Cumulative E-File History 2012

FED

Locator:	0659EE
Taxpayer Name:	Civista Medical Center, Inc.
Return Type:	990, 990

Submitted Date	5/13/2014 1:50:32 PM
Acknowledgement Date	5/13/2014 2:29:20 PM
Status	Accepted
Submission ID	23695320141335000028

Print Close

Form **8879-EO**

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

For calendar year 2012, or fiscal year beginning 07/01 , 2012, and ending 06/30 , 20 13

OMB No. 1545-1878

2012

Department of the Treasury
Internal Revenue Service

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

Name of exempt organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

Name and title of officer

ERIK BOAS, CFO

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

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

1a	Form 990 check here ▶ [X]	**b**	**Total revenue,** if any (Form 990, Part VIII, column (A), line 12)	**1b**	117206743.
2a	Form 990-EZ check here ▶ [ ]	**b**	**Total revenue,** if any (Form 990-EZ, line 9)	**2b**	
3a	Form 1120-POL check here ▶ [ ]	**b**	**Total tax** (Form 1120-POL, line 22)	**3b**	
4a	Form 990-PF check here ▶ [ ]	**b**	**Tax based on investment income** (Form 990-PF, Part VI, line 5)	**4b**	
5a	Form 8868 check here ▶ [ ]	**b**	**Balance Due** (Form 8868, Part I, line 3c or Part II, line 8c)	**5b**	

Part II Declaration and Signature Authorization of Officer

Under penalties of perjury, I declare that I am an officer of the above organization and that I have examined a copy of the organization's 2012 electronic return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the organization's electronic return and, if applicable, the organization's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize GRANT THORNTON LLP to enter my PIN 14288 as my signature

ERO firm name

Enter five numbers, but do not enter all zeros

on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

[ ] As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2012 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ Erik Boas Date ▶ 05/08/2014

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN. 23695336605

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2012 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ Frank S. Smith Date ▶ 5/05/2014

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

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

OMB No. 1545-0047

2012

Open to Public Inspection

A For the 2012 calendar year, or tax year beginning 07/01, 2012, and ending 06/30, 20 13

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

C Name of organization: CIVISTA MEDICAL CENTER, INC.

Doing Business As:

Number and street (or P.O. box if mail is not delivered to street address): 5 GARRETT AVE

Room/suite:

City, town or post office, state, and ZIP code: LA PLATA, MD 20646

D Employer identification number: 52-0445374

E Telephone number: (301) 609-4130

G Gross receipts $ 117,206,743.

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? ☐ Yes ☒ No

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

H(c) Group exemption number ▶

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

J Website: ▶ WWW.CIVISTA.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ 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, INC. IS A COMPONENT OF A REGIONAL INTEGRATED HEALTH SYSTEM SERVING THE HEALTH NEEDS OF CHARLES COUNTY AND THE CITIZENS OF SOUTHERN MARYLAND.

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

3	Number of voting members of the governing body (Part VI, line 1a)	3	16.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	13.
5	Total number of individuals employed in calendar year 2012 (Part V, line 2a)	5	1,020.
6	Total number of volunteers (estimate if necessary)	6	118.
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	144,140.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	32,420.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	165,000.	528,633.
9	Program service revenue (Part VIII, line 2g)	111,209,188.	118,309,645.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	88,269.	796,545.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	542,401.	-2,428,080.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	112,004,858.	117,206,743.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	34,654.	58,392.
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)	48,691,670.	53,090,677.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	55,007,273.	56,619,499.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	103,733,597.	109,768,568.
19	Revenue less expenses. Subtract line 18 from line 12	8,271,261.	7,438,175.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	147,245,093.	143,406,844.
21	Total liabilities (Part X, line 26)	116,457,768.	104,014,817.
22	Net assets or fund balances. Subtract line 21 from line 20	30,787,325.	39,392,027.

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: 05/08/2014

▶ ERIK BOAS CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
FRANK GIARDINI	Frank D. Giardini	5/05/2014		P00532355

Firm's name ▶ GRANT THORNTON LLP — Firm's EIN ▶ 36-6055558

Firm's address ▶ 2001 MARKET STREET, SUITE 700 PHILADELPHIA, PA 19103 — Phone no. 215-561-4200

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2012)

JSA
2E1010 1.000
0659EE 700P V 12-7.12 0180223-00037

Form **8868**
(Rev. January 2013)
Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File an Exempt Organization Return

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

OMB No. 1545-1709

- 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.

Enter filer's identifying number, see instructions

Type or print	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
File by the due date for filing your return. See instructions.	CIVISTA MEDICAL CENTER, INC.	52-0445374
	Number, street, and room or suite no. If a P.O. box, see instructions. 5 GARRETT AVE	Social security number (SSN)
	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 or Form 990-EZ	01	Form 990-T (corporation)	07
Form 990-BL	02	Form 1041-A	08
Form 4720- (individual)	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 ▶ ERIK BOAS

Telephone No. ▶ 301 609-4130 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 02/17, 20 14, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

▶ ☐ calendar year 20 ____ or

▶ X tax year beginning 07/01, 2012, and ending 06/30, 20 13.

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**	**$**
b	If this application is for Form 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	**3b**	**$**
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**	**$**

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.

- If you are filing for an **Additional (Not Automatic) 3-Month Extension, complete only Part II** and check this box . . . . . ▶ X

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).

Enter filer's identifying number, see instructions

Type or print	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
	CIVISTA MEDICAL CENTER, INC.	52-0445374
File by the due date for filing your return. See instructions.	Number, street, and room or suite no. If a P.O. box, see instructions. 5 GARRETT AVE	Social security number (SSN)
	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 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	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 ▶ ERIK BOAS
  Telephone No. ▶ 301 609-4130 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 14.

5 For calendar year _____, or other tax year beginning 07/01, 20 12, and ending 06/30, 20 13.

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 ADDITIONAL TIME NEEDED TO FILE A COMPLETE AND ACCURATE RETURN.

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	$
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	$

Signature and Verification must be completed for Part II only.

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 ▶ MANAGER Date ▶ 2/10/14

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

4a (Code:) (Expenses $ 86,303,830. including grants of $ 58,392.) (Revenue $ 118,693,209.)

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 ▶ 86,303,830.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		X
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments-other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		X
c	Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		X
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12 a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14 a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b	X	
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20 a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	202		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	1,020		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a		X	
b	If "Yes," enter the name of the foreign country: ▶ CAYMAN ISLANDS See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

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

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year.	1a 16		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
b	Enter the number of voting members included in line 1a, above, who are independent	1b 13		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? . . .	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6	X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9		X

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

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

Section C. Disclosure

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

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

☐ Own website ☒ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

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

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶ERIK BOAS 5 GARRETT AVE LA PLATA, MD 20646 301-609-4130

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 (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) SHELLY CULHANE VICE CHAIR	2.00	X		X				0	0	0
(2) B. LARRY JENKINS JR DIRECTOR	1.00	X						0	0	0
(3) R. WAYNE BARNES DIRECTOR	1.00	X						0	0	0
(4) SARA A. MIDDLETON DIRECTOR	1.00	X						0	0	0
(5) CANDICE QUINN KELLY EX-OFFICIO/DIRECTOR	1.00	X						0	0	0
(6) FAYE REED EX-OFFICIO/DIR/RETIRED 12/1/12	1.00	X						0	0	0
(7) KHADAR BAIG DIRECTOR	1.00	X						0	0	0
(8) VAN MITCHELL DIRECTOR	1.00	X						0	0	0
(9) LOUIS JENKINS, JR. CHAIRMAN	2.00	X		X				0	0	0
(10) SEETARAMAYYA NAGULA DIRECTOR	1.00	X						0	0	0
(11) RICHARD WINKLER SECRETARY/TREASURER	2.00	X		X				0	0	0
(12) MICHAEL CADY DIRECTOR	1.00	X						0	0	0
(13) ASHVIN J. PATEL, M.D. EX-O/CHIEFSTAFF/END12/31/12	2.00	X		X				0	0	0
(14) JAMES BURKE DIRECTOR	1.00	X						0	0	0

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) JOHN ASHWORTH	1.00									
EX-OFFICIO/DIRECTOR	49.00	X						0	588,536.	20,541.
(16) ROBERT CHRENCIK	1.00									
EX-OFFICIO/DIRECTOR	49.00	X						0	2,174,569.	234,466.
(17) NOEL CERVINO	40.00									
EX-OFFICIO/PRESIDENT & CEO	10.00	X		X				0	525,741.	66,648.
(18) JOEL SEWCHAND, M.D.	2.00									
EX-O/CHIEFSTAFF/BEGIN 1/1/13		X		X				0	0	0
(19) ERIK BOAS	40.00									
CHIEF FINANCIAL OFFICER	10.00			X				0	265,742.	23,363.
(20) MARK DUMAIS	40.00									
CHIEF MEDICAL OFFICER					X			0	374,083.	43,464.
(21) GARY HERBEK	40.00									
CHIEF OPERATING OFFICER					X			201,210.	0	22,802.
(22) MELANIE SAGE	40.00									
VP PATIENT CARE/NURSE EXEC.					X			167,724.	0	13,920.
(23) PAUL BLACKWOOD	40.00									
VP PLANNING						X		181,054.	0	21,287.
(24) KATHERINE MIDDLETON	40.00									
RN						X		157,974.	0	15,818.
(25) MARILYN GREGORY	40.00									
CLINICAL NURSE IV						X		171,838.	0	8,420.
1b Sub-total ▶								0	0	0
c Total from continuation sheets to Part VII, Section A ▶								1,211,269.	3,928,671.	523,146.
d Total (add lines 1b and 1c) ▶								1,211,269.	3,928,671.	523,146.

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

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
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 ▶ 19

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) GABRIEL ABIOLA PHARMACY CLINICAL MANAGER	40.00					X		161,112.	0	20,526.
(27) STACEY COOK VP HUMAN RESOURCES	40.00					X		170,357.	0	31,891.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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

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

Section B. Independent Contractors

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

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

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 ▶

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 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	500,878.			
	e	Government grants (contributions)	1e				
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	27,755.			
	g	Noncash contributions included in lines 1a-1f: $					
	h	**Total.** Add lines 1a-1f		528,633.			
Program Service Revenue			**Business Code**				
	2a	NET PATIENT REVENUE	900099	118,309,645.	118,309,645.		
	b						
	c						
	d						
	e						
	f	All other program service revenue					
	g	**Total.** Add lines 2a-2f		118,309,645.			
	3	Investment income (including dividends, interest, and other similar amounts)		18,876.			18,876.
	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	777,669.				
	b	Less: cost or other basis and sales expenses					
	c	Gain or (loss)	777,669.				
	d	Net gain or (loss)		777,669.			777,669.
Other Revenue	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	144,140.		144,140.	
	b	CAFETERIA & COFFEE BAR SALES	900099	339,080.	339,080.		
	c	MEDICAL RECORD COPIES & APPLICATION FEE	900099	33,110.	33,110.		
	d	All other revenue	900099	-2,944,410.	11,374.		-2,955,784.
	e	**Total.** Add lines 11a-11d		-2,428,080.			
	12	**Total revenue.** See instructions		117,206,743.	118,693,209.	144,140.	-2,159,239.

