMP. (6)=FORMER

	(A) NAME AND TITLE	(B) HOURS	(C) POSITION (1)(2)(3)(4)(5)(6)	COMPENSATION FROM (D) ORG.	(E) REL. ORG.	(F) OTHER
29	SEYED ALI MOHAMMADI PHYSICIAN	40.00	X	296,957.	0.	21,844.
30	MARA DAIDONE PHYSICIAN	40.00	X	396,296.	0.	22,287.
31	FAISAL BHINDER PHYSICIAN	40.00	X	364,554.	0.	23,003.
32	APARAJITA MAHATA PHYSICIAN	40.00	X	264,010.	0.	22,999.
33	SEBLE GABRE-MADHIN PHYSICIAN	40.00	X	248,018.	0.	10,826.

ATTACHMENT 3

FORM 990, PART VII, COLUMN B - ESTIMATED AVERAGE PER WEEK

NAME AND TITLE — HOURS DEVOTED FOR RELATED ORGANIZATION

Name of the organization: CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number: 52-0619000

ATTACHMENT 3 (CONT'D)

CLIFF STEWART	
DIRECTOR	1.00
DEAN SCHLEICHER	
DIRECTOR	1.00
KEVIN BETZ	
DIRECTOR	1.00
GAIL GIBSON	
SECRETARY	1.00
EMAD AL BANNA	
DIRECTOR	1.00
CHARLES JUDGE	
DIRECTOR	1.00
MARY KRUG	
DIRECTOR	1.00
VICTOR CORNELLIER	
DIRECTOR	1.00
KEVIN NIETMANN	
TREASURER	2.00
MARSHA PLATER	
DIRECTOR	1.00
SALLY SHOWALTER	
CHAIRPERSON	3.00
LAURIE UHEREK	
VICE CHAIRPERSON	1.00
JAMES XINIS	
PRESIDENT AND CEO	8.00
PETER DALY	
DIRECTOR	1.00
PAMELA LUCAS	
DIRECTOR	1.00
JOHN WEIGEL	
DIRECTOR	1.00
CIARAN BROWNE	
DIRECTOR	1.00
ANWAR MUNSHI	
DIRECTOR	1.00
HENRY TRENTMAN	
DIRECTOR	1.00
PATRICIA EDDLEMAN	
DIRECTOR	1.00
BARBARA ESTES	
DIRECTOR	1.00
RICHARD FLEMING	
DIRECTOR	1.00
ROBERT KERTIS	
VP FINANCE	8.00
ROBERT MCWHIRT	
VP CNE PATIENT CARE SERVICES	0.00
SUSAN DOHONY	
VP CQO PERFORM IMPROVEMENT	0.00
EDWARD GROGAN	
VP IT	0.00

Name of the organization: CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number: 52-0619000

ATTACHMENT 3 (CONT'D)

ROBERT SCHLAGER VP MEDICAL AFFAIRS	0.00
BARBARA POLAK VP CLINICAL SERVICES	0.00
SEYED ALI MOHAMMADI PHYSICIAN	0.00
MARA DAIDONE PHYSICIAN	0.00
FAISAL BHINDER PHYSICIAN	0.00
APARAJITA MAHATA PHYSICIAN	0.00
SEBLE GABRE-MADHIN PHYSICIAN	0.00

ATTACHMENT 4

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
TWIN CONTRACTING CORP 5700-H GENERAL WASHINGTON DRIVE ALEXANDRIA, VA 22312	BUILDING CONTRACTOR	601,109.
EMERGENCY MEDICINE ASSOCIATES PA PC 20010 CENTURY BLD STE 200 GERMANTOWN, MD 20874	URGENT CARE PHYS STF	494,273.
MARYLAND INPATIENT CARE SPECIALISTS LLC 6934 AVIATION BLVD STE B GLEN BURNIE, MD 21061	HOSPITALIST	474,220.
ERDMAN COMPANY 600 MARSHALL DRIVE WAUNAKEE, WI 53597	BUILDING CONTRACTOR	834,090.
CALVERT INTERNAL MEDICINE GROUP 110 HOSPITAL RD STE 310 PRINCE FREDERICK, MD 20678	OP CARDIAC TEST SERV	450,165.
TOTAL COMPENSATION		2,853,857.

