



2010 Income Tax Returns

CIVISTA MEDICAL CENTER, INC.



KPMG LLP
Suite 1200
1676 International Drive
McLean, VA 22102

Telephone 703-286-8000
Fax 703-286-8010

Private

Mr. Jim Clague
Civista Medical Center, Inc.
5 Garrett Ave
La Plata, MD 20646

Enclosed are the original and one copy of your income tax return(s) for the period ended June 30, 2011 for Civista Medical Center, Inc. as follows:

- 2010 990 - Return of Organization Exempt from Income Tax
- 2010 Schedule A - Public Charity Status and Public Support
- 2010 Schedule B - Schedule of Contributors
- 2010 Schedule C - Political Campaign and Lobbying Activities
- 2010 Schedule D - Supplemental Financial Statements
- 2010 Schedule F - Statement of Activities Outside the United States
- 2010 Schedule H - Hospitals
- 2010 Schedule I - Grants & Other Assist. to Org/Gov/Ind. in the U.S
- 2010 Schedule J - Compensation Information
- 2010 Schedule K - Supplemental Information on Tax-Exempt Bonds
- 2010 Schedule L - Transactions with Interested Persons
- 2010 Schedule O - Supplemental Information to Form 990 or 990EZ
- 2010 Schedule R - Related Organizations and Unrelated Partnerships
- 2010 990-T - Exempt Organization Business Income Tax Return
- 2010 8453-EO - U.S. Individual Income Tax Declaration for e-filing
- 2010 Maryland Corporation Income Tax Return

Each original should be dated, signed and filed in accordance with the filing instructions included with the copy of the return. This bound copy is for your use and should be retained for your files.

These returns were prepared from information provided by you or your representative. The preparation of tax returns does not include the independent verification of information used. Therefore, we recommend you review the returns before signing to ensure there are no omissions or misstatements. If you note anything which may require a change to the returns, please contact us before filing them.

Also enclosed are the original source documents you furnished, if any, for our use in preparing the return(s). Upon an audit of the return(s), requests may be made for supporting documentation. Therefore, we recommend that you retain all pertinent records.

A tax-exempt organization is required to provide copies of Form 990 if it receives such a request. A reasonable fee for providing such copies may be charged. Note that if an organization makes Form 990 "widely available" an organization is not required to provide copies at any time. An example of "widely available" is posting the Form 990 to an organization's internet address so that the general public can freely access and download it



Mr. Jim Clague

to print a copy. If someone visits an organization to inspect a Form 990 in person, the organization must still allow inspection at the office; however, if the person requests a copy of Form 990, the organization can disclose the internet address from which he/she can print a copy of the Form 990.

We recommend that the return(s) be mailed by either registered or certified mail with the sender's receipt postmarked to prove filing before the due date.

We sincerely appreciate this opportunity to serve you. Please contact us if you have questions concerning the returns or if we may be of further assistance.

KPMG LLP

Enclosure(s)

Cumulative e-File History 2010	
FED	
Locator:	26035M
Taxpayer Name:	Civista Medical Center, Inc.
Return Type:	990
Submitted Date:	03/29/2012 13:54:37
Acknowledgement Date:	03/29/2012 14:26:26
Status:	Accepted
Submission ID:	54028020120895000003

Instructions for filing
Civista Medical Center, Inc.
Form 8453-EO - Exempt Org. Declaration & Signature for E-filing
for the period ended June 30, 2011

Signature...

The original Form 8453-EO should be signed (use full name) and dated by the taxpayer.

Filing...

Return your signed Form 8453-EO declaration to:

KPMG LLP
1676 International Drive
McLean VA 22102

Payment of tax...

No payment of tax is required.

DO NOT separately file form 990 with the Internal Revenue Service. Doing so will delay the processing of your return.

We must receive your signed form before we can electronically transmit your return which is due on May 15, 2012. We would appreciate your returning this form as soon as possible as this will expedite the processing of your return. The Internal Revenue Service will notify us when your return is accepted. Your return is not considered filed until the Internal Revenue Service confirms their acceptance, which may occur after the due date of your return.

Exempt Organization Declaration and Signature for Electronic Filing

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

For use with Forms 990, 990-EZ, 990-PF, 1120-POL, and 8868

▶ See instructions on back.

2010

Department of the Treasury
Internal Revenue Service

Name of exempt organization

Employer identification number

CIVISTA MEDICAL CENTER, INC.

52-0445374

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

Check the box for the type of return being filed with Form 8453-EO and enter the applicable amount, if any, from the return. If you check the box on line 1a, 2a, 3a, 4a, or 5a below and the amount on that line of 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-). If you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

1a Form 990 check here ▶ <input checked="" type="checkbox"/>	b Total revenue, if any (Form 990, Part VIII, column (A), line 12) . . .	1b	<u>105416111.</u>
2a Form 990-EZ check here ▶ <input type="checkbox"/>	b Total revenue, if any (Form 990-EZ, line 9)	2b	
3a Form 1120-POL check here ▶ <input type="checkbox"/>	b Total tax (Form 1120-POL, line 22)	3b	
4a Form 990-PF check here ▶ <input type="checkbox"/>	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b	
5a Form 8868 check here ▶ <input type="checkbox"/>	b Balance due (Form 8868, line 3c)	5b	

Part II Declaration of Officer

6 I authorize the U.S. Treasury and its designated Financial Agent to initiate an Automated Clearing House (ACH) 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.

If a copy of this return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I certify that I executed the electronic disclosure consent contained within this return allowing disclosure by the IRS of this Form 990/990-EZ/990-PF (as specifically identified in Part I above) to the selected state agency(ies).

Under penalties of perjury, I declare that I am an officer of the above named 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.

Sign Here ▶

[Handwritten Signature]
Signature of officer

3/27/12
Date

President + CEO
Title

Part III Declaration of Electronic Return Originator (ERO) and Paid Preparer (see instructions)

I declare that I have reviewed the above organization's return and that the entries on Form 8453-EO are complete and correct to the best of my knowledge. If I am only a collector, I am not responsible for reviewing the return and only declare that this form accurately reflects the data on the return. The organization officer will have signed this form before I submit the return. I will give the officer a copy of all forms and information to be filed with the IRS, and have followed all other requirements in Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns. If I am also the Paid Preparer, under penalties of perjury I declare that I have examined the above organization's return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. This Paid Preparer declaration is based on all information of which I have any knowledge.

ERO's Use Only	ERO's signature ▶ <i>[Handwritten Signature]</i>	Date <u>3/27/12</u>	Check if also paid preparer <input checked="" type="checkbox"/>	Check if self-employed <input type="checkbox"/>	ERO's SSN or PTIN <u>P00451522</u>
	Firm's name (or yours if self-employed), address, and ZIP code ▶ <u>KPMG LLP</u> <u>1676 INTERNATIONAL DRIVE</u> <u>MCLEAN VA 22102</u>	EIN <u>13-5565207</u>		Phone no. <u>703-286-8000</u>	

Under penalties of perjury, I declare that I have examined the above return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer is based on all information of which the preparer has any knowledge.

Paid Preparer's Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ▶				Firm's EIN ▶
	Firm's address ▶				Phone no.

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)

Department of the Treasury
Internal Revenue Service

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

A For the 2010 calendar year, or tax year beginning 07/01, 2010, and ending 06/30, 2011

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization CIVISTA MEDICAL CENTER, INC.			D Employer identification number 52-0445374	
	Doing Business As			E Telephone number (301) 609-4130	
	Number and street (or P.O. box if mail is not delivered to street address)		Room/suite		
	City or town, state or country, and ZIP + 4 5 GARRETT AVE LA PLATA, MD 20646			G Gross receipts \$ 105,445,758.	
F Name and address of principal officer: NOEL CERVINO 5 GARRETT AVE LA PLATA, MD 20646			H(a) Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			H(b) Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			If "No," attach a list. (see instructions)		
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			H(c) Group exemption number ▶		
J Website: ▶ WWW.CIVISTA.ORG					
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			L Year of formation: 1980 M State of legal domicile: MD		

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: CIVISTA MEDICAL CENTER PROVIDES EXCELLENT CARE TO EACH PATIENT IN A SAFE, CARING AND FAMILY-CENTERED ENVIRONMENT.		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	15.
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	14.
	5 Total number of individuals employed in calendar year 2010 (Part V, line 2a)	5	1,016.
	6 Total number of volunteers (estimate if necessary)	6	129.
	7a Total gross unrelated business revenue from Part VIII, column (C), line 12	7a	155,988.
b Net unrelated business taxable income from Form 990-T, line 34	7b	35,260.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	27,613.	1,677,803.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	101,981,695.	103,083,914.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	131,108.	109,879.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	526,449.	544,515.
		102,666,865.	105,416,111.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	93,470.	86,592.
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	45,152,262.	47,133,035.
	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)	55,574,825.	53,602,980.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	100,820,557.	100,822,607.	
19 Revenue less expenses. Subtract line 18 from line 12	1,846,308.	4,593,504.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21 Total liabilities (Part X, line 26)	125,692,844.	128,003,508.
	22 Net assets or fund balances. Subtract line 21 from line 20.	108,395,171.	103,718,743.
		17,297,673.	24,284,765.

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 Scott Sherman	Preparer's signature	Date 3/27/12	Check if self-employed <input type="checkbox"/>	PTIN P00451522
	Firm's name ▶ KPMG LLP	Firm's EIN ▶ 13-5565207		Phone no. 703-286-8000	
	Firm's address ▶ 1676 INTERNATIONAL DRIVE MCLEAN, VA 22102				

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

For Paperwork Reduction Act Notice, see the separate instructions.

Application for Extension of Time To File an Exempt Organization Return

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

- If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** and check this box **X**
- If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** (on page 2 of this form).

Do not complete Part II unless you have already been granted an automatic 3-month extension on a previously filed Form 8868.

Electronic filing (e-file). You can electronically file Form 8868 if you need a 3-month automatic extension of time to file (6 months for a corporation required to file Form 990-T), or an additional (not automatic) 3-month extension of time. You can electronically file Form 8868 to request an extension of time to file any of the forms listed in Part I or Part II with the exception of Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts, which must be sent to the IRS in paper format (see instructions). For more details on the electronic filing of this form, visit www.irs.gov/efile and click on *e-file for Charities & Nonprofits*.

Part I Automatic 3-Month Extension of Time. Only submit original (no copies needed).

A corporation required to file Form 990-T and requesting an automatic 6-month extension - check this box and complete Part I only

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

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization CIVISTA MEDICAL CENTER, INC.	Employer identification number 52-0445374
	Number, street, and room or suite no. If a P.O. box, see instructions. 5 GARRETT AVE PO BOX 1070	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. LA PLATA, MD 20646	

Enter the Return code for the return that this application is for (file a separate application for each return)

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

- The books are in the care of ► **JIM CLAGUE**

Telephone No. ► **301 609-5154** FAX No. ► _____

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

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 02/15, 2012, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

► calendar year 20____ or

► tax year beginning 07/01, 2010, and ending 06/30, 2011.

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

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

Caution. If you are going to make an electronic fund withdrawal with this Form 8868, see Form 8453-EO and Form 8879-EO for payment instructions.

For Paperwork Reduction Act Notice, see Instructions.

- If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** and check this box.
- Note.** Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.
- If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** (on page 1).

Part II Additional (Not Automatic) 3-Month Extension of Time. Only file the original (no copies needed).

Type or print <small>File by the extended due date for filing your return. See instructions.</small>	Name of exempt organization CIVISTA MEDICAL CENTER, INC.	Employer identification number 52-0445374
	Number, street, and room or suite no. If a P.O. box, see instructions. 5 GARRETT AVE	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. LA PLATA, MD 20646	

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

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

STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.