Part IX Statement of Functional Expenses

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

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

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 United States. See Part IV, line 21	58,392.	58,392.		
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	0			
3 Grants and other assistance to governments, organizations, and individuals outside the United States. 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	1,343,495.	1,047,926.	295,569.	
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	42,613,830.	33,238,787.	9,375,043.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,272,144.	992,272.	279,872.	
9 Other employee benefits	4,823,686.	3,762,475.	1,061,211.	
10 Payroll taxes	3,037,522.	2,369,267.	668,255.	
11 Fees for services (non-employees):				
a Management	0			
b Legal	449,663.		449,663.	
c Accounting	17,910.		17,910.	
d Lobbying	13,018.		13,018.	
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	0			
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	8,293,712.	6,469,095.	1,824,617.	
12 Advertising and promotion	316,244.	246,670.	69,574.	
13 Office expenses	4,252,676.	3,317,087.	935,589.	
14 Information technology	0			
15 Royalties	0			
16 Occupancy	2,671,064.	2,083,430.	587,634.	
17 Travel	55,069.	42,954.	12,115.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	0			
20 Interest	2,974,635.	2,320,215.	654,420.	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	3,932,621.	3,067,444.	865,177.	
23 Insurance	2,380,636.	1,856,896.	523,740.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a SUPPLIES AND DRUGS	18,686,003.	14,575,082.	4,110,921.	
b PURCHASED SERVICES	6,648,597.	5,149,260.	1,499,337.	
c BAD DEBT	4,922,763.	4,922,763.		
d DUES & SUBSCRIPTIONS	609,137.	475,127.	134,010.	
e All other expenses	395,751.	308,688.	87,063.	
25 **Total functional expenses.** Add lines 1 through 24e	109,768,568.	86,303,830.	23,464,738.	
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)	0			

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	0	1	0
	2	Savings and temporary cash investments	37,974,354.	2	28,125,065.
	3	Pledges and grants receivable, net	0	3	0
	4	Accounts receivable, net	11,344,222.	4	11,705,089.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0	6	0
	7	Notes and loans receivable, net	0	7	0
	8	Inventories for sale or use	1,490,645.	8	1,459,352.
	9	Prepaid expenses and deferred charges	930,555.	9	459,932.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 107,621,747.			
	b	Less: accumulated depreciation — 10b: 38,611,562.	66,994,942.	10c	69,010,185.
	11	Investments - publicly traded securities	0	11	0
	12	Investments - other securities. See Part IV, line 11	0	12	0
	13	Investments - program-related. See Part IV, line 11	0	13	0
	14	Intangible assets	0	14	0
	15	Other assets. See Part IV, line 11	28,510,375.	15	32,647,221.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	147,245,093.	16	143,406,844.
Liabilities	17	Accounts payable and accrued expenses	13,117,763.	17	12,114,172.
	18	Grants payable	0	18	0
	19	Deferred revenue	0	19	0
	20	Tax-exempt bond liabilities	54,348,613.	20	0
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties	21,568,471.	23	20,599,450.
	24	Unsecured notes and loans payable to unrelated third parties	0	24	0
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	27,422,921.	25	71,301,195.
	26	**Total liabilities.** Add lines 17 through 25	116,457,768.	26	104,014,817.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	30,770,543.	27	39,182,155.
	28	Temporarily restricted net assets	16,782.	28	209,872.
	29	Permanently restricted net assets	0	29	0
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ [ ] and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	30,787,325.	33	39,392,027.
	34	Total liabilities and net assets/fund balances	147,245,093.	34	143,406,844.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	117,206,743.
2	Total expenses (must equal Part IX, column (A), line 25)	2	109,768,568.
3	Revenue less expenses. Subtract line 2 from line 1	3	7,438,175.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	30,787,325.
5	Net unrealized gains (losses) on investments	5	-7,209.
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	1,173,736.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	39,392,027.

Part XII Financial Statements and Reporting

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

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

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization	**Employer identification number**
CIVISTA MEDICAL CENTER, INC.	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-Non-functionally integrated

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

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

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

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

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2012 (line 6, column (f) divided by line 11, column (f)) **14** %

15 Public support percentage from 2011 Schedule A, Part II, line 14 **15** %

16a **33 1/3% support test - 2012.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test - 2011.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10%-facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10%-facts-and-circumstances test - 2011.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) 2012	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2012 (line 8, column (f) divided by line 13, column (f))	15	%
16	Public support percentage from 2011 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2012** (line 10c, column (f) divided by line 13, column (f))	17	%
18	Investment income percentage from **2011** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2012.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3 %, and line 17 is not more than 33 1/3 %, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2011.** 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; and Part III, line 12. Also complete this part for any additional information. (See instructions).

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

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

▶ **See separate instructions.**

OMB No. 1545-0047

2012

Open to Public Inspection

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part V, 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 35c (Proxy Tax), then

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

Name of organization	Employer identification number
CIVISTA MEDICAL CENTER, INC.	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 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 the 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 (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

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
1a 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.		
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-		

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.

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? ☐ **Yes** ☐ **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)** 2009	**(b)** 2010	**(c)** 2011	**(d)** 2012	**(e)** Total
2a 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)).**

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		13,018.
j Total. Add lines 1c through 1i			13,018.
2 a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	**1**		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	**2**		
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?	**3**		

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

1	Dues, assessments and similar amounts from members	**1**	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	**2a**	
b	Carryover from last year	**2b**	
c	Total	**2c**	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	**3**	
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?	**4**	
5	Taxable amount of lobbying and political expenditures (see instructions)	**5**	

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; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

SEE PAGE 4

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

LOBBYING ACTIVITIES

SCHEDULE C, PART II-B, LINE 1I

THE ORGANIZATION DOES NOT ENGAGE IN ANY DIRECT LOBBYING ACTIVITIES. 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 7.71% AND 23.98% OF MEMBER DUES WERE USED FOR LOBBYING PURPOSES AND AS SUCH, THE ORGANIZATION HAS REPORTED THIS AMOUNT ON SCHEDULE C PART IV AS LOBBYING ACTIVITIES.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

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

OMB No. 1545-0047

2012

Open to Public Inspection

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b Assets included in Form 990, Part X ▶ $

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The percentages in lines 2a, 2b, and 2c should equal 100%.

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

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

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

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings		78,614,777.	20,792,336.	57,822,441.
c Leasehold improvements		498,563.	226,341.	272,222.
d Equipment		27,017,211.	17,592,885.	9,424,326.
e Other		1,491,196.		1,491,196.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				69,010,185.

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	2,675.
(2) OTHER CURRENT RECEIVABLES	1,193,245.
(3) INV CHES POTOMAC HEALTHCARE	3,317,448.
(4) OTHER ASSETS	7,513,265.
(5) PHYSICIAN LOANS	192,844.
(6) INVESTMENT IN JV FREESTATE	15,000.
(7) INVESTMENT MARYLAND ECARE	10,000.
(8) DUE FROM AFFILIATES	15,829,221.
(9) ECONOMIC INTEREST - NET ASSETS	4,573,523.
(10)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	32,647,221.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ADVANCES FROM THIRD PARTIES	3,235,242.
(3) ACCRUED PENSION COSTS	5,139,192.
(4) DUE TO AFFILIATES	54,715,931.
(5) LEASE LIABILITIES	450,311.
(6) MALPRACTICE IBNR	2,764,484.
(7) OTHER LIABILITIES	4,996,035.
(8)	
(9)	
(10)	
(11)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	71,301,195.

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

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

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 XIII.)	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 XIII.)	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 XII 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 XIII.)	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 XIII.)	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 XIII 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, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

SEE PAGE 5

Part XIII Supplemental Information *(continued)*

LIABILITY FOR UNCERTAIN TAX POSITION (ASC 740)

SCHEDULE D, PART X, LINE 2

THE ORGANIZATION IS A SUBSIDIARY OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (THE CORPORATION). THE CORPORATION ADOPTED THE PROVISIONS OF ASC 740, ACCOUNTING FOR UNCERTAINTY IN THE INCOME TAXES (FIN 48) ON JULY 1, 2007. THE FOOTNOTE RELATED TO ASC 740 IN THE CORPORATION'S AUDITED FINANCIAL STATEMENTS IS AS FOLLOWS:

THE CORPORATION FOLLOWS A THRESHOLD OF MORE-LIKELY-THAN-NOT FOR RECOGNITION AND DERECOGNITION OF TAX POSITIONS TAKEN OR EXPECTED TO BE TAKEN IN A TAX RETURN. MANAGEMENT DOES NOT BELIEVE THAT THERE ARE ANY UNRECOGNIZED TAX BENEFITS THAT SHOULD BE RECOGNIZED.

SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

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

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

OMB No. 1545-0047

2012

Open to Public Inspection

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 its grants and other 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 its grants and other assistance 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	984,413.
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						
(11)						
(12)						
(13)						
(14)						
(15)						
(16)						
(17)						
3a	Sub-total					984,413.
b	Total from continuation sheets to Part I					
c	**Totals** (add lines 3a and 3b)					984,413.

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. 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)*	[X] 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	[X] 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)*	[X] 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, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund. (see Instructions for Form 8621)*	[ ] Yes	[X] 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	[X] 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	[X] 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; amounts of investments vs. expenditures per region); 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).

ACTIVITIES PER REGION

SCHEDULE F, PART I, LINE 3

CIVISTA MEDICAL CENTER, INC. JOINED THE UNIVERSITY OF MARYLAND MEDICAL

SYSTEM CORPORATION'S MALPRACTICE PROGRAM AS OF MARCH 1, 2013.

SCHEDULE H
(Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2012

Open to Public Inspection

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	1a	X	
b	If "Yes," was it a written policy?	1b	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☒ 200% ☐ Other _____ %	3a	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☒ 300% ☐ 350% ☐ 400% ☐ Other _____%	3b	X	
c	If the organization used factors other than FPG in determining 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, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a	Did the organization prepare a community benefit report during the tax year?	6a	X	
b	If "Yes," did the organization make it available to the public?	6b	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			3,546,328.		3,546,506.	3.23
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			3,546,328.		3,546,506.	3.23
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			694,485.		694,485.	.63
f Health professions education (from Worksheet 5)			348,551.		348,551.	.32
g Subsidized health services (from Worksheet 6)			5,869,444.	3,316,475.	2,552,969.	2.33
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			74,237.		74,237.	.07
j **Total.** Other Benefits			6,986,717.	3,316,475.	3,670,242.	3.35
k **Total.** Add lines 7d and 7j			10,533,045.	3,316,475.	7,216,748.	6.58

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			298.		298.	
3 Community support			35,421.		35,421.	.03
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			10,333.		10,333.	.01
7 Community health improvement advocacy			795.		795.	
8 Workforce development			139,564.	6,032.	133,532.	.12
9 Other						
10 Total			186,411.	6,032.	180,379.	.16

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

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount 2 3,357,621.			
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. 3			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	47,171,538.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	43,581,711.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	3,589,827.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other		

Section C. Collection Practices

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

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

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

Part V Facility Information

Section A. Hospital Facilities

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

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

Name, address, and primary website address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 CIVISTA MEDICAL CENTER INC. 5 GARRETT AVE LA PLATA MD 20646	X	X					X			
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group CIVISTA MEDICAL CENTER INC.

