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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

OMB No 1545-0047

2010

Open to Public Inspection

A For the 2010 calendar year, or tax year beginning 01-01-2010 and ending 12-31-2010

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

C Name of organization
COMMUNITY MERCY HEALTH PARTNERS

Doing Business As
SPRINGFIELD REGIONAL MEDICAL CENTER

Number and street (or P O box if mail is not delivered to street address)
One South Limestone Street

Room/suite

City or town, state or country, and ZIP + 4
Springfield, OH 45502

D Employer identification number
31-0785684

E Telephone number
(937) 328-7000

G Gross receipts $ 300,727,005

F Name and address of principal officer
MARK WIENER PRESIDENT AND CEO
1 S LIMESTONE ST
SPRINGFIELD, OH 45502

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

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

H(c) Group exemption number ▶ 0928

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

J Website: ▶ WWW COMMUNITY-MERCY ORG

K Form of organization ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 1983

M State of legal domicile OH

Part I Summary

1 Briefly describe the organization's mission or most significant activities
THE MISSION OF COMMUNITY MERCY HEALTH PARTNERS IS TO EXTEND THE HEALING MINISTRY OF JESUS BY IMPROVING THE HEALTH OF OUR COMMUNITIES WITH EMPHASIS ON PEOPLE WHO ARE POOR AND UNDER-SERVED

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

Activities & Governance

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	15
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	12
5	Total number of individuals employed in calendar year 2010 (Part V, line 2a)	**5**	3,318
6	Total number of volunteers (estimate if necessary)	**6**	962
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	20,220
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	-49,147

		Prior Year	Current Year
Revenue	**8** Contributions and grants (Part VIII, line 1h)	452,663	1,477,204
	9 Program service revenue (Part VIII, line 2g)	306,780,216	288,667,356
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	2,072,807	6,978,038
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,839,352	3,604,407
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	313,145,038	300,727,005
Expenses	**13** Grants and similar amounts paid (Part IX, column (A), lines 1–3)	450,000	446,756
	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)	147,740,310	138,891,138
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	b Total fundraising expenses (Part IX, column (D), line 25) ▶0		
	17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24f)	163,907,101	149,532,368
	18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	312,097,411	288,870,262
	19 Revenue less expenses Subtract line 18 from line 12	1,047,627	11,856,743

		Beginning of Current Year	End of Year
Net Assets or Fund Balances	**20** Total assets (Part X, line 16)	257,797,472	338,674,626
	21 Total liabilities (Part X, line 26)	105,668,189	172,451,855
	22 Net assets or fund balances Subtract line 21 from line 20	152,129,283	166,222,771

Part II Signature Block

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

Sign Here

Signature of officer — Date: 2011-11-03

DEBORAH BLOOMFIELD DIVISIONAL CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed ▶☐	PTIN
Firm's name ▶ BKD LLP				Firm's EIN ▶
Firm's address ▶ 312 WALNUT STREET SUITE 300 CINCINNATI, OH 45202				Phone no ▶ (513) 621-8300

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

THE MISSION OF COMMUNITY MERCY HEALTH PARTNERS IS TO CARRY OUT THE CATHOLIC HEALTH PARTNERS MISSION WITHIN OUR COMMUNITY BY PROVIDING SAFE, EFFECTIVE, PATIENT/RESIDENT CENTERED, TIMELY AND COST EFFICIENT CARE AND EDUCATION TO MEET THE HEALTH NEEDS OF ALL PEOPLE, ESPECIALLY THE POOR AND UNDER-SERVED OUR COMMITMENT TO THIS HEALING MINISTRY WILL BE EVIDENCED BY EXCEPTIONAL CARE, COMPASSION, AND RESPECT FOR THE DIVERSE RELIGIOUS BELIEFS AND FAITH TRADITIONS OF THOSE WE SERVE

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ Yes ☐ No

If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . ☐ Yes ☑ No

If "Yes," describe these changes on Schedule O

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

4a (Code) (Expenses $ 234,554,799 including grants of $ 446,756) (Revenue $ 288,667,356)

COMMUNITY MERCY HEALTH PARTNERS IS COMMITTED TO DELIVERING EXCEPTIONAL CARE AND COMPASSION AS IT SEEKS TO MEET THE HEALTH CARE NEEDS OF ALL PEOPLE, ESPECIALLY THE POOR AND UNDER-SERVED DURING 2010 COMMUNITY MERCY HEALTH PARTNERS PROVIDED $19,327,732 IN COMMUNITY BENEFITS REPRESENTING 7 08% OF TOTAL OPERATING EXPENSES

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** ▶ $ 234,554,799

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete Schedule B, Schedule of Contributors (see instruction)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		
6	Did the organization maintain any donor advised funds or any similar funds or accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in term, permanent,or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		No
11	If the organization's answer to any of the following questions is 'Yes,' then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line10? *If "Yes," complete Schedule D, Part VI.*	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII.*	11b	Yes	
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII.*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX.*	11d		No
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X.*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X.*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI, XII, and XIII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered 'No' to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, and program service activities outside the United States? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the U S ? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the U S ? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000, of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)*	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospitals? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach its audited financial statement to this return? **Note.** Some Form 990 filers that operate one or more hospitals must attach audited financial statements (see instructions)	20b		No

Part IV Checklist of Required Schedules *(continued)*

21	Did the organization report more than $5,000 of grants and other assistance to governments and organizations in the United States on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	**21**	Yes	
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	**22**		No
23	Did the organization answer "Yes" to Part VII, Section A, questions 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b–24d and complete Schedule K. If "No," go to line 25*	**24a**		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	**26**		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties? (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**		No
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**	Yes	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	**33**	Yes	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1*	**34**	Yes	
35	Is any related organization a controlled entity within the meaning of section 512(b)(13)?	**35**	Yes	
a	Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2* ☑ Yes ☐ No			
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	1a	0		
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		1c		
2a	Enter the number of employees reported on Form W-3, *Transmittal of Wage and Tax Statements* filed for the calendar year ending with or within the year covered by this return	2a	3,318		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		2b	Yes	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?		3a	Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*		3b	Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		4a		No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for Form TD F 90-22 1, Report of Foreign Bank and Financial Accounts				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		5a		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		5b		No
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		5c		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible?		6a		No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		6b		
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?		7a		No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		7b		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		7c		No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		7e		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		7f		No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		7h		
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?		8		
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?		9a		
b	Did the organization make a distribution to a donor, donor advisor, or related person?		9b		
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?		12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O		13a		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?		14a		No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*		14b		

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	15		
b	Enter the number of voting members included in line 1a, above, who are independent	1b	12		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		2	Yes	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? . .		3		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		4		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets? .		5		No
6	Does the organization have members or stockholders?		6	Yes	
7a	Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?		7a	Yes	
b	Are any decisions of the governing body subject to approval by members, stockholders, or other persons? . .		7b	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?		8a	Yes	
b	Each committee with authority to act on behalf of the governing body?		8b	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		9		No