- The books are in the care of **JIM CLAGUE**
Telephone No. **301 609-5154** FAX No.
- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____ . If this is for the whole group, check this box . If it is for part of the group, check this box and attach a list with the names and EINs of all members the extension is for.
- 4 I request an additional 3-month extension of time until 05/15, 20 12 .
- 5 For calendar year _____, or other tax year beginning 07/01, 20 10, and ending 06/30, 20 11 .
- 6 If the tax year entered in line 5 is for less than 12 months, check reason: Initial return Final return
 Change in accounting period
- 7 State in detail why you need the extension INFORMATION NECESSARY TO PREPARE A COMPLETE AND ACCURATE RETURN IS NOT YET AVAILABLE.

8a If this application is for Form 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	8a \$	0.
b If this application is for Form 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	8b \$	
c Balance Due. Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	8c \$	0.

Signature and Verification

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form.

Signature  Title CPA Date 11/16/11

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:
**CIVISTA MEDICAL CENTER IS A NOT-FOR-PROFIT HOSPITAL CREATED TO
PROVIDE EXCELLENCE IN ACUTE HEALTHCARE AND PREVENTIVE SERVICES IN
CHARLES COUNTY AND THE SURROUNDING COMMUNITIES.**

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 \$ 75,910,376. including grants of \$ 86,592.) (Revenue \$ 103,083,914.)

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 ► **75,910,376.**

Part IV Checklist of Required Schedules

Table with 3 columns: Question number, Yes, No. Rows include questions 1 through 20b regarding organizational requirements and reporting.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, and Yes/No checkboxes. Rows include questions 21 through 38 regarding grants, compensation, tax-exempt bonds, excess benefit transactions, and Schedule O completion.

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 1a through 14b regarding Form 1096, Form W-2G, backup withholding, Form W-3, unrelated business gross income, foreign accounts, prohibited tax shelter transactions, annual gross receipts, deductible contributions, and charitable trusts.

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

Table with 3 columns: Question, Yes, No. Rows include: 1a (15), 1b (14), 2 (X), 3 (X), 4 (X), 5 (X), 6 (X), 7a (X), 7b (X), 8a (X), 8b (X), 9 (X).

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

Table with 3 columns: Question, Yes, No. Rows include: 10a (X), 10b, 11a (X), 11b, 12a (X), 12b (X), 12c (X), 13 (X), 14 (X), 15a (X), 15b (X), 16a (X), 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD,
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply. [] Own website [] Another's website [X] 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: JIM CLAGUE 5 GARRETT AVE LA PLATA, MD 20646 301-609-5154

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			
(1) KHADAR BAIG DIRECTOR	3.00	X					0.	0.	0.	
(2) WAYNE BARNES DIRECTOR	3.00	X					0.	0.	0.	
(3) JAMES BURKE DIRECTOR	3.00	X					0.	0.	0.	
(4) MICHAEL CADY DIRECTOR	3.00	X					0.	0.	0.	
(5) C DEVADASON EX-OFFICIO	3.00	X					0.	0.	0.	
(6) LOUIS JENKINS JR VICE CHAIR	3.00	X		X			0.	0.	0.	
(7) CANDICE QUINN KELLY EX-OFFICIO	3.00	X					0.	0.	0.	
(8) SARA MIDDLETON CHAIR	3.00	X		X			0.	0.	0.	
(9) VAN MITCHELL DIRECTOR	3.00	X					0.	0.	0.	
(10) SEETARAMAYYA NAGULA DIRECTOR	3.00	X					0.	0.	0.	
(11) ASHVIN J PATEL MD CHIEF OF STAFF	4.00	X		X			0.	0.	0.	
(12) SURYAKANT PATEL DIRECTOR	3.00	X					0.	0.	0.	
(13) BARBARA STEPURA DIRECTOR	3.00	X					0.	0.	0.	
(14) RICHARD WINKLER SECRETARY/TREASURER	3.00	X		X			0.	0.	0.	
(15) NOEL CERVINO PRESIDENT & CEO	40.00	X		X			445,695.	0.	63,432.	
(16) ERIK BOAS CFO	40.00			X			239,415.	0.	21,308.	

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) MARK DUMAIS CHIEF INFO OFFICER	40.00			X				182,189.	0.	24,816.
(18) MELANIE SAGE VICE PRESIDENT PATIENT CARE	40.00				X			164,191.	0.	18,732.
(19) GARY HERBEK COO	40.00				X			228,060.	0.	22,717.
(20) MARILYN GREGORY CLINICAL NURSE IV	40.00					X		164,064.	0.	6,356.
(21) LISA WILTROUT PHYSICIAN	40.00					X		141,491.	0.	4,891.
(22) JOAN HUMULOCK CLINICAL NURSE IV	40.00					X		140,603.	0.	3,692.
(23) STACEY COOK VICE PRESIDENT, HR	40.00					X		147,506.	0.	20,655.
(24) KATHERINE MIDDLETON RN, OR	40.00					X		131,247.	0.	5,933.
(25) CHRISTINE STEFANIDES FORMER PRESIDENT & CEO							X	111,214.	0.	19,222.
(26) KEVIN BURBULES FORMER CHIEF INFO OFFICER							X	146,735.	0.	18,404.
(27)										
(28)										
1b Sub-total								2,242,410.	0.	230,158.
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)								2,242,410.	0.	230,158.

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 **31**

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

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization.

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 2		

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 **24**

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	1,587,803.					
	e Government grants (contributions) . .	1e	90,000.					
	f All other contributions, gifts, grants, and similar amounts not included above .	1f	0.					
	g Noncash contributions included in lines 1a-1f: \$ _____							
	h Total. Add lines 1a-1f			1,677,803.				
Program Service Revenue			Business Code					
	2a NET PATIENT REVENUE		900099	103,083,914.	103,083,914.			
	b _____							
	c _____							
	d _____							
	e _____							
	f All other program service revenue							
	g Total. Add lines 2a-2f			103,083,914.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			139,526.			139,526.	
	4 Income from investment of tax-exempt bond proceeds . . .			0.				
	5 Royalties			0.				
			(i) Real	(ii) Personal				
	6a Gross Rents							
	b Less: rental expenses							
	c Rental income or (loss)							
	d Net rental income or (loss)				0.			
			(i) Securities	(ii) Other				
	7a Gross amount from sales of assets other than inventory							
	b Less: cost or other basis and sales expenses			29,647.				
	c Gain or (loss)			-29,647.				
	d Net gain or (loss)				-29,647.		-29,647.	
	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 ANSWERING SERVICE		561000		155,988.		155,988.		
b CAFETERIA AND COFFEE BAR SALES		900099		331,070.			331,070.	
c APPLICATION FEES		900099		5,000.	5,000.			
d All other revenue		900099		52,457.	52,457.			
e Total. Add lines 11a-11d				544,515.				
12 Total revenue. See instructions				105,416,111.	103,141,371.	155,988.	440,949.	

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	86,592.	86,592.		
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22	0.			
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	627,700.	502,160.	125,540.	0.
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.			
7 Other salaries and wages	38,553,382.	30,842,706.	7,710,676.	0.
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	1,135,979.	908,783.	227,196.	0.
9 Other employee benefits	3,961,570.	3,169,256.	792,314.	0.
10 Payroll taxes	2,854,404.	2,283,523.	570,881.	0.
11 Fees for services (non-employees):				
a Management	200,000.	0.	200,000.	0.
b Legal	404,096.	0.	404,096.	0.
c Accounting	300,651.	0.	300,651.	0.
d Lobbying	67,500.	0.	67,500.	0.
e Professional fundraising services. See Part IV, line 17	0.			
f Investment management fees	0.			
g Other	10,160,566.	8,128,453.	2,032,113.	0.
12 Advertising and promotion	174,327.	130,745.	43,582.	0.
13 Office expenses	0.			
14 Information technology	0.			
15 Royalties	0.			
16 Occupancy	2,109,300.	1,096,836.	1,012,464.	0.
17 Travel	36,613.	9,153.	27,460.	0.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	0.			
20 Interest	3,175,167.	0.	3,175,167.	0.
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	4,454,144.	4,142,354.	311,790.	0.
23 Insurance	2,123,376.	0.	2,123,376.	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 <u>SUPPLIES AND DRUGS</u>	17,088,729.	15,892,518.	1,196,211.	0.
b <u>BAD DEBT</u>	7,208,495.	7,208,495.	0.	0.
c <u>OTHER</u>	1,841,943.	242,249.	1,599,694.	0.
d <u>EQUIPMENT RENTAL AND MAINT</u>	3,835,478.	1,265,708.	2,569,770.	0.
e <u>TELEPHONE</u>	422,595.	845.	421,750.	0.
f All other expenses	0.			0.
25 Total functional expenses. Add lines 1 through 24f	100,822,607.	75,910,376.	24,912,231.	0.
26 Joint Costs. Check here <input type="checkbox"/> 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		1
	2	Savings and temporary cash investments	29,116,660.	2 33,434,372.
	3	Pledges and grants receivable, net		3
	4	Accounts receivable, net	10,886,077.	4 9,697,092.
	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		7
	8	Inventories for sale or use	1,588,468.	8 1,533,556.
	9	Prepaid expenses and deferred charges	854,589.	9 895,718.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 103,000,316.	
	b	Less: accumulated depreciation	10b 39,881,340.	10c 63,118,976.
	11	Investments - publicly traded securities	75,000.	11 0.
	12	Investments - other securities. See Part IV, line 11		12
	13	Investments - program-related. See Part IV, line 11		13
	14	Intangible assets		14
	15	Other assets. See Part IV, line 11	17,751,002.	15 19,323,794.
16	Total assets. Add lines 1 through 15 (must equal line 34)	125,692,844.	16 128,003,508.	
Liabilities	17	Accounts payable and accrued expenses	16,336,955.	17 14,668,027.
	18	Grants payable		18
	19	Deferred revenue		19
	20	Tax-exempt bond liabilities	58,529,039.	20 57,930,947.
	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	20,920,214.	23 20,008,435.
	24	Unsecured notes and loans payable to unrelated third parties		24
	25	Other liabilities. Complete Part X of Schedule D	12,608,963.	25 11,111,334.
	26	Total liabilities. Add lines 17 through 25	108,395,171.	26 103,718,743.
Net Assets or Fund Balances	Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27	Unrestricted net assets	13,665,143.	27 23,796,141.
	28	Temporarily restricted net assets	3,632,530.	28 488,624.
	29	Permanently restricted net assets		29
	Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30
	31	Paid-in or capital surplus, or land, building, or equipment fund		31
	32	Retained earnings, endowment, accumulated income, or other funds		32
	33	Total net assets or fund balances	17,297,673.	33 24,284,765.
	34	Total liabilities and net assets/fund balances	125,692,844.	34 128,003,508.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	105,416,111.
2	Total expenses (must equal Part IX, column (A), line 25)	2	100,822,607.
3	Revenue less expenses. Subtract line 2 from line 1	3	4,593,504.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	17,297,673.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	2,393,588.
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	24,284,765.

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: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?		X
2b	Were the organization's financial statements audited by an independent accountant?	X	
2c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	X	
2d	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: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> 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?		X
3b	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.		

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 CIVISTA MEDICAL CENTER, INC.	Employer identification number 52-0445374
---	---

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 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?

- (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?
- (ii) A family member of a person described in (i) above?
- (iii) A 35% controlled entity of a person described in (i) or (ii) above?

	Yes	No
11g(i)		
11g(ii)		
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									

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

Schedule A (Form 990 or 990-EZ) 2010

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

Table with 7 columns: (a) 2006, (b) 2007, (c) 2008, (d) 2009, (e) 2010, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2006, (b) 2007, (c) 2008, (d) 2009, (e) 2010, (f) Total. Rows include: 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; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2010; 15 Public support percentage from 2009 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2010; b 33 1/3% support test - 2009; 17a 10%-facts-and-circumstances test - 2010; b 10%-facts-and-circumstances test - 2009; 18 Private foundation.

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

Table with 7 columns: Calendar year (or fiscal year beginning in), (a) 2006, (b) 2007, (c) 2008, (d) 2009, (e) 2010, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Gross receipts from admissions, merchandise sold or services performed; 3 Gross receipts from activities that are not an unrelated trade or business; 4 Tax revenues levied for the organization's benefit; 5 The value of services or facilities furnished by a governmental unit; 6 Total; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 7c Add lines 7a and 7b; 8 Public support (Subtract line 7c from line 6).

