

IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2015, or fiscal year beginning 07/01, 2015, and ending 06/30, 20 16

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

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

2015

Department of the Treasury
Internal Revenue Service

Name of exempt organization

CIVISTA MEDICAL CENTER, INC.

Name and title of officer

ERIK BOAS, CFO

Employer identification number

52-0445374

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 ▶ | <input checked="" type="checkbox"/> | b | Total revenue, if any (Form 990, Part VIII, column (A), line 12) . . . | 1b | <u>134941686.</u> |
| 2a | Form 990-EZ check here ▶ | <input type="checkbox"/> | b | Total revenue, if any (Form 990-EZ, line 9) | 2b | |
| 3a | Form 1120-POL check here ▶ | <input type="checkbox"/> | b | Total tax (Form 1120-POL, line 22) | 3b | |
| 4a | Form 990-PF check here ▶ | <input type="checkbox"/> | b | Tax based on investment income (Form 990-PF, Part VI, line 5). | 4b | |
| 5a | Form 8868 check here ▶ | <input type="checkbox"/> | b | Balance Due (Form 8868, 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 2015 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

I authorize GRANT THORNTON LLP to enter my PIN

| | | | | |
|---|---|---|---|---|
| 1 | 4 | 2 | 8 | 8 |
|---|---|---|---|---|

 as my signature
ERO firm name Enter five numbers, but do not enter all zeros

on the organization's tax year 2015 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 2015 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ 

Date ▶ 04/26/2017

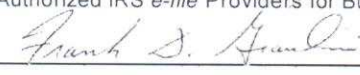
Part III Certification and Authentication

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

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 2 | 3 | 6 | 9 | 5 | 3 | 3 | 6 | 6 | 0 | 5 |
|---|---|---|---|---|---|---|---|---|---|---|

do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2015 electronically filed return for the organization indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature ▶ 

Date ▶ 04/24/2017

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

For Paperwork Reduction Act Notice, see back of form.

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Form **990**

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

2015

Department of the Treasury
Internal Revenue Service

▶ Do not enter Social Security numbers on this form as it may be made public.
▶ Information about Form 990 and its instructions is at www.irs.gov/form990.

Open to Public Inspection

A For the **2015** calendar year, or tax year beginning 07/01, 2015, and ending 06/30, 2016

| | | | | | | |
|--|--|--|--|--|--|--|
| B | Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending | C Name of organization <u>CIVISTA MEDICAL CENTER, INC.</u> | | | D Employer identification number <u>52-0445374</u> | |
| | | Doing Business As | | | E Telephone number <u>(301) 609-4130</u> | |
| | | Number and street (or P.O. box if mail is not delivered to street address) Room/suite <u>5 GARRETT AVENUE</u> | | | | |
| | | City or town, state or province, country, and ZIP or foreign postal code <u>LA PLATA, MD 20646</u> | | | | |
| F Name and address of principal officer: <u>NOEL CERVINO</u> <u>5 GARRETT AVE LA PLATA, MD 20646</u> | | | G Gross receipts \$ <u>134,941,686.</u> | | | |
| I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527 | | | H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| J Website: ▶ <u>WWW.CHARLESREGIONAL.ORG</u> | | | H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶ | | | L Year of formation: <u>1980</u> M State of legal domicile: <u>MD</u> | | | |
| H(c) Group exemption number ▶ | | | | | | |

Part I Summary

| | | | | |
|------------------------------------|--|--|--------------|--------------|
| Activities & Governance | 1 | Briefly describe the organization's mission or most significant activities: <u>CIVISTA MEDICAL CENTER, INC. IS A COMPONENT OF A REGINAL INTEGRATED HEALTH SYSTEM SERVING THE HEALTH NEEDS OF CHARLES COUNTY AND THE CITIZENS OF SOUTHERN MARYLAND.</u> | | |
| | 2 | Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets. | | |
| | 3 | Number of voting members of the governing body (Part VI, line 1a) | 3 | 17. |
| | 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 2015 (Part V, line 2a) | 5 | 1,074. |
| | 6 | Total number of volunteers (estimate if necessary) | 6 | 120. |
| | 7a | Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 76,089. |
| 7b | Net unrelated business taxable income from Form 990-T, line 34 | 7b | -63,117. | |
| Revenue | 8 | Contributions and grants (Part VIII, line 1h) | 0. | 0. |
| | 9 | Program service revenue (Part VIII, line 2g) | 132,649,970. | 133,783,449. |
| | 10 | Investment income (Part VIII, column (A), lines 3, 4, and 7d) | 551,842. | 504,610. |
| | 11 | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 557,258. | 653,627. |
| | 12 | Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 133,759,070. | 134,941,686. |
| Expenses | 13 | Grants and similar amounts paid (Part IX, column (A), lines 1-3) | 52,129. | 21,000. |
| | 14 | Benefits paid to or for members (Part IX, column (A), line 4) | 0. | 0. |
| | 15 | Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) | 54,048,003. | 53,950,667. |
| | 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) | 64,633,320. | 67,198,823. |
| | 18 | Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) | 118,733,452. | 121,170,490. |
| 19 | Revenue less expenses. Subtract line 18 from line 12 | 15,025,618. | 13,771,196. | |
| Net Assets or Fund Balances | 20 | Total assets (Part X, line 16) | 149,948,298. | 153,443,724. |
| | 21 | Total liabilities (Part X, line 26) | 103,563,868. | 96,591,224. |
| | 22 | Net assets or fund balances. Subtract line 21 from line 20 | 46,384,430. | 56,852,500. |

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 | | Date |
| | Type or print name and title | |

| | | | | | |
|-------------------------------|--|--------------------------------|---------------------------|---|--------------------------|
| Paid Preparer Use Only | Print/Type preparer's name <u>FRANK GIARDINI</u> | Preparer's signature | Date <u>05/11/2017</u> | Check <input type="checkbox"/> if self-employed | PTIN <u>P00532355</u> |
| | Firm's name ▶ <u>GRANT THORNTON LLP</u> | Firm's EIN ▶ <u>36-6055558</u> | | | |
| | Firm's address ▶ <u>2001 MARKET STREET, SUITE 700 PHILADELPHIA, PA 19103</u> | Phone no. <u>215-561-4200</u> | | | |

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** (2015)

Application for Extension of Time To File an Exempt Organization Return

► **File a separate application for each return.**
► Information about Form 8868 and its instructions is at www.irs.gov/form8868.

- 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 File by the due date for filing your return. See instructions. | Name of exempt organization or other filer, see instructions. CIVISTA MEDICAL CENTER, INC. | Employer identification number (EIN) or 52-0445374 |
| | Number, street, and room or suite no. If a P.O. box, see instructions. 5 GARRETT AVENUE | 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)

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

- The books are in the care of ► ERIK BOAS, 5 GARRETT AVE LA PLATA, MD 20646

Telephone No. ► 301 609-4130 FAX No. ► 301 934-0053

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

1 I request an automatic 3-month (6 months for a corporation required to file Form 990-T) extension of time until 02/15, 2017, to file the exempt organization return for the organization named above. The extension is for the organization's return for:

► calendar year 20____ or

► tax year beginning 07/01, 2015, and ending 06/30, 2016.

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

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

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

For Privacy Act and Paperwork Reduction Act Notice, see instructions.

| Cumulative e-File History 2015 | |
|---------------------------------------|------------------------------|
| FED | |
| Locator: | 0659EE |
| Taxpayer Name: | Civista Medical Center, Inc. |
| Return Type: | 990, 990 & 990T (Corp) |
| | |
| Submitted Date: | 10/10/2016 16:27:47 |
| Acknowledgement Date: | 10/10/2016 16:57:19 |
| Status: | Accepted |
| Submission ID: | 23695320162845000013 |

• 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 <small>File by the due date for filing your return. See instructions.</small> | Name of exempt organization or other filer, see instructions. CIVISTA MEDICAL CENTER, INC. | Employer identification number (EIN) or 52-0445374 |
| | Number, street, and room or suite no. If a P.O. box, see instructions. 5 GARRETT AVENUE, PO BOX 1070 | 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 (other than individual) | 09 |
| Form 990-PF | 04 | Form 5227 | 10 |
| Form 990-T (sec. 401(a) or 408(a) trust) | 05 | Form 6069 | 11 |
| Form 990-T (trust other than above) | 06 | Form 8870 | 12 |

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, 5 GARRETT AVE LA PLATA, MD 20646
 Telephone No. 301 609-4130 Fax No. 301 934-0053

• 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, 2017.

5 For calendar year _____, or other tax year beginning 07/01, 2015, and ending 06/30, 2016.

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 IS NEEDED TO GATHER INFORMATION NECESSARY TO FILE A COMPLETE AND ACCURATE RETURN.

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

Signature and Verification 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 Frank S. Gianini Title TAX PRINCIPAL Date 01/31/2017

| Cumulative e-File History 2015 | |
|---------------------------------------|------------------------------|
| FED | |
| Locator: | 0659EE |
| Taxpayer Name: | Civista Medical Center, Inc. |
| Return Type: | 990, 990 & 990T (Corp) |
| | |
| Submitted Date: | 01/31/2017 10:00:31 |
| Acknowledgement Date: | 01/31/2017 10:27:21 |
| Status: | Accepted |
| Submission ID: | 23695320170315000019 |

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III Yes No

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 \$ 103,180,311. including grants of \$ 21,000.) (Revenue \$ 134,360,987.)

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 ▶ 103,180,311.

Part IV Checklist of Required Schedules

Table with 3 columns: Question number, Yes, No. Rows 1-19 with various questions about organization activities and financial reporting.

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for line numbers (1a-14b), descriptions, and Yes/No checkboxes. Includes entries for Form 1096, Form W-2G, Form W-3, Form 990-T, Form 8886-T, Form 8282, Form 8899, Form 1098-C, Form 990, Form 720, and Form 700P.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (17), 1b (13), 2 (X), 3 (X), 4 (X), 5 (X), 6 (X), 7a (X), 7b (X), 8a (X), 8b (X), 9 (X).

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

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

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.
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records: 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 or note to any line 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 CHAIRMAN | 1.00 0. | X | | X | | | | 0. | 0. | 0. |
| (2) RICHARD WINKLER VICE CHAIR | 1.00 0. | X | | X | | | | 0. | 0. | 0. |
| (3) WAYNE BARNES SECRETARY/TREASURER | 1.00 0. | X | | X | | | | 0. | 0. | 0. |
| (4) LOUIS JENKINS, JR. PAST BOARD CHAIR | 1.00 0. | X | | | | | | 0. | 0. | 0. |
| (5) DIANNA ABNEY, M.D. DIRECTOR | 1.00 0. | X | | | | | | 0. | 0. | 0. |
| (6) KHADAR BAIG, M.D. DIRECTOR | 1.00 0. | X | | | | | | 0. | 0. | 0. |
| (7) BRIANNA BOWLING DIRECTOR | 1.00 0. | X | | | | | | 0. | 0. | 0. |
| (8) MICHAEL CADY DIRECTOR | 1.00 0. | X | | | | | | 0. | 0. | 0. |
| (9) ANTHONY COVINGTON DIRECTOR | 1.00 0. | X | | | | | | 0. | 0. | 0. |
| (10) RICHARD FERRARO, M.D. EX-OFFICIO DIRECTOR | 1.00 0. | X | | | | | | 0. | 0. | 0. |
| (11) B. LARRY JENKINS, JR., M.D. DIRECTOR | 1.00 0. | X | | | | | | 0. | 0. | 0. |
| (12) SARA A. MIDDLETON DIRECTOR | 1.00 0. | X | | | | | | 0. | 0. | 0. |
| (13) ASHVIN J. PATEL, M.D. DIRECTOR | 1.00 0. | X | | | | | | 0. | 0. | 0. |
| (14) JOSEPH SLATER DIRECTOR | 1.00 0. | 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) ROBERT CHRENCIK EX-OFFICIO/DIRECTOR | 1.00 49.00 | X | | | | | 0. | 2,562,797. | 23,637. | |
| 16) JON P. BURNS EX-OFFICIO/DIRECTOR | 1.00 49.00 | X | | | | | 0. | 654,203. | 23,637. | |
| 17) NOEL CERVINO EX-OFFICIO/PRESIDENT & CEO | 40.00 10.00 | X | | X | | | 668,210. | 0. | 20,869. | |
| 18) CANDICE QUINN KELLY EX-OFFICIO DIRECTOR | 1.00 0. | X | | | | | 0. | 0. | 0. | |
| 19) ERIK BOAS CHIEF FINANCIAL OFFICER | 40.00 10.00 | | | X | | | 339,196. | 0. | 8,801. | |
| 20) MARK R. DUMAIS CHIEF MEDICAL OFFICER | 40.00 0. | | | | X | | 749,963. | 0. | 21,451. | |
| 21) DANA LEVY CHIEF NURSING OFFICER | 40.00 0. | | | | X | | 245,876. | 0. | 30,467. | |
| 22) PAUL BLACKWOOD VP PLANNING | 40.00 0. | | | | | X | 251,495. | 0. | 38,043. | |
| 23) WILLIAM GRIMES VP ANCILLIARY SERVICES | 40.00 0. | | | | | X | 217,045. | 0. | 22,169. | |
| 24) MARILYN GREGORY RN | 40.00 0. | | | | | X | 177,840. | 0. | 2,447. | |
| 25) KATHERINE MIDDLETON RN | 40.00 0. | | | | | X | 190,606. | 0. | 2,426. | |
| 1b Sub-total | | | | | | | 0. | 0. | 0. | |
| c Total from continuation sheets to Part VII, Section A | | | | | | | 3,007,204. | 3,997,732. | 238,093. | |
| d Total (add lines 1b and 1c) | | | | | | | 3,007,204. | 3,997,732. | 238,093. | |

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 **▶ 46**

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

Section B. Independent Contractors

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

| (A) Name and business address | (B) Description of services | (C) Compensation |
|----------------------------------|--------------------------------|---------------------|
| 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 **▶ 32**

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

Table with 6 main columns: (A) Name and title, (B) Average hours per week, (C) Position, (D) Reportable compensation from the organization, (E) Reportable compensation from related organizations, (F) Estimated amount of other compensation. Includes entries for Eugene Suwandhi and John W. Ashworth.

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 46

Table with 3 columns: Question, Yes, No. Contains questions 3, 4, and 5 regarding compensation reporting.

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.