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

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

Section C. Disclosure

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

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

☐ Own website ☐ Another's website ☑ Upon request

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

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization ▶

DEBORAH BLOOMFIELD
4600 MCAULEY PLACE
CINCINNATI, OH 45242
(513) 981-5056

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) MARK WIENER PRESIDENT & CEO	40	X		X				442,002	0	51,509
(2) JOHN DEMPSEY VP CFO & TREASURER	40			X				280,816	0	35,140
(3) SUSAN HAYES VP SENIOR HEALTH & HOUSING	40				X			191,498	0	91,768
(4) TERRANCE WEINBURGER VP MISSION SERVICES	40				X			232,710	0	33,918
(5) KATRINA ENGLISH VP GENERAL COUNSEL	40				X			234,341	0	39,539
(6) JAMES N DOYLE SECRETARY	1	X		X				1,081	0	0
(7) RICHARD W FURAY MD TRUSTEE	1	X						926	0	0
(8) SR DORIS A GOTTEMOELLER RSM TRUSTEE, CHP SVP MISSION/VALUES INTEGRATION	1	X						0	0	0
(9) PIUS KURIAN MD TRUSTEE	1	X						0	0	0
(10) JAMES MAY TRUSTEE, SVP CHP & DIVISIONAL CEO	1	X						0	937,068	177,170
(11) MICHAEL S MCKEE MD CHAIR	1	X		X				0	0	0
(12) PLATO N PAVLATOS TRUSTEE	1	X						0	0	0
(13) PAMELA YOUNG PHD VICE CHAIR	1	X		X				1,090	0	0
(14) JOSEPH R JACKSON TRUSTEE	1	X						926	0	0
(15) RAVI C KHANNA MD TRUSTEE	1	X						0	0	0
(16) MARK B ROBERTSON TRUSTEE	1	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(17) HOMER A SMITH TRUSTEE	1	X						0	0	0
(18) E'LISE DELANGLADE SPRIGGS TRUSTEE	1	X						1,081	0	0
(19) GREGORY SMITH STAFF PHARMACIST	40					X		154,024	0	18,697
(20) JAMES GOODRICH MD PHYSICIAN	40					X		195,638	0	19,556
(21) SANA WAIKHOM MD PHYSICIAN	40					X		172,680	0	18,553
(22) JENELLE ZELINSKI DIRECTOR OF FINANCE	40					X		180,769	0	20,157
(23) REV DARRYL L GRAYSON TRUSTEE	1	X						0	0	0
(24) KATHLEEN M HUGHES TRUSTEE	1	X						926	0	0
(25) RON CONNOVICH VP FACILITY MANAGEMENT	40				X			168,946	0	34,428
(26) D TERRY BOYS VP CHIEF NURSING OFFICER	40				X			209,496	0	20,003
(27) DONALD B JOHNSON MD VP MEDICAL AFFAIRS	40				X			226,944	0	15,719
(28) ROBERT GONDOS CONTROLLER	40					X		159,906	0	102,471
1b Sub-Total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)								2,855,800	937,068	678,628

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 in reportable compensation from the organization ▶ 69

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

Section B. Independent Contractors

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

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

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 ▶ 0

Part VIII Statement of Revenue

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a Federated campaigns . . 1a					
	b Membership dues 1b					
	c Fundraising events 1c					
	d Related organizations . . . 1d	874,305				
	e Government grants (contributions) 1e					
	f All other contributions, gifts, grants, and similar amounts not included above 1f	602,899				
	g Noncash contributions included in lines 1a-1f $					
	h **Total.** Add lines 1a-1f . . . . . ▶		1,477,204			
Program Service Revenue		Business Code				
	2a NET PATIENT SERVICE REVENUE	621990	286,730,692	286,730,692		
	b INCOME FROM JV'S AND PARTNERSHIPS	900003	509,080	509,080		
	c SCHOOL OF NURSING TUITION	611600	688,864	688,864		
	d PURCHASE DISCOUNTS	900099	66,423	66,423		
	e CORPORATE WELLNESS	900099	190,048	190,048		
	f All other program service revenue		482,249	482,249	0	0
	g **Total.** Add lines 2a–2f . . . . . ▶		288,667,356			
	3 Investment income (including dividends, interest and other similar amounts) . . . . . ▶		6,978,038			6,978,038
	4 Income from investment of tax-exempt bond proceeds . . ▶		0			
	5 Royalties . . . . . ▶		0			
		(i) Real	(ii) Personal			
	6a Gross Rents					
	b Less rental expenses					
	c Rental income or (loss)	0	0			
	d Net rental income or (loss) . . . . . ▶		0			
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory					
	b Less cost or other basis and sales expenses					
	c Gain or (loss)	0	0			
	d Net gain or (loss) . . . . . ▶		0			
Other Revenue	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18 . . . a					
	b Less direct expenses . . . b					
	c Net income or (loss) from fundraising events . . ▶		0			
	9a Gross income from gaming activities See Part IV, line 19 . a					
	b Less direct expenses . . . . . b					
	c Net income or (loss) from gaming activities . . . ▶		0			
	10a Gross sales of inventory, less returns and allowances . a					
	b Less cost of goods sold . . b					
	c Net income or (loss) from sales of inventory . . ▶		0			
	Miscellaneous Revenue	Business Code				
	11a CAFETERIA	722210	583,325			583,325
	b CHILDCARE	624410	454,830			454,830
	c CATERING	722320	1,171,656		20,220	1,151,436
	d All other revenue		1,394,596	0	0	1,394,596
	e **Total.** Add lines 11a–11d . . . . . ▶		3,604,407			
	12 **Total revenue.** See Instructions . . . ▶		300,727,005	288,667,356	20,220	10,562,225

Part IX Statement of Functional Expenses

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U S See Part IV, line 21	446,756	446,756		
2 Grants and other assistance to individuals in the U S See Part IV, line 22	0			
3 Grants and other assistance to governments, organizations, and individuals outside the U S See Part IV, lines 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	2,314,807	1,851,846	462,961	
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	109,424,554	87,539,643	21,884,911	
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	4,346,265	3,477,012	869,253	
9 Other employee benefits	14,924,222	11,939,378	2,984,844	
10 Payroll taxes	7,881,290	6,305,032	1,576,258	
a Fees for services (non-employees) Management	4,270,233	3,416,186	854,047	
b Legal	522,697		522,697	
c Accounting	549,028		549,028	
d Lobbying	0			
e Professional fundraising services *See Part IV, line 17*	0			
f Investment management fees	0			
g Other	40,235,016	32,188,013	8,047,003	
12 Advertising and promotion	0			
13 Office expenses	46,134,738	36,907,790	9,226,948	
14 Information technology	4,435,185	3,548,148	887,037	
15 Royalties	0			
16 Occupancy	8,676,158	6,940,926	1,735,232	
17 Travel	1,016,928	813,542	203,386	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	0			
20 Interest	0			
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	19,603,537	15,682,830	3,920,707	
23 Insurance	2,304,194	1,843,355	460,839	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24f If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O)				
a BAD DEBT EXPENSE	16,310,211	16,310,211		
b LTC BED TAXES	1,845,746	1,845,746		
c MEMBERSHIP DUES	798,564	638,851	159,713	
d MISCELLANEOUS	-147,002	-117,601	-29,401	
e OHIO FRANCHISE FEES	2,977,135	2,977,135		
f All other expenses	0	0	0	0
25 **Total functional expenses.** Add lines 1 through 24f	288,870,262	234,554,799	54,315,463	0
26 **Joint costs.** Check here ▶ ☐ if following SOP 98-2 (ASC 958-720) Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation	0			

Part X Balance Sheet

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing		-5,925,311	1	2,418,141
	2	Savings and temporary cash investments		363,005	2	363,231
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		25,629,866	4	27,665,515
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L			5	
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers, and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Schedule L			6	
	7	Notes and loans receivable, net		2,191,766	7	4,973,593
	8	Inventories for sale or use		4,293,957	8	4,143,292
	9	Prepaid expenses and deferred charges		3,294,012	9	1,665,005
	10a	Land, buildings, and equipment cost or other basis *Complete Part VI of Schedule D*	10a 524,072,285			
	b	Less accumulated depreciation	10b 337,475,907	127,596,802	10c	186,596,378
	11	Investments—publicly traded securities			11	
	12	Investments—other securities See Part IV, line 11		94,251,618	12	104,787,082
	13	Investments—program-related See Part IV, line 11			13	0
	14	Intangible assets			14	
	15	Other assets See Part IV, line 11		6,101,757	15	6,062,389
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		257,797,472	16	338,674,626
Liabilities	17	Accounts payable and accrued expenses		39,819,066	17	31,443,189
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability *Complete Part IV of Schedule D*			21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons *Complete Part II of Schedule L*			22	
	23	Secured mortgages and notes payable to unrelated third parties		49,216,482	23	123,392,075
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities Complete Part X of Schedule D		16,632,641	25	17,616,591
	26	**Total liabilities.** Add lines 17 through 25		105,668,189	26	172,451,855
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		148,535,631	27	162,570,720
	28	Temporarily restricted net assets		2,697,518	28	2,755,917
	29	Permanently restricted net assets		896,134	29	896,134
		Organizations that do not follow SFAS 117, check here ▶ ☐ and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		152,129,283	33	166,222,771
	34	Total liabilities and net assets/fund balances		257,797,472	34	338,674,626