Section B. Total Support

Table with 7 columns: Calendar year (or fiscal year beginning in), (a) 2006, (b) 2007, (c) 2008, (d) 2009, (e) 2010, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 10b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975; 10c Add lines 10a and 10b; 11 Net income from unrelated business activities not included in line 10b; 12 Other income. Do not include gain or loss from the sale of capital assets; 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

Table with 3 columns: Description, 2010, 2009. Row 15: Public support percentage for 2010 (line 8, column (f) divided by line 13, column (f)). Row 16: Public support percentage from 2009 Schedule A, Part III, line 15.

Section D. Computation of Investment Income Percentage

Table with 3 columns: Description, 2010, 2009. Row 17: Investment income percentage for 2010 (line 10c, column (f) divided by line 13, column (f)). Row 18: Investment income percentage from 2009 Schedule A, Part III, line 17.

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

19b 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 of Contributors

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

2010

Name of the organization CIVISTA MEDICAL CENTER, INC.	Employer identification number 52-0445374
--	--

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33¹/₃% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), and received from any one contributor, during the year, a contribution of the greater of (1) \$5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h or (ii) Form 990-EZ, line 1. Complete Parts I and II.

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

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

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

Name of organization **CIVISTA MEDICAL CENTER, INC.**

Employer identification number
52-0445374

Part I Contributors (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
1	MARYLAND DEPARTMENT OF GENERAL SERVICES/ 80 CALVERT STREET ANNAPOLIS, MD 21404	\$ 90,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
-----	-----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
-----	-----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
-----	-----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
-----	-----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
-----	-----	\$ -----	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities
For Organizations Exempt From Income Tax Under section 501(c) and section 527

OMB No. 1545-0047

2010

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization is described below.**
▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part VI, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35a (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization CIVISTA MEDICAL CENTER, INC.	Employer identification number 52-0445374
---	---

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities on behalf of or in opposition to candidates for public office in Part IV.
- 2 Political expenditures ▶ \$ _____
- 3 Volunteer hours _____

Part I-B Complete if the organization is exempt under section 501(c)(3).

- 1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ \$ _____
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$ _____
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? Yes No
- 4a Was a correction made? Yes No
- b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ \$ _____
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ \$ _____
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ \$ _____
- 4 Did the filing organization file **Form 1120-POL** for this year? Yes No
- 5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
(1)	-----			
(2)	-----			
(3)	-----			
(4)	-----			
(5)	-----			
(6)	-----			

Part II-A Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).

- A** Check if the filing organization belongs to an affiliated group.
- B** Check if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1 a	Total lobbying expenditures to influence public opinion (grass roots lobbying)														
b	Total lobbying expenditures to influence a legislative body (direct lobbying)														
c	Total lobbying expenditures (add lines 1a and 1b)														
d	Other exempt purpose expenditures														
e	Total exempt purpose expenditures (add lines 1c and 1d)														
f	Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">If the amount on line 1e, column (a) or (b) is:</th> <th>The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
g	Grassroots nontaxable amount (enter 25% of line 1f)														
h	Subtract line 1g from line 1a. If zero or less, enter -0-														
i	Subtract line 1f from line 1c. If zero or less, enter -0-														
j	If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes <input type="checkbox"/> No												

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) Total
2 a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

Table with 3 main columns: (a) Yes/No, (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation...; 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

Table with 3 columns: Question, Yes, No. Rows include: 1 Were substantially all (90% or more) dues received nondeductible by members?; 2 Did the organization make only in-house lobbying expenditures of \$2,000 or less?; 3 Did the organization agree to carryover lobbying and political expenditures from the prior year?

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) if BOTH Part III-A, lines 1 and 2 are answered "No" OR if Part III-A, line 3 is answered "Yes."

Table with 2 main columns: Question, Amount. Rows include: 1 Dues, assessments and similar amounts from members; 2 Section 162(e) nondeductible lobbying and political expenditures; 3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues; 4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?; 5 Taxable amount of lobbying and political expenditures (see instructions)

Part IV Supplemental Information

Complete this part to provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; and Part II-B, line 1i. Also, complete this part for any additional information.

SEE PAGE 4

Horizontal dashed lines for supplemental information input.

Part IV Supplemental Information (continued)

LOBBYING ACTIVITIES

THE ORGANIZATION DOES NOT ENGAGE IN ANY DIRECT LOBBYING ACTIVITIES. THE ORGANIZATION PAYS BAXTER BAKER A MONTHLY FEE TO REPRESENT CIVISTA AS WELL AS OTHER MARYLAND HOSPITALS TO ASSIST IN LOBBYING AND ADVERTISING FOR THE HOSPITALS. THE ORGANIZATION PAYS MEMBERSHIP DUES TO THE MARYLAND HOSPITAL ASSOCIATION (MHA) AND THE AMERICAN HOSPITAL ASSOCIATION (AHA). MHA AND AHA ENGAGE IN MANY SUPPORT ACTIVITIES INCLUDING LOBBYING AND ADVOCATING FOR THEIR MEMBER HOSPITALS. THE MHA AND AHA REPORTED THAT 8.65% AND 24.42% OF MEMBER DUES WERE USED FOR LOBBYING PURPOSES AND AS SUCH, THE ORGANIZATION HAS REPORTED THIS AMOUNT ON SCHEDULE C, PART II-B AS LOBBYING ACTIVITIES.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2010

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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.

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

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.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 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?, 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?

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

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 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., 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?, 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)?, 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.

Table with 2 columns: Revenues, Assets. Rows include: 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., 1b 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

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

Schedule D (Form 990) 2010

JSA 0E1268 1.000

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?

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?

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

Table with 2 columns: Description, Amount. Rows: 1c Beginning balance, 1d Additions during the year, 1e Distributions during the year, 1f Ending balance.

2a Did the organization include an amount on Form 990, Part X, line 21?

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.

Table with 6 columns: (a) Current year, (b) Prior year, (c) Two years back, (d) Three years back, (e) Four years back. Rows: 1a-1g (Beginning of year balance, Contributions, Net investment earnings, gains, and losses, Grants or scholarships, Other expenditures for facilities and programs, Administrative expenses, 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:

- (i) unrelated organizations
(ii) related organizations

Table with 2 columns: Yes, No. Rows: 3a(i), 3a(ii), 3b

b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?

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.

Table with 5 columns: Description of investment, (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows: 1a Land, 1b Buildings, 1c Leasehold improvements, 1d Equipment, 1e Other, Total.

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) SECURITY DEPOSITS	3,684.
(2) OTHER CURRENT RECEIVABLES	36,936.
(3) INV CHES POTOMAC HEALTHCARE	2,867,151.
(4) ASSETS LIMITED TO USE	6,493,301.
(5) PHYSICIANS LOAN	222,589.
(6) INVEST IN JV FREESTATE	15,441.
(7) DEFERRED FINANCING COSTS	2,150,670.
(8) INVESTMENT MARYLAND ECARE	10,000.
(9) DUE FROM AFFILIATES	3,571,346.
(10) ECON INT IN NET ASSETS OF FDTN	3,952,676.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	19,323,794.

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

1. (a) Description of liability	(b) Amount	
(1) Federal income taxes		
(2) ADVANCES FROM THIRD PARTIES	3,409,780.	
(3) ACCRUED INTEREST PAYABLE	1,336,007.	
(4) ACCRUED PENSION COSTS	4,197,886.	
(5) DUE TO AFFILIATE	247,418.	
(6) LEASE LIABILITIES	420,131.	
(7) MALPRACTICE IBNR	1,500,112.	
(8) _____		
(9) _____		
(10) _____		
(11) _____		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	11,111,334.	

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.

FIN 48 FOOTNOTE

THE ORGANIZATION ACCOUNTS FOR UNCERTAINTY IN INCOME TAXES IN ACCORDANCE

WITH FIN 48 (AS CODIFIED). THE ORGANIZATION'S AUDITED FINANCIAL

STATEMENTS DO NOT INCLUDE ANY LIABILITIES FOR UNCERTAIN TAX POSITIONS.

Part XIV Supplemental Information *(continued)*

**SCHEDULE F
(Form 990)**

Statement of Activities Outside the United States

OMB No. 1545-0047

2010

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.**
▶ **Attach to Form 990. ▶ See separate instructions.**

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 14b.

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

3 Activities per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e.g., fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
(1) CENTRAL AMERICA/CARIBBEAN			PROGRAM SERVICES	INSURANCE	1,651,125.
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Sub-total					1,651,125.
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)					1,651,125.

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

Schedule F (Form 990) 2010

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 15, for any recipient who received more than \$5,000. Check this box if no one recipient received more than \$5,000
 Part II can be duplicated if additional space is needed.

1	(a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
(11)									
(12)									
(13)									
(14)									
(15)									
(16)									

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter

3 Enter total number of other organizations or entities

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 16.
 Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							

Part IV Foreign Forms

- 1 Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926).* Yes No

- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A).* Yes No

- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons with respect to Certain Foreign Corporations. (see Instructions for Form 5471).* Yes No

- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund. (see Instructions for Form 8621)* Yes No

- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons with respect to Certain Foreign Partnerships. (see Instructions for Form 8865).* Yes No

- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to file Form 5713, International Boycott Report (see Instructions for Form 5713)* Yes No

Part V Supplemental Information

Complete this part to provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information (see instructions).

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2010

Open to Public Inspection

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<input checked="" type="checkbox"/>	
b If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care to low income individuals? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
b Did the organization use FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
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"?	<input checked="" type="checkbox"/>	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		
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?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6a Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization make it available to the public?	<input checked="" type="checkbox"/>	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

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)			1,410,086.		1,410,086.	1.41
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			1,410,086.		1,410,086.	1.41
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	36	168619	533,851.	650.	533,201.	.53
f Health professions education (from Worksheet 5)	7	280	330,757.		330,757.	.33
g Subsidized health services (from Worksheet 6)	7	145	1,643,721.	181,814.	1,461,907.	1.46
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)	15	1772	123,141.		123,141.	.12
j Total Other Benefits	65	170816	2,631,470.	182,464.	2,449,006.	2.44
k Total. Add lines 7d and 7j	65	170816	4,041,556.	182,464.	3,859,092.	3.85

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

Schedule H (Form 990) 2010

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	142	7,790.	275.	7,515.	.01
3 Community support	7	13	36,522.		36,522.	.04
4 Environmental improvements						
5 Leadership development and training for community members	1		10,617.		10,617.	.01
6 Coalition building	3	20	3,990.		3,990.	
7 Community health improvement advocacy	2		447.		447.	
8 Workforce development	5		253,270.		253,270.	.25
9 Other						
10 Total	21	175	312,636.	275.	312,361.	.31

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

- Does the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?
- Enter the amount of the organization's bad debt expense (at cost)
- Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy
- 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.