Name of the organization: CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number: 52-0619000

ATTACHMENT 5

FORM 990, PART VIII - INVESTMENT INCOME

DESCRIPTION	(A) TOTAL REVENUE	(B) RELATED OR EXEMPT REVENUE	(C) UNRELATED BUSINESS REV.	(D) EXCLUDED REVENUE
INVESTMENT INCOME	117,589.			117,589.
K-1 CPHA	150,756.			150,756.
TOTALS	268,345.			268,345.

ATTACHMENT 6

FORM 990, PART X - NOTES AND LOANS RECEIVABLE

BORROWER:	CHESAPEAKE NEUROLOGY ASSOCIATES
ORIGINAL AMOUNT:	30,000.
INTEREST RATE:	2.500000
DATE OF NOTE:	04/01/2009
MATURITY DATE:	04/01/2012

BEGINNING BALANCE DUE	24,149.
ENDING BALANCE DUE	14,233.
TOTAL BEGINNING NOTES AND LOANS RECEIVABLE	24,149.
TOTAL ENDING NOTES AND LOANS RECEIVABLES	14,233.

ATTACHMENT 7

FORM 990, PART X - PREPAID EXPENSES AND DEFERRED CHARGES

DESCRIPTION	ENDING BOOK VALUE
PREPAID EXPENSES	1,339,803.
PREPAID RENT	49,120.
TOTALS	1,388,923.

ATTACHMENT 8

Name of the organization: CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number: 52-0619000

ATTACHMENT 8 (CONT'D)

FORM 990, PART X - INVESTMENTS - PUBLICLY TRADED SECURITIES

DESCRIPTION	ENDING BOOK VALUE	COST OR FMV
EQUITY MUTUAL FUNDS	1,878,578.	FMV
FIXED INCOME MUTUAL FUNDS	865,413.	FMV
US GOVERNMENT ISSUES	3,604,825.	FMV
TOTALS	6,348,816.	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Employer identification number
52-0619000

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

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) CALVERT PHYSICIANS ASSOCIATES 26-3828176 100 HOSPITAL RD PRINCE FREDERICK, MD 20678	HEALTHCARE	MD	5,055,227.	2,810,078.	CMH
(2)					
(3)					
(4)					
(5)					
(6)					

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
(1) CALVERT HEALTH SYSTEM INC 52-2347324 100 HOSPITAL RD PRINCE FREDERICK, MD 20678	HEALTHCARE	MD	501(C)(3)	170B1AIII	N/A		
(2) CMH HOLDING CO 52-2176827 100 HOSPITAL RD PRINCE FREDERICK, MD 20678	REAL ESTATE	MD	501(C)(2)		CHS		
(3) CMH II HOLDING CO 52-2178784 100 HOSPITAL RD PRINCE FREDERICK, MD 20678	REAL ESTATE	MD	501(C)(2)		CHS		
(4) CALVERT MEMORIAL HOSPITAL FOUNDATION INC 52-1680647 100 HOSPITAL RD PRINCE FREDERICK, MD 20678	FUND RAISING	MD	501(C)(3)	509(A)(3)	CMH		
(5)							
(6)							
(7)							

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
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** (Complete if the organization answered "Yes" 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
(1) CALVERT HEALTH VENTURES INC 52-1625432 100 HOSPITAL RD PRINCE FREDERICK, MD 20678	HEALTHCARE	MD	CMH	C CORP	540,462.	5,555,211.	100.0000
(2) CALVERT COMMUNITY HEALTH INC 52-1996371 100 HOSPITAL RD PRINCE FREDERICK, MD 20678	HEALTHCARE	MD	CMH	C CORP	0.	0.	100.0000
(3)							
(4)							
(5)							
(6)							
(7)							