Table with 3 columns: (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 or note to any line in this Part VIII.

| | | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512-514 | |
|---|--|--|----------------------|----------------------|--|---|--|--|
| Contributions, Gifts, Grants and Other Similar Amounts | 1a Federated campaigns | 1a | | | | | | |
| | b Membership dues | 1b | | | | | | |
| | c Fundraising events | 1c | | | | | | |
| | d Related organizations | 1d | | | | | | |
| | e Government grants (contributions) . . | 1e | | | | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above . | 1f | | | | | | |
| | g Noncash contributions included in lines 1a-1f: \$ | | | | | | | |
| | h Total. Add lines 1a-1f ▶ | | | 0. | | | | |
| Program Service Revenue | | | Business Code | | | | | |
| | 2a NET PATIENT REVENUE | | 900099 | 133,783,449. | 133,783,449. | | | |
| | b | | | | | | | |
| | c | | | | | | | |
| | d | | | | | | | |
| | e | | | | | | | |
| | f All other program service revenue | | | | | | | |
| g Total. Add lines 2a-2f ▶ | | | 133,783,449. | | | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts). ▶ | | | 264,665. | | | 264,665. | |
| | 4 Income from investment of tax-exempt bond proceeds . ▶ | | | 0. | | | | |
| | 5 Royalties ▶ | | | 0. | | | | |
| | 6a Gross rents | (i) Real | (ii) Personal | | | | | |
| | | b Less: rental expenses | | | | | | |
| | | c Rental income or (loss) | | | | | | |
| | | d Net rental income or (loss) ▶ | | | 0. | | | |
| | 7a Gross amount from sales of assets other than inventory | (i) Securities | (ii) Other | | | | | |
| | | 239,945. | | | | | | |
| | | b Less: cost or other basis and sales expenses | | | | | | |
| | | c Gain or (loss) | 239,945. | | | | | |
| | d Net gain or (loss) ▶ | | | 239,945. | | | 239,945. | |
| | 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 CAFETERIA & COFFEE BAR SALES | | 900099 | 344,479. | 344,479. | | | | |
| b CHANGE IN EQUITY OF AFFILIATES CPHA | | 900099 | 202,741. | 202,741. | | | | |
| c ANSWERING SERVICE | | 561000 | 76,089. | | 76,089. | | | |
| d All other revenue | | 900099 | 30,318. | 30,318. | | | | |
| e Total. Add lines 11a-11d ▶ | | | 653,627. | | | | | |
| 12 Total revenue. See instructions. ▶ | | | 134,941,686. | 134,360,987. | 76,089. | 504,610. | | |

Part IX Statement of Functional Expenses

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|--|-----------------------|---------------------------------|--|-----------------------------|
| 1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 | 21,000. | 21,000. | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22 | 0. | | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 | 0. | | | |
| 4 Benefits paid to or for members | 0. | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 2,003,245. | 995,839. | 1,007,406. | |
| 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 | 39,407,610. | 33,496,469. | 5,911,141. | |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 2,616,198. | 2,223,768. | 392,430. | |
| 9 Other employee benefits | 6,773,145. | 5,757,173. | 1,015,972. | |
| 10 Payroll taxes | 3,150,469. | 2,677,899. | 472,570. | |
| 11 Fees for services (non-employees): | | | | |
| a Management | 0. | | | |
| b Legal | 396,648. | | 396,648. | |
| c Accounting | 0. | | | |
| d Lobbying | 6,220. | | 6,220. | |
| 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.) ATCH 3 | 16,405,863. | 14,551,551. | 1,854,312. | |
| 12 Advertising and promotion | 95,161. | | 95,161. | |
| 13 Office expenses | 2,896,186. | | 2,896,186. | |
| 14 Information technology | 0. | | | |
| 15 Royalties | 0. | | | |
| 16 Occupancy | 2,425,651. | 2,061,803. | 363,848. | |
| 17 Travel | 75,345. | 64,043. | 11,302. | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | 0. | | | |
| 19 Conferences, conventions, and meetings | 178,651. | 151,853. | 26,798. | |
| 20 Interest | 2,792,280. | 2,373,438. | 418,842. | |
| 21 Payments to affiliates | 0. | | | |
| 22 Depreciation, depletion, and amortization | 4,749,454. | 4,037,036. | 712,418. | |
| 23 Insurance | 2,901,631. | 2,778,003. | 123,628. | |
| 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 <u>SUPPLIES AND DRUGS</u> | 14,070,744. | 14,070,744. | | |
| b <u>PURCHASED SERVICES</u> | 12,455,691. | 10,587,337. | 1,868,354. | |
| c <u>BAD DEBT</u> | 4,969,676. | 4,969,676. | | |
| d <u>EQUIPMENT SERVICE CONTRACTS</u> | 1,237,540. | 1,051,909. | 185,631. | |
| e All other expenses | 1,542,082. | 1,310,770. | 231,312. | |
| 25 Total functional expenses. Add lines 1 through 24e | 121,170,490. | 103,180,311. | 17,990,179. | |
| 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 <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) | 0. | | | |

Part X Balance Sheet

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

| | | (A) Beginning of year | | (B) End of year |
|---|--|--------------------------|--------------|------------------------|
| Assets | 1 Cash - non-interest-bearing | 0. | 1 | 11,899,409. |
| | 2 Savings and temporary cash investments | 20,680,284. | 2 | 0. |
| | 3 Pledges and grants receivable, net | 0. | 3 | 0. |
| | 4 Accounts receivable, net | 7,944,863. | 4 | 7,721,480. |
| | 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 | 1,675,458. | 8 | 1,487,388. |
| | 9 Prepaid expenses and deferred charges | 319,972. | 9 | 479,198. |
| | 10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a 120,506,243. | | |
| | b Less: accumulated depreciation | 10b 45,380,606. | 70,324,409. | 10c 75,125,637. |
| | 11 Investments - publicly traded securities | 20,278,998. | 11 | 11,177,000. |
| | 12 Investments - other securities. See Part IV, line 11 | 0. | 12 | 16,746,296. |
| | 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 | 28,724,314. | 15 | 28,807,316. |
| 16 Total assets. Add lines 1 through 15 (must equal line 34) | 149,948,298. | 16 | 153,443,724. | |
| Liabilities | 17 Accounts payable and accrued expenses | 13,697,614. | 17 | 13,136,413. |
| | 18 Grants payable | 0. | 18 | 0. |
| | 19 Deferred revenue | 0. | 19 | 0. |
| | 20 Tax-exempt bond liabilities | 0. | 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 | 18,484,229. | 23 | 5,508,806. |
| | 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 | 71,382,025. | 25 | 77,946,005. |
| | 26 Total liabilities. Add lines 17 through 25 | 103,563,868. | 26 | 96,591,224. |
| Net Assets or Fund Balances | Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. | | | |
| | 27 Unrestricted net assets | 46,291,833. | 27 | 56,759,903. |
| | 28 Temporarily restricted net assets | 92,597. | 28 | 92,597. |
| | 29 Permanently restricted net assets | 0. | 29 | 0. |
| | Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. | | | |
| | 30 Capital stock or trust principal, or current funds | | 30 | |
| | 31 Paid-in or capital surplus, or land, building, or equipment fund | | 31 | |
| | 32 Retained earnings, endowment, accumulated income, or other funds | | 32 | |
| | 33 Total net assets or fund balances | 46,384,430. | 33 | 56,852,500. |
| | 34 Total liabilities and net assets/fund balances | 149,948,298. | 34 | 153,443,724. |

Part XI Reconciliation of Net Assets

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

| | | | |
|-----------|--|-----------|--------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 134,941,686. |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 121,170,490. |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 13,771,196. |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 46,384,430. |
| 5 | Net unrealized gains (losses) on investments | 5 | -583,785. |
| 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 | -2,719,341. |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 56,852,500. |

Part XII Financial Statements and Reporting

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

- 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?
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?
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? 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?
- 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.

| | Yes | No |
|-----------|-----|----|
| 2a | | X |
| 2b | X | |
| 2c | X | |
| 3a | X | |
| 3b | X | |

Form **990** (2015)

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2015

Open to Public Inspection

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

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

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

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E (Form 990 or 990-EZ).)
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8 A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9 An 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 in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
 - f Enter the number of supported organizations
 - g Provide the following information about the supported organization(s).

| (i) Name of supported organization | (ii) EIN | (iii) Type of organization (described on lines 1-9 above (see instructions)) | (iv) Is the organization listed in your governing document? | | (v) Amount of monetary support (see instructions) | (vi) Amount of other support (see instructions) |
|------------------------------------|----------|--|---|----|---|---|
| | | | Yes | No | | |
| (A) | | | | | | |
| (B) | | | | | | |
| (C) | | | | | | |
| (D) | | | | | | |
| (E) | | | | | | |
| Total | | | | | | |

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

Schedule A (Form 990 or 990-EZ) 2015

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

Section A. Public Support

Table with 7 columns: (a) 2011, (b) 2012, (c) 2013, (d) 2014, (e) 2015, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2011, (b) 2012, (c) 2013, (d) 2014, (e) 2015, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2015; 15 Public support percentage from 2014 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2015; b 33 1/3% support test - 2014; 17a 10%-facts-and-circumstances test - 2015; b 10%-facts-and-circumstances test - 2014; 18 Private foundation.

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

Section A. Public Support

| Calendar year (or fiscal year beginning in) ► | (a) 2011 | (b) 2012 | (c) 2013 | (d) 2014 | (e) 2015 | (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) 2011 | (b) 2012 | (c) 2013 | (d) 2014 | (e) 2015 | (f) Total |
|---|----------|----------|----------|----------|----------|-----------|
| 9 Amounts from line 6. | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 13 Total support. (Add lines 9, 10c, 11, and 12.) | | | | | | |
| 14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here <input type="checkbox"/> | | | | | | |

Section C. Computation of Public Support Percentage

| | | |
|--|-----------|---|
| 15 Public support percentage for 2015 (line 8, column (f) divided by line 13, column (f)) | 15 | % |
| 16 Public support percentage from 2014 Schedule A, Part III, line 15 | 16 | % |

Section D. Computation of Investment Income Percentage

| | | |
|---|-----------|---|
| 17 Investment income percentage for 2015 (line 10c, column (f) divided by line 13, column (f)) | 17 | % |
| 18 Investment income percentage from 2014 Schedule A, Part III, line 17 | 18 | % |

19a 33 1/3% support tests - 2015. 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 - 2014. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

(Complete only if you checked a box in line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

| | Yes | No |
|--|-----|----|
| 1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i> | | |
| 2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i> | | |
| 3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i> | | |
| b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i> | | |
| c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i> | | |
| 4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked 11a or 11b in Part I, answer (b) and (c) below.</i> | | |
| b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i> | | |
| c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i> | | |
| 5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i> | | |
| b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document? | | |
| c Substitutions only. Was the substitution the result of an event beyond the organization's control? | | |
| 6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i> | | |
| 7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i> | | |
| 8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i> | | |
| 9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i> | | |
| b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i> | | |
| c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i> | | |
| 10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer 10b below.</i> | | |
| b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i> | | |

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

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

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

| Section C - Distributable Amount | | | Current Year |
|--|----------|--|--------------|
| 1 Adjusted net income for prior year (from Section A, line 8, Column A) | 1 | | |
| 2 Enter 85% of line 1 | 2 | | |
| 3 Minimum asset amount for prior year (from Section B, line 8, Column A) | 3 | | |
| 4 Enter greater of line 2 or line 3 | 4 | | |
| 5 Income tax imposed in prior year | 5 | | |
| 6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions) | 6 | | |

7 Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).

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

| Section D - Distributions | Current Year |
|--|--------------|
| 1 Amounts paid to supported organizations to accomplish exempt purposes | |
| 2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| 3 Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| 4 Amounts paid to acquire exempt-use assets | |
| 5 Qualified set-aside amounts (prior IRS approval required) | |
| 6 Other distributions (describe in Part VI). See instructions. | |
| 7 Total annual distributions. Add lines 1 through 6. | |
| 8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions. | |
| 9 Distributable amount for 2015 from Section C, line 6 | |
| 10 Line 8 amount divided by Line 9 amount | |

| Section E - Distribution Allocations (see instructions) | (i) Excess Distributions | (ii) Underdistributions Pre-2015 | (iii) Distributable Amount for 2015 |
|---|-----------------------------|--|---|
| 1 Distributable amount for 2015 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2015 (reasonable cause required-see instructions) | | | |
| 3 Excess distributions carryover, if any, to 2015: | | | |
| a | | | |
| b | | | |
| c | | | |
| d From 2013 | | | |
| e From 2014 | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2015 distributable amount | | | |
| i Carryover from 2010 not applied (see instructions) | | | |
| j Remainder. Subtract lines 3g, 3h, and 3i from 3f. | | | |
| 4 Distributions for 2015 from Section D, line 7: \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2015 distributable amount | | | |
| c Remainder. Subtract lines 4a and 4b from 4. | | | |
| 5 Remaining underdistributions for years prior to 2015, if any. Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions). | | | |
| 6 Remaining underdistributions for 2015. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions). | | | |
| 7 Excess distributions carryover to 2016. Add lines 3j and 4c. | | | |
| 8 Breakdown of line 7: | | | |
| a | | | |
| b | | | |
| c Excess from 2013 | | | |
| d Excess from 2014 | | | |
| e Excess from 2015 | | | |

Part VI **Supplemental Information.** 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)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

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

2015

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.**

If the organization answered "Yes," on 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," on 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," on Form 990, Part IV, line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then

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

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

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

- 1 Provide a description of the organization's direct and indirect political campaign activities 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) | | | | |

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

Schedule C (Form 990 or 990-EZ) 2015

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. | | | | | | | | | | | | | | |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width: 70%; text-align: left;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table> | If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | Not over \$500,000 | 20% of the amount on line 1e. | Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000. | Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000. | Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000. | Over \$17,000,000 | \$1,000,000. | | |
| If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: | | | | | | | | | | | | | |
| Not over \$500,000 | 20% of the amount on line 1e. | | | | | | | | | | | | | |
| Over \$500,000 but not over \$1,000,000 | \$100,000 plus 15% of the excess over \$500,000. | | | | | | | | | | | | | |
| Over \$1,000,000 but not over \$1,500,000 | \$175,000 plus 10% of the excess over \$1,000,000. | | | | | | | | | | | | | |
| Over \$1,500,000 but not over \$17,000,000 | \$225,000 plus 5% of the excess over \$1,500,000. | | | | | | | | | | | | | |
| Over \$17,000,000 | \$1,000,000. | | | | | | | | | | | | | |
| g Grassroots nontaxable amount (enter 25% of line 1f) | | | | | | | | | | | | | | |
| h Subtract line 1g from line 1a. If zero or less, enter -0- | | | | | | | | | | | | | | |
| i Subtract line 1f from line 1c. If zero or less, enter -0- | | | | | | | | | | | | | | |
| j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | |

4-Year Averaging Period Under section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

| Lobbying Expenditures During 4-Year Averaging Period | | | | | |
|--|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 2012 | (b) 2013 | (c) 2014 | (d) 2015 | (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)).