	Yes	No
1	X	
2		
3		
5		
6		
7		
9a	X	
9b	X	

Section B. Medicare

- Enter total revenue received from Medicare (including DSH and IME)
- Enter Medicare allowable costs of care relating to payments on line 5
- Subtract line 6 from line 5. This is the surplus (or shortfall)
- 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

- Does the organization have a written debt collection policy during the tax year?
- 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

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 (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: CIVISTA MEDICAL CENTER

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 If "Yes," indicate what the Needs Assessment describes (check all that apply):	1	
a	<input type="checkbox"/> A definition of the community served by the hospital facility		
b	<input type="checkbox"/> Demographics of the community		
c	<input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input type="checkbox"/> How data was obtained		
e	<input type="checkbox"/> The health needs of the community		
f	<input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs		
j	<input type="checkbox"/> 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? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):	5	
a	<input type="checkbox"/> Hospital facility's website		
b	<input type="checkbox"/> Available upon request from the hospital facility		
c	<input type="checkbox"/> 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	<input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b	<input type="checkbox"/> Execution of the implementation strategy		
c	<input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d	<input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e	<input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f	<input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g	<input type="checkbox"/> Prioritization of health needs in its community		
h	<input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i	<input type="checkbox"/> 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			
8	Did the hospital facility have in place during the tax year a written financial assistance policy that: 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? If "Yes," indicate the FPG family income limit for eligibility for free care: __ __ __ %	9	

Part V Facility Information (continued) CIVISTA MEDICAL CENTER

		Yes	No
10	Used FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate the FPG family income limit for eligibility for discounted care: _ _ _ %	10	
11	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply):	11	
a	<input type="checkbox"/> Income level		
b	<input type="checkbox"/> Asset level		
c	<input type="checkbox"/> Medical indigency		
d	<input type="checkbox"/> Insurance status		
e	<input type="checkbox"/> Uninsured discount		
f	<input type="checkbox"/> Medicaid/Medicare		
g	<input type="checkbox"/> State regulation		
h	<input type="checkbox"/> 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? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	13	
a	<input type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input type="checkbox"/> The policy was attached to billing invoices		
c	<input type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input type="checkbox"/> The policy was available on request		
g	<input type="checkbox"/> 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	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> 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? If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):	16	
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> 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	<input type="checkbox"/> Notified patients of the financial assistance policy on admission		
b	<input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c	<input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d	<input type="checkbox"/> Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance		
e	<input type="checkbox"/> Other (describe in Part VI)		

Part V Facility Information (continued) CIVISTA MEDICAL CENTER

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? If "No," indicate the reasons why (check all that apply):		
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility did not have a policy relating to emergency medical care		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input type="checkbox"/> 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	<input type="checkbox"/> The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility		
b	<input type="checkbox"/> The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility		
c	<input type="checkbox"/> The hospital facility used the Medicare rate for those services		
d	<input type="checkbox"/> 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? 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? 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? _____

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 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.

SCHEDULE H SUPPLEMENTAL INFORMATION**PART I, LINE 6A:**

AN ANNUAL COMMUNITY BENEFIT REPORT IS PREPARED FOR EACH FISCAL YEAR
 ENDING JUNE 30. THIS REPORT IS SUBMITTED TO THE HEALTH SERVICES COST
 REVIEW COMMISSION (HSCRC), A STATE REGULATORY AGENCY, BY DECEMBER 31
 OF EACH YEAR.

IN ADDITION, A SUMMARY OF THE COMMUNITY BENEFITS PROVIDED BY THE
 MEDICAL CENTER IS LOCATED ON OUR WEBSITE:

[HTTP://WWW.CIVISTA.ORG/FUSEACTION-ABOUTUS.SHOWCOMMUNITYBENEFITS.HTM](http://www.civista.org/fuseaction-aboutus.showcommunitybenefits.htm)

PART I, LINE 7:

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

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.

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. ADDITIONALLY, NET REVENUES FOR MEDICAID

SHOULD REFLECT THE FULL IMPACT ON THE HOSPITAL OF ITS SHARE OF THE

MEDICAID ASSESSMENT.

PART III, LINE 4:

CIVISTA REPORTS BAD DEBT EXPENSE IN ACCORDANCE WITH GENERALLY ACCEPTED

ACCOUNTING PRINCIPLES (GAAP) HFMA 15. THE PROVISION FOR BAD DEBTS IS

BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET

COLLECTIONS CONSIDERING HISTORICAL BUSINESS AND ECONOMIC CONDITIONS,

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.

TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS.

PERIODICALLY THROUGHOUT THE YEAR, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED UPON HISTORICAL WRITE-OFF EXPERIENCE BY PAYOR CATEGORY, AS WELL AS, THE ACCUMULATION OF RECEIVABLE BALANCES BY PERIOD OUTSTANDING. THE RESULTS OF THIS REVIEW ARE THEN USED TO MAKE ANY NECESSARY MODIFICATIONS TO THE PROVISION FOR BAD DEBTS AND THE ESTABLISHED ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES. AFTER COLLECTION OF AMOUNTS DUE FROM INSURERS, THE CORPORATION FOLLOWS INTERNAL GUIDELINES FOR PLACING CERTAIN PAST DUE BALANCES WITH COLLECTION AGENCIES.

PART III, LINE 8:

IN MARYLAND, THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) STARTED SETTING HOSPITAL RATES IN 1974. AT THAT TIME, THE HSCRC APPROVED RATES APPLIED ONLY TO COMMERCIAL INSURERS. IN 1977, THE HSCRC NEGOTIATED A WAIVER FROM MEDICARE HOSPITAL PAYMENT RULES FOR MARYLAND HOSPITALS TO BRING THE FEDERAL MEDICARE PAYMENTS UNDER HSCRC

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.

CONTROL.

MEDICARE REIMBURSES MARYLAND HOSPITALS ACCORDING TO RATES ESTABLISHED

BY THE HSCRC AS LONG AS THE STATE CONTINUES TO MEET A TWO-PART TEST.

THIS TWO-PART WAIVER TEST ALLOWS MEDICARE TO PARTICIPATE IN THE

MARYLAND SYSTEM AS LONG AS TWO CONDITIONS ARE MET:

- ALL OTHER PAYERS PARTICIPATING IN THE SYSTEM PAY HSCRC

SET RATES AND

- THE RATE OF GROWTH IN MEDICARE PAYMENTS TO MARYLAND

HOSPITALS FROM 1981 TO THE PRESENT IS NOT GREATER THAN THE RATE OF

GROWTH IN MEDICARE PAYMENTS TO HOSPITALS NATIONALLY OVER THE

SAME TIME FRAME.

NEEDS ASSESSMENT:

CIVISTA HEALTH INC AND THE CHARLES COUNTY DEPARTMENT OF HEALTH

COLLABORATED TO COMPLETE A COMPREHENSIVE ASSESSMENT OF THE HEALTH NEEDS

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.

(CHNA) OF CHARLES COUNTY, MARYLAND. AN EPIDEMIOLOGIST WITH A MASTER'S

DEGREE IN PUBLIC HEALTH EPIDEMIOLOGY WAS CONTRACTED TO ANALYZE THE

QUALITATIVE AND QUANTITATIVE DATA. CIVISTA LEAD THE EFFORT AND COVERED

80% OF THE COST OF THE CHNA.

TO PROVIDE A COMPREHENSIVE ASSESSMENT OF THE HEALTH NEEDS OF THE COUNTY,

A FOUR METHOD PLAN WAS DEVELOPED WHICH INCLUDED 4 DIFFERENT SOURCES OF

DATA: A LONG ONLINE SURVEY OF CHARLES COUNTY RESIDENTS PERCEPTIONS OF

HEALTH AND HEALTH BEHAVIORS, A SHORT PAPER SURVEY ON HEALTH PERCEPTIONS

THROUGHOUT THE COUNTY, 7 FOCUS GROUPS WITH COMMUNITY LEADERS, CITIZENS,

AND STAKEHOLDERS, AND A QUANTITATIVE DATA ANALYSIS.

THE USE OF THE MULTIPLE DATA COLLECTION METHODS STRENGTHENED THE VALIDITY

OF THE ASSESSMENT'S FINDINGS, AS WELL AS ENSURING THAT CHARLES COUNTY

RESIDENTS HAD AN OPPORTUNITY TO PARTICIPATE IN THE ASSESSMENT PROCESS AND

TO FEEL INVESTED IN ITS OUTCOME. 302 CHARLES COUNTY RESIDENTS COMPLETED

THE 74 QUESTION ONLINE SURVEY THAT WAS CREATED USING SURVEY MONKEY. THE

LINK TO THE SURVEY WAS AVAILABLE ON THE CIVISTA HEALTH INC WEBSITE. 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.

FIRST SECTION OF THE SURVEY ASKED PARTICIPANTS ABOUT THEIR PERCEPTION OF HEALTH AND HEALTH SERVICES WITHIN THE COUNTY. THE SECOND SECTION ASKED THEM ABOUT THEIR HEALTH BEHAVIORS, IN ORDER TO DETERMINE THEIR RISK FOR THE DEVELOPMENT OF CERTAIN HEALTH CONDITIONS.

SEVEN FOCUS GROUPS WERE HELD THROUGHOUT THE COUNTY. THE FOCUS GROUP TOPICS INCLUDED: AGE RELATED HEALTH ISSUES, CHRONIC DISEASE SPECIFIC HEALTH, SPECIAL POPULATIONS, COUNTY LEADERSHIP, SUBSTANCE ABUSE, YOUTH THROUGH THE SCHOOL NURSES, AND THE PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY (PHCC) (COMMUNITY LEADERS AND STAKEHOLDERS). APPROXIMATELY 165 PEOPLE PARTICIPATED IN THE COUNTY FOCUS GROUPS.

QUANTITATIVE DATA WAS ANALYZED FOR SEVERAL HEALTH TOPICS INCLUDING: MORTALITY, POPULATION AND DEMOGRAPHIC DATA, NATIONALITY, INFANT MORTALITY, HEART DISEASE, STROKE, HYPERTENSION, ACCESS TO HEALTH CARE/HEALTH INSURANCE, CANCER, ASTHMA, INJURIES, DIABETES, OBESITY, OSTEOPOROSIS, ARTHRITIS, DEMENTIA/ALZHEIMER'S DISEASE, COMMUNICABLE DISEASE, SEXUALLY TRANSMITTED DISEASES, HIV/AIDS, MENTAL HEALTH, DENTAL

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.

HEALTH, SUBSTANCE ABUSE, DISABILITIES, AND TOBACCO USE.

CUMULATIVE ANALYSIS OF ALL QUANTITATIVE AND QUALITATIVE DATA IDENTIFIED

THE TOP 10 HEALTH NEEDS OF CHARLES COUNTY WHICH WAS PRESENTED TO THE PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY, A COALITION OF CHARLES COUNTY AGENCIES AND ORGANIZATIONS. THE DIRECTION OF PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY IS GUIDED BY THE STEERING COMMITTEE WHICH CONSISTS OF LEADERSHIP FROM CIVISTA, CHARLES COUNTY DEPARTMENT OF HEALTH, CHARLES COUNTY PUBLIC SCHOOLS AND THE COLLEGE OF SOUTHERN MARYLAND.

FOCUS GROUPS INCLUDED REPRESENTATIVES FROM THE FOLLOWING ORGANIZATIONS:

PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY

CIVISTA HEALTH

CIVISTA HEALTH, BOARD OF DIRECTORS

CHARLES COUNTY DEPARTMENT OF HEALTH

UNIVERSITY OF MARYLAND CLINICAL TRIALS PROGRAM

BEL ALTON ALUMNI ASSOCIATION

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.

CHARLES COUNTY DEPARTMENT OF COMMUNITY SERVICES, TRANSPORTATION

TRI COUNTY COUNCIL FOR SOUTHERN MARYLAND

MINISTER'S ALLIANCE OF CHARLES COUNTY

CC DEPARTMENT OF SOCIAL SERVICES

MARYLAND FOUNDATION FOR QUALITY HEALTHCARE

HEALTH PARTNER'S CLINIC

SHILOH COMMUNITY UNITED METHODIST CHURCH

CC NURSING AND REHABILITATION CENTER

ALZHEIMER'S ASSOCIATION

CENTER FOR CHILDREN

CHESAPEAKE POTOMAC HOME HEALTH AGENCY

COLLEGE OF SOUTHERN MARYLAND

CHARLES COUNTY DEPARTMENT OF AGING

PRIORITY PARTNERS

BIG BROTHERS/BIG SISTERS

COMMUNITY HISPANIC ADVOCATES

BLACK LEADERSHIP COUNCIL FOR EXCELLENCE

YOUNG RESEARCHERS COMMUNITY PROJECT

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.