For single facility filers only: line number of hospital facility (from Schedule H, Part V, Section A) 1

			Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)				
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	1	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
3	In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? 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	X	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	X	
5	Did the hospital facility make its CHNA report widely available to the public?	5	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website			
b	[X] Available upon request from the hospital facility			
c	[ ] Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):			
a	[X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	[X] Execution of the implementation strategy			
c	[X] Participation in the development of a community-wide plan			
d	[X] Participation in the execution of a community-wide plan			
e	[X] Inclusion of a community benefit section in operational plans			
f	[X] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		X
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		X
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy CIVISTA MEDICAL CENTER INC.

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:		
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 200 %		
	If "No," explain in Part VI the criteria the hospital facility used.		
11	Used FPG to determine eligibility for providing *discounted* care?	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 300 %		
	If "No," explain in Part VI the criteria the hospital facility used.		
12	Explained the basis for calculating amounts charged to patients?	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):		
a	[X] Income level		
b	[X] Asset level		
c	[X] Medical indigency		
d	[X] Insurance status		
e	[X] Uninsured discount		
f	[X] Medicaid/Medicare		
g	[X] State regulation		
h	[ ] Other (describe in Part VI)		
13	Explained the method for applying for financial assistance?	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a	[X] The policy was posted on the hospital facility's website		
b	[X] The policy was attached to billing invoices		
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	[X] The policy was posted in the hospital facility's admissions offices		
e	[X] The policy was provided, in writing, to patients on admission to the hospital facility		
f	[X] The policy was available on request		
g	[ ] Other (describe in Part VI)		

Billing and Collections

15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:		
a	[ ] Reporting to credit agency		
b	[ ] Lawsuits		
c	[ ] Liens on residences		
d	[ ] Body attachments		
e	[ ] Other similar actions (describe in Part VI)		
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP?		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:		
a	[ ] Reporting to credit agency		
b	[ ] Lawsuits		
c	[ ] Liens on residences		
d	[ ] Body attachments		
e	[ ] Other similar actions (describe in Part VI)		

Part V Facility Information *(continued)* CIVISTA MEDICAL CENTER INC.

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- **a** [X] Notified individuals of the financial assistance policy on admission
- **b** [X] Notified individuals of the financial assistance policy prior to discharge
- **c** [X] Notified individuals of the financial assistance policy in communications with the patients regarding the patients' bills
- **d** [X] Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** [ ] Other (describe in Part VI)

Policy Relating to Emergency Medical Care

			Yes	No
19	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?	19	X	
	If "No," indicate why:			
a	[ ] The hospital facility did not provide care for any emergency medical conditions			
b	[ ] The hospital facility's policy was not in writing			
c	[ ] The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d	[ ] Other (describe in Part VI)			

Changes to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a	[ ] The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b	[ ] The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c	[ ] The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d	[X] Other (describe in Part VI)			
21	During the tax year, did the hospital facility charge any of its FAP- eligible individuals, to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?	20		X
	If "Yes," explain in Part VI.			
22	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	21		X
	If "Yes," explain in Part VI.			

Part V Facility Information *(continued)*

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

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

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

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.

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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.

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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.

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

RELATED ORGANIZATION REPORT

SCHEDULE H, 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, THE ANNUAL COMMUNITY BENEFIT REPORT IS AVAILABLE

UPON REQUEST AT THE ENTITY'S CORPORATE OFFICES.

COST ATTRIBUTABLE TO A PHYSICAL CLINIC

SCHEDULE H, 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 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 PAYOR'S RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO

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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

SCHEDULE H, PART I, LINE 7B, COLUMNS (C) THROUGH (F)

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

SCHEDULE H, PART I, LINE 7F COLUMN (C)

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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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SCHEDULE H, PART I, LINE 7F COLUMN (D)

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

Part VI Supplemental Information

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1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

COMMUNITY BUILDING ACTIVITIES

SCHEDULE H, PART II

AS THE ONLY HOSPITAL SERVING CHARLES COUNTY, MARYLAND, CIVISTA MEDICAL CENTER SUPPORTS PROGRAMS AND ACTIVITIES WHERE THE HOSPITAL'S EXPERTISE AND RESOURCES CAN INFLUENCE THE FUNDAMENTAL ISSUES THAT AFFECT THE HEALTH OF THE COMMUNITY. CIVISTA SUPPORTS ECONOMIC DEVELOPMENT OF THE COMMUNITY THROUGH LEADERSHIP PARTICIPATION IN ORGANIZATIONS SUCH AS THE ECONOMIC DEVELOPMENT COMMISSION AND THE TRI-COUNTY COUNCIL OF SOUTHERN MARYLAND. HOSPITAL ADMINISTRATION PARTICIPATES IN HEALTHCARE WORKFORCE DEVELOPMENT THROUGH BY SERVING ON COMMITTEES SUCH AS THE CHARLES COUNTY COMMISSIONER'S HEALTHCARE TASKFORCE AND SUPPORT OF COLLEGE OF SOUTHERN MARYLAND NURSING AND ALLIED HEALTH PROGRAMS. IN ADDITION, CIVISTA MEDICAL CENTER PARTICIPATES AND SUPPORTS THE BLACK LEADERSHIP COUNCIL ON EXCELLENCE'S YOUNG RESEARCHERS COMMUNITY PROJECT WHICH OFFERS DISADVANTAGE YOUTH IN HIGH SCHOOL AN OPPORTUNITY TO SHADOW MEDICAL

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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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PROFESSIONALS. ACCORDING TO THE 2007 MARYLAND PHYSICIAN WORKFORCE STUDY, THE SOUTHERN MARYLAND REGION HAS A PHYSICIAN SHORTAGE FOR PRIMARY CARE PHYSICIANS. SOUTHERN MARYLAND HAD THE REGIONAL LOW REQUIREMENT FOR PRIMARY CARE PHYSICIANS PER 100,000 RESIDENTS OF 56.5. THE MARYLAND STATE AVERAGE RATE WAS 58.2 PER 100,000 RESIDENTS. UNDER MEDICAL SPECIALTIES, THE SOUTHERN MARYLAND REGION HAD A SHORTAGE FOR CARDIOLOGY, DERMATOLOGY, ENDOCRINOLOGY, GASTROENTEROLOGY, HEMATOLOGY, ONCOLOGY, INFECTIOUS DISEASE, NEPHROLOGY, PSYCHIATRY, PULMONARY MEDICINE, AND RHEUMATOLOGY. THE ONLY MEDICAL SPECIALTIES WITH ADEQUATE PHYSICIAN SUPPLIES WERE ALLERGY AND NEUROLOGY. CHARLES COUNTY HAS ONE NEUROLOGIST WHICH IS DEEMED ADEQUATE FOR THE POPULATION HOWEVER, THE PHYSICIAN PLANS TO RETIRE WHICH WILL LEAVE THE COUNTY IN A CRITICAL SHORTAGE IN THIS SPECIALTY. AS A RESULT OF THE PREVAILING PHYSICIAN SHORTAGE, AND TO MITIGATE THE EFFECTS OF THE LACK OF ACCESS OF THE COMMUNITY TO MEDICAL CARE, CIVISTA MEDICAL CENTER, ALONG WITH THE UNIVERSITY OF MARYLAND HAS DEVELOPED A ROBUST AND ONGOING PHYSICIAN RECRUITMENT AND RETAINMENT PROGRAM.

Part VI Supplemental Information

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1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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BAD DEBT EXPENSE

SCHEDULE H, PART III, LINE 2 & 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, 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 VI Supplemental Information

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1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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MEDICARE COST REPORT

SCHEDULE H, 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 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.

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.

Part VI Supplemental Information

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COLLECTION PRACTICES

SCHEDULE H, PART III, LINE 9B

THE ORGANIZATION EXPECTS PAYMENT AT THE TIME THE SERVICE IS PROVIDED. OUR POLICY IS TO COMPLY WITH ALL STATE AND FEDERAL LAW AND THIRD PARTY REGULATIONS AND TO PERFORM ALL CREDIT AND COLLECTION FUNCTIONS IN A DIGNIFIED AND RESPECTFUL MANNER. EMERGENCY SERVICES WILL BE PROVIDED TO ALL PATIENTS REGARDLESS OF ABILITY TO PAY. FINANCIAL ASSISTANCE IS AVAILABLE FOR PATIENTS BASED ON FINANCIAL NEED AS DEFINED IN THE FINANCIAL ASSISTANCE POLICY. THE ORGANIZATION DOES NOT DISCRIMINATE ON THE BASIS OF AGE, RACE, CREED, SEX OR ABILITY TO PAY.

PATIENTS WHO ARE UNABLE TO PAY MAY REQUEST A FINANCIAL ASSISTANCE APPLICATION AT ANY TIME PRIOR TO SERVICE OR DURING THE BILLING AND COLLECTION PROCESS. THE ORGANIZATION MAY REQUEST THE PATIENT TO APPLY FOR MEDICAL ASSISTANCE PRIOR TO APPLYING FOR FINANCIAL ASSISTANCE. THE ACCOUNT WILL NOT BE FORWARDED FOR COLLECTION DURING THE MEDICAL ASSISTANCE APPLICATION PROCESS OR THE FINANCIAL ASSISTANCE APPLICATION

Part VI Supplemental Information

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PROCESS.

INDIVIDUALS ELIGIBLE FOR FINANCIAL ASSISTANCE

SCHEDULE H, PART V, SECTION B, LINE 20D

ALL PATIENTS ARE CHARGED STATE REGULATED RATES REGARDLESS OF THEIR

ABILITY TO PAY.

INDIVIDUALS ELIGIBLE FOR FINANCIAL ASSISTANCE

SCHEDULE H, PART V, SECTION B, LINE 22

AS PREVIOUSLY DISCUSSED IN AN EARLIER SCHEDULE H NARRATIVE, THE STATE OF

MARYLAND IS A UNIQUE STATE IN REGARD TO THE PROVISION OF HEALTH CARE

SERVICES AND THEIR RELATED CHARGES BY HOSPITALS. ALL HOSPITAL CHARGES

PROCESSED TO ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, ARE SET THROUGH

MARYLAND'S HEALTH SERVICES COST COMMISSION. ACCORDINGLY, ALL HOSPITAL

CHARGES ARE NOT GROSS CHARGES AS DEFINED BY THE IRS UNDER INTERNAL

REVENUE CODE SECTION 501(R)(5)(B).

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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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.).

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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.

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

COMMUNITY HEALTH CARE NEEDS ASSESSMENT

SCHEDULE H, PART VI, LINE 2

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND IMPLEMENTATION PLAN (CCHIP)

DESCRIPTION OF CHNA PROCESS:

CIVISTA HEALTH AND THE CHARLES COUNTY DEPARTMENT OF HEALTH (CCDOH)
COLLABORATED TO COMPLETE A COMPREHENSIVE ASSESSMENT OF THE HEALTH NEEDS
(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

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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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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 ENSURED THAT CHARLES COUNTY

RESIDENTS HAD AN OPPORTUNITY TO PARTICIPATE IN THE ASSESSMENT PROCESS AND

TO FEEL INVESTED IN ITS OUTCOME. THREE HUNDRED AND TWO (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 THREE 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

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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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INCLUDING CIVISTA WAITING ROOMS, CCDOH WAITING ROOMS, LIBRARIES, SENIOR CENTERS, COMMUNITY CENTERS. THIRTY FIVE WERE COMPLETED IN SPANISH (17.5%).