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12) . . .	1	300,727,005
2	Total expenses (must equal Part IX, column (A), line 25)	2	288,870,262
3	Revenue less expenses Subtract line 2 from line 1	3	11,856,743
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) . .	4	152,129,283
5	Other changes in net assets or fund balances (explain in Schedule O)	5	2,236,745
6	Net assets or fund balances at end of year Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	166,222,771

Part XII Financial Statements and Reporting

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

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

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
COMMUNITY MERCY HEALTH PARTNERS

Employer identification number
31-0785684

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

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

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

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

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

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

_____

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

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

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

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

9 ☐ An organization that normally receives (1) more than 331/3% 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 331/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)

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

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

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

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

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

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

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

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

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public Support.** Subtract line 5 from line 4						

Section B. Total Support

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

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

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

Section C. Computation of Public Support Percentage

14 Public Support Percentage for 2010 (line 6 column (f) divided by line 11 column (f)) **14**

15 Public Support Percentage for 2009 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2010.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

b **33 1/3% support test—2009.** If the organization did not check the box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

17a **10%-facts-and-circumstances test—2010.** If the organization did not check a box on line 13, 16a, or 16b and line 14 is 10% or more, and if the organization meets the "facts and circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization ▶☐

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants ")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public Support** (Subtract line 7c from line 6)						

Section B. Total Support

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

14 **First Five Years** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section501(c)(3) organization, check this box and **stop here** ▶☐

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

19a **33 1/3% support tests—2010.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3% and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

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

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

Part IV **Supplemental Information.** Supplemental Information. Complete this part to provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

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SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

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

OMB No 1545-0047

2010

Open to Public Inspection

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

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

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

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

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

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

Name of the organization	Employer identification number
COMMUNITY MERCY HEALTH PARTNERS	31-0785684

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 funtion activities ▶ $ _____

3 Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b ▶ $ 0

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-

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

A Check ☐ if the filing organization belongs to an affiliated group

B Check ☐ if the filing organization checked box A and "limited control" provisions apply

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing Organization's Totals	(b) Affiliated Group Totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount Enter the amount from the following table in both columns		
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a If zero or less, enter -0-		
i Subtract line 1f from line 1c If zero or less, enter -0-		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000
Over $17,000,000	$1,000,000

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ Yes ☐ No

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) Total
2a Lobbying non-taxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots non-taxable 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)).

		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?	Yes		
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?	Yes		
f	Grants to other organizations for lobbying purposes?	Yes		31,449
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities? If "Yes," describe in Part IV		No	
j	Total lines 1c through 1i			31,449
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) non-deductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	0
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV Supplemental Information

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

Identifier	Return Reference	Explanation
LOBBYING ACTIVITIES	PART II-B, LINE 1	LOBBYING ACTIVITIES PERFORMED INCLUDE BOTH THE USE OF VOLUNTEERS ENCOURAGED TO WRITE LETTERS TO PUBLIC OFFICIALS ON ISSUES THAT IMPACT THE ORGANIZATION'S ABILITY TO CONTINUE TO PROVIDE HEALTH SERVICES TO THE COMMUNITIES SERVED, AND THE USE OF PAID STAFF MEMBERS AND MANAGEMENT PERSONNEL PAID MANAGEMENT PERSONNEL REGULARLY ISSUE MAILINGS TO LEGISLATORS ATTEMPTING TO INFLUENCE LEGISLATIVE MATTERS AND REFERENDUM, AND ORGANIZE AND HOST MEETINGS AMONG HOSPITAL EXECUTIVES AND THEIR LEGISLATORS REGARDING ISSUES THAT IMPACT THE ORGANIZATION'S ABILITY TO CONTINUE PROVIDING HEALTHCARE SERVICES TO ITS PATIENTS AND TO CONTINUE IMPROVING THE HEALTH OF THE COMMUNITIES WE SERVE PAID STAFF MEMBERS HAVE, ON LIMITED OCCASIONS, WRITTEN TO LEGISLATORS ON SUCH ISSUES THE PRIMARY PURPOSE FOR LOBBYING ACTIVITIES IS TO ENHANCE THE ORGANIZATION'S PUBLIC POSITION ON LEGISLATIVE AND REGULATORY ISSUES THAT IMPACT PATIENT CARE THROUGHOUT OUR SYSTEM THE ORGANIZATION FOCUSES ON PUBLIC POLICY ISSUES THAT EXTEND OUR HEALING MINISTRY TO THOSE WHO ARE POOR AND UNDERSERVED IN THE COMMUNITIES WE SERVE TO CARRY OUT THESE EFFORTS, THE ORGANIZATION PARTNERS WITH EXPERT CONSULTANTS AND PROFESSIONAL TRADE ASSOCIATIONS TO BUILD AWARENESS AND EXECUTE SPECIFIC STRATEGIES THAT WILL YIELD A FAVORABLE OUTCOME FOR PATIENT CARE IN THE ORGANIZATION'S FACILITIES WHERE THEY ARE TREATED

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11, or 12.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
COMMUNITY MERCY HEALTH PARTNERS

Employer identification number
31-0785684

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

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

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

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

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

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

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

			Held at the End of the Year
a	Total number of conservation easements	2a	
b	Total acreage restricted by conservation easements	2b	
c	Number of conservation easements on a certified historic structure included in (a)	2c	
d	Number of conservation easements included in (c) acquired after 8/17/06	2d	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	(a) Current Year	(b) Prior Year	(c) Two Years Back	(d) Three Years Back	(e) Four Years Back
1a Beginning of year balance					
b Contributions					
c Investment earnings or losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

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

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

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

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

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

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

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		3,762,538		3,762,538
b Buildings		180,702,800	148,171,836	32,530,964
c Leasehold improvements				0
d Equipment		203,583,168	189,304,071	14,279,097
e Other		136,023,779		136,023,779
Total. Add lines 1a-1e *(Column (d) should equal Form 990, Part X, column (B), line 10(c).)* ▶				186,596,378

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives	0	
(2) Closely-held equity interests	0	
(3) Other (A) CATHOLIC HEALTH PARTNERS INVESTMENT MANAGEMENT PROGRAM	104,787,082	F
Total. *(Column (b) should equal Form 990, Part X, col (B) line 12)* ▶	104,787,082	

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

(a) Description of investment type	(b) Book value	(c) Method of valuation Cost or end-of-year market value
Total. *(Column (b) should equal Form 990, Part X, col (B) line 13)* ▶		

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

(a) Description	(b) Book value
Total. *(Column (b) should equal Form 990, Part X, col.(B) line 15.)* . . . . . ▶	

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

1 (a) Description of Liability	(b) Amount
Federal Income Taxes	0
DEFERRED INCOME	247,132
ACCRUED PENSION	15,916,860
ACCRUED POST RETIREMENT BENEFITS	384,039
OTHER	1,068,560
Total. *(Column (b) should equal Form 990, Part X, col (B) line 25)* ▶	17,616,591

2. Fin 48 (ASC 740) Footnote In Part XIV, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC740)

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

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	
3	Excess or (deficit) for the year Subtract line 2 from line 1	3	0
4	Net unrealized gains (losses) on investments	4	
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV)	8	0
9	Total adjustments (net) Add lines 4 - 8	9	0
10	Excess or (deficit) for the year per financial statements Combine lines 3 and 9	10	0

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

1	Total revenue, gains, and other support per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV)	2d	0		
e	Add lines **2a** through **2d**			2e	0
3	Subtract line **2e** from line **1**			3	0
4	Amounts included on Form 990, Part VIII, line 12, but not on line **1**				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIV)	4b	0		
c	Add lines **4a** and **4b**			4c	0
5	Total Revenue Add lines **3** and **4c.** (This should equal Form 990, Part I, line 12)			5	0