PINNACLE CENTER (MENTAL HEALTH)

HOSPICE

BREAST CANCER SUPPORT ADVOCATES

CHARLES COUNTY PUBLIC SCHOOLS SCHOOL NURSES

CHARLES COUNTY COMMISSIONERS

CHARLES COUNTY EMERGENCY SERVICES

CHARLES COUNTY SHERIFF'S OFFICE

SO MD DELEGATES

CHARLES COUNTY COMMUNITY FOUNDATION

COMMUNITY PHYSICIANS

CHARLES COUNTY FIRE AND RESCUE BOARD

SURVEYS FROM COMMUNITY STAKEHOLDERS

302 CHARLES COUNTY RESIDENTS COMPLETED THE 74 QUESTION ONLINE SURVEY

THAT WAS CREATED USING SURVEY MONKEY. THE LINK TO THE SURVEY WAS

AVAILABLE ON THE CIVISTA HEALTH WEBSITE.

A SHORT 3 QUESTION SURVEY WAS DISTRIBUTED THROUGHOUT THE COUNTY REGARDING

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.

PERCEPTIONS OF HEALTH WITHIN THE COUNTY. A TOTAL OF 200 SHORT SURVEYS

WERE COMPLETED. SURVEYS WERE LOCATED THROUGHOUT THE COUNTY INCLUDING

CIVISTA WAITING ROOMS, CHARLES COUNTY DEPARTMENT OF HEALTH WAITING ROOMS,

LIBRARIES, SENIOR CENTERS, COMMUNITY CENTERS. 35 WERE COMPLETED IN

SPANISH (17.5%).

PART III, LINE 9B:

REGARDLESS OF THE STATUS OF COLLECTIONS, IF A PATIENT APPLIES FOR

FINANCIAL ASSISTANCE AND MEETS THE ELIGIBILITY REQUIREMENTS, THE BALANCE

IS WRITTEN OFF ACCORDING TO THE PERCENTAGE THEY QUALIFY FOR.

PATIENT EDUCATION ON ELIGIBILITY FOR ASSISTANCE:

CIVISTA MEDICAL CENTER POSTS ITS CHARITY CARE POLICY, OR A SUMMARY

THEREOF, AND FINANCIAL ASSISTANCE CONTACT INFORMATION IN ADMISSIONS

AREAS, EMERGENCY ROOMS, OTHER AREAS OF THE FACILITY IN WHICH ELIGIBLE

PATIENTS ARE LIKELY TO PRESENT. PATIENTS ARE PROVIDED COUNSELING, IF

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.

APPLICABLE, ON AVAILABLE FINANCIAL ASSISTANCE OPTIONS UPON ADMISSION

AND/OR DISCHARGE INCLUDING ELIGIBILITY FOR GOVERNMENT OR STATE BENEFITS.

ASSISTANCE IS PROVIDED WHERE APPLICABLE, ON COMPLETION OF PAPERWORK FOR

SUCH PROGRAMS. IN ADDITION, THE POLICY IS AVAILABLE ON THE CIVISTA

WEBSITE (WWW.CIVISTA.ORG) AND IS POSTED IN THE LOCAL PAPER TWICE EACH

YEAR.

COMMUNITY INFORMATION:

CHARLES COUNTY GEOGRAPHIC AND DEMOGRAPHIC PROFILE:

CHARLES COUNTY IS A LARGELY RURAL JURISDICTION LOCATED APPROXIMATELY 18

MILES SOUTH OF WASHINGTON, D.C. IT IS ONE OF FIVE MARYLAND COUNTIES,

WHICH ARE PART OF THE WASHINGTON, DC MD VA METROPOLITAN AREA. AT 461

SQUARE MILES, CHARLES COUNTY IS THE EIGHTH LARGEST OF MARYLAND'S TWENTY

FOUR COUNTIES AND ACCOUNTS FOR ABOUT 5 PERCENT OF MARYLAND'S TOTAL

LANDMASS. THE NORTHERN PART OF THE COUNTY IS THE "DEVELOPMENT DISTRICT"

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.

WHERE COMMERCIAL, RESIDENTIAL, AND BUSINESS GROWTH IS FOCUSED. THE MAJOR COMMUNITIES OF CHARLES COUNTY ARE LA PLATA, THE COUNTY SEAT; PORT TOBACCO, INDIAN HEAD, AND ST CHARLES; AND THE MAIN COMMERCIAL CLUSTER OF HUGHESVILLE WALDORF WHITE PLAINS. APPROXIMATELY 60 PERCENT OF COUNTY'S RESIDENTS LIVE IN THE GREATER WALDORF LA PLATA AREA. CHARLES COUNTY HAS EXPERIENCED RAPID GROWTH SINCE 1970, EXPANDING ITS POPULATION FROM 47,678 TO 120,546 IN THE 2000 CENSUS.

CURRENT US CENSUS 2010 ESTIMATES ARE THAT THE POPULATION NOW EXCEEDS 146,551. THIS MAGNITUDE OF GROWTH CAN BE SEEN IN THE CHANGES IN POPULATION DENSITY. THE 1990 CENSUS SHOWED THAT THERE WERE 219.4 INDIVIDUALS PER SQUARE MILE, AND BY 2000, THERE WERE 261.5 INDIVIDUALS PER SQUARE MILE AN INCREASE OF 19.2 PERCENT. THIS PERCENT CHANGE IN POPULATION GROWTH CONTINUED FROM 2000 TO 2010 WHEN CHARLES COUNTY EXPERIENCED A 21.6% INCREASE IN POPULATION. THE PERCENT CHANGE IN THE POPULATION GROWTH FOR CHARLES COUNTY HAS BEEN MARKEDLY GREATER THAN THE CHANGE SEEN IN THE MARYLAND STATE POPULATION GROWTH (9.0%).

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.

AS THE POPULATION OF THE COUNTY CHANGES, THE DIVERSITY OF THE COUNTY ALSO INCREASES. THE AFRICAN AMERICAN POPULATION HAS EXPERIENCED THE GREATER INCREASES IN POPULATION. IN 2000, AFRICAN AMERICANS MADE UP 26% OF THE TOTAL CHARLES COUNTY POPULATION; BY 2009, THEY NOW COMPRISE 41% OF THE TOTAL COUNTY POPULATION. FOR 2009, MINORITIES MAKE UP 49.7% OF THE CHARLES COUNTY POPULATION. THE HISPANIC COMMUNITY HAS ALSO SEEN INCREASES OVER THE PAST FEW YEARS. THEY NOW COMPRISE 4.3% OF THE TOTAL COUNTY POPULATION. THIS IS ONE OF THE HIGHEST PERCENTAGES AMONG THE 24 MARYLAND JURISDICTIONS.

THE AGE BREAKDOWN OF THE CHARLES COUNTY POPULATION SHOWS A YOUNG POPULATION BETWEEN THE AGES OF 18 44 YEARS. THE JUVENILE POPULATION (UNDER 17 YEARS) MAKES UP 27% OF THE CHARLES COUNTY POPULATION.

THE 2009 CHARLES COUNTY GENDER BREAKDOWN IS APPROXIMATELY 50/50. MALES MAKE UP 48.7% OF THE POPULATION, AND FEMALES MAKE UP 51.3% OF THE COUNTY POPULATION.

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.

EMPLOYMENT AND ECONOMIC INDICATORS FOR THE COUNTY ARE FAIRLY STRONG. THE

2005-2009 US CENSUS ESTIMATES FOR CHARLES COUNTY FOUND THAT 73.8% OF THE

POPULATION IS CURRENTLY IN THE LABOR WORK FORCE. THE CHARLES COUNTY

MEDIAN HOUSEHOLD INCOME WAS \$85,899, WELL ABOVE THE MARYLAND MEDIAN

HOUSEHOLD INCOME OF \$69,193. THE PERCENTAGE OF ALL CHARLES COUNTY PEOPLE

WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL IS 4.9%.

THE ESTIMATE OF PEOPLE WITH NO HEALTH INSURANCE COVERAGE IN CHARLES

COUNTY IS 9.4%. THE PERCENTAGE OF CHARLES COUNTY RESIDENTS WHO HAVE

PUBLIC HEALTH INSURANCE IS 17.4%.

THE LIFE EXPECTANCY FROM BIRTH FOR A CHARLES COUNTY RESIDENT AS

CALCULATED FOR 2008 2009 WAS 78.1 YEARS. THIS IS SIMILAR TO THE STATE

AVERAGE LIFE EXPECTANCY OF 78.6 YEARS. THERE WERE A TOTAL OF 871 DEATHS

IN CHARLES COUNTY IN 2009. THE 2007 2009 CHARLES COUNTY ALL CAUSE

MORTALITY RATE WAS 845.2 PER 100,000 POPULATION. THIS RATE IS HIGHER THAN

THE MARYLAND STATE ALL CAUSE MORTALITY RATE OF 768.4 PER 100,000

POPULATION.

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 NUMBER ONE CAUSE OF DEATH FOR THE TIME PERIOD 2009 AND FOR THE TIME PERIOD 2007-2009 WAS HEART DISEASE. THE 2007-2009 CHARLES COUNTY HEART DISEASE DEATH RATE WAS 228.5 PER 100,000. THIS IS ALSO HIGHER THAN THE MARYLAND STATE RATE OF 196.8 PER 100,000.

CHARLES COUNTY HAD HIGHER 2007-2009 MORTALITY RATES THAN MARYLAND FOR HEART DISEASE, CANCER, CHRONIC LOWER RESPIRATORY DISEASE, ACCIDENTS, AND DIABETES MELLITUS.

TWO THIRDS OF THE DEATHS IN CHARLES COUNTY IN 2009 WERE AMONG THE WHITE POPULATION. THEY MAKE UP APPROXIMATELY HALF OF THE TOTAL COUNTY POPULATION.

WHEN COMPARING BY 2009 CALCULATED CRUDE DEATH RATES, THE RATE IS MUCH HIGHER IN THE WHITE POPULATION. THE 2009 CHARLES COUNTY WHITE DEATH RATE WAS 739.9 PER 100,000. THIS IS MUCH HIGHER THAN THE CHARLES COUNTY TOTAL 2009 CRUDE DEATH RATE OF 612.4 PER 100,000 AND HIGHER THAN THE DEATH RATES FOR BLACKS (468.8), FOR ASIANS AND PACIFIC ISLANDERS (308.2), AND

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.

FOR HISPANICS (142.8).

THERE IS A HIGH LEVEL OF HOME OWNERSHIP IN CHARLES COUNTY (81.9%). THE
 MEDIAN VALUE OF A HOUSING UNIT IN CHARLES COUNTY IS HIGHER THAN THE
 MARYLAND AVERAGE (\$352,000 VS. \$326,400). THE AVERAGE NUMBER OF PEOPLE IN
 A CHARLES COUNTY HOUSEHOLD IS 2.84 PERSONS.

CHARLES COUNTY RESIDENTS ARE A COMMUTER POPULATION. THEY SPEND AN AVERAGE
 OF 40.5 MINUTES OF TRAVEL TIME TO WORK EACH DAY.

CHARLES COUNTY HAS A LARGER PERCENTAGE OF HIGH SCHOOL GRADUATES THAN
 MARYLAND (90.2% VS. 87.5%); HOWEVER, CHARLES COUNTY HAS A SMALLER
 PERCENTAGE OF INDIVIDUALS WITH A BACHELOR'S DEGREE OR HIGHER THAN
 MARYLAND DOES (25.4% VS. 35.2%).

COMMUNITY BUILDING ACTIVITIES:

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.

CIVISTA MEDICAL CENTER SPONSORS COMMUNITY BUILDING INITIATIVES FOR

EXAMPLE:

1. PHYSICIAN RECRUITMENT EFFORTS THROUGH FUNDED PHYSICIAN

RECRUITMENT POSITION AT CIVISTA MEDICAL CENTER; STAFF PARTICIPATION IN

GROUPS SUCH THE MARYLAND HEALTHCARE ROUNDTABLE, MARYLAND HEALTHCARE

COMMISSION; MANAGEMENT AGREEMENT WITH UNIVERSITY OF MARYLAND MEDICAL

SYSTEM.

RECRUITMENT OF PHYSICIANS TO CHARLES COUNTY CONCENTRATING IN THE HIGH

PRIORITY AREAS OF THE 83 SPECIALTIES LACKING; PHYSICIAN RECRUITER

RETAINED BY CIVISTA; EVALUATION BY NUMBER OF PHYSICIANS SUCCESSFULLY

RECRUITED AND PLACED.