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.

SURVEY FOR COMMUNITY MEMBERS:

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

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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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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%).

THE CHNA WAS COMPLETED DURING THE FISCAL YEAR ENDED JUNE 30, 2012 AND IS CURRENTLY BEING IMPLEMENTED. THIS CHNA REPORT AND IMPLEMENTATION PLAN WAS APPROVED BY UMMC BOARD OF DIRECTORS ON JUNE 28, 2012. THE CHNA REPORT IS AVAILABLE ON THE FOLLOWING WEBSITE:

WWW.CHARLESREGIONAL.ORG/.../CHARLESCOUNTYCOMMUNITYHEALTHNEEDSASSESSMENT2011.PDF

DESCRIPTION OF INDIVIDUALS AND ORGANIZATIONS CONSULTED FOR CHNA INPUT:

SEVEN FOCUS GROUPS WERE HELD THROUGHOUT THE COUNTY WITH REPRESENTATION FROM THE FOLLOWING ORGANIZATIONS. THE FOCUS GROUP TOPICS INCLUDED: AGE RELATED HEALTH ISSUES, CHRONIC DISEASE SPECIFIC HEALTH, SPECIAL POPULATIONS, COUNTY LEADERSHIP, SUBSTANCE ABUSE, YOUTH THROUGH THE SCHOOL

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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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NURSES, AND THE PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY (PHCC)

(COMMUNITY LEADERS AND STAKEHOLDERS). APPROXIMATELY 165 PEOPLE

PARTICIPATED IN THE COUNTY FOCUS GROUPS FROM THE FOLLOWING

ORGANIZATIONS:

PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY

CIVISTA MEDICAL CENTER

CIVISTA HEALTH, BOARD OF DIRECTORS

CHARLES COUNTY DEPARTMENT OF HEALTH

UNIVERSITY OF MARYLAND CLINICAL TRIALS PROGRAM

BEL ALTON ALUMNI COMMUNITY DEVELOPMENT ASSOCIATION

CHARLES COUNTY DEPARTMENT OF COMMUNITY SERVICES, TRANSPORTATION

TRI COUNTY COUNCIL FOR SOUTHERN MARYLAND

MINISTER'S ALLIANCE OF CHARLES COUNTY

CHARLES COUNTY DEPARTMENT OF SOCIAL SERVICES

MARYLAND FOUNDATION FOR QUALITY HEALTHCARE

HEALTH PARTNER'S CLINIC

GREATER BADEN FQHC

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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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SHILOH COMMUNITY UNITED METHODIST CHURCH

CHARLES COUNTY 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)

HOSPICE OF CHARLES COUNTY

BREAST CANCER SUPPORT ADVOCATES

CHARLES COUNTY PUBLIC SCHOOLS SCHOOL NURSES

CHARLES COUNTY COMMISSIONERS

Part VI Supplemental Information

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CHARLES COUNTY EMERGENCY SERVICES

CHARLES COUNTY SHERIFF'S OFFICE

SO. MD DELEGATION

CHARLES COUNTY COMMUNITY FOUNDATION

COMMUNITY PHYSICIANS

CHARLES COUNTY FIRE AND RESCUE BOARD

LIFESTYLES, INC. (HOMELESS)

PRIORITIZATION OF COMMUNITY HEALTH NEEDS

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.

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CUMULATIVE ANALYSIS OF ALL QUANTITATIVE AND QUALITATIVE DATA IDENTIFIED

THE TOP 11 HEALTH NEEDS OF CHARLES COUNTY WHICH WAS PRESENTED TO THE

PHCC, A COALITION OF CHARLES COUNTY AGENCIES AND ORGANIZATIONS. THE

DIRECTION OF PHCC IS GUIDED BY THE STEERING COMMITTEE WHICH CONSISTS OF

LEADERSHIP FROM CIVISTA HEALTH, CCDOH, CCPS AND THE CSM, AS WELL AS A

PUBLIC HEALTH EPIDEMIOLOGIST.

PHCC EXECUTIVE COMMITTEE:

NOEL A. CERVINO	CEO	CIVISTA HEALTH
DR. DEVADASON	HEALTH OFFICER	CC HEALTH DEPARTMENT (CCDOH)
DR. BRAD GOTTFRIED	PRESIDENT	COLLEGE OF SOUTHERN MARYLAND
JIM RICHMOND	SUPERINTENDENT	CHARLES COUNTY PUBLIC SCHOOLS

PHCC STEERING COMMITTEE:

JOYCE RIGGS	DIR., COMMUNITY DEVELOPMENT & PLANNING	CHI
FAY REED, RN	DEPUTY HEALTH OFFICER	CCDOH
WILLIAM LEEBEL	PUBLIC INFORMATION OFFICER	CCDOH

Part VI Supplemental Information

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LINDA SMITH PROJECT COORDINATOR CSM

TANISHA SAUNDERS COORDINATOR OF INTEGRATED STUDENT SERV. CCPS

AMBER STARN, MPH EPIDEMIOLOGIST CHI

ELIGIBILITY EDUCATION

SCHEDULE H, PART VI, LINE 3

CIVISTA MEDICAL CENTER POSTS ITS FINANCIAL ASSISTANCE POLICY (FAP), OR A SUMMARY THEREOF, AS WELL AS FINANCIAL ASSISTANCE CONTACT INFORMATION, IN ADMISSIONS AREAS, EMERGENCY ROOMS, BUSINESS OFFICES AND OTHER AREAS OF THE FACILITY WHERE ELIGIBLE PATIENTS ARE LIKELY TO PRESENT. IN ADDITION, THE POLICY IS AVAILABLE ON THE CIVISTA WEBSITE AND IS POSTED IN THE LOCAL PAPER TWICE EACH YEAR.

THE FAP IS WRITTEN IN A CULTURALLY SENSITIVE AND AT AN APPROPRIATE READING LEVEL. IT IS AVAILABLE IN ENGLISH AND SPANISH.

DURING THE INTAKE OR DISCHARGE PROCESS OR WHEN THERE IS CONTACT REGARDING

Part VI Supplemental Information

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A BILLING MATTER, IF A PATIENT DISCLOSES FINANCIAL DIFFICULTY OR

CONCERN WITH PAYMENT OF THE BILL, THE PATIENT IS PROVIDED WITH FAP

INFORMATION.

ADDITIONALLY, ASSISTANCE IS PROVIDED FOR PATIENTS OR THEIR FAMILIES IN

QUALIFICATION AND APPLICATION OF GOVERNMENT BENEFITS, MEDICAID AND OTHER

STATE PROGRAMS.

DESCRIPTION OF COMMUNITY SERVED

SCHEDULE H, PART VI, LINE 4

THE COMMUNITY BENEFIT SERVICE AREA FOR CIVISTA MEDICAL CENTER IS ALL 28

ZIP CODES LOCATED WITHIN THE BORDERS OF CHARLES COUNTY. THIS INCLUDES THE

SIX ZIP CODES IDENTIFIED AS THE PRIMARY SERVICE AREA. CIVISTA MEDICAL

CENTER IS CHARLES COUNTY'S ONLY HOSPITAL AND, AS SUCH, SERVES THE

RESIDENTS OF THE ENTIRE COUNTY.

GEOGRAPHY

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; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.

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CHARLES COUNTY IS LOCATED 23 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 458 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" 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 THE COUNTY'S RESIDENTS LIVE IN THE GREATER WALDORF LA PLATA AREA. BY CONTRAST, THE SOUTHERN (COBB NECK AREA) AND WESTERN (NANJEMOY, INDIAN HEAD, MARBURY) AREAS OF THE REGION STILL REMAIN VERY RURAL WITH SMALLER POPULATIONS.

POPULATION

CHARLES COUNTY HAS EXPERIENCED RAPID GROWTH SINCE 1970, EXPANDING ITS POPULATION FROM 47,678 IN 1970 TO 120,546 IN THE 2000 CENSUS AND 146,551

Part VI Supplemental Information

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IN THE 2010 CENSUS. THE CURRENT CENSUS BUREAU 2012 ESTIMATES THE

POPULATION AT 150,592 FOR A 2.8% INCREASE IN TWO YEARS. THE 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, WHICH INCREASED

TO 261.5 INDIVIDUALS PER SQUARE MILE BY 2000, AN INCREASE OF 19.2%, AND

TO 320.2 INDIVIDUALS PER SQUARE MILE BY 2010, AN INCREASE OF 22.5%.

TRANSPORTATION

THE PERCENT CHANGE IN THE POPULATION GROWTH FOR CHARLES COUNTY HAS BEEN

SLIGHTLY GREATER THAN THE CHANGE SEEN IN THE MARYLAND POPULATION GROWTH.

THIS GROWTH HAS CREATED TRANSPORTATION ISSUES FOR THE COUNTY IN

PARTICULAR FOR THE "DEVELOPMENT DISTRICT" IN THE NORTHERN PART OF THE

COUNTY WHERE MANY RESIDENTS COMMUTE TO WASHINGTON D.C. TO WORK. THE

AVERAGE WORK COMMUTE TIME FOR A CHARLES COUNTY RESIDENT IS 42.3 MINUTES

WHICH IS HIGHER THAN THE MARYLAND AVERAGE BY SLIGHTLY MORE THAN 10

MINUTES. PUBLIC TRANSPORTATION CONSISTS OF COMMUTER BUS FOR OUT OF

COUNTY TRAVEL AND THE COUNTY RUN VAN GO BUS SERVICE FOR IN COUNTY

Part VI Supplemental Information

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TRANSPORTATION.

DIVERSITY

AS THE POPULATION OF THE COUNTY CHANGES, THE DIVERSITY OF THE COUNTY ALSO INCREASES. THE AFRICAN AMERICAN POPULATION HAS EXPERIENCED THE GREATEST INCREASE. IN 2000, AFRICAN AMERICANS MADE UP 26% OF THE TOTAL CHARLES COUNTY POPULATION; BY 2012, THEY COMPRISE 42.4% OF THE TOTAL COUNTY POPULATION. AS OF 2012, MINORITIES MAKE UP ROUGHLY 54% OF THE CHARLES COUNTY POPULATION. THE HISPANIC COMMUNITY HAS ALSO SEEN INCREASES OVER THE PAST FEW YEARS. THEY NOW COMPRISE 4.7% OF THE TOTAL COUNTY POPULATION. THIS IS THE ONE OF THE HIGHEST PERCENTAGES AMONG THE 24 MARYLAND JURISDICTIONS.

ECONOMY

EMPLOYMENT AND ECONOMIC INDICATORS FOR THE COUNTY ARE FAIRLY STRONG. THE 2010 US CENSUS ESTIMATES FOUND THAT 73.8% OF THE CHARLES COUNTY POPULATION IS CURRENTLY IN THE LABOR WORK FORCE. THE 2011 UPDATE

Part VI Supplemental Information

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ESTIMATES THAT APPROXIMATELY 5.6% OF CHARLES COUNTY INDIVIDUALS ARE

LIVING BELOW THE POVERTY LEVEL, UP 0.4% FROM 2010, HOWEVER THIS IS LOWER

THAN THE MARYLAND RATE OF 9% IN 2011. THE CHARLES COUNTY MEDIAN HOUSEHOLD

INCOME WAS $92,135, AN INCREASE OF $3,310 OVER THE 2010 ESTIMATES AND

STILL WELL ABOVE THE MARYLAND MEDIAN HOUSEHOLD INCOME OF $72,419. THE

DIVERSITY OF THE COUNTY IS ALSO REPRESENTED IN THE BUSINESS COMMUNITY

WITH 29.3% OF ALL CHARLES COUNTY BUSINESSES BEING BLACK OWNED FIRMS. THIS

IS HIGHER THAN THE STATE OF MARYLAND AT 19.3%.