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

1	Total expenses and losses per audited financial statements			1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIV)	2d	0		
e	Add lines **2a** through **2d**			2e	0
3	Subtract line **2e** from line **1**			3	0
4	Amounts included on Form 990, Part IX, line 25, but not on line **1:**				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIV)	4b	0		
c	Add lines **4a** and **4b**			4c	0
5	Total expenses Add lines **3** and **4c.** (This should equal Form 990, Part I, line 18)			5	0

Part XIV Supplemental Information

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

Identifier	Return Reference	Explanation
FIN 48 (ASC 740) footnote	Schedule D, Part X, Line 2	THE COMPANY [CATHOLIC HEALTH PARTNERS AND AFFILIATED ENTITIES] COMPLETED AN ANALYSIS OF ITS TAX POSITIONS IN ACCORDANCE WITH APPLICABLE ACCOUNTING GUIDANCE AT DECEMBER 31, 2010 AND 2009, AND DETERMINED THAT NO AMOUNTS WERE REQUIRED TO BE RECOGNIZED IN THE CONSOLIDATED FINANCIAL STATEMENTS AT DECEMBER 31, 2010 OR 2009

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
COMMUNITY MERCY HEALTH PARTNERS

Employer identification number
31-0785684

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheets 1 and 2)		5,030	8,564,322	3,293,894	5,270,428	1 930 %
b Unreimbursed Medicaid (from Worksheet 3, column a)		56,976	38,043,460	25,824,337	12,219,123	4 480 %
c Unreimbursed costs—other means-tested government programs (from Worksheet 3, column b)					0	0 %
d **Total** Financial Assistance and Means-Tested Government Programs	0	62,006	46,607,782	29,118,231	17,489,551	6 410 %
Other Benefits						
e Community health improvement services and community benefit operations (from (Worksheet 4)	3		338,023	4,863	333,160	0 120 %
f Health professions education (from Worksheet 5)	1		1,712,402	732,783	979,619	0 360 %
g Subsidized health services (from Worksheet 6)	2		1,043,815	240,155	803,660	0 290 %
h Research (from Worksheet 7)					0	0 %
i Cash and in-kind contributions to community groups (from Worksheet 8)	1		7,800		7,800	0 %
j **Total** Other Benefits	7	0	3,102,040	977,801	2,124,239	0 770 %
k **Total.** Add lines 7d and 7j	7	62,006	49,709,822	30,096,032	19,613,790	7 180 %

Part II Community Building Activities during the tax year, and describe in Part VI how its 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					0	0 %
2	Economic development					0	0 %
3	Community support	4		382,350		382,350	0 140 %
4	Environmental improvements					0	0 %
5	Leadership development and training for community members					0	0 %
6	Coalition building					0	0 %
7	Community health improvement advocacy					0	0 %
8	Workforce development					0	0 %
9	Other					0	0 %
10	**Total**	4	0	382,350	0	382,350	0 140 %

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 Heathcare Financial Management Association Statement No 15?	1			No
2	Enter the amount of the organization's bad debt expense (at cost)	2	4,994,914		
3	Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy	3	2,893		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	52,597,989		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	53,095,326		
7	Subtract line 6 from line 5 This is the surplus or (shortfall)	7	-497,337		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used				

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a	Does the organization have a written debt collection policy?	9a	Yes	
b	If "Yes," does the organization's collection policy contain provisions on the collection practices to be followed for patients who are known to qualify for charity care or financial assistance? Describe in Part VI	9b	Yes	

Part IV Management Companies and Joint Ventures

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership%	(e) Physicians' profit % or stock ownership %
1	MERCY SURGERY CENTER	OPERATE FREESTANDING AMBULATORY SURGERY CENTER	49 %	0 %	51 %
2	MERCY MEDICAL OFFICE CONDOMINIUM ASSOCIATION	REAL PROPERTY MANAGEMENT	49 6 %	0 %	50 4 %
3	NORTHPARK CONDOMINIUM ASSOCIATION	REAL PROPERTY MANAGEMENT	55 %	0 %	45 %
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 3

	Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)
1	SPRINGFIELD REGIONAL MEDICAL CENTER 2615 E HIGH ST SPRINGFIELD,OH 45503	X	X					X		
2	SPRINGFIELD REGIONAL MEDICAL CENTER 1343 N FOUNTAIN BLVD SPRINGFIELD,OH 45504	X	X					X		
3	MERCY MEMORIAL HOSPITAL 904 SCIOTO STREET URBANA,OH 43078	X	X			X		X		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: SPRINGFIELD REGIONAL MEDICAL CENTER

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

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

Part V Facility Information *(continued)*

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care to low income individuals?	10		
If "Yes," indicate the FPG family income limit for eligibility for discounted care __%			
11 Explained the basis for calculating amounts charged to patients?	11		
If "Yes," indicate the factors used in determining such amounts (check all that apply)			
a ☐ Income level			
b ☐ Asset level			
c ☐ Medical indigency			
d ☐ Insurance status			
e ☐ Uninsured discount			
f ☐ Medicaid/Medicare			
g ☐ State regulation			
h ☐ Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	12		
13 Included measures to publicize the policy within the community served by the hospital facility?	13		
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☐ The policy was posted at all times on the hospital facility's web site			
b ☐ The policy was attached to all billing invoices			
c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d ☐ The policy was posted in the hospital facility's admissions offices			
e ☐ The policy was provided, in writing, to patients upon admission to the hospital facility			
f ☐ The policy was available upon request			
g ☐ Other (describe in Part VI)			
Billing and Collections			
14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14		
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year			
a ☐ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other (describe in Part VI)			
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year?	16		
If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)			
a ☐ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other (describe in Part VI)			
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply)			
a ☐ Notified patients of the financial assistance policy upon admission			
b ☐ Notified patients of the financial assistance policy prior to discharge			
c ☐ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d ☐ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e ☐ Other (describe in Part VI)			

Part V Facility Information *(continued)*

Policy Relating to Emergency Medical Care

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

Charges for Medical Care

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: SPRINGFIELD REGIONAL MEDICAL CENTER

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 2

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

Part V Facility Information *(continued)*

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care to low income individuals?	10		
If "Yes," indicate the FPG family income limit for eligibility for discounted care __%			
11 Explained the basis for calculating amounts charged to patients?	11		
If "Yes," indicate the factors used in determining such amounts (check all that apply)			
a ☐ Income level			
b ☐ Asset level			
c ☐ Medical indigency			
d ☐ Insurance status			
e ☐ Uninsured discount			
f ☐ Medicaid/Medicare			
g ☐ State regulation			
h ☐ Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	12		
13 Included measures to publicize the policy within the community served by the hospital facility?	13		
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☐ The policy was posted at all times on the hospital facility's web site			
b ☐ The policy was attached to all billing invoices			
c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d ☐ The policy was posted in the hospital facility's admissions offices			
e ☐ The policy was provided, in writing, to patients upon admission to the hospital facility			
f ☐ The policy was available upon request			
g ☐ Other (describe in Part VI)			
Billing and Collections			
14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14		
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year			
a ☐ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other (describe in Part VI)			
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year?	16		
If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)			
a ☐ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other (describe in Part VI)			
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply)			
a ☐ Notified patients of the financial assistance policy upon admission			
b ☐ Notified patients of the financial assistance policy prior to discharge			
c ☐ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d ☐ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e ☐ Other (describe in Part VI)			