Table with 3 main columns: (a) Yes/No, (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation...; a Volunteers?; b Paid staff or management...; c Media advertisements?; d Mailings to members...; e Publications...; f Grants to other organizations...; g Direct contact with legislators...; h Rallies, demonstrations...; i Other activities?; j Total. Add lines 1c through 1i; 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?; 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).

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

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

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

Part IV Supplemental Information

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, lines 1 and 2 (see instructions); 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 11

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 6.15% AND 22.12% OF MEMBER DUES WERE USED FOR LOBBYING PURPOSES AND AS SUCH, THE ORGANIZATION HAS REPORTED THIS AMOUNT ON SCHEDULE C PART II-B AS LOBBYING ACTIVITIES.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

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

2015

Attach to Form 990.

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Name of the organization

Employer identification number

CIVISTA MEDICAL CENTER, INC.

52-0445374

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

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

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate value of contributions to (during year), 3 Aggregate value of grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?, 6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

Part II Conservation Easements.

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

Table with 2 columns: Description, Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year., 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year, 4 Number of states where property subject to conservation easement is located, 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?, 6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?, 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

Table with 2 columns: Description, Amount. Rows include: 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items., 1b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenue 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 Revenue included in Form 990, Part VIII, line 1, b Assets included in Form 990, Part X.

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

Schedule D (Form 990) 2015

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?

Part IV Escrow and Custodial Arrangements.

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

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?
b If "Yes," explain the arrangement in Part XIII and complete the following table:
Table with columns: Amount, 1c Beginning balance, 1d Additions during the year, 1e Distributions during the year, 1f Ending balance
2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?
b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

Part V Endowment Funds.

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

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

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
a Board designated or quasi-endowment %
b Permanent endowment %
c Temporarily restricted endowment %
The percentages on lines 2a, 2b, and 2c should equal 100%.

- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
(i) unrelated organizations
(ii) related organizations
b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?
Table with Yes/No columns for 3a(i), 3a(ii), 3b

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

Part VI Land, Buildings, and Equipment.

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

Table with 5 columns: (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows include: 1a Land, b Buildings, c Leasehold improvements, d Equipment, e Other, Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)

Part VII Investments - Other Securities.

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

| (a) Description of security or category (including name of security) | (b) Book value | (c) Method of valuation: Cost or end-of-year market value |
|---|----------------|--|
| (1) Financial derivatives | | |
| (2) Closely-held equity interests | | |
| (3) Other | | |
| (A) OTHER SECURITIES | 16,746,296. | |
| (B) | | |
| (C) | | |
| (D) | | |
| (E) | | |
| (F) | | |
| (G) | | |
| (H) | | |
| Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶ | 16,746,296. | |

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

| (a) Description | (b) Book value |
|---|----------------|
| (1) OTHER ASSETS | 18,925,467. |
| (2) ECONOMIC INTEREST- NET ASSETS | 4,897,254. |
| (3) INV. CHES POTOMAC HEALTHCARE | 3,555,913. |
| (4) DUE FROM AFFILIATES | 1,065,328. |
| (5) OTHER CURRENT RECEIVABLES | 186,044. |
| (6) PHYSICIAN LOANS | 165,837. |
| (7) SECURITY DEPOSITS | 11,473. |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶ | 28,807,316. |

Part X Other Liabilities.

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

| 1. (a) Description of liability | (b) Book value |
|---|----------------|
| (1) Federal income taxes | |
| (2) DUE TO AFFILIATES | 56,175,298. |
| (3) ACCRUED PENSION COSTS | 10,287,227. |
| (4) MALPRACTICE IBNR | 3,782,002. |
| (5) ADVANCES FROM THIRD PARTIES | 3,734,841. |
| (6) OTHER LIABILITIES | 3,514,918. |
| (7) LEASE LIABILITIES | 451,719. |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶ | 77,946,005. |

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

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include description, sub-row labels (2a-2d, 4a-4b), and totals (1, 2e, 3, 4c, 5).

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include description, sub-row labels (2a-2d, 4a-4b), and totals (1, 2e, 3, 4c, 5).

Part XIII Supplemental Information.

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

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 H
(Form 990)**

Hospitals

OMB No. 1545-0047

2015

Open to Public Inspection

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**

▶ **Attach to Form 990.**

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

Part I Financial Assistance and Certain Other Community Benefits at Cost

| | Yes | No |
|---|-----|----|
| 1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | X | |
| 1b If "Yes," was it a written policy? | X | |
| 2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities | | |
| 3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. | | |
| a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free care</i> ? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ % | X | |
| b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted care</i> ? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ % | X | |
| c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. | | |
| 4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | X | |
| 5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | X | |
| 5b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | X | |
| 5c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? | | X |
| 6a Did the organization prepare a community benefit report during the tax year? | X | |
| 6b If "Yes," did the organization make it available to the public? | 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) | | | 2,820,688. | | 2,820,688. | 2.43 |
| 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 | | | 2,820,688. | | 2,820,688. | 2.43 |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | 763,165. | 7,000. | 756,165. | .65 |
| f Health professions education (from Worksheet 5) | | | 336,839. | | 336,839. | .28 |
| g Subsidized health services (from Worksheet 6) | | | 5,657,335. | 23,348. | 5,633,987. | 4.85 |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | 100,089. | | 100,089. | .08 |
| j Total Other Benefits | | | 6,857,428. | 30,348. | 6,827,080. | 5.86 |
| k Total Add lines 7d and 7j. | | | 9,678,116. | 30,348. | 9,647,768. | 8.29 |

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

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|---|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 Physical improvements and housing | | | | | | |
| 2 Economic development | | | 3,428. | | 3,428. | |
| 3 Community support | | | 65,491. | 30,000. | 35,491. | .03 |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | | | | | | |
| 6 Coalition building | | | 3,497. | | 3,497. | |
| 7 Community health improvement advocacy | | | 1,129. | | 1,129. | |
| 8 Workforce development | | | 173,423. | | 173,423. | .14 |
| 9 Other | | | | | | |
| 10 Total | | | 246,968. | 30,000. | 216,968. | .17 |

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? | 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. | | |
| 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 | | |
| 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) | 49,182,907. |
| 6 Enter Medicare allowable costs of care relating to payments on line 5 | 48,802,606. |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall) | 380,301. |
| 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: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other | |

Section C. Collection Practices

| | | |
|---|---|--|
| 9a Did the organization have a written debt collection policy during the tax year? | 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 | 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, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

| | Licensed hospital | 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 AVENUE LA PLATA MD 20646 WWW.CHARLESREGIONAL.ORG 08-001 | X | X | | | | | X | | | 1 |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

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

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

Community Health Needs Assessment

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

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

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

| | | Yes | No |
|---|--|-----|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 13 | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP: | X | |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>300.0000</u> % | | |
| b | <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input checked="" type="checkbox"/> Underinsurance status | | |
| g | <input type="checkbox"/> Residency | | |
| h | <input type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | X | |
| 15 | Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply): | X | |
| a | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| 16 | Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | X | |
| a | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>HTTP://WWW.CHARLESREGIONAL.ORG</u> | | |
| b | <input type="checkbox"/> The FAP application form was widely available on a website (list url): _____ | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>WWW.CHARLESREGIONAL.ORG</u> | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input type="checkbox"/> Other (describe in Section C) | | |

Billing and Collections

| | | | |
|-----------|--|---|--|
| 17 | Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | X | |
| 18 | Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP: | | |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e | <input type="checkbox"/> None of these actions or other similar actions were permitted | | |

Part V Facility Information *(continued)*

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

| | | Yes | No |
|-----------|---|-----|----|
| 19 | Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged: | | X |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply): | | |
| a | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission | | |
| b | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | |
| c | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | |
| d | <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| f | <input type="checkbox"/> None of these efforts were made | | |

Policy Relating to Emergency Medical Care

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

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

| | | | |
|-----------|---|--|---|
| 22 | Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care. | | |
| a | <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | |
| b | <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | |
| c | <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | |
| d | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 23 | During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C. | | X |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C. | | X |

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

FINANCIAL ASSISTANCE POLICY

SCHEDULE H, PART V, SECTION B

IN COMPLIANCE WITH IRC 501 (R) REGULATIONS, CIVISTA MEDICAL CENTER HAS REVISED THEIR FINANCIAL ASSISTANCE POLITY TO ENSURE COMPLIANCE WITH IRS REGULATIONS.

INPUT FROM INDIVIDUALS REPRESENTING THE COMMUNITY

SCHEDULE H, PART V, SECTION B, LINE 5

FROM JULY 2014 TO MARCH 2015, THE UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER, IN COLLABORATION WITH THE CHARLES COUNTY DEPARTMENT OF HEALTH (CCDOH) UNDERTOOK A COMPREHENSIVE ASSESSMENT OF THE HEALTH NEEDS OF CHARLES COUNTY, MARYLAND.

TO PROVIDE A COMPREHENSIVE ASSESSMENT OF THE HEALTH NEEDS OF THE COUNTY, A FOUR METHOD PLAN WAS DEVELOPED WHICH INCLUDED 4 DIFFERENT SOURCES OF DATA: A LONG ONLINE SURVEY OF CHARLES COUNTY RESIDENTS PERCEPTIONS OF HEALTH AND HEALTH BEHAVIORS, A SHORT PAPER SURVEY ON HEALTH PERCEPTIONS THROUGHOUT THE COUNTY, 15 FOCUS GROUPS WITH COMMUNITY LEADERS, CITIZENS, AND STAKEHOLDERS, AND A QUANTITATIVE DATA ANALYSIS OF SECONDARY, PUBLISHED DATA. DATA COLLECTION OCCURRED BETWEEN JULY 2014 AND FEBRUARY 2015.

THE USE OF THE MULTIPLE DATA COLLECTION METHODS STRENGTHENED THE VALIDITY OF THE ASSESSMENT'S FINDINGS AS WELL AS ENSURING THAT CHARLES COUNTY RESIDENTS HAD AN OPPORTUNITY TO PARTICIPATE IN THE ASSESSMENT PROCESS AND

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

TO FEEL INVESTED IN ITS OUTCOME.

FIFTEEN FOCUS GROUPS WERE PERFORMED THROUGHOUT THE COUNTY BETWEEN JULY 2014 AND FEBRUARY 2015. THE FOCUS GROUP TOPICS INCLUDED: CHRONIC DISEASE SPECIFIC HEALTH, SPECIAL POPULATIONS, COUNTY LEADERSHIP, DRUG AND ALCOHOL COUNCIL MEMBERS, CHARLES COUNTY SUBSTANCE ABUSE ADVISORY COALITION MEMBERS, YOUTH THROUGH THE SCHOOL NURSES, IN-HOUSE HEALTH DEPARTMENT NURSES, FITNESS AND NUTRITION, MINORITY HEALTH AND HEALTH DISPARITIES, PREVENTION AND SAFETY, FAITH-BASED LEADERS, BEHAVIORAL HEALTH, REPRODUCTIVE AND INFANT HEALTH, CANCER, AND ACCESS TO CARE. APPROXIMATELY 235 PEOPLE PARTICIPATED IN THE COUNTY FOCUS GROUPS. ATTENDANCE FOR THOSE MEETINGS RANGED FROM 5 TO 100 PEOPLE. PARTICIPANTS REPRESENTED ALL SERVICE ORGANIZATIONS WITHIN THE COMMUNITY. THEY PROVIDE SERVICES TO ALL FACETS OF THE COMMUNITY INCLUDING WOMEN, INFANTS, SCHOOL AGED CHILDREN, THOSE WHO ARE INCARCERATED, THOSE WITH MENTAL HEALTH PROBLEMS, THOSE WITH FINANCIAL/HOUSING/EMPLOYMENT/HEALTH ISSUES, THE UN- AND UNDERINSURED, THE HUNGRY, THOSE WITH CHRONIC HEALTH CONDITIONS, THE HOMELESS, THE ELDERLY, COLLEGE STUDENTS, MEDICALLY UNDERSERVED, ALL FAITHS AND RELIGIONS, AND MINORITIES, JUST TO NAME A FEW.

A COMPLETE LISTING OF THE NAMES OF THE COMMUNITY REPRESENTATIVES PARTICIPATING IN THE FOCUS GROUPS IS LOCATED AS AN ADDENDUM TO UM CRMC'S CHNA (UM CRMC 2015 CHNA)BEGINNING ON PAGE 242.

806 CHARLES COUNTY RESIDENTS COMPLETED THE 27 QUESTION ONLINE SURVEY THAT

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

WAS CREATED USING SURVEY MONKEY. THE LINK TO THE SURVEY WAS AVAILABLE ON THE UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER 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.

MOST OF THE RESPONDENTS ARE FROM CHARLES COUNTY (82.4%). THE SECOND LARGEST PERCENTAGE IS FROM ST MARY'S COUNTY (7.22%). ONLY 4% REPORTED LIVING OUTSIDE OF SOUTHERN MARYLAND (CHARLES, CALVERT, ST MARY'S, OR PG). APPROXIMATELY 69% OF THE RESPONDENTS WERE BETWEEN THE AGES OF 35-64 YEARS. THE HIGHEST PERCENTAGE WAS IN THE 45-54 YEAR AGE GROUP (30%). THE OVERWHELMING MAJORITY OF THE RESPONDENTS WERE FEMALE (81%). MINORITIES WERE UNDER-REPRESENTED IN THE FY 2012 SURVEY. THEREFORE, INCREASED OUTREACH WAS DONE WITH THE HELP OF COMMUNITY PARTNERS AND AGENCIES TO BOLSTER MINORITY PARTICIPATION IN THE FY 2015 SURVEY. THESE EFFORTS WERE SUCCESSFUL. MINORITIES MADE UP 35% OF THE TOTAL 2014 SURVEY POPULATION. AFRICAN AMERICANS COMPRISED 30% OF THE RESPONDENTS, FOLLOWED BY 4% ASIAN/PACIFIC ISLANDER AND 1% AMERICAN INDIAN/NATIVE AMERICAN. FOURTEEN RESPONDENTS SELF REPORTED AS 2 OR MORE RACES. APPROXIMATELY 4% OF THE SURVEY RESPONDENTS SELF IDENTIFIED AS HISPANIC. THIS IS SIMILAR TO THE COUNTY OVERALL HISPANIC POPULATION OF 5%.