EDUCATION

CHARLES COUNTY HAS A LARGER PERCENTAGE OF HIGH SCHOOL GRADUATES THAN

MARYLAND (90.6% VS. 88.2%); HOWEVER, CHARLES COUNTY HAS A SMALLER

PERCENTAGE THAN MARYLAND OF INDIVIDUALS WITH A BACHELOR'S DEGREE OR

HIGHER (26.3% VS. 36.1%).

HOUSING

THERE IS A HIGH LEVEL OF HOME OWNERSHIP IN CHARLES COUNTY (80.1%),

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HOWEVER, THIS IS SLIGHTLY DOWN FROM THE 2010 LEVEL OF 81.8%. THE MEDIAN

VALUE OF A HOUSING UNIT IN CHARLES COUNTY IS HIGHER THAN THE MARYLAND

AVERAGE ($341,200 VS. $319,800). HOME VALUES ACROSS MARYLAND HAVE

DECREASED AND CHARLES COUNTY SHOWED A SLIGHTLY LARGER DECREASE THAN THE

MARYLAND AVERAGE (4% VS. 3%). THE AVERAGE HOUSEHOLD SIZE IN CHARLES

COUNTY IS 2.86 PERSONS.

LIFE EXPECTANCY

THE LIFE EXPECTANCY FOR A CHARLES COUNTY RESIDENT, AS CALCULATED FOR 2009

2011, WAS 78.4 YEARS. THIS IS SIMILAR TO THE STATE AVERAGE LIFE

EXPECTANCY OF 79.2 YEARS.

BIRTHS

THERE WERE 1,923 BIRTHS IN CHARLES COUNTY IN 2012. CHARLES COUNTY

REPRESENTS 54% OF THE BIRTHS IN SOUTHERN MARYLAND (UP 11% FROM 2009) AND

2.6% OF THE TOTAL BIRTHS IN MARYLAND FOR 2012.

MINORITIES MADE UP JUST OVER HALF OF THE BABIES BORN IN CHARLES COUNTY IN

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2012 (51.5%) WHICH IS IN LINE WITH THE COMPOSITION OF THE COUNTY.

SOURCE: 2012 MARYLAND VITAL STATISTICS REPORT

PROMOTING THE HEALTH OF THE COMMUNITY

SCHEDULE H, PART VI, LINE 5

IMPLEMENTATION STRATEGY: THE CHARLES COUNTY HEALTH IMPROVEMENT PLAN (CCHIP):

UPON COMPLETION OF THE CHNA, THE STEERING COMMITTEE OF PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY (PHCC) REVIEWED THE RESULTS AND THE IDENTIFIED TOP 11 HEALTH NEEDS. THE STEERING COMMITTEE SET COUNTY OBJECTIVES THROUGH 2014 BASED ON MARYLAND SHIP OBJECTIVES AND HEALTHY PEOPLE 2020 GOALS.

THE RESULTS AND GOALS WERE PRESENTED TO THE PHCC MEMBERSHIP AT THE QUARTERLY GENERAL MEMBERSHIP MEETING. SIX TEAMS WERE FORMED BASED ON

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EXPERTISE AND INTEREST TO FORMULATE 3 YEAR ACTION PLANS TO ADDRESS THE

FOLLOWING HEALTH NEEDS USING ONE OR MORE OF THE "SEVEN STRATEGIES FOR

COMMUNITY CHANGE" FOUND ON THE LAST PAGE OF THE CHARLES COUNTY HEALTH

IMPROVEMENT PLAN .

1. REPRODUCTIVE HEALTH

A. HEALTHY BABIES (INFANT MORTALITY DISPARITY)

B. STD REDUCTION/PREVENTION

2. CHRONIC DISEASE

A. HEART DISEASE

B. DIABETES

C. OBESITY

3. ACCESS TO CARE

A. DENTAL HEALTH

B. TRANSPORTATION

C. PHYSICIAN SHORTAGE

4. CANCER TEAM

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A. LUNG CANCER

B. PROSTATE CANCER

C. COLORECTAL CANCER

5. INJURY AND VIOLENCE FREE COMMUNITY

A. ROADWAY INCIDENTS

B. INJURIES AND FALL PREVENTION

6. BEHAVIORAL HEALTH

A. SUBSTANCE ABUSE

B. MENTAL HEALTH

THE CHARLES COUNTY HEALTH NEEDS ASSESSMENT AND HEALTH IMPROVEMENT PLAN

WERE PRESENTED TO THE CIVISTA HEALTH BOARD OF DIRECTORS AND APPROVED.

ANNUAL UPDATES TO THE PLAN ARE REVIEWED AND APPROVED.

THE CCHIP OBJECTIVES ARE THE CHARLES COUNTY HEALTH IMPROVEMENT PLAN AND

AVAILABLE AT:

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HTTP://WWW.CHARLESREGIONAL.ORG/INDEX.CFM?FUSEACTION=HEALTHRESOURCES.SHOWHE

ALTHACTIONPLANS

THE HEALTH IMPROVEMENT TEAM ACTION PLANS (IMPLEMENTATION PLANS) ARE

AVAILABLE AT:

HTTP://WWW.CHARLESREGIONAL.ORG/INDEX.CFM?FUSEACTION=HEALTHRESOURCES.SHOWHE

ALTHACTIONPLANS

ALL THE PRIMARY NEEDS OUTLINED IN THE NEEDS ASSESSMENT ARE BEING

ADDRESSED BY CIVISTA HEALTH EITHER DIRECTLY (I.E., OB CLINIC, PHYSICIAN

RECRUITMENT) OR THROUGH PARTNERSHIPS WITH OTHER ORGANIZATIONS (I.E.,

CHILDHOOD OBESITY PROGRAM, FETAL INFANT MORTALITY, PROSTATE CANCER) OR

THROUGH THE PHCC WHICH IS LED AND PRIMARILY FINANCED BY CIVISTA HEALTH.

WHERE A NEED IS APPROPRIATELY ADDRESSED BY ANOTHER ENTITY, CIVISTA

PROVIDES LEADERSHIP THROUGH THE CHARLES COUNTY HEALTH IMPROVEMENT PLAN

AND THE LOCAL HEALTH COALITION (PHCC) TO COMMUNICATE INITIATIVES, PROVIDE

FINANCIAL SUPPORT AND/OR ASSISTANCE WHEN NEEDED AND REVIEW RESULTS (I.E.,

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SUBSTANCE ABUSE, MENTAL HEALTH).

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ADDRESSED AND FUNDED BY CIVISTA EITHER DIRECTLY (I.E., OB CLINIC,

PHYSICIAN RECRUITMENT) OR THROUGH PARTNERSHIPS WITH OTHER ORGANIZATIONS

(I.E., CHILDHOOD OBESITY PROGRAM, FETAL INFANT MORTALITY). WHERE A NEED

IS APPROPRIATELY ADDRESSED BY ANOTHER ENTITY, CIVISTA PROVIDES LEADERSHIP

THROUGH THE CHARLES COUNTY HEALTH IMPROVEMENT PLAN AND THE COALITION OF

PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY TO COMMUNICATE INITIATIVES,

PROVIDE ASSISTANCE WHEN NEEDED AND REVIEW RESULTS (I.E., SUBSTANCE ABUSE,

MENTAL 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

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MEDICAL STAFF IN THE COMMUNITY. CONTINUING MEDICAL EDUCATION SEMINARS AND

GRAND ROUNDS ARE OPEN TO ALL COMMUNITY PHYSICIANS.

AFFILIATED HEALTH CARE SYSTEM ROLES

SCHEDULE H, PART VI, LINE 6

CIVISTA MEDICAL CENTER IS A MEMBER OF THE UNIVERSITY OF MARYLAND MEDICAL

SYSTEM (UMMS). SYSTEM HOSPITALS MEET MONTHLY TO COORDINATE AND PLAN

COMMUNITY BENEFIT OPERATIONS SUCH AS HEALTH NEEDS ASSESSMENTS AND

MARYLAND STATE HEALTH IMPROVEMENT PLAN OBJECTIVES. UMMS PROVIDES

LEADERSHIP AND GUIDANCE TO LOCAL SYSTEM JURISDICTIONS REGARDING ALIGNMENT

WITH SYSTEM AND STATE WIDE GOALS.

SOUTHERN MARYLAND HAD THE HIGHEST PERCENTAGE OF PHYSICIAN SHORTAGES OF

ALL OF THE REGIONS IN MARYLAND (89.9%). TO ADDRESS THE SHORTAGE, CIVISTA

MEDICAL CENTER AND UMMS HAVE DEVELOPED A RECRUITMENT AND RETENTION PLAN

TO SUCCESSFULLY ATTRACT AND RETAIN PRIVATE PHYSICIANS TO THE COMMUNITY.

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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.

8 **Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

COMMUNITY BENEFIT REPORT STATE FILINGS

SCHEDULE H, PART VI, LINE 7

COMMUNITY BENEFIT REPORT WAS FILED IN THE STATE OF MARYLAND.

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

2012

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? . . . . . [X] 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. 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) MARCH OF DIMES 2120 WASHINGTON BLVD STE 425	13-1846366	501(C)(3)	11,000.				MARCH FOR BABIES SPONSORSHIP
(2) CHARLES COUNTY CHAMBER OF COMMERCE 101 CENTENNIAL STREET STE A	52-0699475	501(C)(3)	6,450.				2013 EXPO SPONSORSHIP
(3) CIVISTA HEALTH FOUNDATION 6 GARRETT AVENUE LA PLATA, MD 20646	52-1414564	501(C)(3)	13,000.				SOUTHERN MD CAREGIVERS SPONSOR
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

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

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

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, Part III, column (b), and any other additional information.

PROCEDURE FOR MONITORING USE OF GRANT FUNDS INSIDE U.S.

PART I, LINE 2

CIVISTA MEDICAL CENTER MAKES FINANCIAL AND IN-KIND CONTRIBUTIONS TO

VARIOUS 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

2012

Open to Public Inspection

Name of the organization
CIVISTA MEDICAL CENTER, INC.