Part V Facility Information *(continued)*

Policy Relating to Emergency Medical Care

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

Charges for Medical Care

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: MERCY MEMORIAL HOSPITAL

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 3

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

Part V Facility Information *(continued)*

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care to low income individuals?	10		
If "Yes," indicate the FPG family income limit for eligibility for discounted care __%			
11 Explained the basis for calculating amounts charged to patients?	11		
If "Yes," indicate the factors used in determining such amounts (check all that apply)			
a ☐ Income level			
b ☐ Asset level			
c ☐ Medical indigency			
d ☐ Insurance status			
e ☐ Uninsured discount			
f ☐ Medicaid/Medicare			
g ☐ State regulation			
h ☐ Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	12		
13 Included measures to publicize the policy within the community served by the hospital facility?	13		
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☐ The policy was posted at all times on the hospital facility's web site			
b ☐ The policy was attached to all billing invoices			
c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d ☐ The policy was posted in the hospital facility's admissions offices			
e ☐ The policy was provided, in writing, to patients upon admission to the hospital facility			
f ☐ The policy was available upon request			
g ☐ Other (describe in Part VI)			
Billing and Collections			
14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14		
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year			
a ☐ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other (describe in Part VI)			
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year?	16		
If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)			
a ☐ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other (describe in Part VI)			
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply)			
a ☐ Notified patients of the financial assistance policy upon admission			
b ☐ Notified patients of the financial assistance policy prior to discharge			
c ☐ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d ☐ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e ☐ Other (describe in Part VI)			

Part V Facility Information *(continued)*

Policy Relating to Emergency Medical Care

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

Charges for Medical Care

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

Part V Facility Information *(continued)*

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

How many non-hospital facilities did the organization operate during the tax year? **5**

	Name and address	Type of Facility (Describe)
1	MCAULEY CENTER 906 SCIOTO STREET URBANA,OH 43078	SKILLED NURSING FACILITY
2	MCAULEY CENTER 906 SCIOTO STREET URBANA,OH 43078	SKILLED NURSING FACILITY
3	MCAULEY CENTER 906 SCIOTO STREET URBANA,OH 43078	SKILLED NURSING FACILITY
4	MCAULEY CENTER 906 SCIOTO STREET URBANA,OH 43078	SKILLED NURSING FACILITY
5	MCAULEY CENTER 906 SCIOTO STREET URBANA,OH 43078	SKILLED NURSING FACILITY
6		
7		
8		
9		
10		

Part VI Supplemental Information

Complete this part to provide the following information

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

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

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

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

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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