A SHORT 4 QUESTION SURVEY WAS DISTRIBUTED THROUGHOUT THE COUNTY REGARDING PERCEPTIONS OF HEALTH WITHIN THE COUNTY. THE A TOTAL OF 1,002 SHORT

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SURVEYS WERE COMPLETED. ONGOING SURVEY COLLECTION WAS CONDUCTED AT THE CHARLES COUNTY DEPARTMENT OF HEALTH'S NURSING, SUBSTANCE ABUSE, AND MENTAL HEALTH CLINICS; THE UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER'S WAITING ROOMS AND CARDIAC REHABILITATION PROGRAM; THE CENTER FOR CHILDREN; HEALTH PARTNERS INC; THE WESTERN COUNTY FAMILY MEDICAL CENTER; AND CAMBRIDGE PEDIATRICS. THE COMMUNITY WAS ALSO SURVEYED AT LARGE EVENTS SUCH AS MISSION OF MERCY, CHARLES COUNTY HOMELESS RESOURCE DAY, THE CHARLES COUNTY FAIR, COLLEGE OF SOUTHERN MARYLAND HEALTH AND WELLNESS FAIR, LIFESTYLES FOOD DISTRIBUTION DAYS, NANJEMOY BACK TO SCHOOL FAIR, NANJEMOY NATIONAL NIGHT OUT, AND NANJEMOY HERITAGE DAYS.

A CRITICAL PART OF THE NEEDS ASSESSMENT PROCESS IS TO INVITE THE COMMUNITY TO EXPRESS THEIR PERCEPTIONS OF HEALTH STATUS. QUALITATIVE DATA CUMULATED FROM THIS PROCESS WAS USED IN CONJUNCTION WITH THE QUANTITATIVE HEALTH DATA TO DETERMINE THE MOST IMPORTANT HEALTH ISSUES WITHIN THE COUNTY.

CHNA CONDUCTED WITH ONE OR MORE ORGANIZATIONS OTHER THAN HOSPITAL SCHEDULE H, PART V, SECTION B, LINE 6B
UM CRMC LED THE EFFORT AND COVERED 100% OF THE COST OF THE CHNA HOWEVER THE HOSPITAL WORKED COLLABORATIVELY WITH THE CHARLES COUNTY DEPARTMENT OF HEALTH AND THE LOCAL HEALTH IMPROVEMENT COALITION - PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY (PHCC) TO COMPLETE THE CHNA. EXECUTIVE LEADERSHIP OF PHCC CONSISTS OF THE CEO OF UM CRMC, THE COUNTY HEALTH

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

OFFICER, THE SUPERINTENDENT OF CHARLES COUNTY PUBLIC SCHOOLS AND THE
PRESIDENT OF THE COLLEGE OF SOUTHERN OF SOUTHERN MARYLAND. MEMBERSHIP OF
THE PHCC CONSISTS OF OVER 30 NONPROFIT AND COUNTY AGENCIES.

EXECUTIVE COMMITTEE OF LHIC

-CHARLES COUNTY DEPT. OF HEALTH, DIANNA ABNEY, MD, CHARLES COUNTY HEALTH
OFFICER

-CHARLES COUNTY PUBLIC SCHOOLS, DR. KIM HILL, SUPERINTENDENT

-COLLEGE OF SOUTHERN MARYLAND, DR. BRAD GOTTFRIED, PRESIDENT

-UM CRMC, NOEL CERVINO, PRESIDENT AND CEO

STEERING COMMITTEE OF LHIC

-CHARLES COUNTY DEPT. OF HEALTH, WILLIAM LEEBEL, PUBLIC INFORMATION
OFFICER

-CHARLES COUNTY PUBLIC SCHOOLS, JENNIFER CONTE, COORDINATOR OF STUDENT
INTERVENTION PROGRAMS

-COLLEGE OF SOUTHERN MARYLAND, LINDA SMITH, PROJECT COORDINATOR, SAFE
COMMUNITIES

-UM CRMC, JOYCE RIGGS, DIR., COMMUNITY DEVELOPMENT AND PLANNING

SUBCOMMITTEES:

-HEALTH PARTNERS CLINIC, CHRISSIE MULCAHEY, DIRECTOR, CHAIR, ACCESS TO
CARE

-CHARLES COUNTY DEPT. OF HEALTH, MARY BETH KLICK, TOBACCO PREVENTION
COORDINATOR, CO-CHAIR, CHRONIC DISEASE PREVENTION AND MANAGEMENT

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SUBCOMMITTEE

-UM CRMC, AMY ZIMMERMAN, CO CHAIR, CHRONIC DISEASE SUB COMM.

-CHARLES COUNTY CORE SERVICES, KARYN BLACK, DIRECTOR, CO-CHAIR,

BEHAVIORAL HEALTH SUBCOMMITTEE

-CHARLES COUNTY DEPT. OF HEALTH, ANGELA DEAL, COMMUNITY HEALTH EDUCATOR,

CO-CHAIR, CHRONIC DISEASE PREVENTION AND MANAGEMENT SUBCOMMITTEE

-CHARLES COUNTY DEPARTMENT OF HEALTH, LAURA BORAWSKI, COMMUNITY OUTREACH

WORKER, CO-CHAIR, CHRONIC DISEASE PREVENTION AND MANAGEMENT SUBCOMMITTEE

NEEDS NOT ADDRESSED BY THE MOST RECENTLY CONDUCTED CHNA

SCHEDULE H, PART V, SECTION B, LINE 11

BASED ON THE PRIORITY SCORE USING THE HANLON METHOD, THE HEALTH

PRIORITIES CHOSEN INCLUDE:

1. CHRONIC DISEASE PREVENTION AND MANAGEMENT

- MAJOR CARDIOVASCULAR DISEASE (HEART DISEASE, HYPERTENSION, AND STROKE)

- OBESITY AND OVERWEIGHT

- DIABETES PREVALENCE

- CANCER

2. BEHAVIORAL HEALTH

- SUBSTANCE USE DISORDERS (ALCOHOL, DRUG, AND TOBACCO USE)

- MENTAL HEALTH

3. ACCESS TO CARE

- PHYSICIAN RECRUITMENT AND RETENTION

- SOCIAL DETERMINANTS OF HEALTH (TRANSPORTATION, HEALTH LITERACY)

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

ALL 3 PRIORITIES OUTLINED IN THE CHNA ARE BEING ADDRESSED BY UM CRMC EITHER DIRECTLY (PHYSICIAN RECRUITMENT), OR THROUGH PARTNERSHIPS WITH OTHER ORGANIZATIONS (I.E. CHRONIC DISEASE SELF-MANAGEMENT PROGRAM), OR THROUGH THE LHIC, PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY (PHCC) WHICH IS CO-LED AND FINANCIALLY SUPPORTED BY UM CRMC. WHERE A NEED IS APPROPRIATELY ADDRESSED BY ANOTHER COMMUNITY ENTITY, UM CRMC PROVIDES LEADERSHIP AND/OR FUNDING THROUGH THE CHARLES COUNTY HEALTH IMPROVEMENT PLAN AND THE LOCAL HEALTH COALITION (PHCC) TO COMMUNICATE INITIATIVES, PROVIDE FINANCIAL SUPPORT AND/OR ASSISTANCE OR DATA WHEN NEEDED, AND REVIEW RESULTS (I.E., SUBSTANCE ABUSE, MENTAL HEALTH). EACH LHIC TEAM HAS DEVELOPED AND IMPLEMENTED STRATEGIES SPECIFIC TO THEIR IDENTIFIED PRIORITIES AND REPORTS BACK QUARTERLY TO THE LHIC STEERING COMMITTEE. THE HOSPITAL PROVIDES SUPPORT AND OVERSIGHT TO THE TEAMS AS A CRITICAL MEMBER OF THE LHIC STEERING COMMITTEE. THE HOSPITAL'S DIRECTOR OF COMMUNITY DEVELOPMENT AND PLANNING SERVES AS THE CO-CHAIR OF THE COUNTY LHIC.

INDIVIDUALS ELIGIBLE FOR FINANCIAL ASSISTANCE

SCHEDULE H, PART V, SECTION B, LINE 22D

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 24

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

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

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 V Facility Information (continued)

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

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

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

Part VI Supplemental Information

Provide the following information.

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

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 15 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 BREAKOUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE.

Part VI Supplemental Information

Provide the following information.

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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) & (D)

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES

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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 BUILDING ACTIVITIES

SCHEDULE H, PART II

AS THE ONLY HOSPITAL SERVING CHARLES COUNTY, MARYLAND, UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER (UM CRMC) SUPPORTS PROGRAMS AND ACTIVITIES WHERE THE HOSPITAL'S EXPERTISE AND RESOURCES CAN INFLUENCE THE FUNDAMENTAL ISSUES THAT AFFECT THE HEALTH OF THE COMMUNITY.

UM CRMC SUPPORTS ECONOMIC DEVELOPMENT OF THE COMMUNITY THROUGH LEADERSHIP PARTICIPATION IN ORGANIZATIONS SUCH AS THE CHAMBER OF COMMERCE, ECONOMIC DEVELOPMENT COMMISSION, LEADERSHIP SOUTHERN MARYLAND, AND THE TRI-COUNTY COUNCIL OF SOUTHERN MARYLAND. UM CRMC PARTICIPATES IN MANY COUNTY, STATE

Part VI Supplemental Information

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AND REGION-WIDE EMERGENCY PREPAREDNESS PLANNING ACTIVITIES AND DRILLS WITH OUR COMMUNITY PARTNERS SUCH AS EMERGENCY SERVICES, FIRE AND RESCUE, DEPARTMENT OF HEALTH, COUNTY GOVERNMENT, FEMA AND MEMA. THIS SERVES TO ENSURE THAT IN THE EVENT OF A DISASTER, THE HOSPITAL IS READY TO SUPPORT AND CARE FOR OUR COMMUNITY.

HOSPITAL ADMINISTRATION PARTICIPATES IN HEALTHCARE WORKFORCE DEVELOPMENT 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, UM CRMC PARTICIPATES AND SUPPORTS THE BLACK LEADERSHIP COUNCIL ON EXCELLENCE'S YOUNG RESEARCHERS COMMUNITY PROJECT WHICH OFFERS DISADVANTAGED YOUTH IN HIGH SCHOOL AN OPPORTUNITY TO SHADOW MEDICAL PROFESSIONALS.

ACCORDING TO MARYLAND HEALTH WORKFORCE STUDY PHASE 2 REPORT (JANUARY 2014), THE SOUTHERN MARYLAND REGION HAS A PHYSICIAN SHORTAGE FOR PRIMARY CARE PHYSICIANS. IN CHARLES COUNTY, THE PRIMARY CARE PHYSICIAN FTE DEMAND IS GREATER THAN THE PRIMARY CARE FTE SUPPLY (7.4 VS. 6.1). THERE IS AN

Part VI Supplemental Information

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18% SHORTFALL IN THE PRIMARY CARE SERVICES SUPPLY TO FULFILL THE CURRENT DEMAND. 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 FTE PER 10,000 SUPPLY RATES FOR PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND PSYCHOLOGISTS IN CHARLES COUNTY IS MUCH LOWER THAN THE RATES FOR MARYLAND. THE DEMAND FOR PSYCHIATRISTS IN CHARLES COUNTY IS MUCH HIGHER THAN THE COUNTY SUPPLY FOR PSYCHIATRY. CHARLES COUNTY HAS A SHORTAGE BETWEEN 50-75% OF FULL TIME EQUIVALENT PSYCHIATRISTS. AS A RESULT OF THE PREVAILING PHYSICIAN SHORTAGE, AND TO MITIGATE THE EFFECTS OF THE LACK OF ACCESS OF THE COMMUNITY TO MEDICAL CARE, UM CRMC HAS DEVELOPED A ROBUST AND ONGOING PHYSICIAN RECRUITMENT AND RETAINMENT PROGRAM.

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

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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.

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

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BRING THE FEDERAL MEDICARE PAYMENTS UNDER HSCRC CONTROL.

IN 2014, MARYLAND'S WAIVER WITH MEDICARE WAS RENEGOTIATED AND UPDATED TO REFLECT THE CURRENT HEALTHCARE ENVIRONMENT. UNDER THIS NEW WAIVER, SEVERAL CRITERIA WERE ESTABLISHED TO MONITOR THE SUCCESS OF THE SYSTEM IN CONTROLLING HEALTHCARE COSTS AND THE CONTINUANCE OF THE WAIVER ITSELF:

1. REVENUE GROWTH PER CAPITA
2. MEDICARE HOSPITAL REVENUE PER BENEFICIARY
3. MEDICARE ALL PROVIDER REVENUE GROWTH PER BENEFICIARY
4. MEDICARE READMISSION RATES
5. HOSPITAL ACQUIRED CONDITION RATE

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. CURRENTLY, CIVISTA MEDICAL CENTER IS IN

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THE PROCESS OF UPDATING ITS BILLING AND COLLECTIONS PROCESS TO ENSURE IT IS IN COMPLIANCE WITH THE NEW IRC SECTION 501(R) REGULATIONS. 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 PROCESS.

UMMC MAKES EVERY EFFORT TO MAKE FINANCIAL ASSISTANCE INFORMATION AVAILABLE TO OUR PATIENTS INCLUDING, BUT NOT LIMITED TO:

- SIGNAGE IN MAIN ADMITTING AREAS AND EMERGENCY ROOMS OF THE HOSPITAL
- UMMC WEBSITE

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-PATIENT HANDBOOK DISTRIBUTED TO ALL PATIENTS

-BROCHURES EXPLAINING FINANCIAL ASSISTANCE ARE MADE AVAILABLE IN ALL

PATIENT CARE AREAS

-PATIENT PLAIN LANGUAGE SHEETS - NEWLY REVISED IN JUNE 2016, THIS HANDOUT

WAS REVISED AND IS AT THE 5TH GRADE READING LEVEL (AVAILABLE IN ENGLISH,

SPANISH, FRENCH & CHINESE BASED ON TOP LANGUAGES SPOKEN BY UMMC

PATIENTS)

-APPEARING IN PRINT MEDIA THROUGH LOCAL NEWSPAPERS

COMMUNITY HEALTH CARE NEEDS ASSESSMENT

SCHEDULE H, PART VI, LINE 2

FROM JULY 2014 TO MARCH 2015, THE UNIVERSITY OF MARYLAND CHARLES REGIONAL

MEDICAL CENTER UNDERTOOK A COMPREHENSIVE ASSESSMENT OF THE HEALTH NEEDS

OF CHARLES COUNTY, MARYLAND.