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

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**		X
b	Gift, grant, or capital contribution to other organization(s)	**1b**		X
c	Gift, grant, or capital contribution from other organization(s)	**1c**	X	
d	Loans or loan guarantees to or for other organization(s)	**1d**		X
e	Loans or loan guarantees by other organization(s)	**1e**		X
f	Sale of assets to other organization(s)	**1f**		X
g	Purchase of assets from other organization(s)	**1g**		X
h	Exchange of assets	**1h**		X
i	Lease of facilities, equipment, or other assets to other organization(s)	**1i**	X	
j	Lease of facilities, equipment, or other assets from other organization(s)	**1j**	X	
k	Performance of services or membership or fundraising solicitations for other organization(s)	**1k**	X	
l	Performance of services or membership or fundraising solicitations by other organization(s)	**1l**	X	
m	Sharing of facilities, equipment, mailing lists, or other assets	**1m**	X	
n	Sharing of paid employees	**1n**	X	
o	Reimbursement paid to other organization for expenses	**1o**	X	
p	Reimbursement paid by other organization for expenses	**1p**	X	
q	Other transfer of cash or property to other organization(s)	**1q**		X
r	Other transfer of cash or property from other organization(s)	**1r**		X

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

	(a) Name of other organization	(b) Transaction type (a–r)	(c) Amount involved	(d) Method of determining amount involved
(1)	CALVERT MEMORIAL HOSPITAL FOUNDATION INC	C AND L	454,698.	FMV
(2)	CALVERT HEALTH VENTURES INC	K AND J	239,726.	FMV
(3)	CMH HOLDING CO	K AND J	494,050.	FMV
(4)	CMH II HOLIDNG CO	I, J AND K	1,420,447.	FMV
(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) Are all partners section 501(c)(3) organizations?		(e) Share of end-of-year assets	(f) Disproportionate allocations?		(g) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(h) General or managing partner?	
			Yes	No		Yes	No		Yes	No
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
(11)										
(12)										
(13)										
(14)										
(15)										
(16)										

Part VII **Supplemental Information**

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

0E7000 1.000

RENT AND ROYALTY INCOME

Taxpayer's Name	Identifying Number
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY	52-0619000

DESCRIPTION OF PROPERTY
CHILD CARE CENTER

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

REAL RENTAL INCOME	26,400.	
OTHER INCOME		
TOTAL GROSS INCOME		26,400.
OTHER EXPENSES:		
SEE ATTACHMENT		
DEPRECIATION (SHOWN BELOW)		
LESS: Beneficiary's Portion		
AMORTIZATION		
LESS: Beneficiary's Portion		
DEPLETION		
LESS: Beneficiary's Portion		
TOTAL EXPENSES		27,281.
TOTAL RENT OR ROYALTY INCOME (LOSS)		-881.

Less Amount to	
Rent or Royalty	
Depreciation	
Depletion	
Investment Interest Expense	
Other Expenses	
Net Income (Loss) to Others	
Net Rent or Royalty Income (Loss)	-881.
Deductible Rental Loss (if Applicable)	

SCHEDULE FOR DEPRECIATION CLAIMED

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

SUPPLEMENT TO RENT AND ROYALTY SCHEDULE

OTHER DEDUCTIONS

SUPPLIES	584.
UTILITIES	8,100.
LEASES & RENTALS	3,411.
PURCHASED SERVICES	15,186.
	27,281.

0E7000 1.000

RENT AND ROYALTY INCOME

Taxpayer's Name	Identifying Number
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY	52-0619000

DESCRIPTION OF PROPERTY

109 WESTLAKE BLVD CONDO

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

REAL RENTAL INCOME	13,750.	
OTHER INCOME		
TOTAL GROSS INCOME		13,750.
OTHER EXPENSES:		
SEE ATTACHMENT		
DEPRECIATION (SHOWN BELOW)	6,153.	
LESS: Beneficiary's Portion		
AMORTIZATION		
LESS: Beneficiary's Portion		
DEPLETION		
LESS: Beneficiary's Portion		
TOTAL EXPENSES		14,654.
TOTAL RENT OR ROYALTY INCOME (LOSS)		-904.
Less Amount to		
Rent or Royalty		
Depreciation		
Depletion		
Investment Interest Expense		
Other Expenses		
Net Income (Loss) to Others		
Net Rent or Royalty Income (Loss)		-904.
Deductible Rental Loss (if Applicable)		

SCHEDULE FOR DEPRECIATION CLAIMED

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

SUPPLEMENT TO RENT AND ROYALTY SCHEDULE

OTHER DEDUCTIONS

TAXES	2,503.
UTILITIES	3,898.
CONDO FEE	2,100.
	8,501.