A. IN NOVEMBER 2009, CIVISTA HEALTH SIGNED MANAGEMENT AGREEMENT

WITH UNIVERSITY OF MARYLAND MEDICAL SYSTEM WITH PHYSICIAN RECRUITMENT AS

MAJOR INITIATIVE.

B. ACCORDING TO THE MARYLAND HEALTH COMMISSION, 83 PHYSICIAN

SPECIALTIES ARE IN SHORTAGE IN THE SOUTHERN MARYLAND AREA. OF PARTICULAR

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.

LACK IN CHARLES COUNTY IS OBSTETRICS AND GYNECOLOGY. IN 2009, ONLY 6

OB/GYN PHYSICIANS WERE PROVIDING CARE AT CIVISTA- 4 OF WHOM ARE EMPLOYED

BY CIVISTA MEDICAL CENTER AND ALSO PROVIDER CARE FOR PRENATAL CLINIC FOR

THE UNINSURED AND UNDERINSURED. THE RISING INFANT MORTALITY RATE IN

CHARLES COUNTY RAISED THE RECRUITMENT OF OB/GYN PRACTITIONERS TO PRIORITY

ONE. RECRUITMENT EFFORTS ARE ONGOING FOR OTHER PHYSICIAN SPECIALTIES ARE

ONGOING FOR ORTHOPEDICS, ONCOLOGY, GENERAL SURGERY AND GASTROENTEROLOGY.

2. CIVISTA MEDICAL CENTER PARTICIPATES AS A LEAD ORGANIZATION IN

PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY (PHCC), A 70 PLUS MEMBER

ORGANIZATION OF HEALTH PROVIDING NOT FOR PROFITS, BUSINESSES, AND

ORGANIZATIONS. THE OTHER LEAD ORGANIZATIONS ARE CHARLES COUNTY DEPARTMENT

OF HEALTH, CHARLES COUNTY PUBLIC SCHOOLS AND COLLEGE OF SOUTHERN

MARYLAND. THROUGH PHCC, THE COMMUNITY HEATH NEEDS ASSESSMENT IS

COMPLETED.

3. EMERGENCY/DISASTER PREPAREDNESS

CIVISTA MEDICAL CENTER PARTICIPATES IN JOINT DISASTER PREPAREDNESS

DRILLS AND PLANNING SESSIONS WITH FEDERAL, COUNTY, STATE

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.

AND REGIONAL ENTITIES FOR ISSUES SUCH AS H1N1, NEIMS AND INAUGURAL

DISASTER PLANNING AND PREPAREDNESS. ADDITIONALLY, CIVISTA PARTICIPATES IN

INDIAN HEAD NAVAL BASE DISASTER SUPPORT. DISASTER PREPAREDNESS MEDICAL

EQUIPMENT IS PURCHASED FOR EMERGENCY PURPOSES.

PROMOTION OF COMMUNITY HEALTH:

THE MAJORITY OF THE GOVERNING BODY, THE BOARD OF DIRECTORS, OF CIVISTA

MEDICAL CENTER IS COMPRISED OF PERSONS WHO RESIDE IN THE COMMUNITY SERVED

BY THE HOSPITAL AND WHO ARE NEITHER EMPLOYEES NOR CONTRACTORS OF THE

ORGANIZATION.

CIVISTA MEDICAL CENTER EXTENDS MEDICAL PRIVILEGES TO ALL QUALIFIED

MEDICAL STAFF IN THE COMMUNITY. CONTINUING MEDICAL EDUCATION SEMINARS AND

GRAND ROUNDS ARE OPEN TO ALL COMMUNITY PHYSICIANS.

STATE FILING OF COMMUNITY BENEFIT REPORT

MD,

**SCHEDULE I
(Form 990)**

Department of the Treasury
Internal Revenue Service

**Grants and Other Assistance to Organizations,
Governments, and Individuals in the United States**

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.

OMB No. 1545-0047

2010

**Open to Public
Inspection**

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

Part I General Information on Grants and Assistance

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

Part II Grants and Other Assistance to Governments and Organizations in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Check this box if no one recipient received more than \$5,000. Part II can be duplicated if additional space is needed

1	(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1)	HEALTH PARTNERS INC PO BOX 1865 WALDORF, MD 20604	52-1767044	501(C)(3)	49,992.				DONATION
(2)	CHARLES COUNTY DEPARTMENT OF HEALTH 250 WILLIAMS STREET LA PLATA, MD 20646	52-2046030	501(C)(3)	15,000.				PROSTATE CANCER PROG
(3)	HABITAT FOR HUMANITY INTERNATIONAL INC. LA PLATA, MD 20646	52-1715451	501(C)(3)		21,600.	FMV	EQUIPMENT	EQUIPMENT
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								

- 2 Enter total number of section 501(c)(3) and government organizations 3
- 3 Enter total number of other organizations ▶

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

Schedule I (Form 990) (2010)

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1					
2					
3					
4					
5					
6					
7					

Part IV Supplemental Information. Complete this part to provide the information required in Part I, line 2, and any other additional information.

PART I, LINE 2

CIVISTA MEDICAL CENTER MAKES FINANCIAL AND IN-KIND CONTRIBUTIONS TO
VARIOUS CHARITABLE ORGANIZATIONS IN THE COMMUNITY.

**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

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

Part I Questions Regarding Compensation

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

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

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?

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.

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

4 During the year, did any person listed 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** **X**

	Yes	No
1a		
1b		
2		
3		
4a		X
4b		X
4c		X
5a		X
5b		X
6a		X
6b		X
7		X
8		X
9		X

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

Schedule J (Form 990) 2010

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 NOEL CERVINO	(i)	303,519.	132,000.	10,176.	50,848.	12,584.	509,127.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
2 ERIK BOAS	(i)	182,112.	54,900.	2,403.	19,582.	1,726.	260,723.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
3 MARILYN GREGORY	(i)	164,064.	0.	0.	2,600.	3,756.	170,420.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
4 STACEY COOK	(i)	140,006.	7,500.	0.	10,832.	9,824.	168,162.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
5 MARK DUMAIS	(i)	177,885.	0.	4,304.	19,303.	5,513.	207,005.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
6 MELANIE SAGE	(i)	156,691.	7,500.	0.	16,500.	2,232.	182,923.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
7 GARY HERBEK	(i)	220,560.	7,500.	0.	16,500.	6,217.	250,777.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
8 CHRISTINE STEFANIDES	(i)	111,214.	0.	0.	19,015.	207.	130,436.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
9 KEVIN BURBULES	(i)	139,235.	7,500.	0.	14,972.	3,432.	165,139.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

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

**SCHEDULE K
(Form 990)**

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

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

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

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 MARYLAND HEALTH AND HIGHER EDUCATIONAL FACILITIES	52-0936061	574217UL7	02/09/2005	60,097,615.	HOSPITAL ADDITIONS/RENOVATIONS		X		X		X
B											
C											
D											

Part II Proceeds

	A		B		C		D	
1 Amount of bonds retired								
2 Amount of bonds legally defeased								
3 Total proceeds of issue	60,097,615.							
4 Gross proceeds in reserve funds	4,511,625.							
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows								
7 Issuance costs from proceeds	3,796,282.							
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds	51,789,708.							
11 Other spent proceeds								
12 Other unspent proceeds								
13 Year of substantial completion	2007							
	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						

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

Schedule K (Form 990) 2010

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								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
5 Were any gross proceeds invested beyond an available temporary period?		X						
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).

SEE SCHEDULE O

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

CIVISTA MEDICAL CENTER, INC.

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**

Employer identification number

52-0445374

DESCRIPTION OF 990 REVIEW PROCESS

PART VI, LINE 11

THE PROCESS FOR REVIEWING THE FORM 990 BEGINS WITH CIVISTA'S STAFF ACCOUNTANT WORKING WITH THE CONTROLLER IN REVIEWING THE FIRST DRAFT FORM 990. THE STAFF ACCOUNTANT AND CONTROLLER WILL COORDINATE WITH THE INDEPENDENT ACCOUNTING FIRM, KPMG, TO UPDATE ANY NECESSARY CHANGES. WHILE THE CONTROLLER SCHEDULES THE SERVICES OF KPMG TO PRESENT THE FINAL DRAFT FORM 990 TO THE FINANCE COMMITTEE OF THE BOARD OF DIRECTORS, THE CHIEF FINANCIAL OFFICER WILL REVIEW THE DOCUMENT BEFORE THE FINAL DRAFT IS GENERATED. ONCE ALL NECESSARY CORRECTIONS ARE MADE, COPIES OF THE FINAL DRAFT FORM 990 WILL BE PROVIDED TO THE FINANCE COMMITTEE PRIOR TO THE MEETING FOR THEIR REVIEW (WHICH WILL BE REQUIRED TO BE KEPT CONFIDENTIAL UNTIL THE FORM 990 IS FINALIZED AND SIGNED). THE FINAL DRAFT FORM 990 WILL BE PRESENTED BY KPMG AT THE FINANCE COMMITTEE MEETING FOR QUESTIONS AND FINAL APPROVAL. ONCE THE FINANCE COMMITTEE APPROVES THE FORM 990 TO BE SIGNED, THE PRESIDENT AND CHIEF EXECUTIVE OFFICER WILL SIGN AS CIVISTA'S AUTHORIZED SIGNER. THE FINAL FORM 990 WILL BE PROVIDED TO THE FULL BOARD OF DIRECTORS FOR INFORMATIONAL PURPOSES BEFORE FILING.

PROCESS FOR DETERMINING COMPENSATION

PART VI, LINE 15

THE ORGANIZATION UTILIZES AN INDEPENDENT COMPENSATION COMMITTEE, AN INDEPENDENT COMPENSATION CONSULTANT, A WRITTEN EMPLOYMENT CONTRACT, A COMPENSATION SURVEY OR STUDY, AND APPROVAL BY THE BOARD/COMPENSATION

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

COMMITTEE. THE CHIEF EXECUTIVE OFFICER/PRESIDENT AND THE EXECUTIVE COMMITTEE OF THE BOARD REVIEWS AND APPROVES THE COMPENSATION FOR THE ORGANIZATION'S TOP MANAGEMENT OFFICIALS AND OTHER OFFICERS AND KEY EMPLOYEES. THE SALARY OF MANAGEMENT EMPLOYEES ARE BASED A MARKET STUDY OF COMPARABLE POSITIONS, EDUCATION, AND EXPERIENCE AS RELATED TO THE MANAGER'S POSITION. IN ORDER TO DETERMINE THE MANAGER'S SALARY, THE COMPENSATION AND BENEFITS SPECIALIST COMPLETES A RELATIVE MARKET STUDY TO OBTAIN INFORMATION ABOUT COMPARABLE JOBS IN THE HEALTHCARE INDUSTRY. HUMAN RESOURCES EVALUATES THE MARKET STUDY AND THEN MAKES A RECOMMENDATION. HUMAN RESOURCES ALSO USES DATA PREPARED BY INDEPENDENT COMPENSATION CONSULTANTS. AFTER DECIDING ON THE COMPENSATION OF THE MANAGEMENT EMPLOYEE, THE DECISION IS DOCUMENTED IN THE EXECUTIVE COMMITTEE MINUTES. THE YEAR THAT THIS PROCESS WAS LAST UNDERTAKEN FOR THESE TYPES OF POSITIONS WAS IN THE CURRENT YEAR. THE CHIEF EXECUTIVE OFFICER/PRESIDENT IS THE ONLY EMPLOYEE WHO HAS A WRITTEN CONTRACT. EFFECTIVE OCTOBER 1, 2009, THE CHIEF EXECUTIVE OFFICER, CHIEF FINANCIAL OFFICER, CHIEF MEDICAL OFFICER AND CHIEF INFORMATION OFFICER ARE EMPLOYEES OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) AND THEIR COMPENSATION PACKAGES ARE DETERMINED PER AN UMMS EXECUTIVE COMPENSATION COMMITTEE.