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

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HEALTH AND HEALTH BEHAVIORS, A SHORT PAPER SURVEY ON HEALTH PERCEPTIONS THROUGHOUT THE COUNTY, 15 FOCUS GROUPS WITH COMMUNITY LEADERS, CITIZENS, AND STAKEHOLDERS, AND A QUANTITATIVE DATA ANALYSIS OF SECONDARY, PUBLISHED DATA. DATA COLLECTION OCCURRED BETWEEN JULY 2014 AND FEBRUARY 2015.

THE USE OF THE MULTIPLE DATA COLLECTION METHODS STRENGTHENED THE VALIDITY OF THE ASSESSMENT'S FINDINGS AS WELL AS ENSURING THAT CHARLES COUNTY RESIDENTS HAD AN OPPORTUNITY TO PARTICIPATE IN THE ASSESSMENT PROCESS AND TO FEEL INVESTED IN ITS OUTCOME.

FIFTEEN FOCUS GROUPS WERE PERFORMED THROUGHOUT THE COUNTY BETWEEN JULY 2014 AND FEBRUARY 2015. THE FOCUS GROUP TOPICS INCLUDED: CHRONIC DISEASE SPECIFIC HEALTH, SPECIAL POPULATIONS, COUNTY LEADERSHIP, DRUG AND ALCOHOL COUNCIL MEMBERS, CHARLES COUNTY SUBSTANCE ABUSE ADVISORY COALITION MEMBERS, YOUTH THROUGH THE SCHOOL NURSES, IN-HOUSE HEALTH DEPARTMENT NURSES, FITNESS AND NUTRITION, MINORITY HEALTH AND HEALTH DISPARITIES, PREVENTION AND SAFETY, FAITH-BASED LEADERS, BEHAVIORAL HEALTH,

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REPRODUCTIVE AND INFANT HEALTH, CANCER, AND ACCESS TO CARE. APPROXIMATELY
235 PEOPLE PARTICIPATED IN THE COUNTY FOCUS GROUPS.

806 CHARLES COUNTY RESIDENTS COMPLETED THE 27 QUESTION ONLINE SURVEY THAT
WAS CREATED USING SURVEY MONKEY. THE LINK TO THE SURVEY WAS AVAILABLE ON
THE UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER 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 4 QUESTION SURVEY WAS DISTRIBUTED THROUGHOUT THE COUNTY REGARDING
PERCEPTIONS OF HEALTH WITHIN THE COUNTY. THE A TOTAL OF 1,002 SHORT
SURVEYS WERE COMPLETED. ONGOING SURVEY COLLECTION WAS CONDUCTED AT THE
CHARLES COUNTY DEPARTMENT OF HEALTH'S NURSING, SUBSTANCE ABUSE, AND
MENTAL HEALTH CLINICS; THE UNIVERSITY OF MARYLAND CHARLES REGIONAL
MEDICAL CENTER'S WAITING ROOMS AND CARDIAC REHABILITATION PROGRAM; THE
CENTER FOR CHILDREN; HEALTH PARTNERS INC; THE WESTERN COUNTY FAMILY

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MEDICAL CENTER; AND CAMBRIDGE PEDIATRICS. THE COMMUNITY WAS ALSO SURVEYED AT LARGE EVENTS SUCH AS MISSION OF MERCY, CHARLES COUNTY HOMELESS RESOURCE DAY, THE CHARLES COUNTY FAIR, COLLEGE OF SOUTHERN MARYLAND HEALTH AND WELLNESS FAIR, LIFESTYLES FOOD DISTRIBUTION DAYS, NANJEMOY BACK TO SCHOOL FAIR, NANJEMOY NATIONAL NIGHT OUT, AND NANJEMOY HERITAGE DAYS.

QUANTITATIVE DATA WAS ANALYZED FOR VARIOUS 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, ENVIRONMENTAL HEALTH, SEXUALLY TRANSMITTED DISEASES, HIV/AIDS, MENTAL HEALTH, DENTAL HEALTH, SUBSTANCE ABUSE, DISABILITIES, AND TOBACCO USE.

ELIGIBILITY EDUCATION

SCHEDULE H, PART VI, LINE 3

UM CRMC POSTS ITS CHARITY CARE POLICY, OR A SUMMARY THEREOF, AS WELL AS

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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 hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

FINANCIAL ASSISTANCE CONTACT INFORMATION IN ADMISSIONS AREAS, EMERGENCY ROOMS, BUSINESS OFFICES AND OTHER AREAS OF THE FACILITY WHERE ELIGIBLE PATIENTS ARE LIKELY TO PRESENT. ADDITIONALLY, THE POLICY AND PLAIN LANGUAGE VERSION ARE AVAILABLE ON THE HOSPITAL'S PUBLIC WEBSITE.

THE FAP IS WRITTEN IN A CULTURALLY SENSITIVE AND AT AN APPROPRIATE READING LEVEL. IT IS AVAILABLE IN ENGLISH AND SPANISH. ALL PATIENT ACCESS CUSTOMER SERVICE STAFF HAVE TRAINING IN THE FINANCIAL ASSISTANCE PROCESS.

DURING THE INTAKE OR DISCHARGE PROCESS OR WHEN THERE IS CONTACT REGARDING A BILLING MATTER, IF A PATIENT DISCLOSES FINANCIAL DIFFICULTY OR CONCERN WITH PAYMENT OF THE BILL, THE PATIENT IS PROVIDED WITH FAP INFORMATION. A PACKET WITH THE APPLICATION, CRITERIA AND A DOCUMENTATION CHECKLIST IS PROVIDED. ASSISTANCE COMPLETING THE APPLICATION IS AVAILABLE. ADDITIONALLY, ASSISTANCE IS PROVIDED FOR PATIENTS OR THEIR FAMILIES IN QUALIFICATION AND APPLICATION OF GOVERNMENT BENEFITS, MEDICAID AND OTHER STATE PROGRAMS. ONCE AN APPLICATION IS PROCESSED AND

Part VI Supplemental Information

Provide the following information.

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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.

IF IT IS DEEMED INCOMPLETE, A LETTER IS SENT TO THE PATIENT REQUESTING THE MISSING OR INCOMPLETE ITEMS. PATIENTS MAY CALL THE CALL CENTER OR COME INTO THE PATIENT ACCESS OFFICE FOR ASSISTANCE.

DESCRIPTION OF COMMUNITY SERVED

SCHEDULE H, PART VI, LINE 4

THE UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER IS CHARLES COUNTY'S ONLY HOSPITAL AND, AS SUCH, SERVES THE RESIDENTS OF THE ENTIRE COUNTY.

GEOGRAPHY

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

Part VI Supplemental Information

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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 IN THE 2010 CENSUS. THE CURRENT 2016 CENSUS BUREAU ESTIMATES THE POPULATION AT 156,118 FOR A 6.1% INCREASE IN FOUR 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%.

Part VI Supplemental Information

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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 COUNTY WHERE MANY RESIDENTS COMMUTE TO WASHINGTON D.C. TO WORK. THE AVERAGE WORK COMMUTE TIME FOR A CHARLES COUNTY RESIDENT IS 42.8 MINUTES WHICH IS HIGHER THAN THE MARYLAND AVERAGE OF 32.0 MINUTES. PUBLIC TRANSPORTATION CONSISTS OF COMMUTER BUSES FOR OUT-OF-COUNTY TRAVEL AND THE COUNTY-RUN VAN GO BUS SERVICE FOR IN-COUNTY 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 2014, THEY COMPRISE 43.8% OF THE TOTAL COUNTY POPULATION. AS OF 2014, MINORITIES COMPRISE ROUGHLY 54% OF THE CHARLES COUNTY POPULATION. THE HISPANIC COMMUNITY HAS ALSO SEEN INCREASES OVER

Part VI Supplemental Information

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THE PAST FEW YEARS. THEY NOW COMPRISE 5.3% OF THE TOTAL COUNTY POPULATION. THIS IS THE ONE OF THE HIGHEST PERCENTAGES AMONG THE 24 MARYLAND JURISDICTIONS. CHARLES COUNTY ALSO HAS ONE OF THE LARGEST AMERICAN INDIAN/NATIVE AMERICAN POPULATIONS IN THE STATE OF MARYLAND AT 0.8% OF THE TOTAL COUNTY POPULATION.

THE 2015 CHARLES COUNTY GENDER BREAKDOWN IS APPROXIMATELY 50/50. MALES MAKE UP 48.3% OF THE POPULATION, AND FEMALES MAKE UP 51.7% OF THE COUNTY POPULATION.

ECONOMY

EMPLOYMENT AND ECONOMIC INDICATORS FOR THE COUNTY ARE FAIRLY STRONG. THE 2010-2014 US CENSUS AMERICAN COMMUNITY SURVEY ESTIMATES THAT 70.4% OF THE CHARLES COUNTY POPULATION IS CURRENTLY IN THE LABOR WORK FORCE. THE 2010-2014 5-YEAR ESTIMATE FOR CHARLES COUNTY FOUND THAT APPROXIMATELY 7.6% OF CHARLES COUNTY INDIVIDUALS ARE LIVING BELOW THE POVERTY LEVEL; HOWEVER, THIS IS LOWER THAN THE MARYLAND RATE OF 10.0%. THE CHARLES COUNTY MEDIAN HOUSEHOLD INCOME WAS \$91,910, WELL ABOVE THE MARYLAND

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MEDIAN HOUSEHOLD INCOME OF \$74,149.THE DIVERSITY OF THE COUNTY IS ALSO REPRESENTED IN THE BUSINESS COMMUNITY WITH 46% OF ALL CHARLES COUNTY BUSINESSES BEING MINORITY-OWNED FIRMS. THIS IS HIGHER THAN THE STATE OF MARYLAND AT 38%.

EDUCATION

CHARLES COUNTY HAS A LARGER PERCENTAGE OF HIGH SCHOOL GRADUATES THAN MARYLAND (91.6% VS. 89.0%); HOWEVER, CHARLES COUNTY HAS A SMALLER PERCENTAGE THAN MARYLAND OF INDIVIDUALS WITH A BACHELOR'S DEGREE OR HIGHER (26.8% VS. 37.3%).

HOUSING

THERE IS A HIGH LEVEL OF HOME OWNERSHIP IN CHARLES COUNTY (77.9%); HOWEVER, THIS IS SLIGHTLY DOWN FROM THE 2010 LEVEL (81.8%). THE MEDIAN VALUE OF A HOUSING UNIT IN CHARLES COUNTY IS SIMILAR TO THE MARYLAND AVERAGE (\$287,000 VS. \$287,500). HOME VALUES ACROSS MARYLAND HAVE DECREASED AND CHARLES COUNTY SHOWED A SIMILAR DOWNWARD TREND. THE AVERAGE HOUSEHOLD SIZE IN CHARLES COUNTY IS 2.86 PERSONS.

Part VI Supplemental Information

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SOURCE: 2010-2014 US CENSUS BUREAU'S AMERICAN COMMUNITY SURVEY 5 YEAR

ESTIMATES

LIFE EXPECTANCY

THE LIFE EXPECTANCY FOR A CHARLES COUNTY RESIDENT, AS CALCULATED FOR 2014, WAS 79.1 YEARS. THIS IS SLIGHTLY BELOW THE STATE AVERAGE LIFE EXPECTANCY OF 79.8 YEARS.

SOURCE: 2014 MARYLAND VITAL STATISTICS REPORT

BIRTHS

THERE WERE 1,844 BIRTHS IN CHARLES COUNTY IN 2015. CHARLES COUNTY REPRESENTS 44% OF THE BIRTHS IN SOUTHERN MARYLAND AND 2.5% OF THE TOTAL BIRTHS IN MARYLAND FOR 2015.

MINORITIES MADE UP JUST OVER HALF OF THE BABIES BORN IN CHARLES COUNTY IN 2015 (52%) WHICH IS IN LINE WITH THE COMPOSITION OF THE COUNTY.

SOURCE: 2015 MARYLAND PRELIMINARY VITAL STATISTICS REPORT

Part VI Supplemental Information

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PROMOTING THE HEALTH OF THE COMMUNITY

SCHEDULE H, PART VI, LINE 5

UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER (UM CRMC) IS THE PARENT COMPANY OF A REGIONAL INTEGRATED HEALTH SYSTEM SERVING THE HEALTH NEEDS OF CHARLES COUNTY AND THE CITIZENS OF SOUTHERN MARYLAND.

GOVERNANCE IS PROVIDED THROUGH A COMMUNITY VOLUNTEER BOARD OF DIRECTORS.

UM CRMC'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 COLLABORATING WITH HEALTH -

PROVIDING AGENCY PARTNERS. COMMUNITY HEALTH IMPROVEMENT STRATEGIES ARE

INCLUDED IN THE ORGANIZATION'S STRATEGIC PLAN.

UM CRMC PROVIDED \$12.8 MILLION IN CHARITY CARE, HEALTH PROFESSIONS

EDUCATION, COMMUNITY BENEFIT OPERATIONS, COMMUNITY HEALTH IMPROVEMENT

SERVICES, SUBSIDIZED HEALTH SERVICES, CASH AND IN-KIND DONATIONS AND

COMMUNITY BUILDING ACTIVITIES IN FY 2016. THIS YEAR, WE PROVIDED AND

Part VI Supplemental Information

Provide the following information.