Identifier	ReturnReference	Explanation
Subsidized Health Services	Schedule H, Part I, Line 7g	COMMUNITY MERCY HEALTH PARTNERS (CMHP) OPERATES THE MERCY WELL CHILD PEDIATRIC CLINIC SERVICES ARE PROVIDED PRIMARILY BY A NURSE PRACTITIONER, HOWEVER, WE DO HAVE A STAFF PHYSICIAN (ON OUR PAYROLL) WHO PROVIDES ON-CALL COVERAGE AND LIMITED ON-SITE HOURS WE REPORTED $520,396 AS SUBSIDIZED SERVICES FOR THIS PROGRAM
Bad Debt Expense excluded from financial assistance calculation	Schedule H, Part I, Line 7, column(f)	16,310,211
Costing Methodology used to calculate financial assistance	Schedule H, Part I, Line 7	COST OF CHARITY CARE WAS CALCULATED WITH A COST TO CHARGE RATIO USING WORKSHEET 2 THE COST RELATED TO MEDICAID PATIENTS WAS DETERMINED USING THE HOSPITAL COST ACCOUNTING SYSTEM AND INCLUDED BOTH INPATIENTS AND OUTPATIENTS FOR TRADITIONAL MEDICAID AND MEDICAID MANAGED CARE PLANS FOR SUBSIDIZED SERVICES THE HOSPITAL'S COST ACCOUNTING SYSTEM IS USED TO DETERMINE COST RELATED TO THE SPECIFIC SERVICE EXCLUDING TRADITIONAL MEDICAID AND MEDICAID MANAGED CARE PATIENTS COSTS FOR CHARITY AND BAD DEBT ACCOUNTS ARE DEDUCTED USING A RATIO OF COST TO CHARGE SPECIFIC TO THAT SUBSIDIZED SERVICE COSTS FOR OTHER PROGRAMS REFLECT THE DIRECT AND INDIRECT COSTS OF PROVIDING THOSE PROGRAMS
Community Building Activities	Schedule H, Part II	COMMUNITY MERCY HEALTH PARTNERS (CMHP) ENSURES ACCESS TO HEALTH SERVICES BY RECRUITING AND PROVIDING TRANSITIONAL SUPPORT TO PHYSICIANS TO ATTRACT THEM TO THE COMMUNITY FOR SPECIALTIES WHERE THERE IS A DEMONSTRATED NEED AN APPROPRIATE SUPPLY OF PHYSICIANS IS NECESSARY TO ENSURE THAT RESIDENTS HAVE ACCESS TO ADEQUATE AND TIMELY DIAGNOSIS AND TREATMENT FOR ALL HEALTH CONDITIONS IN 2008, CMHP ENGAGED DEMPSTER HEALTHCARE GROUP TO STUDY PHYSICIAN SHORTAGES AND ASSIST WITH A STRATEGIC PLAN FOR PHYSICIAN RECRUITING THE DEMPSTER REPORT RECOMMENDED A RECRUITMENT GOAL OF AT LEAST 30 NEW PHYSICIANS BETWEEN 2008 AND 2011
Bad debt expense - financial statement footnote	Schedule H, Part III, Line 4	THE ORGANIZATION'S AUDITED FINANCIAL STATEMENTS DO NOT CONTAIN A FOOTNOTE THAT DESCRIBES BAD DEBT EXPENSE BAD DEBT IS CLASSIFIED AS AN OPERATING EXPENSE THIS TREATMENT IS CONSISTENT WITH THE HFMA PRINCIPLES AND PRACTICES BOARD STATEMENT NO 15 AND WITH THE AICPA AUDIT AND ACCOUNTING GUIDE FOR HEALTH CARE ORGANIZATIONS AN AGGREGATE COST TO CHARGE RATIO WAS USED TO PROVIDE BAD DEBT AT COST FOR PART III, LINE 2 REMAINING BALANCES FOR PATIENTS THAT WE KNOW ARE ELIGIBLE FOR CHARITY CARE ARE WRITTEN OFF TO CHARITY CARE PATIENTS WHO MIGHT BE ELIGIBLE FOR CHARITY CARE BUT ARE UNKNOWN TO US ARE WRITTEN OFF TO BAD DEBT AND THEREFORE NOT INCLUDED IN CHARITY CARE THE ESTIMATED AMOUNT OF THE HOSPITAL'S BAD DEBT EXPENSE (AT COST) ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE HOSPITAL'S CHARITY CARE POLICY REPORTED ON PART III, LINE 3 WAS DETERMINED AS FOLLOWS REVIEWED DOLLAR AMOUNTS FOR TOTAL REFERRED FOR ASSISTANCE, APPROVED FOR ASSISTANCE AND APPLICATIONS DENIED BECAUSE OF INCOMPLETE INFORMATION, DEVELOPED THE PERCENTAGE OF APPROVED APPLICATIONS TO COMPLETED APPLICATIONS AND THEN APPLIED PERCENTAGE TO THOSE APPLICATIONS THAT WERE INCOMPLETE THIS PROVIDED AN ESTIMATED AMOUNT OF THOSE APPLICATIONS THAT WERE INCOMPLETE THAT WOULD HAVE QUALIFIED FOR ASSISTANCE IF THE APPLICATION HAD BEEN COMPLETED THE DOLLAR AMOUNT OF CHARITY CARE ACTUALLY WRITTEN OFF REPRESENTS THOSE THAT WERE APPROVED TO CALCULATE THE FULL ESTIMATED AMOUNT OF CHARITY CARE, A CALCULATION WAS DONE TO DETERMINE WHAT 100% OF CHARITY WOULD BE FOR THE TOTAL OF THE APPROVED APPLICATIONS AND THE ESTIMATED AMOUNT FOR THOSE APPLICATIONS THAT WERE INCOMPLETE BUT WOULD HAVE BEEN APPROVED IF COMPLETED THE DIFFERENCE BETWEEN THIS ESTIMATED TOTAL AMOUNT AND THE ACTUAL WRITE-OFF AMOUNT FOR CHARITY CARE WAS THEN APPLIED TO THE RATIO OF COST-OF-CHARGES USED FOR CHARITY CARE AT COST
Community benefit & methodology for determining medicare costs	Schedule H, Part III, Line 8	MEDICARE SHORTFALL IS NOT TREATED AS A COMMUNITY BENEFIT THE AMOUNTS ON PART III, LINE 6 WERE GENERATED BY THE MEDICARE COST REPORT WHICH UTILIZES A DEPARTMENT COST TO CHARGE METHODOLOGY
Collection practices for patients eligible for financial assistance	Schedule H, Part III, Line 9b	PATIENTS KNOWN TO QUALIFY FOR CHARITY CARE OR FINANCIAL ASSISTANCE ARE NOT SENT TO A COLLECTION AGENCY THE ORGANIZATION REPEATEDLY OFFERS PATIENTS ACCESS TO FINANCIAL HELP DURING THEIR HOSPITAL STAY AND AFTER, AS WELL AS WITH EACH BILLING NOTICE BILLS ARE SENT TO A COLLECTION AGENCY AS A LAST RESORT AND ONLY WHEN PATIENTS HAVE THE ABILITY TO PAY SOME PORTION OF THEIR HEALTHCARE EXPENSES BUT REFUSE TO DO SO, WHEN PATIENTS REFUSE TO WORK WITH THE ORGANIZATION TO DETERMINE IF THEY QUALIFY FOR FREE OR DISCOUNTED CARE VIA FEDERAL, STATE, LOCAL OR HOSPITAL ASSISTANCE PROGRAMS, WHEN THE ORGANIZATION IS UNABLE TO LOCATE THE PATIENT OR PERSON RESPONSIBLE FOR THE BILL
Needs assessment	Schedule H, Part VI, Line 2	COMMUNITY MERCY HEALTH PARTNERS (CMHP) USES AN EXISTING COMMUNITY HEALTH NEEDS ASSESSMENT CMHP'S PRIMARY SERVICE AREA INCLUDES CLARK AND CHAMPAIGN COUNTIES THE CLARK COUNTY COMBINED HEALTH DISTRICT AND THE CHAMPAIGN COUNTY HEALTH DISTRICT BOTH PUBLISH (AND PERIODICALLY UPDATE) COMMUNITY HEALTH ASSESSMENT REPORTS CLARK COUNTY'S MOST RECENT REPORT WAS PUBLISHED IN 2008, AND CHAMPAIGN COUNTY'S REPORT WAS PUBLISHED IN 2007 THESE TWO REPORTS ARE PRESENTED IN A COMMON FORMAT, WHICH ADDRESSES NINE CATEGORIES 1 DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS 2 HEALTH RESOURCE AVAILABILITY 3 DEATH, ILLNESS AND INJURY 4 BEHAVIORAL RISK FACTORS 5 MATERNAL, CHILD AND YOUTH HEALTH 6 COMMUNICABLE DISEASES AND SENTINEL EVENTS 7 ENVIRONMENTAL HEALTH INDICATORS 8 SOCIAL AND MENTAL HEALTH 9 QUALITY OF LIFE IN ADDITION, OUR OWN ASSOCIATES HAVE IDENTIFIED NEEDS BASED ON OBSERVATIONS IN ADMISSION/DISCHARGE TRENDS AND OTHER INTERNAL DATA ONE EXAMPLE OF THIS IS OUR PATIENT TRANSPORTATION PROGRAM THAT WAS LAUNCHED DURING 2009 STAFF FROM THE EMERGENCY DEPARTMENT AND CASE MANAGEMENT REPORTED THAT, ON AVERAGE 3-5 TIMES PER WEEK, A PATIENT WOULD BE CLEARED FOR DISCHARGE, BUT WOULD NOT HAVE ANY MEANS OF TRANSPORTATION TO GET HOME THIS WOULD DELAY THE DISCHARGE PROCESS, WHICH IN TURN AFFECTED ER WAIT TIMES AND/OR INPATIENT LENGTH OF STAY THERE ARE NO TAXI COMPANIES IN SPRINGFIELD, AND THE AREA BUS SYSTEM OPERATES ON LIMITED HOURS AND ROUTES THIS NEW PROGRAM OFFERS A SOLUTION FOR PATIENTS NEEDING TRANSPORTATION