Employer identification number
52-0445374

Part I Questions Regarding Compensation

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

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

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

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	JOHN ASHWORTH EX-OFFICIO/DIRECTOR	(i)	0	0	0	0	0	0	0
		(ii)	368,549.	157,673.	62,314.	10,000.	10,541.	609,077.	0
2	ROBERT CHRENCIK EX-OFFICIO/DIRECTOR	(i)	0	0	0	0	0	0	0
		(ii)	1,166,972.	994,524.	13,073.	223,385.	11,081.	2,409,035.	0
3	NOEL CERVINO EX-OFFICIO/PRESIDENT & CEO	(i)	0	0	0	0	0	0	0
		(ii)	337,544.	167,621.	20,576.	61,499.	5,149.	592,389.	0
4	ERIK BOAS CHIEF FINANCIAL OFFICER	(i)	0	0	0	0	0	0	0
		(ii)	192,019.	58,118.	15,605.	23,363.	0	289,105.	0
5	MARK DUMAIS CHIEF MEDICAL OFFICER	(i)	0	0	0	0	0	0	0
		(ii)	271,296.	100,341.	2,446.	36,148.	7,316.	417,547.	0
6	GARY HERBEK CHIEF OPERATING OFFICER	(i)	199,180.	0	2,030.	9,271.	13,531.	224,012.	0
		(ii)	0	0	0	0	0	0	0
7	MELANIE SAGE VP PATIENT CARE/NURSE EXEC.	(i)	147,832.	19,630.	262.	7,670.	6,250.	181,644.	0
		(ii)	0	0	0	0	0	0	0
8	PAUL BLACKWOOD VP PLANNING	(i)	161,783.	17,215.	2,056.	5,494.	15,793.	202,341.	0
		(ii)	0	0	0	0	0	0	0
9	KATHERINE MIDDLETON RN	(i)	157,904.	0	70.	6,481.	9,337.	173,792.	0
		(ii)	0	0	0	0	0	0	0
10	MARILYN GREGORY CLINICAL NURSE IV	(i)	171,637.	0	201.	6,456.	1,964.	180,258.	0
		(ii)	0	0	0	0	0	0	0
11	GABRIEL ABIOLA PHARMACY CLINICAL MANAGER	(i)	154,269.	6,062.	781.	6,995.	13,531.	181,638.	0
		(ii)	0	0	0	0	0	0	0
12	STACEY COOK VP HUMAN RESOURCES	(i)	149,013.	20,859.	485.	7,526.	24,365.	202,248.	0
		(ii)	0	0	0	0	0	0	0
13		(i)							
		(ii)							
14		(i)							
		(ii)							
15		(i)							
		(ii)							
16		(i)							
		(ii)							

Part III Supplemental Information

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

SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN

SCHEDULE J, PART I, LINE 4B

DURING THE FISCAL YEAR-ENDED JUNE 30, 2013, CERTAIN OFFICERS AND KEY EMPLOYEES PARTICIPATED IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN. THE INDIVIDUALS LISTED BELOW HAVE VESTED IN THE PLAN IN A PRIOR YEAR, THEREFORE THE CONTRIBUTIONS TO THE PLAN FOR THE FISCAL YEAR ARE REPORTED AS TAXABLE COMPENSATION AND REPORTED ON SCHEDULE J, PART II, LINE B(III), OTHER REPORTABLE COMPENSATION:

JOHN W. ASHWORTH

THE INDIVIDUAL LISTED BELOW HAS NOT VESTED IN THE PLAN THEREFORE THE ACCRUED CONTRIBUTION TO THE PLAN FOR THE FISCAL YEAR IS REPORTED ON SCHEDULE J, PART II, COLUMN C, RETIREMENT AND OTHER DEFERRED COMPENSATION:

ROBERT A. CHRENCIK

Part III Supplemental Information

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

NON-FIXED PAYMENTS

SCHEDULE J, PART I, LINE 7

BONUSES PAID ARE BASED ON A NUMBER OF VARIABLES INCLUDING BUT NOT LIMITED TO INDIVIDUAL GOAL ACHIEVEMENTS AS WELL AS ORGANIZATION OPERATION ACHIEVEMENTS. THE FINAL DETERMINATION OF THE BONUS AMOUNT IS DETERMINED AND APPROVED BY THE BOARD AS PART OF THE OVERALL COMPENSATION REVIEW OF THE OFFICERS AND KEY EMPLOYEES.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2012

Open to Public Inspection

Name of the organization
CIVISTA MEDICAL CENTER, INC.

Employer identification number
52-0445374

TAX EXEMPT BOND ISSUES

FORM 990, PART IV, QUESTION 24

PURSUANT TO A MASTER LOAN AGREEMENT DATED JUNE 20, 1991 (THE "MASTER LOAN AGREEMENT"), AS AMENDED, THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (THE "CORPORATION") AND SEVERAL OF ITS SUBSIDIARIES HAVE ISSUED DEBT THROUGH THE MARYLAND HEALTH AND HIGHER EDUCATION FACILITY AUTHORITY (THE "AUTHORITY"). AS SECURITY FOR THE PERFORMANCE OF THE BOND OBLIGATION UNDER THE MASTER LOAN AGREEMENT, THE AUTHORITY MAINTAINS A SECURITY INTEREST IN THE REVENUE OF THE OBLIGORS. THE MASTER LOAN AGREEMENT CONTAINS CERTAIN RESTRICTIVE COVENANTS. THESE COVENANTS REQUIRE THAT RATES AND CHARGES BE SET AT CERTAIN LEVELS, LIMIT INCURRENCE OF ADDITIONAL DEBT, REQUIRE COMPLIANCE WITH CERTAIN OPERATING RATIOS AND RESTRICT THE DISPOSITION OF ASSETS.

THE OBLIGATED GROUP UNDER THE MASTER LOAN AGREEMENT INCLUDES THE CORPORATION, THE JAMES LAWRENCE KERNAN HOSPITAL, INC., MARYLAND GENERAL HOSPITAL, INC., BALTIMORE WASHINGTON MEDICAL CENTER, INC., SHORE HEALTH SYSTEM, INC., CHESTER RIVER HOSPITAL CENTER, INC., CIVISTA MEDICAL CENTER, INC., UNIVERSITY OF MARYLAND ST. JOSEPH MEDICAL CENTER, LLC AND THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM FOUNDATION, INC. EACH MEMBER OF THE OBLIGATED GROUP IS JOINTLY AND SEVERALLY LIABLE FOR THE REPAYMENT OF THE OBLIGATIONS UNDER THE MASTER LOAN AGREEMENT OF THE CORPORATION'S $1,267,185,000 OF OUTSTANDING AUTHORITY BONDS ON JUNE 30, 2013. ALL OF THE BONDS WERE ISSUED IN THE NAME OF THE UNIVERSITY OF MARYLAND MEDICAL

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

SYSTEM CORPORATION.

AS OF JUNE 30, 2013, CIVISTA MEDICAL CENTER REFINANCED ITS MARYLAND HEALTH AND HIGHER EDUCATION FACILITY AUTHORITY BONDS. THE ISSUANCE OF DEBT WAS MADE BY THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION FOR THE OBLIGATED GROUP, OF WHICH CIVISTA MEDICAL CENTER IS A MEMBER.

MEMBERS OR STOCKHOLDERS

FORM 990, PART VI, LINE 6, 7A, AND 7B

CIVISTA MEDICAL CENTER, INC. AND UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION MAY ELECT MEMBERS AND APPROVE DECISIONS OF THE CIVISTA MEDICAL CENTER BOARD.

FORM 990 REVIEW PROCESS

FORM 990, PART VI, LINE 11B

THE I.R.S. FORM 990 IS PREPARED AND REVIEWED BY THE ACCOUNTING FIRM OF GRANT THORNTON. ACCOUNTING PERSONNEL IN FINANCE SHARED SERVICES AT THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM GATHER THE INFORMATION NEEDED TO COMPLETE THE RETURN AND INPUT THE DATA INTO THE GRANT THORNTON TAX ORGANIZER. WHEN ALL DATA HAS BEEN ENTERED, THE INFORMATION IS SUBMITTED TO GRANT THORNTON FOR IMPORTATION INTO THEIR TAX SOFTWARE. AT THIS POINT, GRANT THORNTON STAFF MEMBERS REVIEW THE DATA, ASK FOR ADDITIONAL INFORMATION IF NEEDED AND PREPARE THE TAX RETURN. EACH RETURN IS REVIEWED AT SEVERAL LEVELS AT GRANT THORNTON INCLUDING THE TAX PARTNER. AFTER THEIR REVIEW PROCESS, A DRAFT RETURN IS SENT TO THE ACCOUNTING STAFF AT UMMS FOR AN IN-HOUSE REVIEW.

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

UPON COMPLETION OF THE IN-HOUSE REVIEW, GRANT THORNTON IS INSTRUCTED TO MAKE ANY NECESSARY CHANGES AND TO PREPARE THE FINAL TAX RETURN. THE FINAL RETURN UNDERGOES ANOTHER REVIEW BY THE ACCOUNTING STAFF AT FINANCE SHARED SERVICES AND IS ALSO REVIEWED BY THE ACCOUNTING MANAGER, THE DIRECTOR OF FINANCIAL REPORTING, THE VICE PRESIDENT OF FINANCE AND THE CFO, WHO SIGNS THE RETURN. PRIOR TO FILING THE I.R.S. FORM 990, THE ORGANIZATION'S BOARD CHAIRMAN, TREASURER, AUDIT COMMITTEE CHAIRMAN, EXECUTIVE COMMITTEE CHAIRMAN OR OTHER MEMBER OF THE BOARD WITH SIMILAR AUTHORITY WILL REVIEW THE I.R.S. FORM 990. AT THE DISCRETION OF THE REVIEWING BOARD MEMBER, SUCH MEMBER WILL BRING ANY ISSUES OR QUESTIONS RELATED TO THE COMPLETED I.R.S. FORM 990 TO THE ATTENTION OF THE BOARD. NOTWITHSTANDING THE ABOVE, A BOARD RESOLUTION IS NOT REQUIRED FOR THE FILING OF THE ORGANIZATION'S I.R.S. FORM 990. EACH BOARD MEMBER IS PROVIDED WITH A COPY OF THE FINAL I.R.S. FORM 990 BEFORE FILING.

CONFLICT OF INTEREST POLICY MONITORING & ENFORCEMENT

FORM 990, PART VI, LINE 12C

THE ORGANIZATION'S OFFICERS, DIRECTORS, EMPLOYEES AND MEDICAL STAFF MEMBERS, AS APPLICABLE, SHALL DISCLOSE CONFLICTS OF INTEREST OR POTENTIAL CONFLICTS OF INTEREST BETWEEN THEIR PERSONAL INTERESTS AND THE INTERESTS OF THE ORGANIZATION, OR ANY ENTITY CONTROLLED BY OR OWNED IN SUBSTANTIAL PART BY THE ORGANIZATION.

A QUESTIONNAIRE WHICH DISCLOSES POTENTIAL CONFLICTS OF INTEREST IS DISTRIBUTED ANNUALLY TO ALL OFFICERS, DIRECTORS AND KEY EMPLOYEES. THE

Name of the organization: CIVISTA MEDICAL CENTER, INC.

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GENERAL COUNSEL OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION (UMMSC) REVIEWS THE RESPONSES FOR UMMSC, UNIVERSITY SPECIALTY HOSPITAL AND JAMES LAWRENCE KERNAN HOSPITAL. THE CEO OR CFO OF EACH OF THE OTHER ENTITIES IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM REVIEWS THE RESPONSES FOR THOSE ENTITIES.

THE GENERAL COUNSEL, IN CONSULTATION WITH THE AUDIT COMMITTEE, IF NECESSARY, WOULD DETERMINE IF A CONFLICT OF INTEREST EXISTED FOR UMMSC, UNIVERSITY SPECIALTY HOSPITAL AND JAMES LAWRENCE KERNAN HOSPITAL. WITH RESPECT TO THE OTHER ENTITIES IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM, THE GENERAL COUNSEL MAY BE CALLED FOR CONSULT. IF SO, THE GENERAL COUNSEL MAY CONSULT THE AUDIT COMMITTEE, IF NECESSARY.