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SUPPORTED PROGRAMS, ACTIVITIES AND SCREENINGS SUCH AS BLOOD PRESSURE, GLUCOSE, BREAST AND CERVICAL CANCER, COLORECTAL CANCER AND STROKE RISK REDUCTION EDUCATION. MOBILE INTEGRATED HEALTH IS A PROGRAM THAT STARTED IN FY 16 THAT IMPROVES ACCESS TO CARE AND WRAP AROUND HEALTH CARE TO COMMUNITY MEMBERS WITH BARRIERS. IN ADDITION TO PARTICIPATING IN THE PROGRAM UM CRMC WILL CONTRIBUTE FINANCIALLY TO THE PROGRAM FOR 3 YEARS. UM CRMC PROVIDED HEALTH EDUCATION PROGRAMS ON HEARTY HEALTHY EATING, DIABETES EDUCATION, CANCER EDUCATION, BREAST AND CERVICAL CANCER, TOBACCO CESSATION PROGRAM. IN ADDITION, WE SPONSORED AMERICAN CANCER SOCIETY'S LOOK GOOD FEEL BETTER, ADVANCED DIRECTIVES, CAR SAFETY SEAT INSPECTIONS, COMMUNITY DISASTER DRILLS, SCHOOL CAREER DAYS, THE YOUNG RESEARCHES COMMUNITY PROJECT, AND SUPPORT GROUPS SUCH AS STROKE SUPPORT, CARDIAC SUPPORT, AND THE BETTER BREATHERS CLUB. A NEW ADDITION IN FY 16 IS THE LIVING WELL CHRONIC DISEASE SELF-MANAGEMENT PROGRAM, A FREE, 6 WEEK, EVIDENCE BASED PROGRAM TO IMPROVE THE WELL-BEING OF PEOPLE LIVING WITH A VARIETY OF CHRONIC CONDITIONS. THE HOSPITAL OFFERS CLINICS AND CLINIC SERVICES SUCH AS RENAL DIALYSIS SERVICES AND AMERICAN RED CROSS BLOOD DRIVES. WE PARTICIPATED IN COMMUNITY COALITIONS AND BOARDS SUCH AS THE

Part VI Supplemental Information

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UNITED WAY, PARTNERSHIPS FOR A HEALTHIER CHARLES COUNTY, CHARLES COUNTY TOBACCO COALITION, LEADERSHIP SOUTHERN MARYLAND, HOSPICE OF CHARLES COUNTY, HEALTHY FAMILIES, FETAL INFANT MORTALITY BOARD, CENTER FOR ABUSED PERSONS, JUVENILE DRUG COURT, MISSION OF MERCY; CHAMBER OF COMMERCE AND CHARLES COUNTY CHILD ADVOCACY PARTNERSHIP. WE PARTICIPATED IN AND SUPPORTED COMMUNITY EVENTS SUCH AS CHRISTMAS CONNECTION, AMERICAN CANCER SOCIETY'S RELAY FOR LIFE, ALZHEIMER'S WALK, MARCH OF DIMES AND SAFE NIGHTS.

AFFILIATED HEALTH CARE SYSTEM ROLES

SCHEDULE H, PART VI, LINE 6

CIVISTA MEDICAL CENTER (UM CRMC) 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.

Part VI Supplemental Information

Provide the following information.

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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 (UM CRMC) AND UMMS HAVE DEVELOPED A RECRUITMENT AND RETENTION PLAN TO SUCCESSFULLY ATTRACT AND RETAIN PRIVATE PHYSICIANS TO THE COMMUNITY.

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)**

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

OMB No. 1545-0047

2015

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

▶ Attach to Form 990.

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

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

Part I General Information on Grants and Assistance

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

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

| 1 (a) Name and address of organization or government | (b) EIN | (c) IRC section if applicable | (d) Amount of cash grant | (e) Amount of non-cash assistance | (f) Method of valuation (book, FMV, appraisal, other) | (g) Description of non-cash assistance | (h) Purpose of grant or assistance |
|---|------------|-------------------------------|--------------------------|-----------------------------------|---|--|------------------------------------|
| (1) CHARLES REGIONAL MEDICAL CENTER FOUNDATION P.O. BOX 1701 LAPLATA, MD 20646 | 52-1414564 | 501(C)(3) | 8,000. | | | | PAINT THE TOWN PINK |
| (2) MARCH OF DIMES 2110 WASHINGTON BLVD. ARLINGTON, VA 22204 | 13-1846366 | 501(C)(3) | 13,000. | | | | MARCH FOR BABIES |
| (3) | | | | | | | |
| (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 2.

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

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

Schedule I (Form 990) (2015)

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. EACH OF THE CONTRIBUTION RECIPIENTS ARE EITHER GOVERNMENTAL UNITS OR SECTION 501(C)(3) CHARITABLE ORGANIZATIONS WHICH WORK TO FULFILL THE ORGANIZATION'S MISSION OF PROMOTING HEALTH WITHIN THE COMMUNITY.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Compensation Information

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

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2015

**Open to Public
Inspection**

Employer identification number

52-0445374

Part I Questions Regarding Compensation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Schedule J (Form 990) 2015

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

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that 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 in column (B) reported as deferred on prior Form 990 |
|---|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| 1 ROBERT CHRENCIK EX-OFFICIO/DIRECTOR | (i) | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 1,254,208. | 1,054,693. | 253,896. | 10,600. | 13,037. | 2,586,434. |
| 2 JON P. BURNS EX-OFFICIO/DIRECTOR | (i) | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 414,431. | 179,244. | 60,528. | 10,600. | 13,037. | 677,840. |
| 3 NOEL CERVINO EX-OFFICIO/PRESIDENT & CEO | (i) | 386,434. | 204,375. | 77,401. | 10,600. | 10,269. | 689,079. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. |
| 4 ERIK BOAS CHIEF FINANCIAL OFFICER | (i) | 217,392. | 84,000. | 37,804. | 8,801. | 0. | 347,997. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. |
| 5 MARK R. DUMAIS CHIEF MEDICAL OFFICER | (i) | 340,634. | 107,520. | 301,809. | 10,600. | 10,851. | 771,414. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. |
| 6 DANA LEVY CHIEF NURSING OFFICER | (i) | 190,407. | 55,080. | 389. | 25,006. | 5,461. | 276,343. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. |
| 7 PAUL BLACKWOOD VP PLANNING | (i) | 185,126. | 64,260. | 2,109. | 25,006. | 13,037. | 289,538. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. |
| 8 WILLIAM GRIMES VP ANCILLIARY SERVICES | (i) | 164,518. | 47,515. | 5,012. | 21,572. | 597. | 239,214. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. |
| 9 MARILYN GREGORY RN | (i) | 177,497. | 0. | 343. | 1,300. | 1,147. | 180,287. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. |
| 10 KATHERINE MIDDLETON RN | (i) | 190,486. | 0. | 120. | 1,679. | 747. | 193,032. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. |
| 11 EUGENE SUWANDHI, M.D. PEDIATRIC HOSPITALIST PHYS. | (i) | 166,880. | 0. | 93. | 2,600. | 17,909. | 187,482. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. |
| 12 JOHN W. ASHWORTH DIRECTOR | (i) | 0. | 0. | 0. | 0. | 0. | 0. |
| | (ii) | 511,790. | 169,396. | 99,546. | 10,600. | 13,037. | 804,369. |
| 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.

HEALTH OR SOCIAL CLUB DUES

SCHEDULE J, PART I, LINE 1A

UMMS EXECUTIVES RECEIVE A BENEFIT PACKAGE WHICH MAY BE USED TOWARDS HEALTH CLUB DUES OR OTHER HEALTH MAINTENANCE PROGRAMS. SUCH BENEFITS ARE CAPPED AT \$7,000, \$5,000, OR \$3,000 DEPENDING ON JOB TITLE AS DESCRIBED IN THE PROGRAM DOCUMENTS.

SEVERANCE PAYMENT OR CHANGE OF CONTROL PAYMENT

SCHEDULE J, PART I, LINE 4A

DURING THE FISCAL YEAR-ENDED JUNE 30, 2016, CERTAIN OFFICERS AND KEY EMPLOYEES HAVE RECEIVED SEVERANCE PAYMENTS. THESE AMOUNTS ARE REPORTED AS TAXABLE COMPENSATION AND REPORTED ON SCHEDULE J, PART II, LINE B(III), OTHER REPORTABLE COMPENSATION. THE INDIVIDUALS AND AMOUNTS ARE LISTED BELOW:

MARK R. DUMAIS \$45,025

SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN

SCHEDULE J, PART I, LINE 4B

DURING THE FISCAL YEAR ENDED JUNE 30, 2016, CERTAIN OFFICERS AND KEY

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.

EMPLOYEES PARTICIPATED IN THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM
(UMMS) SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN. THE INDIVIDUALS LISTED
BELOW HAVE 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:

DANA LEVY

PAUL BLACKWOOD

WILLIAM GRIMES

DURING THE FISCAL YEAR ENDED JUNE 30, 2016, 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:

ERIK BOAS

NOEL CERVINO

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.

ROBERT A. CHRENCIK

JON P. BURNS

JOHN W. ASHWORTH

DURING THE FISCAL YEAR ENDED JUNE 30, 2016, 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 THE REPORTING TAX YEAR. THEREFORE, THE FULL VALUE OF THE PLAN, INCLUDING ANY CONTRIBUTIONS TO THE PLAN FOR THE CURRENT FISCAL YEAR, IS REPORTED AS TAXABLE COMPENSATION AND REPORTED ON SCHEDULE J, PART II, LINE B(III), OTHER REPORTABLE COMPENSATION. PRIOR YEAR CONTRIBUTIONS TO THE PLAN WERE PREVIOUSLY REPORTED ON FORM 990 AND ARE INDICATED ON SCHEDULE J, PART II, COLUMN (F).

MARK R. DUMAIS

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

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.

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 L
(Form 990 or 990-EZ)

Transactions With Interested Persons

OMB No. 1545-0047

2015

Open To Public Inspection

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**
▶ **Attach to Form 990 or Form 990-EZ.**
▶ **Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.**

Name of the organization
CIVISTA MEDICAL CENTER, INC.

Employer identification number
52-0445374

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

| 1 | (a) Name of disqualified person | (b) Relationship between disqualified person and organization | (c) Description of transaction | (d) Corrected? | |
|-----|---------------------------------|---|--------------------------------|----------------|----|
| | | | | Yes | No |
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ \$ _____

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

Part II Loans to and/or From Interested Persons.
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

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

Part III Grants or Assistance Benefiting Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

| 1 | (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of assistance | (d) Type of assistance | (e) Purpose of assistance |
|------|-------------------------------|---|--------------------------|------------------------|---------------------------|
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |
| (7) | | | | | |
| (8) | | | | | |
| (9) | | | | | |
| (10) | | | | | |

Part IV Business Transactions Involving Interested Persons.

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

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|-------------------------------|---|---------------------------|--------------------------------|---|----|
| | | | | Yes | No |
| (1) JOSEPH SLATER | BOARD MEMBER | 906,743. | PRESIDENT AND CEO OF A VENDOR | | X |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |
| (7) | | | | | |
| (8) | | | | | |
| (9) | | | | | |
| (10) | | | | | |

Part V Supplemental Information

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

PART IV

JOSEPH SLATER IS THE PRESIDENT AND CEO OF ONE OF OUR VENDORS, SOUTHERN MARYLAND ELECTRIC COOPERATIVE, INC.

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

2015

**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 EDUCATIONAL FACILITIES 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, UPPER CHESAPEAKE MEDICAL CENTER, INC., HARFORD MEMORIAL HOSPITAL, INC. 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 \$1,417,355,000 OF OUTSTANDING AUTHORITY BONDS ON JUNE 30,

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

2016. ALL OF THE BONDS WERE ISSUED IN THE NAME OF THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORPORATION AND ARE REPORTED ON SCHEDULE K OF ITS FORM 990.

MEMBERS OR STOCKHOLDERS

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

UNIVERSITY OF MARYLAND CHARLES REGIONAL HEALTH, 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 IRS 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, WHICH IS AN EXCEL-BASED SYSTEM.

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 CIVISTA MEDICAL CENTER, INC. | Employer identification number 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 IRS 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 IRS FORM 990. AT THE DISCRETION OF THE REVIEWING BOARD MEMBER, SUCH MEMBER WILL BRING ANY ISSUES OR QUESTIONS RELATED TO THE COMPLETED IRS FORM 990 TO THE ATTENTION OF THE BOARD.

NOTWITHSTANDING THE ABOVE, A BOARD RESOLUTION IS NOT REQUIRED FOR THE FILING OF THE ORGANIZATION'S IRS FORM 990. EACH BOARD MEMBER IS PROVIDED WITH A COPY OF THE FINAL IRS 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

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

AND KEY EMPLOYEES. THE 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

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

TRANSACTION WITH ANY ORGANIZATION OFFICER, DIRECTOR, EMPLOYEE OR MEMBER OF THE MEDICAL STAFF, INCLUDING 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 IRS 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 IRS INTERMEDIATE SANCTIONS REGULATIONS. THIS PROCESS IS USED TO DETERMINE THE COMPENSATION PACKAGES FOR ALL MANAGEMENT

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

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 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

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

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 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 11 ACUTE CARE HOSPITALS, 1 ACUTE CARE HOSPITAL OWNED IN A JOINT VENTURE ARRANGEMENT 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 9

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|--|--|
| Name of the organization CIVISTA MEDICAL CENTER, INC. | Employer identification number 52-0445374 |
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| | |
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| PENSION LIABILITY ADJUSTMENT | (\$3,697,344) |
| NET ASSETS RELEASED FROM RESTRICTIONS | \$2,150,360 |
| CHANGE IN INTERCOMPANY - EQUITY TRANSFER | (\$867,271) |
| CHANGE IN EQUITY OF AFFILIATES, FOUNDATION | (\$33,005) |
| CHANGE IN FMV OF ALTERNATIVE INVESTMENTS | (\$272,081) |
| | ----- |
| | (\$2,719,341) |
| | ===== |

ATTACHMENT 1

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

UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER (UM CRMC) IS THE PARENT COMPANY OF A REGIONAL INTEGRATED HEALTH SYSTEM SERVING THE HEALTH NEEDS OF CHARLES COUNTY AND THE CITIZENS OF SOUTHERN MARYLAND. GOVERNANCE IS PROVIDED THROUGH A COMMUNITY VOLUNTEER BOARD OF DIRECTORS AND COMMUNITY HEALTH IMPROVEMENT STRATEGIES ARE INCLUDED IN THE ORGANIZATION'S STRATEGIC PLAN. UM CRMC'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. FROM JULY 2014 TO MARCH 2015, THE UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER, IN COLLABORATION WITH THE CHARLES COUNTY DEPARTMENT OF HEALTH (CCDOH) UNDERTOOK A COMPREHENSIVE ASSESSMENT OF THE HEALTH NEEDS OF CHARLES COUNTY, MARYLAND. AN

| | |
|--|--|
| Name of the organization CIVISTA MEDICAL CENTER, INC. | Employer identification number 52-0445374 |
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ATTACHMENT 1 (CONT'D)

EPIDEMIOLOGIST WITH A MASTER'S DEGREE IN PUBLIC HEALTH
 EPIDEMIOLOGY WAS CONTRACTED TO ANALYZE THE QUALITATIVE AND
 QUANTITATIVE DATA. TO PROVIDE A COMPREHENSIVE ASSESSMENT OF THE
 HEALTH NEEDS OF THE COUNTY, A FOUR METHOD PLAN WAS DEVELOPED WHICH
 INCLUDED 4 DIFFERENT SOURCES OF DATA: A LONG ONLINE SURVEY OF
 CHARLES COUNTY RESIDENTS PERCEPTIONS OF HEALTH AND HEALTH
 BEHAVIORS, A SHORT PAPER SURVEY ON HEALTH PERCEPTIONS THROUGHOUT
 THE COUNTY, 15 FOCUS GROUPS WITH COMMUNITY LEADERS, CITIZENS, AND
 STAKEHOLDERS, AND A QUANTITATIVE DATA ANALYSIS OF SECONDARY,
 PUBLISHED DATA. DATA COLLECTION OCCURRED BETWEEN JULY 2014 AND
 FEBRUARY 2015. THE USE OF THE MULTIPLE DATA COLLECTION METHODS
 STRENGTHENED THE VALIDITY OF THE ASSESSMENT'S FINDINGS AS WELL AS
 ENSURING THAT CHARLES COUNTY RESIDENTS HAD AN OPPORTUNITY TO
 PARTICIPATE IN THE ASSESSMENT PROCESS AND TO FEEL INVESTED IN ITS
 OUTCOME.