Patient education of eligibility for assistance	Schedule H, Part VI, Line 3	COMMUNITY MERCY HEALTH PARTNERS (CMHP) POSTS ITS CHARITY CARE POLICY, OR A SUMMARY THEREOF, AND FINANCIAL ASSISTANCE CONTACT INFORMATION IN ADMISSIONS AREAS, EMERGENCY DEPARTMENTS AND OTHER AREAS OF THE ORGANIZATION'S FACILITIES IN WHICH ELIGIBLE PATIENTS ARE LIKELY TO BE PRESENT CMHP PROVIDES A COPY OF THE POLICY, OR A SUMMARY THEREOF, AND FINANCIAL ASSISTANCE CONTACT INFORMATION TO PATIENTS AS PART OF THE INTAKE PROCESS AND WITH DISCHARGE MATERIALS ADDITIONALLY, A COPY OF THE POLICY OR A SUMMARY ALONG WITH FINANCIAL ASSISTANCE CONTACT INFORMATION IS INCLUDED IN PATIENT BILLS CMHP DISCUSSES WITH THE PATIENT THE AVAILABILITY OF VARIOUS GOVERNMENT BENEFITS, SUCH AS MEDICAID OR STATE PROGRAMS, AND ASSISTS THE PATIENT WITH QUALIFICATION FOR SUCH PROGRAMS, WHERE APPLICABLE THE HOSPITAL ELIGIBILITY LINK PROGRAM (HELP) IS A FREE REFERRAL SERVICE PROVIDED BY CMHP THE PURPOSE OF HELP IS TO ASSIST PATIENTS IN OBTAINING MEDICAL BENEFITS THROUGH FEDERAL, STATE, AND HOSPITAL PROGRAMS HELP REPRESENTATIVES WILL PROVIDE THE FOLLOWING SERVICES AT NO COST TO THE PATIENT * EXPLORE ELIGIBILITY UNDER PUBLIC ASSISTANCE PROGRAMS * FILE APPLICATIONS ON PATIENT'S BEHALF * SCHEDULE AND ATTEND APPOINTMENTS * PROVIDE TRANSPORTATION WHEN NECESSARY * PROVIDE MEDICAL DOCUMENTATION TO SOCIAL SECURITY ADMINISTRATION FOR DISABILITY CLAIMS THROUGH HELP, PATIENTS AND THEIR COUNSELORS LOOK AT WHAT OPTIONS ARE AVAILABLE CMHP UNDERSTANDS THAT NOT EVERYONE CAN PAY FOR HEALTHCARE SERVICES HELP IS HERE TO OFFER OPTIONS AND ASSISTANCE FOR THOSE WHO ARE UNINSURED OR UNDERINSURED HELP IS AN EXTENSION OF CHMP'S MISSION TO IMPROVE THE HEALTH OF OUR COMMUNITY WITH EMPHASIS ON THE POOR AND UNDERSERVED MEETING THE NEEDS OF THOSE WITH LIMITED RESOURCES HAS ALWAYS BEEN THE HEART OF OUR MISSION IN 2010, HELP MANAGED 22,505 PATIENT REFERRALS CMHP IS PROUD TO MAKE OUR FINANCIAL ASSISTANCE INFORMATION AVAILABLE TO THE PUBLIC THROUGH OUR WEBSITE, WHICH CAN BE FOUND AT WWW COMMUNITY-MERCY ORG OTHER PATIENT EDUCATION INFORMATION THAT IS PROVIDED FOR ELIGIBILITY OF ASSISTANCE IS AS FOLLOWS * A BILINGUAL REPRESENTATIVE IS AVAILABLE IN OUR HELP PROGRAM TWO BILINGUAL REPRESENTATIVES ARE AVAILABLE IN OUR CUSTOMER SERVICE DEPARTMENT EACH OF THESE REPRESENTATIVES ARE IN OUR REGIONAL OFFICE IN CINCINNATI * STAFF TRAINING ON HOSPITAL CARE ASSURANCE PROGRAM (HCAP) AND HOSPITAL FINANCIAL ASSISTANCE (HFA) WAS PROVIDED IN 2009 BY A PRIVATE AUDITING COMPANY TRAINING INCLUDED A MANUAL AND IN-DEPTH INFORMATION REGARDING THE PREPARATION OF THE COST REPORT LOGS, ACCURATE COMPLETION OF THE HCAP APPLICATION, AS WELL AS AN OVERVIEW OF THE FAQ'S PROVIDED BY THE OHIO HOSPITAL ASSOCIATION * FINANCIAL ASSISTANCE COUNSELORS WORK WITH CASE MANAGERS TO EXPEDITE THE TRANSFER OF PATIENTS TO EXTENDED CARE FACILITIES * FEDERAL POVERTY GUIDELINES ARE POSTED ON OUR WEBSITE AS WELL AS A COPY OF OUR CHARITY APPLICATION * CONSISTENT REVIEW OF SELF PAY PATIENTS FOR RETROACTIVE MEDICAID COVERAGE * SERVICES PROVIDED BY VENDOR TO REACH OUT TO PATIENTS IN BAD DEBT TO SCREEN FOR HCAP ELIGIBILITY
Community information	Schedule H, Part VI, Line 4	COMMUNITY MERCY HEALTH PARTNERS'S (CMHP) PRIMARY SERVICE AREA INCLUDES CLARK AND CHAMPAIGN COUNTIES, WHICH HAVE A TOTAL POPULATION OF APPROXIMATELY 259,200 ACCORDING TO THE MOST RECENT COMMUNITY HEALTH ASSESSMENT REPORTS FROM THE TWO COUNTIES, RESIDENTS OF THE CMHP PRIMARY SERVICE AREA ARE GENERALLY OLDER, POORER AND HAVE WORSE HEALTH STATISTICS THAN STATE AND NATIONAL AVERAGES UNEMPLOYMENT HAS ALSO RISEN IN OUR COMMUNITY DURING THE LAST SEVERAL YEARS, AND WE SERVE A GROWING NUMBER OF UNINSURED AND UNDERINSURED PATIENTS CMHP OWNS TWO OF THE THREE HOSPITALS IN THIS GEOGRAPHIC AREA THE THIRD HOSPITAL (NOT OWNED BY CMHP) IS A LIMITED-SERVICE FOR-PROFIT HOSPITAL THAT SPECIALIZES IN OUTPATIENT AND SHORT-STAY SURGERY, AND IT DOES NOT HAVE AN EMERGENCY DEPARTMENT PART OF THE CITY OF SPRINGFIELD HAS BEEN FEDERALLY DESIGNATED AS A MEDICALLY UNDERSERVED AREA OTHER DEMOGRAPHICS OF OUR SERVICE AREA INCLUDE * PERCENTAGE OF ADULTS WHO HAVE NOT ACHIEVED AT LEAST A HIGH SCHOOL DIPLOMA IS HIGHER THAT BOTH THE STATE AND NATIONAL AVERAGES * HIGHER PERCENTAGE OF RESIDENTS LIVING IN POVERTY THAN IN THE STATE AND NATIONWIDE * UNEMPLOYMENT RATE IS HIGHER THAN BOTH THE STATE AND NATIONAL RATES * MEDIAN HOUSEHOLD INCOME IS BELOW THE STATE MEDIAN AND US MEDIAN * THE POPULATION OF THE SERVICE AREA CONSISTS OF 2 6% NON-ENGLISH SPEAKING PEOPLE * THE POPULATION OF THE SERVICE AREA THAT IS 65 YEARS OR OLDER IS 16% * THE OCCUPATION CLASSIFICATION IN THE COMMUNITY CONSISTS OF 30% BLUE COLLAR, 52% WHITE COLLAR AND 18% SERVICE AND FARM WORKERS THE MAJOR HEALTH PROBLEMS AND/OR LEADING CAUSES OF DEATH IN OUR SERVICE AREA ARE CARDIOVASCULAR DISEASE, DIABETES, EMPHYSEMA AND CANCER MOST OF THESE ARE PREVENTABLE THROUGH PROPER CARE AND MAINTAINING CONTROL OF THE ILLNESS/DISEASE, AS WELL AS CHOOSING HEALTHIER LIFESTYLES IN OUR SERVICE AREA 28% OF THE POPULATION ARE SMOKERS, 40% HAVE HIGH CHOLESTEROL, AND 30-40% ARE OVERWEIGHT OR AT RISK FOR BECOMING OVERWEIGHT IN 2010, CMHP HAD 16,416 ADMISSIONS, 347,766 OUTPATIENT VISITS, AND 89,710 EMERGENCY ROOM VISITS