WHENEVER A CONFLICT OR POTENTIAL CONFLICT OF INTEREST EXISTS, THE NATURE OF THE CONFLICT OR POTENTIAL CONFLICT OF INTEREST MUST BE DISCLOSED IN WRITING TO THE ORGANIZATION'S BOARD, BOARD COMMITTEE, AN OFFICER OF THE ORGANIZATION OR OTHER APPROPRIATE EXECUTIVE. SUCH INDIVIDUAL HAVING A POTENTIAL CONFLICT OF INTEREST SHALL PLAY NO ROLE ON BEHALF OF THE ORGANIZATION, OR ANY ORGANIZATION CONTROLLED OR SUBSTANTIALLY OWNED, IN ANY TRANSACTION IN WHICH A CONFLICT EXISTS.

ALL INVITATIONS FOR BIDS, PROPOSALS OR SOLICITATIONS FOR OFFERS INCLUDE THE FOLLOWING PROVISION: ANY VENDOR, SUPPLIER OR CONTRACTOR MUST DISCLOSE ANY ACTUAL OR POTENTIAL TRANSACTION WITH ANY ORGANIZATION OFFICER, DIRECTOR, EMPLOYEE OR MEMBER OF THE MEDICAL STAFF, INCLUDING

Name of the organization: CIVISTA MEDICAL CENTER, INC.

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FAMILY MEMBERS WITHIN FIVE DAYS OF THE TRANSACTION. FAILURE TO COMPLY WITH THIS PROVISION IS A MATERIAL BREACH OF AGREEMENT.

IN ADDITION, A BOARD DISCLOSURE REPORT IS FILED WITH THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION ON AN ANNUAL BASIS SHOWING ANY BUSINESS TRANSACTIONS BETWEEN THE BOARD MEMBERS AND THE ORGANIZATION.

PROCESS FOR DETERMINING COMPENSATION

FORM 990, PART VI, LINE 15A & 15B

THE ORGANIZATION DETERMINES THE EXECUTIVE COMPENSATION PAID TO ITS EXECUTIVES IN THE FOLLOWING MANNER PRESCRIBED IN THE I.R.S. REGULATIONS: EXECUTIVE COMPENSATION PACKAGES ARE DETERMINED BY A COMMITTEE OF THE BOARD THAT IS COMPOSED ENTIRELY OF BOARD MEMBERS WHO HAVE NO CONFLICT OF INTEREST. THE COMMITTEE ACQUIRES CREDIBLE COMPARABILITY MARKET DATA CONCERNING THE COMPENSATION PACKAGES OF SIMILARLY SITUATED EXECUTIVES. THE COMMITTEE CAREFULLY REVIEWS THAT DATA, THE EXECUTIVE'S PERFORMANCE AND THE PROPOSED COMPENSATION PACKAGES DURING THE DECISION MAKING PROCESS. THE COMMITTEE MEMORIALIZES ITS DELIBERATIONS IN DETAILED MINUTES REVIEWED AND ADOPTED AT THE NEXT-FOLLOWING MEETING. THE COMMITTEE SEEKS AN OPINION OF COUNSEL THAT IT HAS MET THE REQUIREMENTS OF THE I.R.S. INTERMEDIATE SANCTIONS REGULATIONS. THIS PROCESS IS USED TO DETERMINE THE COMPENSATION PACKAGES FOR ALL MANAGEMENT EMPLOYEES FROM THE VICE PRESIDENT LEVEL AND UP.

HOW DOCUMENTS ARE MADE AVAILABLE TO THE PUBLIC

FORM 990, PART VI, LINE 19

IN GENERAL, FINANCIAL AND TAX INFORMATION RELATING TO THE ORGANIZATION IS

Name of the organization: CIVISTA MEDICAL CENTER, INC.

Employer identification number: 52-0445374

DEEMED PROPRIETARY AND NOT SUBJECT TO DISCLOSURE UPON REQUEST. HOWEVER, SPECIFIC PROVISIONS OF FEDERAL AND STATE LAW REQUIRE THE ORGANIZATION TO DISCLOSE CERTAIN LIMITED FINANCIAL AND TAX DATA UPON A SPECIFIC REQUEST FOR THAT INFORMATION.

REQUESTS FOR FORM 990 AND FORM 1023:

A REQUESTOR SEEKING TO REVIEW AND/OR OBTAIN A COPY OF THE ORGANIZATION'S IRS FORM 990 OR FORM 1023 AS FILED WITH THE INTERNAL REVENUE SERVICE, INCLUDING ALL SCHEDULES AND ATTACHMENTS, MAY APPEAR IN PERSON OR SUBMIT A WRITTEN REQUEST. THE MOST RECENT THREE YEARS OF IRS FORM 990 MAY BE REQUESTED.

IF THE REQUESTER APPEARS IN PERSON, THE INDIVIDUAL IS DIRECTED TO THE OFFICE OF THE CHIEF FINANCIAL OFFICER FOR THE ORGANIZATION AND THE FORM 990 AND/OR FORM 1023 ARE MADE AVAILABLE FOR INSPECTION. THE INDIVIDUAL IS PERMITTED TO REVIEW THE RETURN, TAKE NOTES AND REQUEST A COPY. IF REQUESTED, A COPY IS PROVIDED ON THE SAME DAY. A NOMINAL FEE IS CHARGED FOR MAKING THE COPIES. THE ORGANIZATION MAY HAVE AN EMPLOYEE PRESENT DURING THE PUBLIC INSPECTION OF THE DOCUMENT.

WRITTEN REQUESTS FOR AN ENTITY'S FORM 990 OR FORM 1023 ARE DIRECTED IMMEDIATELY TO THE OFFICE OF THE CHIEF FINANCIAL OFFICER FOR THE ORGANIZATION. THE REQUESTED COPIES ARE MAILED WITHIN 30 DAYS OF THE REQUEST. REPRODUCTION FEES AND MAILING COSTS ARE CHARGED TO THE

Name of the organization: CIVISTA MEDICAL CENTER, INC.
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REQUESTOR.

CONFLICT OF INTEREST POLICY AND GOVERNING DOCUMENTS:

IF THE GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY OF OUR ORGANIZATION ARE SUBJECT TO THE FEDERAL PUBLIC DISCLOSURE RULES (OR STATE PUBLIC DISCLOSURE RULES), THESE DOCUMENTS WILL BE MADE PUBLICLY AVAILABLE AS APPLICABLE LAW MAY REQUIRE. OTHERWISE, THE GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY WILL BE PROVIDED TO THE PUBLIC AT THE DISCRETION OF MANAGEMENT.

HOURS ON RELATED ENTITIES

FORM 990, PART VII, SECTION A, COLUMN B

THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM (UMMS) IS A MULTI-ENTITY HEALTH CARE SYSTEM THAT INCLUDES 10 ACUTE CARE HOSPITALS, 3 ACUTE CARE HOSPITALS OWNED IN JOINT VENTURE ARRANGEMENTS AND VARIOUS SUPPORTING ENTITIES. A NUMBER OF INDIVIDUALS PROVIDE SERVICES TO VARIOUS ENTITIES WITHIN THE SYSTEM. IN GENERAL, THE OFFICERS AND KEY EMPLOYEES OF UMMS AVERAGE IN EXCESS OF 40 HOURS PER WEEK SERVING THE DIFFERENT ENTITIES THAT COMPRISE UMMS.

OTHER CHANGES IN NET ASSETS OR FUND BALANCES

FORM 990, PART XI, LINE 5

SWAP COSTS BOND REFINANCING	-76,924
CHANGE IN PENSION LIABILITY	3,625,800
NET ASSETS RELEASED FROM RESTRICTIONS	-117,482

Name of the organization: CIVISTA MEDICAL CENTER, INC.

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CHANGE IN TEMP. RESTRICTED NET ASSETS	-247,450
CHANGE IN EQUITY OF AFFILIATES, FOUNDATION	500,878
CHANGE IN EQUITY OF AFFILIATES, CPHA	411,250
UNREALIZED BONDS FMV ADJUSTMENT	-2,916,360
MISCELLANEOUS	-5,976
TOTAL CHANGE IN NET ASSETS	1,173,736

ATTACHMENT 1

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

CIVISTA HEALTH IS THE PARENT COMPANY OF A REGIONAL INTEGRATED HEALTH SYSTEM SERVING THE HEALTH NEEDS OF CHARLES COUNTY AND THE CITIZENS OF SOUTHERN MARYLAND. CIVISTA MEDICAL CENTER'S 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 HEALTH COLLABORATED WITH THE CHARLES COUNTY DEPARTMENT OF HEALTH (CCDOH) TO COMPLETE A COMPREHENSIVE ASSESSMENT OF THE HEALTH NEEDS (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 FOUR DIFFERENT SOURCES OF DATA: A

Name of the organization: CIVISTA MEDICAL CENTER, INC.

Employer identification number: 52-0445374

ATTACHMENT 1 (CONT'D)

LONG ONLINE SURVEY OF CHARLES COUNTY RESIDENTS PERCEPTIONS OF HEALTH AND HEALTH BEHAVIORS, A SHORT PAPER SURVEY ON HEALTH PERCEPTIONS THROUGHOUT THE COUNTY, SEVEN 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 ENSURED THAT CHARLES COUNTY RESIDENTS HAD AN OPPORTUNITY TO PARTICIPATE IN THE ASSESSMENT PROCESS AND TO FEEL INVESTED IN ITS OUTCOME. THREE HUNDRED AND TWO CHARLES COUNTY RESIDENTS COMPLETED THE 74 QUESTION ONLINE SURVEY THAT WAS CREATED USING SURVEY MONKEY. THE LINK TO THE SURVEY IS 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 THREE 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. THIRTY FIVE WERE COMPLETED IN SPANISH (17.5%). 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

Name of the organization: CIVISTA MEDICAL CENTER, INC.

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ATTACHMENT 1 (CONT'D)

CHARLES COUNTY (PHCC). APPROXIMATELY 165 PEOPLE PARTICIPATED IN THE COUNTY FOCUS GROUPS FROM A WIDE VARIETY OF ORGANIZATIONS AND COMMUNITY 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, CHILDHOOD OBESITY PROGRAM, FAITH-BASED HEALTH EXPO. SUPPORT GROUPS SUCH AS STROKE SUPPORT, PARKINSON'S SUPPORT GROUP, PINK LADIES AND SISTER'S AT HEART AND OSTOMY SUPPORT GROUP. CLINICS AND CLINIC SERVICES SUCH AS PRE NATAL AND OB CLINIC, FLU VACCINE 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 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 COMMISSION FOR WOMEN, CHARLES COUNTY CHILD ADVOCACY PARTNERSHIP, HEALTHCARE ROUNDTABLE COMMUNITY EVENTS SUCH AS CHRISTMAS CONNECTION, RELAY FOR LIFE, ALZHEIMER'S WALK, MARCH OF DIMES, AND SAFE NIGHTS.

Name of the organization: CIVISTA MEDICAL CENTER, INC.