FIFTEEN FOCUS GROUPS WERE PERFORMED THROUGHOUT THE COUNTY BETWEEN
 JULY 2014 AND FEBRUARY 2015. THE FOCUS GROUP TOPICS INCLUDED:
 CHRONIC DISEASE SPECIFIC HEALTH, SPECIAL POPULATIONS, COUNTY
 LEADERSHIP, DRUG AND ALCOHOL COUNCIL MEMBERS, CHARLES COUNTY
 SUBSTANCE ABUSE ADVISORY COALITION MEMBERS, YOUTH THROUGH THE
 SCHOOL NURSES, IN-HOUSE HEALTH DEPARTMENT NURSES, FITNESS AND
 NUTRITION, MINORITY HEALTH AND HEALTH DISPARITIES, PREVENTION AND
 SAFETY, FAITH-BASED LEADERS, BEHAVIORAL HEALTH, REPRODUCTIVE AND
 INFANT HEALTH, CANCER, AND ACCESS TO CARE. APPROXIMATELY 235
 PEOPLE PARTICIPATED IN THE COUNTY FOCUS GROUPS. ATTENDANCE FOR

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

ATTACHMENT 1 (CONT'D)

THOSE MEETINGS RANGED FROM 5 TO 100 PEOPLE. PARTICIPANTS REPRESENTED ALL SERVICE ORGANIZATIONS WITHIN THE COMMUNITY. THEY PROVIDE SERVICES TO ALL FACETS OF THE COMMUNITY INCLUDING WOMEN, INFANTS, SCHOOL AGED CHILDREN, THOSE WHO ARE INCARCERATED, THOSE WITH MENTAL HEALTH PROBLEMS, THOSE WITH FINANCIAL/HOUSING/EMPLOYMENT/HEALTH ISSUES, THE UN- AND UNDERINSURED, THE HUNGRY, THOSE WITH CHRONIC HEALTH CONDITIONS, THE HOMELESS, THE ELDERLY, COLLEGE STUDENTS, MEDICALLY UNDERSERVED, ALL FAITHS AND RELIGIONS, AND MINORITIES, JUST TO NAME A FEW. A COMPLETE LISTING OF THE NAMES OF THE COMMUNITY REPRESENTATIVES PARTICIPATING IN THE FOCUS GROUPS IS LOCATED AS AN ADDENDUM TO UM CRMC'S CHNA (UM CRMC 2015 CHNA) BEGINNING ON PAGE 242. 806 CHARLES COUNTY RESIDENTS COMPLETED THE 27 QUESTION ONLINE SURVEY THAT WAS CREATED USING SURVEY MONKEY. THE LINK TO THE SURVEY WAS AVAILABLE ON THE UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER 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. MOST OF THE RESPONDENTS ARE FROM CHARLES COUNTY (82.4%). THE SECOND LARGEST PERCENTAGE IS FROM ST MARY'S COUNTY (7.22%). ONLY 4% REPORTED LIVING OUTSIDE OF SOUTHERN MARYLAND (CHARLES, CALVERT, ST MARY'S, OR PG). APPROXIMATELY 69% OF THE RESPONDENTS WERE BETWEEN THE AGES OF 35-64 YEARS. THE HIGHEST PERCENTAGE WAS IN THE 45-54 YEAR AGE

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| Name of the organization CIVISTA MEDICAL CENTER, INC. | Employer identification number 52-0445374 |
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ATTACHMENT 1 (CONT'D)

GROUP (30%). THE OVERWHELMING MAJORITY OF THE RESPONDENTS WERE FEMALE (81%). MINORITIES WERE UNDER-REPRESENTED IN THE FY 2012 SURVEY. THEREFORE, INCREASED OUTREACH WAS DONE WITH THE HELP OF COMMUNITY PARTNERS AND AGENCIES TO BOLSTER MINORITY PARTICIPATION IN THE FY 2015 SURVEY. THESE EFFORTS WERE SUCCESSFUL. MINORITIES MADE UP 35% OF THE TOTAL 2014 SURVEY POPULATION. AFRICAN AMERICANS COMPRISED 30% OF THE RESPONDENTS, FOLLOWED BY 4% ASIAN/PACIFIC ISLANDER AND 1% AMERICAN INDIAN/NATIVE AMERICAN. FOURTEEN RESPONDENTS SELF-REPORTED AS 2 OR MORE RACES. APPROXIMATELY 4% OF THE SURVEY RESPONDENTS SELF-IDENTIFIED AS HISPANIC. THIS IS SIMILAR TO THE COUNTY OVERALL HISPANIC POPULATION OF 5%. A SHORT 4 QUESTION SURVEY WAS DISTRIBUTED THROUGHOUT THE COUNTY REGARDING PERCEPTIONS OF HEALTH WITHIN THE COUNTY. A TOTAL OF 1,002 SHORT SURVEYS WERE COMPLETED. ONGOING SURVEY COLLECTION WAS CONDUCTED AT THE CHARLES COUNTY DEPARTMENT OF HEALTH'S NURSING, SUBSTANCE ABUSE, AND MENTAL HEALTH CLINICS; THE UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER'S WAITING ROOMS AND CARDIAC REHABILITATION PROGRAM; THE CENTER FOR CHILDREN; HEALTH PARTNERS INC; THE WESTERN COUNTY FAMILY MEDICAL CENTER; AND CAMBRIDGE PEDIATRICS. THE COMMUNITY WAS ALSO SURVEYED AT LARGE EVENTS SUCH AS MISSION OF MERCY, CHARLES COUNTY HOMELESS RESOURCE DAY, THE CHARLES COUNTY FAIR, COLLEGE OF SOUTHERN MARYLAND HEALTH AND WELLNESS FAIR, LIFESTYLES FOOD DISTRIBUTION DAYS, NANJEMOY BACK TO SCHOOL FAIR, NANJEMOY NATIONAL NIGHT OUT, AND NANJEMOY HERITAGE DAYS. A CRITICAL PART OF THE NEEDS ASSESSMENT PROCESS IS TO INVITE

| | |
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| Name of the organization CIVISTA MEDICAL CENTER, INC. | Employer identification number 52-0445374 |
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ATTACHMENT 1 (CONT'D)

THE COMMUNITY TO EXPRESS THEIR PERCEPTIONS OF HEALTH STATUS.
 QUALITATIVE DATA CUMULATED FROM THIS PROCESS WAS USED IN
 CONJUNCTION WITH THE QUANTITATIVE HEALTH DATA TO DETERMINE THE
 MOST IMPORTANT HEALTH ISSUES WITHIN THE COUNTY.

ACCOMPLISHMENTS:

UM CRMC PROVIDED \$12.8 MILLION IN CHARITY CARE, HEALTH PROFESSIONS
 EDUCATION, COMMUNITY BENEFIT OPERATIONS, COMMUNITY HEALTH
 IMPROVEMENT SERVICES, SUBSIDIZED HEALTH SERVICES, CASH AND IN-KIND
 DONATIONS AND COMMUNITY BUILDING ACTIVITIES IN FY 2016. THE
 HOSPITAL PROVIDED MANY PROGRAMS, SERVICES, ACTIVITIES AND
 SCREENINGS THROUGHOUT THE COMMUNITY. LISTED HERE ARE PROGRAM
 ACCOMPLISHMENTS SPECIFIC TO IDENTIFIED NEEDS FROM THE MOST RECENT
 CHNA:

CHRONIC DISEASE MANAGEMENT AND PREVENTION

- CENTER FOR DIABETES EDUCATION: HIRED CERTIFIED DIABETES
 EDUCATOR; DEVELOPED CURRICULUM; EARNED ACCREDITATION BY AMERICAN
 ASSOCIATION OF DIABETES EDUCATORS; OPENED CENTER IN FY 17
- CHRONIC DISEASE SELF-MANAGEMENT PROGRAM (CDSMP): TRAINED STAFF
 IN UNIVERSITY OF STANFORD'S PROGRAM; OFFERED 3 FREE CDSMP CLASSES
 WITH A TOTAL OF 27 PARTICIPANTS
- COMMUNITY RESOURCE GUIDE: DEVELOPED TO PROMOTE SERVICES AND
 PROGRAMS FOR PEOPLE WITH CHRONIC DISEASE; 1000 DISTRIBUTED
- STROKE EDUCATION AND OUTREACH: STROKE AWARENESS NIGHT AT SO. MD

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| Name of the organization CIVISTA MEDICAL CENTER, INC. | Employer identification number 52-0445374 |
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ATTACHMENT 1 (CONT'D)

BLUE CRABS; COMMUNITY EVENTS; 503 EDUCATED

- BETTER BREATHERS CLUB: EDUCATED 210 PEOPLE FOR COPD AND ASTHMA
MANAGEMENT

- COLORECTAL CANCER EDUCATION: CHARLES COUNTY FAIR - INFLATABLE
COLON; 550 PEOPLE EDUCATED ON EARLY DETECTION

BEHAVIORAL HEALTH

- CHARLES COUNTY PRESCRIPTION DRUG TAKE BACK: PARTNERED WITH CC
GOVERNMENT, MD GOVERNOR'S OFFICE AND LOCAL PHARMACIES; PLANNING
AND LAUNCH IN FY 16

- COMMUNITY EDUCATION AND OUTREACH: COMMUNITY EVENTS, PROJECT
GRADUATION, OPIATE AWARENESS CAMPAIGN (VAN GO), COMMUNITY
PRESENTATION TO PARENTS @ CSM ON DRUG AWARENESS; 9700 EDUCATED

- MENTAL HEALTH FIRST AID TRAINING: ALL CCPS SCHOOL COUNSELORS AND
PRINCIPALS TRAINED; LAW ENFORCEMENT AND FIRST RESPONDERS IN
PROCESS OF TRAINING; 237 TRAINED

- BEHAVIORAL HEALTH COUNSELOR IN ED: CONTRACT WITH CALVERT
MEMORIAL HOSPITAL; EVALUATING THE FEASIBILITY OF TELE-PSYCH
SERVICES IN FY 17

ACCESS TO CARE

- RECRUITED 7 HEALTH CARE PROVIDERS TO THE COMMUNITY
- URGENT CARE: OPENED IN SEPTEMBER 2015; GENERATED 9960 VISITS;
34% OF RESPONDENTS STATED GOING TO URGENT CARE INSTEAD OF ED
- LAUNCHED A COMMUNITY EDUCATION CAMPAIGN ON WHEN TO USE ED VS.

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| Name of the organization CIVISTA MEDICAL CENTER, INC. | Employer identification number 52-0445374 |
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ATTACHMENT 1 (CONT'D)

URGENT CARE; 20,000 DISTRIBUTED

- POPULATION HEALTH DEPARTMENT: HIRED MANAGER AND TWO NURSE

NAVIGATORS

- MOBILE INTEGRATED HEALTH PROGRAM: IN PARTNERSHIP WITH CCDOH AND
CC EMS, SECURED \$350,000 IN 3 YEAR GRANT FUNDING FOR PILOT TO
IMPROVE ACCESS TO CARE AND WRAP AROUND HEALTH CARE TO COMMUNITY
MEMBERS WITH BARRIERS. IN ADDITION TO PARTICIPATING IN THE PROGRAM
UM CRMC WILL CONTRIBUTE FINANCIALLY TO THE PROGRAM FOR 3 YEARS.

- MERGED CRMC'S COMMUNITY COALITION WITH THE ACCESS TO CARE TEAM;
RECRUITED 40 NEW MEMBERS MEETING MONTHLY

- HEALTH LITERACY: IN PARTNERSHIP WITH THE UMMS, DEVELOPED AND
PRESENTED A HEALTH LITERACY EDUCATION VIDEO AND DOCUMENT CHECKLIST
FOR HEALTH CARE WORKERS: 5 GROUP PRESENTATIONS TO DATE

PROMOTED COUNTY HEALTH RESOURCES AT 24 COUNTY EVENTS

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

| <u>NAME AND ADDRESS</u> | <u>DESCRIPTION OF SERVICES</u> | <u>COMPENSATION</u> |
|---|--------------------------------|---------------------|
| FACCHINA CONSTRUCTION COMPANY 102 CENTENNIAL ST., SUITE 201 LA PLATA, MD 20646 | CONSTRUCTION | 4,296,699. |
| MARYLAND INPATIENT CARE SPECIALISTS 7250 PARKWAY DRIVE, SUITE 500 HANOVER, MD 21076 | PHYSICIANS | 1,795,301. |
| HEALOGICS WOUND CARE 3087 MOMENTUM PLACE CHICAGO, IL 60689-5330 | WOUND CARE | 925,925. |

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|--|--|
| Name of the organization CIVISTA MEDICAL CENTER, INC. | Employer identification number 52-0445374 |
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ATTACHMENT 2 (CONT'D)

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

| <u>NAME AND ADDRESS</u> | <u>DESCRIPTION OF SERVICES</u> | <u>COMPENSATION</u> |
|--|--------------------------------|---------------------|
| EMERGENCY MEDICINE ASSOCIATES 20010 CENTURY BLVD., SUITE 200 GERMANTOWN, MD 20874 | CONT STAFFING | 897,612. |
| BAXTER, BAKER, SIDLE CONN & JONES PA 120 EAST BALTIMORE STREET, STE 2100 BALTIMORE, MD 21202 | LEGAL SERVICES | 530,228. |

ATTACHMENT 3

FORM 990, PART IX - OTHER FEES

| <u>DESCRIPTION</u> | (A) <u>TOTAL FEES</u> | (B) <u>PROGRAM SERVICE EXP.</u> | (C) <u>MANAGEMENT AND GENERAL</u> | (D) <u>FUNDRAISING EXPENSES</u> |
|--------------------------------|------------------------------|--|--|--|
| AGENCY EXPENSE/CONTRACTUAL STA | 4,777,352. | 4,060,749. | 716,603. | |
| PROFESSIONAL FEES | 5,086,408. | 4,930,014. | 156,394. | |
| CONSULTING SERVICES | 590,941. | 502,300. | 88,641. | |
| OTHER FEES | 700,327. | 595,278. | 105,049. | |
| SHARED SERVICES | 5,250,835. | 4,463,210. | 787,625. | |
| TOTALS | <u>16,405,863.</u> | <u>14,551,551.</u> | <u>1,854,312.</u> | |