0E7000 1.000

RENT AND ROYALTY INCOME

Taxpayer's Name	Identifying Number
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY	52-0619000

DESCRIPTION OF PROPERTY

MISC RENTAL PROPERTY

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

REAL RENTAL INCOME	4,527.	
OTHER INCOME		
TOTAL GROSS INCOME		4,527.
OTHER EXPENSES:		
DEPRECIATION (SHOWN BELOW)		
LESS: Beneficiary's Portion		
AMORTIZATION		
LESS: Beneficiary's Portion		
DEPLETION		
LESS: Beneficiary's Portion		
TOTAL EXPENSES		
TOTAL RENT OR ROYALTY INCOME (LOSS)		4,527.

Less Amount to	
Rent or Royalty	
Depreciation	
Depletion	
Investment Interest Expense	
Other Expenses	
Net Income (Loss) to Others	
Net Rent or Royalty Income (Loss)	4,527.
Deductible Rental Loss (if Applicable)	

SCHEDULE FOR DEPRECIATION CLAIMED

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

0E7000 1.000

RENT AND ROYALTY INCOME

Taxpayer's Name	Identifying Number
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY	52-0619000

DESCRIPTION OF PROPERTY
411 WESTLAKE DRIVE

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

REAL RENTAL INCOME	8,279.	
OTHER INCOME		
TOTAL GROSS INCOME		8,279.
OTHER EXPENSES: SEE ATTACHMENT		
DEPRECIATION (SHOWN BELOW)	3,516.	
LESS: Beneficiary's Portion		
AMORTIZATION		
LESS: Beneficiary's Portion		
DEPLETION		
LESS: Beneficiary's Portion		
TOTAL EXPENSES		6,648.
TOTAL RENT OR ROYALTY INCOME (LOSS)		1,631.
Less Amount to		
Rent or Royalty		
Depreciation		
Depletion		
Investment Interest Expense		
Other Expenses		
Net Income (Loss) to Others		
Net Rent or Royalty Income (Loss)		1,631.
Deductible Rental Loss (if Applicable)		

SCHEDULE FOR DEPRECIATION CLAIMED

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

SUPPLEMENT TO RENT AND ROYALTY SCHEDULE

OTHER DEDUCTIONS

UTILITIES	1,382.
CONDO FEE	1,750.
	3,132.

0E7000 1.000

RENT AND ROYALTY INCOME

Taxpayer's Name	Identifying Number
CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY	52-0619000

DESCRIPTION OF PROPERTY
137 WINSLOW PLACE

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

REAL RENTAL INCOME	12,600.	
OTHER INCOME		
TOTAL GROSS INCOME		12,600.
OTHER EXPENSES:		
SEE ATTACHMENT		
DEPRECIATION (SHOWN BELOW)		
LESS: Beneficiary's Portion		
AMORTIZATION		
LESS: Beneficiary's Portion		
DEPLETION		
LESS: Beneficiary's Portion		
TOTAL EXPENSES		24,016.
TOTAL RENT OR ROYALTY INCOME (LOSS)		-11,416.
Less Amount to		
Rent or Royalty		
Depreciation		
Depletion		
Investment Interest Expense		
Other Expenses		
Net Income (Loss) to Others		
Net Rent or Royalty Income (Loss)		-11,416.
Deductible Rental Loss (if Applicable)		

SCHEDULE FOR DEPRECIATION CLAIMED

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

SUPPLEMENT TO RENT AND ROYALTY SCHEDULE

OTHER DEDUCTIONS

UTILITIES	3,545.
LEASES AND RENTAL	20,471.
	24,016.

RENT AND ROYALTY SUMMARY

PROPERTY	TOTAL INCOME	DEPLETION/ DEPRECIATION	OTHER EXPENSES	ALLOWABLE NET INCOME
CHILD CARE CENTER	26,400.		27,281.	-881.
109 WESTLAKE BLVD CO	13,750.	6,153.	8,501.	-904.
MISC RENTAL PROPERTY	4,527.			4,527.
411 WESTLAKE DRIVE	8,279.	3,516.	3,132.	1,631.
137 WINSLOW PLACE	12,600.		24,016.	-11,416.
TOTALS	65,556.	9,669.	62,930.	-7,043.