Employer identification number: 52-0445374

ATTACHMENT 2

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
MARYLAND INPATIENT CARE SPECIALISTS 6934 AVIATION BLVD STE B GLEN BURNIE, MD 21061	PHYSICIANS	1,300,000.
SOUTHERN MD PULMONARY & CRITICAL CARE 3575 OLD WASHINGTON RD STE C WALDORF, MD 20602	RESPIRATORY	897,780.
NEWBRIDGE ANESTHESIA LLC 9901 BENTCROSS DRIVE POTOMAC, MD 20854	ANESTHESIA	560,002.
ROI ELIGIBILITY SERVICES CORP 1920 GREENSPRING DRIVE STE 200 TIMONIUM, MD 21094	PT ACCTG PURCH SERV	546,125.
NDG COMMUNICATIONS INC 105 CENTENNIAL STR STE K LAPLATA, MD 20646	ADVERTISING	507,775.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2012

Open to Public Inspection

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" to Form 990, Part IV, line 33.)

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) BALTIMORE WASHINGTON EMERGENCY PHYS INC 52-1756326 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	501(C)(3)	11A	BWMS		X
(2) BALTIMORE WASHINGTON HEALTHCARE SERVICES 52-1830243 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	501(C)(3)	11A	BWMS		X
(3) BALTIMORE WASHINGTON MEDICAL CENTER INC 52-0689917 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	501(C)(3)	03	BWMS		X
(4) BALTIMORE WASHINGTON MEDICAL SYSTEM, INC 52-1830242 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	501(C)(3)	11A	UMMSC		X
(5) BW MEDICAL CENTER FOUNDATION INC 52-1813656 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	FUNDRAISING	MD	501(C)(3)	11C	BWMS		X
(6) NORTH ARUNDEL DEVELOPMENT CORPORATION 52-1318404 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	REAL ESTATE	MD	501(C)(2)		NCC		X
(7) NORTH COUNTY CORPORATION 52-1591355 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	REAL ESTATE	MD	501(C)(2)		BWMS		X

SCHEDULE R (Form 990)

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Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) CHESTER RIVER HEALTH FOUNDATION INC 52-1338861 100 BROWN STREET CHESTERTOWN, MD 21620	FUNDRAISING	MD	501(C)(3)	07	CRHS		X
(2) UNIV OF MD SHORE REGIONAL HEALTH, INC. 52-2046500 100 BROWN STREET CHESTERTOWN, MD 21620	HEALTHCARE	MD	501(C)(3)	11A	UMMSC		X
(3) CHESTER RIVER HOSPITAL CENTER, INC. 52-0679694 100 BROWN STREET CHESTERTOWN, MD 21620	HEALTHCARE	MD	501(C)(3)	03	CRHS		X
(4) CHESTER RIVER MANOR INC 52-6070333 200 MORGNEC ROAD CHESTERTOWN, MD 21620	HEALTHCARE	MD	501(C)(3)	09	CRHS		X
(5) MARYLAND GENERAL CLINICAL PRACTICE GROUP 52-1566211 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	11B	MGHS		X
(6) MARYLAND GENERAL COMM HEALTH FOUNDATION 52-2147532 827 LINDEN AVENUE BALTIMORE, MD 21201	FUNDRAISING	MD	501(C)(3)	11C	MGHS		X
(7) UNIVERSITY OF MARYLAND MIDTOWN HEALTH 52-1175337 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	11B	UMMSC		X

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2012

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CIVISTA MEDICAL CENTER, INC.

Employer identification number
52-0445374

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) MARYLAND GENERAL HOSPITAL INC 52-0591667 827 LINDEN AVENUE BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	03	MGHS		X
(2) CARE HEALTH SERVICES INC 52-1510269 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTHCARE	MD	501(C)(3)	09	SHS		X
(3) DORCHESTER GENERAL HOSPITAL FOUNDATION 52-1703242 219 SOUTH WASHINGTON STREET EASTON, MD 21601	FUNDRAISING	MD	501(C)(3)	11D	SHS		X
(4) MEMORIAL HOSPITAL FOUNDATION INC 52-1282080 219 SOUTH WASHINGTON STREET EASTON, MD 21601	FUNDRAISING	MD	501(C)(3)	11A	SHS		X
(5) SHORE CLINICAL FOUNDATION INC 52-1874111 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTHCARE	MD	501(C)(3)	03	SHS		X
(6) SHORE HEALTH SYSTEM INC 52-0610538 219 SOUTH WASHINGTON STREET EASTON, MD 21601	HEALTHCARE	MD	501(C)(3)	03	UMMSC		X
(7) JAMES LAWRENCE KERNAN HOSP ENDOW FD 23-7360743 2200 KERNAN DRIVE BALTIMORE, MD 21207	FUNDRAISING	MD	501(C)(3)	11B	UMMSC		X

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2012

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CIVISTA MEDICAL CENTER, INC.

Employer identification number
52-0445374

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) JAMES LAWRENCE KERNAN HOSPITAL INC 52-0591639 2200 KERNAN DRIVE BALTIMORE, MD 21207	HEALTHCARE	MD	501(C)(3)	03	UMMSC		X
(2) SHIPLEYS CHOICE MEDICAL PARK INC 04-3643849 22 SOUTH GREENE STREET BALTIMORE, MD 21201	REAL ESTATE	MD	501(C)(2)		UMMSC		X
(3) UMMS FOUNDATION, INC. 52-2238893 22 SOUTH GREENE STREET BALTIMORE, MD 21201	FUNDRAISING	MD	501(C)(3)	11A	UMMSC		X
(4) UNIVERSITY OF MD MEDICAL SYSTEM CORP 52-1362793 22 SOUTH GREENE STREET BALTIMORE, MD 21201	HEALTHCARE	MD	501(C)(3)	03	N/A		X
(5) UNIVERSITY SPECIALTY HOSPITAL 52-0882914 611 SOUTH CHARLES STREET BALTIMORE, MD 21230	HEALTHCARE	MD	501(C)(3)	03	UMMSC		X
(6) CIVISTA HEALTH, INC. 52-2155576 PO BOX 1070 LA PLATA, MD 20646	HEALTHCARE	MD	501(C)(3)	11C	UMMSC		X
(7) CIVISTA HEALTH FOUNDATION, INC. 52-1414564 PO BOX 1070 LA PLATA, MD 20646	FUNDRAISING	MD	501(C)(3)	03	CIVHS		X

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2012

Open to Public Inspection

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" to Form 990, Part IV, line 33.)

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) CIVISTA HEALTH AUXILIARY, INC. 52-1131193 PO BOX 1070 LA PLATA, MD 20646	FUNDRAISING	MD	501(C)(3)	11A	CIVHS		X
(2) UNIV OF MD ST. JOSEPH FOUNDATION, INC 52-1681044 7601 OSLER DRIVE TOWSON, MD 21204	FUNDRAISING	MD	501(C)(3)	11A	UMMSC		X
(3)							
(4)							
(5)							
(6)							
(7)							

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) ARUNDEL PHYSICIANS ASSOCIATES 301 HOSPITAL DRIVE	HEALTHCARE	MD	N/A	N/A								
(2) BALTIMORE WASHINGTON IMAGING, 301 HOSPITAL DRIVE	HEALTHCARE	MD	N/A	N/A								
(3) CENTRAL MARYLAND RADIOLOGY ONC 10710 CHARTER DRIVE	HEALTHCARE	MD	N/A	N/A								
(4) INNOVATIVE HEALTH LLC 52-19972 29165 CANVASBACK DRIVE, SUITE	BILLING	MD	N/A	N/A								
(5) NAH/SUNRISE OF SEVERNA PARK LL 301 HOSPITAL DRIVE	HEALTHCARE	MD	N/A	N/A								
(6) NORTH ARUNDEL SENIOR LIVING LL 301 HOSPITAL DRIVE	HEALTHCARE	MD	N/A	N/A								
(7) SHIPLEY'S IMAGING CENTER LLC 5 22 SOUTH GREENE STREET	HEALTHCARE	MD	N/A	N/A								

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1) ARUNDEL PHYSICIANS ASSOCIATES, INC. 52-1992649 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	N/A	C CORP					
(2) BALTIMORE WASHINGTON HEALTH ENTERPRISES, 52-1936656 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	N/A	C CORP					
(3) BW PROFESSIONAL SERVICES, INC. 52-1655640 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	HEALTHCARE	MD	N/A	C CORP					
(4) CIVISTA CARE PARTNERS, INC. 52-2176314 PO BOX 1070 LA PLATA, MD 20646	HEALTHCARE	MD	N/A	C CORP					
(5) UNIV. MIDTOWN PROF. CENTER A CONDOMINIUM 52-1891126 827 LINDEN AVENUE BALTIMORE, MD 21201	REAL ESTATE	MD	N/A	C CORP					
(6) SHORE HEALTH ENTERPRISES, INC. 52-1363201 219 SOUTH WASHINGTON STREET EASTON, MD 21601	REAL ESTATE	MD	N/A	C CORP					
(7) NA EXECUTIVE BUILDING CONDO ASSN, INC. 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061	REAL ESTATE	MD	N/A	C CORP					

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)	UNIVERSITYCARE LLC 52-1914892 22 SOUTH GREENE STREET	HEALTHCARE	MD	N/A	N/A								
(2)	O'DEA MEDICAL ARTS LIMITED PAR 7601 OSLER DRIVE	RENTAL	MD	N/A	N/A								
(3)													
(4)													
(5)													
(6)													
(7)													

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1)	TERRAPIN INSURANCE COMPANY 98-0129232 P.O. BOX 1109 KY1-1102 GRAND CAYMAN, CJ	INSURANCE	CJ	N/A	C CORP					
(2)	UMMS SELF INSURANCE TRUST 52-6315433 22 SOUTH GREENE STREET BALTIMORE, MD 21201	INSURANCE	MD	N/A	TRUST					
(3)										
(4)										
(5)										
(6)										
(7)										

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

			Yes	No
Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.				
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a	Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	**1a**		X
b	Gift, grant, or capital contribution to related organization(s)	**1b**		X
c	Gift, grant, or capital contribution from related organization(s)	**1c**		X
d	Loans or loan guarantees to or for related organization(s)	**1d**		X
e	Loans or loan guarantees by related organization(s)	**1e**		X
f	Dividends from related organization(s)	**1f**		X
g	Sale of assets to related organization(s)	**1g**		X
h	Purchase of assets from related organization(s)	**1h**		X
i	Exchange of assets with related organization(s)	**1i**	X	
j	Lease of facilities, equipment, or other assets to related organization(s)	**1j**		X
k	Lease of facilities, equipment, or other assets from related organization(s)	**1k**		X
l	Performance of services or membership or fundraising solicitations for related organization(s)	**1l**		X
m	Performance of services or membership or fundraising solicitations by related organization(s)	**1m**		X
n	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	**1n**	X	
o	Sharing of paid employees with related organization(s)	**1o**	X	
p	Reimbursement paid to related organization(s) for expenses	**1p**		X
q	Reimbursement paid by related organization(s) for expenses	**1q**	X	
r	Other transfer of cash or property to related organization(s)	**1r**	X	
s	Other transfer of cash or property from related organization(s)	**1s**	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-s)	(c) Amount involved	(d) Method of determining amount involved
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners section 501(c)(3) organizations? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)													
(2)													
(3)													
(4)													
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Part VII **Supplemental Information**

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