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2015

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

▶ **Attach to Form 990.**

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

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

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

| (a) Name, address, and EIN (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) U. MD CHARLES REGIONAL URGENT CARE, LLC 47-4492342 500 CHARLES STREET LA PLATA, MD 20646 | URGENT CARE | MD | 954,514. | 1,700,210. | CIVSITA MED |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |

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

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

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

Schedule R (Form 990) 2015

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2015

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

▶ **Attach to Form 990.**

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

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

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

| (a) Name, address, and EIN (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" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|-------------------------|--|----------------------------|---|----------------------------------|--|----|
| | | | | | | Yes | No |
| (1) CHESTER RIVER HEALTH FOUNDATION INC 100 BROWN STREET CHESTERTOWN, MD 21620 52-1338861 | FUNDRAISING | MD | 501(C)(3) | 08 | UMSRH | | X |
| (2) UNIV OF MD SHORE REGIONAL HEALTH, INC 100 BROWN STREET CHESTERTOWN, MD 21620 52-2046500 | HEALTHCARE | MD | 501(C)(3) | 11A | UMMSC | | X |
| (3) CHESTER RIVER HOSPITAL CENTER 100 BROWN STREET CHESTERTOWN, MD 21620 52-0679694 | HEALTHCARE | MD | 501(C)(3) | 03 | UMSRH | | X |
| (4) CHESTER RIVER MANOR INC 200 MORGNEC ROAD CHESTERTOWN, MD 21620 52-6070333 | HEALTHCARE | MD | 501(C)(3) | 09 | UMSRH | | X |
| (5) MARYLAND GENERAL CLINICAL PRACTICE GROUP 827 LINDEN AVENUE BALTIMORE, MD 21201 52-1566211 | HEALTHCARE | MD | 501(C)(3) | 11B | UMMTH | | X |
| (6) MARYLAND GENERAL COMM HEALTH FOUNDATION 827 LINDEN AVENUE BALTIMORE, MD 21201 52-2147532 | FUNDRAISING | MD | 501(C)(3) | 11C | UMMTH | | X |
| (7) UNIVERSITY OF MARYLAND MIDTOWN HEALTH, I 827 LINDEN AVENUE BALTIMORE, MD 21201 52-1175337 | HEALTHCARE | MD | 501(C)(3) | 11B | UMMSC | | X |

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

Schedule R (Form 990) 2015

SCHEDULE R (Form 990)

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2015

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990.

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

Name of the organization

Employer identification number

CIVISTA MEDICAL CENTER, INC.

52-0445374

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

Table with 6 columns: (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. Rows 1-6 are empty.

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

Table with 9 columns: (a) Name, address, and EIN of related organization; (b) Primary activity; (c) Legal domicile (state or foreign country); (d) Exempt Code section; (e) Public charity status (if section 501(c)(3)); (f) Direct controlling entity; (g) Section 512(b)(13) controlled entity? (Yes/No). Rows 1-7 contain data for various organizations like MARYLAND GENERAL HOSPITAL INC, CARE HEALTH SERVICES INC, etc.

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

Schedule R (Form 990) 2015

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2015

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

▶ **Attach to Form 990.**

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Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

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

| (a) Name, address, and EIN (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" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|--|-------------------------|--|----------------------------|---|----------------------------------|--|----|
| | | | | | | Yes | No |
| (1) JAMES LAWRENCE KERNAN HOSPITAL INC 2200 KERNAN DRIVE BALTIMORE, MD 21207 52-0591639 | HEALTHCARE | MD | 501(C)(3) | 03 | UMMSC | | X |
| (2) UMMS FOUNDATION, INC. 22 SOUTH GREENE STREET BALTIMORE, MD 21201 52-2238893 | FUNDRAISING | MD | 501(C)(3) | 11A | UMMSC | | X |
| (3) UNIVERSITY OF MD MEDICAL SYSTEM CORP 22 SOUTH GREENE STREET BALTIMORE, MD 21201 52-1362793 | HEALTHCARE | MD | 501(C)(3) | 03 | N/A | | X |
| (4) UNIVERSITY OF MARYLAND CHARLES REGIONAL PO BOX 1070 LA PLATA, MD 20646 52-2155576 | HEALTHCARE | MD | 501(C)(3) | 11C | UMMSC | | X |
| (5) CHARLES REGIONAL MEDICAL CENTER FOUNDATI PO BOX 1070 LA PLATA, MD 20646 52-1414564 | FUNDRAISING | MD | 501(C)(3) | 11A | UMCRH | | X |
| (6) CHARLES REGIONAL MEDICAL CENTER AUXILIAR PO BOX 1070 LA PLATA, MD 21204 52-1131193 | FUNDRAISING | MD | 501(C)(3) | 11A | UMCRH | | X |
| (7) UNIV OF MD ST. JOSEPH FOUNDATION, INC 7601 OSLER DRIVE TOWSON, MD 21014 52-1681044 | FUNDRAISING | MD | 501(C)(3) | 11A | UMMSC | | X |

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

Schedule R (Form 990) 2015

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2015

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

▶ **Attach to Form 990.**

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

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

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

| (a) Name, address, and EIN (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" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|--|-------------------------|--|----------------------------|---|----------------------------------|--|----|
| | | | | | | Yes | No |
| (1) HARFORD MEMORIAL HOSPITAL, INC. 52-0591484 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014 | HEALTHCARE | MD | 501(C)(3) | 03 | UMUCHS | | X |
| (2) UCH LEGACY FUNDING CORPORATION 52-0882914 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014 | FUNDRAISING | MD | 501(C)(3) | 11A | UMUCHS | | X |
| (3) UNIV OF MD UPPER CHESAPEAKE HEALTH SYS. 52-1398513 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014 | HEALTHCARE | MD | 501(C)(3) | 11C; III-FI | UMUCHS | | X |
| (4) UPPER CHESAPEAKE HEALTH FOUNDATION, INC. 52-1398507 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014 | FUNDRAISING | MD | 501(C)(3) | 11A | UMUCHS | | X |
| (5) UPPER CHESAPEAKE MEDICAL CENTER, INC. 52-1253920 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014 | HEALTHCARE | MD | 501(C)(3) | 03 | UMUCHS | | X |
| (6) UPPER CHESAPEAKE MEDICAL SERVICES, INC. 52-1501734 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014 | HEALTHCARE | MD | 501(C)(3) | 09 | UMUCHS | | X |
| (7) UPPER CHESAPEAKE PROPERTIES, INC. 52-1907237 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014 | REAL ESTATE | MD | 501(C)(2) | | UMUCHS | | X |

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

Schedule R (Form 990) 2015

SCHEDULE R (Form 990)

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2015

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990.

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

Name of the organization

CIVISTA MEDICAL CENTER, INC.

Employer identification number

52-0445374

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

Table with 6 columns: (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. Rows 1-6 are empty.

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

Table with 9 columns: (a) Name, address, and EIN of related organization; (b) Primary activity; (c) Legal domicile (state or foreign country); (d) Exempt Code section; (e) Public charity status (if section 501(c)(3)); (f) Direct controlling entity; (g) Section 512(b)(13) controlled entity? (Yes/No). Rows 1-3 contain data for HOSPICE and HEALTHCARE organizations.

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

Schedule R (Form 990) 2015

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|--|-------------------------|--|----------------------------------|--|------------------------------|------------------------------------|--------------------------------------|----|--|-------------------------------------|----|-----------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| (1) ARUNDEL PHYSICIANS ASSOCIATES 301 HOSPITAL DRIVE GLEN BURNIE | HEALTHCARE | MD | N/A | N/A | | | | | | | | |
| (2) BALTIMORE WASHINGTON IMAGING, 301 HOSPITAL DRIVE GLEN BURNIE | HEALTHCARE | MD | N/A | N/A | | | | | | | | |
| (3) INNOVATIVE HEALTH LLC 52-19972 29165 CANVASBACK DRIVE, SUITE | BILLING | MD | N/A | N/A | | | | | | | | |
| (4) CENTRAL MARYLAND RADIOLOGY ONC 10710 CHARTER DRIVE COLUMBIA, | HEALTHCARE | MD | N/A | N/A | | | | | | | | |
| (5) UNIVERSITYCARE LLC 52-1914892 22 SOUTH GREENE STREET BALTIMO | HEALTHCARE | MD | N/A | N/A | | | | | | | | |
| (6) O'DEA MEDICAL ARTS LIMITED PAR 7601 OSLER DRIVE TOWSON, MD 21 | RENTAL | MD | N/A | N/A | | | | | | | | |
| (7) ADVANCED IMAGING AT ST. JOSEPH 7601 OSLER DRIVE TOWSON, MD 21 | HEALTHCARE | MD | N/A | N/A | | | | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512(b)(13) controlled entity? | |
|---|-------------------------|--|----------------------------------|--|------------------------------|------------------------------------|-----------------------------|--|----|
| | | | | | | | | Yes | No |
| (1) ARUNDEL PHYSICIANS ASSOCIATES, INC. 52-1992649 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061 | HEALTHCARE | MD | BWHE | C CORP | | | | | |
| (2) BALTIMORE WASHINGTON HEALTH ENTERPRISES, 52-1936656 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061 | HEALTHCARE | MD | BWMS | C CORP | | | | | |
| (3) BW PROFESSIONAL SERVICES, INC. 52-1655640 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061 | HEALTHCARE | MD | BWHE | C CORP | | | | | |
| (4) UNIV OF MARYLAND CHARLES REGIONAL CARE P 52-2176314 PO BOX 1070 LA PLATA, MD 20646 | HEALTHCARE | MD | CHI | C CORP | | | | | |
| (5) UNIVERSITY MIDTOWN PROF CENTER, A CONDOM 52-1891126 827 LINDEN AVENUE BALTIMORE, MD 21201 | REAL ESTATE | MD | MGHS | C CORP | | | | | |
| (6) NA EXECUTIVE BUILDING CONDO ASSN, INC. 301 HOSPITAL DRIVE GLEN BURNIE, MD 21061 | REAL ESTATE | MD | NADCO | C CORP | | | | | |
| (7) TERRAPIN INSURANCE COMPANY 98-0129232 P.O. BOX 1109 GRAND CAYMAN, CJ KYI-1102 | INSURANCE | CJ | UMMS | C CORP | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|--|-------------------------|--|----------------------------------|--|------------------------------|------------------------------------|--------------------------------------|----|--|-------------------------------------|----|-----------------------------|
| | | | | | | | Yes | No | | Yes | No | |
| (1) UCHS/UMMS REAL ESTATE TRUST 27 520 UPPER CHESAPEAKE DR BEL AI | REAL ESTATE | MD | N/A | N/A | | | | | | | | |
| (2) UNIVERSITY OF MARYLAND CHARLES PO BOX 1070 LAPLATA, MD 20646 | HEALTHCARE | 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" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512(b)(13) controlled entity? | |
|---|-------------------------|--|----------------------------------|--|------------------------------|------------------------------------|-----------------------------|--|----|
| | | | | | | | | Yes | No |
| (1) UMMS SELF INSURANCE TRUST 52-6315433 22 SOUTH GREENE STREET BALTIMORE, MD 21201 | INSURANCE | MD | UMMS | TRUST | | | | | |
| (2) UPPER CHESAPEAKE INSURANCE COMPANY 98-0468438 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014 | INSURANCE | MD | UMUCHS | S CORP | | | | | |
| (3) UPPER CHESAPEAKE HEALTH VENTURES, INC. 52-2031264 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014 | HEALTHCARE | MD | UMUCHS | C CORP | | | | | |
| (4) UPPER CHESAPEAKE MEDICAL CENTER LAND CON 77-0674478 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014 | REAL ESTATE | MD | UC MED CRT | C CORP | | | | | |
| (5) UPPER CHESAPEAKE MEDICAL OFFICE BUILDING 52-1946829 520 UPPER CHESAPEAKE DR BEL AIR, MD 21014 | REAL ESTATE | MD | UC HLTH VENT | C CORP | | | | | |
| (6) UNIVERSITY OF MARYLAND HEALTH ADVANTAGE, 46-1411902 22 SOUTH GREENE STREET BALTIMORE, MD 21201 | INSURANCE | MD | UMMS | C CORP | | | | | |
| (7) UNIVERSITY OF MARYLAND HEALTH PARTNERS, 45-2815803 22 SOUTH GREENE STREET BALTIMORE, MD 21201 | INSURANCE | MD | UMMS | C CORP | | | | | |

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

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

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512(b)(13) controlled entity? | |
|--|-------------------------|--|----------------------------------|--|------------------------------|------------------------------------|-----------------------------|--|----|
| | | | | | | | | Yes | No |
| (1) UNIVERSITY OF MARYLAND MEDICAL SYSTEM HE 22 SOUTH GREENE STREET BALTIMORE, MD 21201 45-2815722 | INSURANCE | MD | UMMS | C CORP | | | | | |
| (2) SHORE ORTHOPEDICS, INC. 219 S. WASHINGTON STREET EASTON, MD 21601 37-1817260 | HEALTHCARE | MD | SHS | C CORP | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| (5) | | | | | | | | | |
| (6) | | | | | | | | | |
| (7) | | | | | | | | | |

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

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

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

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

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

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

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

| (a) Name, address, and EIN of entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (e) Are all partners section 501(c)(3) organizations? | | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? | | (i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|---|-------------------------|--|--|--|----|------------------------------|------------------------------------|--------------------------------------|----|--|-------------------------------------|----|-----------------------------|
| | | | | Yes | No | | | Yes | No | | Yes | No | |
| (1) | | | | | | | | | | | | | |
| (2) | | | | | | | | | | | | | |
| (3) | | | | | | | | | | | | | |
| (4) | | | | | | | | | | | | | |
| (5) | | | | | | | | | | | | | |
| (6) | | | | | | | | | | | | | |
| (7) | | | | | | | | | | | | | |
| (8) | | | | | | | | | | | | | |
| (9) | | | | | | | | | | | | | |
| (10) | | | | | | | | | | | | | |
| (11) | | | | | | | | | | | | | |
| (12) | | | | | | | | | | | | | |
| (13) | | | | | | | | | | | | | |
| (14) | | | | | | | | | | | | | |
| (15) | | | | | | | | | | | | | |
| (16) | | | | | | | | | | | | | |

Part VII **Supplemental Information**

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