CONFLICTS MONITORING AND ENFORCEMENT

PART VI, LINE 12C

THE CONFLICTS MONITORING AND ENFORCEMENT POLICY IS ESTABLISHED TO PROHIBIT ACTIVITIES THAT MAY CONFLICT OR APPEAR TO CONFLICT WITH CIVISTA'S BUSINESS. EMPLOYEES IN KEY POSITIONS AT CIVISTA HAVE AN

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

OBLIGATION TO CIVISTA TO AVOID CONFLICT OF INTEREST SITUATIONS. KEY EMPLOYEES ARE EXEMPT ADMINISTRATIVE AND NON-EXEMPT EMPLOYEES WHO HAVE THE AUTHORITY TO MAKE COMMITMENTS FOR CIVISTA RESOURCES. ALL KEY EMPLOYEES MUST SIGN A DISCLOSURE OF BUSINESS INTEREST/CONFLICT OF INTEREST STATEMENT. IT IS THE POLICY OF CIVISTA THAT KEY EMPLOYEES DISCLOSE ANY DETAIL OF ANY ACTIVITIES OR INTERESTS WHICH MAY CONFLICT OR APPEAR TO CONFLICT WITH CIVISTA'S BUSINESS. CONFLICT OF INTEREST BEHAVIORS ARE VARIED; HOWEVER, IT WOULD BE PROHIBITED FOR AN EMPLOYEE TO BE DIRECTLY CONNECTED IN ANY MANNER WITH ANY BUSINESS OR ENTITY WHICH SELLS OR PROVIDES MATERIALS, SUPPLIES, EQUIPMENT, FACILITIES OR SERVICES TO OR WHICH IS IN DIRECT OR INDIRECT COMPETITION WITH OR WHICH IS A CUSTOMER OF CIVISTA. ALL EMPLOYEES SHALL REFRAIN FROM ANY CONDUCT DURING THE PERFORMANCE OF THEIR DUTIES THAT HAS THE APPEARANCE OF IMPROPRIETY OR THAT COULD REASONABLY BE CONSTRUED AS CONTRARY TO THE INTERESTS AND MISSION OF THIS ORGANIZATION. AN EMPLOYEE MAY NOT ACCEPT CASH IN ANY AMOUNT OR OTHER PERSONAL GIFTS HAVING ANY VALUE OR ANY OTHER PERSONAL FAVORS FOR PERFORMANCE WHICH GOES BEYOND COMMON COURTESY IN THE PERFORMANCE OF HIS/HER JOB DUTIES FROM ANYONE WITH WHOM CIVISTA HAS OR IS LIKELY TO HAVE ANY BUSINESS DEALINGS. THESE INDIVIDUALS MAY INCLUDE AN EMPLOYEE, PERSPECTIVE EMPLOYEES, CUSTOMERS, COMPETITORS OR VENDORS. AN EMPLOYEE MAY NOT DISCLOSE DIRECTLY OR INDIRECTLY ANY INFORMATION OF ANY KIND ACQUIRED IN THE COURSE OF EMPLOYMENT OR ASSOCIATION WITH CIVISTA OR USE ANY SUCH INFORMATION TO FURTHER ANY PERSONAL INTERESTS OR TO THE DETRIMENT OF CIVISTA. ANY EMPLOYEE WHO HAS KNOWLEDGE OF ACTIVITIES THAT HE OR SHE BELIEVES MAY VIOLATE ANY OF THESE PROCEDURES HAS AN OBLIGATION

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

TO REPORT THEM IMMEDIATELY TO THEIR SUPERVISOR/DEPARTMENT MANAGER OR THE VICE PRESIDENT, HUMAN RESOURCES. ANY INDIVIDUAL WHO KNOWINGLY VIOLATES THIS POLICY IS SUBJECT TO DISCIPLINARY ACTION UP TO AND INCLUDING DISCHARGE IN ADDITION TO POTENTIAL CRIMINAL PROSECUTION. WHILE ALL EMPLOYEES ARE REQUIRED TO SIGN A CONFLICT OF INTEREST DISCLOSURE, IT IS THE POLICY OF CIVISTA THAT KEY EMPLOYEES DISCLOSE ANY DETAIL OF ANY ACTIVITIES OR INTERESTS WHICH MAY CONFLICT OR APPEAR TO CONFLICT WITH CIVISTA'S BUSINESS. THE RESPONSES ARE INITIALLY REVIEWED BY HUMAN RESOURCES. IF ANYTHING IS DISCLOSED, THE DISCLOSURE IS SENT TO THE COMPLIANCE OFFICER WHO CONSULTS WITH OUTSIDE ATTORNEYS. AFTER REVIEW OF THE DISCLOSURES, IF A CONFLICT IS IDENTIFIED, THE EMPLOYEE WOULD BE NOTIFIED OF THE CONFLICT AND ASKED TO REFRAIN FROM ANY FURTHER ACTIVITY. DEPENDING ON THE CONFLICT, THE APPROPRIATE ACTION WOULD BE FOR THE PERSON INVOLVED TO RECUSE THEMSELVES. IF AN INDIVIDUAL KNOWINGLY VIOLATES THIS POLICY, THEY WILL BE SUBJECT TO DISCIPLINARY ACTION UP TO AND INCLUDING DISCHARGE IN ADDITION TO POTENTIAL CRIMINAL PROSECUTION. AS PART OF THE ANNUAL COMPETENCIES, EVERY EMPLOYEE COMPLETES A ONLINE MODULE IN HEALTHSTREAM, CIVISTA'S ONLINE SUPPORT PAGE, WHICH DETAILS THEIR RESPONSIBILITY FOR DISCLOSURE UNDER THE POLICY.

DOCUMENTATION AVAILABILITY

PART VI, LINE 19

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

MANAGEMENT SERVICES AGREEMENT

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

PART VI, LINE 3

EFFECTIVE OCTOBER 1, 2009, CIVISTA HEALTH AND ITS RELATED ORGANIZATIONS SIGNED A MANAGEMENT SERVICES AGREEMENT WITH UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION ("UMMS", A SECTION 501(C)(3) ORGANIZATION) WHEREBY UMMS PROVIDES MANAGEMENT SUPERVISION FOR THE OPERATION AND STRATEGIC DEVELOPMENT OF CIVISTA WITH THE GOAL OF IMPROVING SERVICE, QUALITY OF CARE AND OTHER AREAS OF OPERATION. THE CHIEF EXECUTIVE OFFICER, THE CHIEF FINANCIAL OFFICER, THE CHIEF MEDICAL OFFICER, AND THE CHIEF INFORMATION OFFICER ARE EMPLOYEES OF UMMS, BUT CIVISTA MEDICAL CENTER REIMBURSES UMMS FOR THEIR COMPENSATION PACKAGES. IN ADDITION TO REIMBURSING UMMS FOR THE SERVICES OF THE SENIOR EXECUTIVE PERSONNEL, CIVISTA MEDICAL CENTER PAYS UMMS A FEE FOR OTHER SERVICES UNDER THE AGREEMENT.

EFFECTIVE JULY 1, 2011, THE COMPANY ENTERED INTO AN AFFILIATED AGREEMENT WITH UMMS, WHEREBY UMMS BECAME THE SOLE CORPORATE MEMBER OF THE COMPANY. THE RESIDENTS OF THE REGION SERVED BY THE COMPANY WILL BENEFIT FROM ACCELERATED DEPLOYMENT OF CLINICAL PROGRAMS AND TECHNOLOGIES AND IMPROVED ACCESS TO PHYSICIANS.

SCHEDULE K

PART I

AMOUNTS	CUSIP NUMBERS -----
\$ 540,000	574217UL7
555,000	574217UM5

Name of the organization CIVISTA MEDICAL CENTER, INC.	Employer identification number 52-0445374
---	---

575,000	574217UN3
590,000	574217UP8
610,000	574217UQ6
630,000	574217UR4
650,000	574217US2
675,000	574217UT0
700,000	574217UU7
730,000	574217UV5
760,000	574217UW3
790,000	574217UX1
820,000	574217UY9
7,900,000	574217UZ6
10,425,000	574217VA0
32,050,000	574217VB8
\$59,000,000	BONDS AT REDEMPTION PRICE

PART II

OF THE PROCEEDS REPORTED AS ISSUANCE COSTS, \$1,180,000 OF THE PROCEEDS WERE USED FOR BOND ISSUANCE COSTS (INCLUDING UNDERWRITERS' DISCOUNT) AND \$2,616,282 OF THE PROCEEDS WERE USED FOR CREDIT ENHANCEMENT.

OTHER CHANGES IN NET ASSETS

FORM 990, PART XI, LINE 5

CHANGE IN MINIMUM PENSION LIABILITY	3,682,607
NET ASSETS RELEASED FROM RESTRICTION	(1,289,019)

Name of the organization CIVISTA MEDICAL CENTER, INC.	Employer identification number 52-0445374
--	--

TOTAL TO PART XI, LINE 5 2,393,588

BEGINNING NET ASSETS WERE ADJUSTED TO INCLUDE THE MEDICAL CENTER'S
ECONOMIC INTEREST IN THE NET ASSETS OF CIVISTA HEALTH FOUNDATION.

ATTACHMENT 1

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

CIVISTA MEDICAL CENTER COMMUNITY BENEFITS PROGRAM UTILIZES A
PLANNED, MANAGED, ORGANIZED, AND MEASURED APPROACH TO MEETING THE
IDENTIFIED COMMUNITY NEEDS OF THE AREA WE SERVE. THE MISSION IS TO
IMPROVE OVERALL COMMUNITY HEALTH BY IMPROVING ACCESS TO HEALTH
CARE, ENHANCING THE HEALTH OF THE COMMUNITY, ADVANCING HEALTHCARE
KNOWLEDGE AND WORKING WITH HEALTH - PROVIDING AGENCY PARTNERS.
CIVISTA MEDICAL CENTER IN PARTNERSHIP WITH THE CHARLES COUNTY
DEPARTMENT OF HEALTH (CCDOTT), HAS CONDUCTED A HEALTH NEEDS
ASSESSMENT OF CHARLES COUNTY EVERY 5 YEARS. BEGINNING CALENDAR
YEAR 2011, IN ACCORDANCE WITH NEW REGULATIONS, THE HEALTH NEEDS
ASSESSMENT WILL BE CONDUCTED EVERY 3 YEARS. THE DATA INCLUDED IN
THIS REPORT WAS COLLECTED IN CALENDAR YEAR 2011. CIVISTA MEDICAL
CENTER AND THE CHARLES COUNTY DEPARTMENT OF HEALTH COLLABORATED TO
COMPLETE A COMPREHENSIVE HEALTH NEEDS ASSESSMENT (CHNA) OF CHARLES
COUNTY, MARYLAND. AN EPIDEMIOLOGIST WITH A MASTER'S DEGREE IN
PUBLIC HEALTH EPIDEMIOLOGY WAS CONTRACTED TO ANALYZE THE
QUALITATIVE AND QUANTITATIVE DATA. CIVISTA LEAD THE EFFORT AND

Name of the organization CIVISTA MEDICAL CENTER, INC.	Employer identification number 52-0445374
---	---

ATTACHMENT 1 (CONT'D)