Form **4797**

Department of the Treasury
Internal Revenue Service (99)

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

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

OMB No. 1545-0184

2010

Attachment Sequence No. **27**

Name(s) shown on return

CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

Identifying number

52-0619000

1 Enter the gross proceeds from sales or exchanges reported to you for 2010 on Form(s) 1099-B or 1099-S (or substitute statement) that you are including on line 2, 10, or 20 (see instructions) 1

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

2 (a) Description of property	(b) Date acquired (mo., day, yr.)	(c) Date sold (mo., day, yr.)	(d) Gross sales price	(e) Depreciation allowed or allowable since acquisition	(f) Cost or other basis, plus improvements and expense of sale	(g) Gain or (loss) Subtract (f) from the sum of (d) and (e)
ATTACHMENT 1						13,284.

3	Gain, if any, from Form 4684, line 42	3	
4	Section 1231 gain from installment sales from Form 6252, line 26 or 37	4	
5	Section 1231 gain or (loss) from like-kind exchanges from Form 8824	5	
6	Gain, if any, from line 32, from other than casualty or theft	6	
7	Combine lines 2 through 6. Enter the gain or (loss) here and on the appropriate line as follows:	7	13,284.
	Partnerships (except electing large partnerships) and S corporations. Report the gain or (loss) following the instructions for Form 1065, Schedule K, line 10, or Form 1120S, Schedule K, line 9. Skip lines 8, 9, 11, and 12 below.		
	Individuals, partners, S corporation shareholders, and all others. If line 7 is zero or a loss, enter the amount from line 7 on line 11 below and skip lines 8 and 9. If line 7 is a gain and you did not have any prior year section 1231 losses, or they were recaptured in an earlier year, enter the gain from line 7 as a long-term capital gain on the Schedule D filed with your return and skip lines 8, 9, 11, and 12 below.		
8	Nonrecaptured net section 1231 losses from prior years (see instructions)	8	
9	Subtract line 8 from line 7. If zero or less, enter -0-. If line 9 is zero, enter the gain from line 7 on line 12 below. If line 9 is more than zero, enter the amount from line 8 on line 12 below and enter the gain from line 9 as a long-term capital gain on the Schedule D filed with your return (see instructions)	9	

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

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

11	Loss, if any, from line 7	11	( )
12	Gain, if any, from line 7 or amount from line 8, if applicable	12	
13	Gain, if any, from line 31	13	
14	Net gain or (loss) from Form 4684, lines 34 and 41a	14	
15	Ordinary gain from installment sales from Form 6252, line 25 or 36	15	
16	Ordinary gain or (loss) from like-kind exchanges from Form 8824	16	
17	Combine lines 10 through 16	17	
18	For all except individual returns, enter the amount from line 17 on the appropriate line of your return and skip lines a and b below. For individual returns, complete lines a and b below:		
a	If the loss on line 11 includes a loss from Form 4684, line 38, column (b)(ii), enter that part of the loss here. Enter the part of the loss from income-producing property on Schedule A (Form 1040), line 28, and the part of the loss from property used as an employee on Schedule A (Form 1040), line 23. Identify as from "Form 4797, line 18a." See instructions	18a	
b	Redetermine the gain or (loss) on line 17 excluding the loss, if any, on line 18a. Enter here and on Form 1040, line 14	18b	

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

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

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

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

30 Total gains for all properties. Add property columns A through D, line 24	30	
31 Add property columns A through D, lines 25b, 26g, 27c, 28b, and 29b. Enter here and on line 13	31	
32 Subtract line 31 from line 30. Enter the portion from casualty or theft on Form 4684, line 36. Enter the portion from other than casualty or theft on Form 4797, line 6	32	

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

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

CALVERT MEMORIAL HOSPITAL OF CALVERT COUNTY

52-0619000

Supplement to Form 4797 Part I Detail

ATTACHMENT 1

Description	Date Acquired	Date Sold	Gross Sales Price	Depreciation Allowed or Allowable	Cost or Other Basis	Gain or (Loss) for entire year
SALE OF EQUIPMENT			13,284.	32,038.	32,038.	13,284.
Totals						13,284.