COVERED 80% OF THE COST OF THE CHNA. TO PROVIDE A COMPREHENSIVE ASSESSMENT OF THE HEALTH NEEDS OF THE COUNTY, A FOUR PART METHOD PLAN WAS DEVELOPED WHICH INCLUDED 4 DIFFERENT SOURCES OF DATA: A LONG ONLINE SURVEY OF CHARLES COUNTY RESIDENTS PERCEPTIONS OF HEALTH AND HEALTH BEHAVIORS, A SHORT PAPER SURVEY ON HEALTH PERCEPTIONS THROUGHOUT THE COUNTY, 7 FOCUS GROUPS WITH COMMUNITY LEADERS, CITIZENS, AND STAKEHOLDERS, AND A QUANTITATIVE DATA ANALYSIS. THE USE OF THE MULTIPLE DATA COLLECTION METHODS STRENGTHENED THE VALIDITY OF THE ASSESSMENT'S FINDINGS, AS WELL AS ENSURING THAT CHARLES COUNTY RESIDENTS HAD AN OPPORTUNITY TO PARTICIPATE IN THE ASSESSMENT PROCESS AND TO FEEL INVESTED IN ITS OUTCOME. 302 CHARLES COUNTY RESIDENTS COMPLETED THE 74 QUESTION ONLINE SURVEY THAT WAS CREATED USING SURVEY MONKEY. THE LINK TO THE SURVEY WAS AVAILABLE ON THE CIVISTA HEALTH WEBSITE. THE FIRST SECTION OF THE SURVEY ASKED PARTICIPANTS ABOUT THEIR PERCEPTION OF HEALTH AND HEALTH SERVICES WITHIN THE COUNTY. THE SECOND SECTION ASKED THEM ABOUT THEIR HEALTH BEHAVIORS, IN ORDER TO DETERMINE THEIR RISK FOR THE DEVELOPMENT OF CERTAIN HEALTH CONDITIONS. A SHORT 3 QUESTION SURVEY WAS DISTRIBUTED THROUGHOUT THE COUNTY REGARDING PERCEPTIONS OF HEALTH WITHIN THE COUNTY. A TOTAL OF 200 SHORT SURVEYS WERE COMPLETED. SURVEYS WERE LOCATED THROUGHOUT THE COUNTY INCLUDING CIVISTA WAITING ROOMS, CCDOH WAITING ROOMS, LIBRARIES, SENIOR CENTERS, COMMUNITY CENTERS. 35 WERE COMPLETED IN SPANISH (17.5%). SEVEN FOCUS GROUPS WERE HELD THROUGHOUT THE COUNTY. THE FOCUS GROUP TOPICS INCLUDED: AGE-RELATED HEALTH

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

ATTACHMENT 1 (CONT'D)

ISSUES, CHRONIC DISEASE SPECIFIC HEALTH, SPECIAL POPULATIONS, COUNTY LEADERSHIP, SUBSTANCE ABUSE, YOUTH THROUGH THE SCHOOL NURSES, AND THE PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY (PHCC) (COMMUNITY LEADERS AND STAKEHOLDERS). APPROXIMATELY 165 PEOPLE PARTICIPATED IN THE COUNTY FOCUS GROUPS.

QUANTITATIVE DATA WAS ANALYZED FOR SEVERAL HEALTH TOPICS INCLUDING: MORTALITY, POPULATION AND DEMOGRAPHIC DATA, NATALITY, INFANT MORTALITY, HEART DISEASE, STROKE, HYPERTENSION, ACCESS TO HEALTH CARE/HEALTH UNINSURANCE, CANCER, ASTHMA, INJURIES, DIABETES, OBESITY, OSTEOPOROSIS, ARTHRITIS, DEMENTIA/ALZHEIMER'S DISEASE, COMMUNICABLE DISEASE, SEXUALLY TRANSMITTED DISEASES, HIV/AIDS, MENTAL HEALTH, DENTAL HEALTH, SUBSTANCE ABUSE, DISABILITIES, AND TOBACCO USE. CUMULATIVE ANALYSIS OF ALL QUANTITATIVE AND QUALITATIVE DATA IDENTIFIED THE TOP 10 HEALTH NEEDS OF CHARLES COUNTY WHICH WAS PRESENTED TO THE PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY, A COALITION OF CHARLES COUNTY AGENCIES AND ORGANIZATIONS. THE DIRECTION OF PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY IS GUIDED BY THE STEERING COMMITTEE WHICH CONSISTS OF LEADERSHIP FROM CIVISTA, CHARLES COUNTY DEPARTMENT OF HEALTH, CHARLES COUNTY PUBLIC SCHOOLS AND THE COLLEGE OF SOUTHERN MARYLAND. FOCUS GROUPS INCLUDED REPRESENTATIVES FROM THE FOLLOWING ORGANIZATIONS:

PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY:

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

ATTACHMENT 1 (CONT'D)

" CIVISTA HEALTH

" CIVISTA HEALTH, BOARD OF DIRECTORS

" CHARLES COUNTY DEPARTMENT OF HEALTH

" UNIVERSITY OF MARYLAND CLINICAL TRIALS PROGRAM

" BEL ALTON ALUMNI ASSOCIATION

" CHARLES COUNTY DEPARTMENT OF COMMUNITY SERVICES,
TRANSPORTATION

" TRI COUNTY COUNCIL FOR SOUTHERN MARYLAND

" MINISTER'S ALLIANCE OF CHARLES COUNTY

" CC DEPARTMENT OF SOCIAL SERVICES

" MARYLAND FOUNDATION FOR QUALITY HEALTHCARE

" HEALTH PARTNER'S CLINIC

" SHILOH COMMUNITY UNITED METHODIST CHURCH

" CC NURSING AND REHABILITATION CENTER

" ALZHEIMER'S ASSOCIATION

" CENTER FOR CHILDREN

" CHESAPEAKE POTOMAC HOME HEALTH AGENCY

" COLLEGE OF SOUTHERN MARYLAND

" CHARLES COUNTY DEPARTMENT OF AGING

" PRIORITY PARTNERS

" BIG BROTHERS/BIG SISTERS

" COMMUNITY HISPANIC ADVOCATES

" BLACK LEADERSHIP COUNCIL FOR EXCELLENCE

" YOUNG RESEARCHERS COMMUNITY PROJECT

" PINNACLE CENTER (MENTAL HEALTH)

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

ATTACHMENT 1 (CONT'D)

" HOSPICE

" BREAST CANCER SUPPORT ADVOCATES

" CHARLES COUNTY PUBLIC SCHOOLS - SCHOOL NURSES

" CHARLES COUNTY COMMISSIONERS

" CHARLES COUNTY EMERGENCY SERVICES

" CHARLES COUNTY SHERIFF'S OFFICE

" SO MD DELEGATES

" CHARLES COUNTY COMMUNITY FOUNDATION

" COMMUNITY PHYSICIANS

" CHARLES COUNTY FIRE AND RESCUE BOARD

ACCOMPLISHMENTS: CIVISTA MEDICAL CENTER PROVIDED OVER \$4.1 MILLION IN CHARITY CARE, HEALTH PROFESSIONS EDUCATION, COMMUNITY BENEFIT OPERATIONS, COMMUNITY HEALTH IMPROVEMENT SERVICES, SUBSIDIZED HEALTH SERVICES, CASH AND IN-KIND DONATIONS AND COMMUNITY BUILDING ACTIVITIES IN FY2011. THIS YEAR, WE PROVIDED AND SUPPORTED PROGRAMS AND ACTIVITIES SUCH AS: SCREENINGS AND EDUCATION; HEART DISEASE; BLOOD PRESSURE SCREENINGS; STROKE SCREENINGS; EDUCATION PROGRAMS SUCH AS STROKE RISK REDUCTION; AND LOWERING YOUR CHOLESTEROL AND VITAMIN D CLASSES. CANCER SCREENINGS SUCH AS PROSTATE SCREENING, BREAST AND CERVICAL EXAMS AND TOBACCO CESSATION PROGRAM, COMMUNITY EDUCATION PROGRAMS AND SERVICES SUCH AS, ACS'S LOOK GOOD FEEL BETTER PROGRAM, ADVANCED DIRECTIVES, ARTHRITIS AND OSTEOPOROSIS, BREASTFEEDING, COMMUNITY DISASTER DRILLS, SCHOOL CAREER DAYS, WE CAN! CHILDHOOD OBESITY PROGRAM AND

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

ATTACHMENT 1 (CONT'D)

FAITH-BASED HEALTH EXPO. SUPPORT GROUPS SUCH AS STROKE SUPPORT, PARKINSON'S SUPPORT GROUP, PINK LADIES AND SISTER'S AT HEART. CLINICS AND CLINIC SERVICES SUCH AS PRE NATAL AND OB CLINIC, RENAL DIALYSIS SERVICES, AMERICAN RED CROSS BLOOD DRIVES, COMMUNITY COMMITTEES, BOARDS, AND ORGANIZATIONS (EMPLOYEE PARTICIPATION) SUCH AS UNITED WAY, PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY, CHARLES COUNTY TOBACCO COALITION, LEADERSHIP SOUTHERN MARYLAND, HOSPICE OF CHARLES COUNTY, HEALTHY FAMILIES, HEALTH PARTNERS FREE CLINIC BOARD, FETAL INFANT MORTALITY BOARD, CENTER FOR ABUSED PERSONS, JUVENILE DRUG COURT; CHAMBER OF COMMERCE, CHARLES COUNTY CHILD ADVOCACY PARTNERSHIP, COMMUNITY EVENTS SUCH AS CHRISTMAS CONNECTION, ACS'S RELAY FOR LIFE, ALZHEIMER'S WALK, MARCH OF DIMES, AND SAFE NIGHTS.

ATTACHMENT 2990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
MARYLAND INPATIENT CARE SPECIALISTS 2007 TIDEWATER COLONY WAY STE 1-A ANNAPOLIS, MD 21401	PHYSICIANS	1,300,000.
DIGITRACE CARE SERVICES INC 200 CORPORATE PLACE STE 58 PEABODY, MA 01960	EEG PURCHASED SERV	599,675.
ROI ELIGIBILITY SERVICES CORP 1920 GREENSPRING DR STE 200 TIMONIUM, MD 21094	PT ACCTG PURCH SERV	592,564.
MAYFLOWER TEXTILE SERVICE PO BOX 20659 BALTIMORE, MD 21223	LAUNDRY	398,752.

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

ATTACHMENT 2 (CONT'D)990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
NDG COMMUNICATIONS, INC 105 CENTENNIAL STREET, SUITE K LA PLATA, MD 20646	MARKETING	264,148.
TOTAL COMPENSATION		<u>3,155,139.</u>

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2010

**Open to Public
Inspection**

▶ **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.**

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

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) -----					
(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	No
(1) CIVISTA HEALTH INC 5 GARRETT AVE LA PLATA, MD 20646 52-2155576	PARENT	MD	501(C)(3)	11C	N/A		X
(2) CIVISTA HEALTH FOUNDATION INC 616 E CHARLES ST LA PLATA, MD 20646 52-1414564	FUNDRAISING	MD	501(C)(3)	11A	CIVISTA HLTH	X	
(3) CIVISTA HEALTH AUXILIARY INC 5 GARRETT AVE LA PLATA, MD 20646 52-1131193	AUXILIARY	MD	501(C)(3)	9	CIVISTA HLTH	X	
(4) -----							
(5) -----							
(6) -----							
(7) -----							

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

Schedule R (Form 990) 2010

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(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) CIVISTA CARE PARTNERS INC 52-2176314 5 GARRETT AVE LA PLATA, MD 20646	HEALTHCARE	MD	CIVISTA HLTH	C CORP			
(2) -----							
(3) -----							
(4) -----							
(5) -----							
(6) -----							
(7) -----							

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

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

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

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(1) CIVISTA HEALTH INC	Q	1,206,066.	CASH
(2) CIVISTA HEALTH FOUNDATION INC	R	1,015,000.	CASH
(3) CIVISTA HEALTH FOUNDATION INC	Q	1,340,000.	CASH
(4) CIVISTA HEALTH FOUNDATION INC	P	217,422.	CASH
(5) CIVISTA HEALTH FOUNDATION INC	N	201,332.	CASH
(6) CIVISTA CARE PARTNERS INC	R	250,000.	CASH

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

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

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(1) CIVISTA CARE PARTNERS INC CCS LLC	R	220,437.	CASH
(2) CIVISTA CARE PARTNERS INC CCS LLC	Q	105,142.	CASH
(3) CIVISTA CARE PARTNERS INC CCP LLC	R	575,000.	CASH
(4) CIVISTA CARE PARTNERS INC CCP LLC	Q	460,000.	CASH
(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).