Promotion of community health	Schedule H, Part VI, Line 5	COMMUNITY MERCY HEALTH PARTNERS (CMHP) OPERATES EMERGENCY ROOMS OPEN TO ALL REGARDLESS OF ABILITY TO PAY IN ADDITION TO PROVIDING EMERGENCY SERVICES, CMHP ALSO PROVIDES MINOR EMERGENCY AND URGENT CARE SERVICES TO ALL REGARDLESS OF ABILITY TO PAY CMHP PARTICIPATES IN MEDICAID, MEDICARE, CHAMPUS AND/OR OTHER GOVERNMENT SPONSORED HEALTH PROGRAMS IN ADDITION TO OUR PARTICIPATION IN THESE PROGRAMS, CMHP ABSORBED $497,337 IN UNREIMBURSED MEDICARE COSTS DURING 2010 CMHP OPERATES SKILLED NURSING UNITS, ICU, NEWBORN NURSERY, WOUND CARE, DIABETES MANAGEMENT, OUTPATIENT PEDIATRICS, SUBSTANCE ABUSE, PRESCRIPTION ASSISTANCE AND A CRITICAL ACCESS HOSPITAL CMHP HAS AN OPEN MEDICAL STAFF WITH PRIVILEGES AVAILABLE TO ALL QUALIFIED PHYSICIANS IN THE AREA THE MAJORITY OF THE GOVERNING BODY CONSISTS OF INDEPENDENT PERSONS REPRESENTATIVE OF THE COMMUNITY SERVED BY CMHP THROUGH THE SPRINGFIELD REGIONAL SCHOOL OF NURSING (SRSN), CMHP PREPARES ENTRY-LEVEL PRACTITIONERS TO PROVIDE SERVICES IN A VARIETY OF SETTINGS GRADUATES OF THE TWO-YEAR PROGRAM AT SRSN ARE PREPARED FOR THE REGISTERED NURSING LICENSING EXAMINATION CMHP PARTICIPATES IN MEDICAID, MEDICARE, CHAMPUS, AND/OR OTHER GOVERNMENT - SPONSORED HEALTH CARE PROGRAMS CMHP FURTHERS ITS EXEMPT PURPOSE BY PROVIDING THE FOLLOWING COMMUNITY BENEFIT PROGRAMS IN THE COMMUNITIES IN WHICH IT SERVES COMMUNITY MERCY MED ASSIST HELPS AREA RESIDENTS WHO CANNOT AFFORD THEIR PRESCRIPTION MEDICATIONS DURING 2010, THE MED ASSIST TEAM PROVIDED OVER $2 4 MILLION IN PRESCRIPTION ASSISTANCE TO 2,027 CLIENTS COMMUNITY MERCY REACH OFFERS OUTPATIENT TREATMENT FOR CHEMICAL DEPENDENCY BY LICENSED PROFESSIONALS WHO HAVE MASTER'S-LEVEL EDUCATION REACH ALSO OFFERS AN INNOVATIVE AND EFFECTIVE SMOKING CESSATION PROGRAM THAT INCORPORATES EXERCISE AND NUTRITION/WEIGHT CONTROL TO PROMOTE AN OVERALL HEALTHY LIFESTYLE MERCY WELL CHILD IS A PEDIATRIC CLINIC THAT IDENTIFIES AND ADDRESSES POTENTIAL HEALTH AND DEVELOPMENTAL CONCERNS IN CHILDREN THE CLINIC PROMOTES QUALITY PEDIATRIC CARE WITH A HOLISTIC APPROACH TO MEET THE HEALTH, SOCIAL AND EMOTIONAL NEEDS OF CHILDREN AND FAMILIES MERCY WELL CHILD SERVES CHILDREN FROM INFANTS TO AGE 21, REGARDLESS OF THE FAMILIES' INCOME OR INSURANCE STATUS THE PETTICREW CENTER FOR ADULT SERVICES IS THE ONLY PROVIDER OF ADULT DAY CARE IN THE SPRINGFIELD AREA THIS SERVICE OFFERS AN ALTERNATIVE TO IN-HOME CARE OR PERMANENT PLACEMENT IN A NURSING FACILITY, AND IT PROVIDES A BREAK FOR CAREGIVERS WHILE THEY WORK OR ATTEND TO THEIR OWN PERSONAL NEEDS CMHP'S EMERGENCY DEPARTMENT TREATS AN INCREASING NUMBER OF PATIENTS WHO USE THE FACILITY FOR PRIMARY CARE NEEDS PATIENT DEMOGRAPHICS REFLECT THE CHANGING COMMUNITY AS IN OTHER COMMUNITIES, SOME AREA PHYSICIANS PLACE LIMITS ON THEIR ACCEPTANCE OF MEDICAID PATIENTS IN ADDITION, SOME PRIMARY CARE PHYSICIANS REFER PATIENTS WITH AFTER-HOURS NEEDS DIRECTLY TO AREA EMERGENCY ROOMS COMMUNITY GROUPS AND INDIVIDUALS ARE VERY SUPPORTIVE OF CMHP FOR THE PAST DECADE, THE ROCKING HORSE CENTER HAS BEEN A KEY PARTNER WITH CMHP IN MAKING BASIC HEALTHCARE MORE ACCESSIBLE, ESPECIALLY FOR THE POOR AND UNDERSERVED EARLY IN 2009, ROCKING HORSE WAS GRANTED STATUS AS A FEDERALLY QUALIFIED HEALTH CENTER, WHICH WILL PROVIDE HIGHER LEVELS OF MEDICAID REIMBURSEMENT IN ADDITION, CMHP AND ROCKING HORSE COLLABORATED TO DEVELOP AN ER REFERRAL PROCESS, TO IDENTIFY PATIENTS WHO DID NOT HAVE A MEDICAL HOME AND TO PROVIDE FOLLOW-UP CARE
Affiliated health care system	Schedule H, Part VI, Line 6	COMMUNITY MERCY HEALTH PARTNERS (CMHP) IS A MEMBER OF COMMUNITY MERCY HEALTH SYSTEMS CMHP IS SPONSORED BY THE SISTERS OF MERCY AND HAS BEEN AN INTEGRAL PART OF THE COMMUNITY SINCE 1950 CMHP INCLUDES AN ACUTE CARE HOSPITAL AND A CRITICAL CARE ACCESS HOSPITAL WITH APPROXIMATELY 641 LICENSED BEDS COMBINED COMMUNITY MERCY HEALTH SYSTEM COMMUNITY BENEFIT FOR 2010 PER THE AUDIT FOOTNOTE IS AS FOLLOWS TOTAL 2010 COMMUNITY BENEFIT $23 8 MILLION BENEFITS TO THE BROADER COMMUNITY $2 3 MILLION UNREIMBURSED CARE FOR THOSE WHO ARE POOR AND QUALIFY FOR MEDICAID $15 3 MILLION COST OF CARE FOR THOSE WHO COULD NOT AFFORD TO PAY $5 9 MILLION SUPPORT FOR OTHER PROGRAMS FOR THOSE WHO ARE POOR $0 3 MILLION COMMUNITY BENEFIT AS PERCENT OF TOTAL EXPENSE 8 3 PERCENT CMHP IS A MEMBER OF CATHOLIC HEALTH PARTNERS (CHP) CHP IS THE CONTINUATION OF THE HEALTH MINISTRY STARTED MORE THAN 150 YEARS AGO BY OUR CO-SPONSORING CONGREGATIONS THE SISTERS OF MERCY, REGIONAL COMMUNITY OF CINCINNATI (OH), THE MID-ATLANTIC COMMUNITY, MERION STATION, PA, THE SISTERS OF HUMILITY OF MARY, THE FRANCISCAN SISTERS OF THE POOR, AND COVENANT HEALTH SYSTEMS OUR SYSTEM OF REGIONAL HEALTH CARE PROVIDERS SERVES LOCAL HEALTH NEEDS IN COMMUNITIES IN OHIO, KENTUCKY, PENNSYLVANIA AND TENNESSEE CHP IS FOCUSED ON IMPROVING THE HEALTH OF COMMUNITIES WE SERVE BY PROVIDING INTEGRATED HEALTH SERVICES THROUGH FACILITIES THAT INCLUDE ACUTE CARE HOSPITALS, LONG-TERM CARE RESIDENCES, HOUSING SITES FOR THE ELDERLY, HOME HEALTH AGENCIES, HOSPICE PROGRAMS, OUTREACH SERVICES AND WELLNESS CENTERS OUR HOSPITALS INCLUDE FOUR CRITICAL ACCESS FACILITIES OFFERING ESSENTIAL HEALTH SERVICES THAT WOULD OTHERWISE NOT EXIST IN THOSE COMMUNITIES WE CARE FOR EVERYONE WHO COMES TO US, REGARDLESS OF THEIR ABILITY TO PAY AS WE HAVE DONE FOR DECADES, WE PROVIDE EXTENSIVE SERVICES TO THE BROADER COMMUNITY, WITH EMPHASIS ON SERVICES FOR PERSONS WHO ARE POOR AND UNDER-SERVED CHP'S HOME OFFICE PROVIDES SERVICES AND SUPPORT TO THE ENTIRE SYSTEM, INCLUDING BUT NOT LIMITED TO PROVIDING GOVERNANCE, MANAGEMENT OVERSIGHT, STRATEGIC LEADERSHIP, FOCUSING RESOURCES TO ASSURE THE HEALING MISSION, PROVIDING ACCESS TO LOWER COST DEBT FINANCING TO SUPPORT OPERATIONS, IMPROVING CLINICAL OUTCOMES AND REDUCING OPERATING COSTS SYSTEM-WIDE COMMUNITY BENEFIT FOR 2010 PER THE AUDIT FOOTNOTE IS AS FOLLOWS TOTAL 2010 COMMUNITY BENEFIT $365 1 MILLION BENEFITS TO THE BROADER COMMUNITY $77 1 MILLION UNREIMBURSED CARE FOR THOSE WHO ARE POOR AND QUALIFY FOR MEDICAID $131 7 MILLION COST OF CARE FOR THOSE WHO COULD NOT AFFORD TO PAY $123 2 MILLION SUPPORT FOR OTHER PROGRAMS FOR THOSE WHO ARE POOR $33 1 MILLION COMMUNITY BENEFIT AS PERCENT OF TOTAL EXPENSE 8 5 PERCENT
COMMUNITY BENEFIT REPORT	PART VI, LINE 7	CMHP IS NOT REQUIRED TO FILE A COMMUNITY BENEFIT REPORT IN ANY STATE
COMMUNITY BENEFIT REPORT	PART I, LINE 6A	COMMUNITY MERCY HEALTH PARTNERS PUBLISHES AN ANNUAL COMMUNITY BENEFIT REPORT A COPY OF THIS REPORT CAN BE FOUND ON THE COMPANY'S WEBSITE AT WWW COMMUNITY-MERCY ORG

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990**

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
COMMUNITY MERCY HEALTH PARTNERS

Employer identification number
31-0785684

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . ☐ Yes ☑ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Governments and Organizations in the United States.

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 for any recipient that received more than $5,000. Check this box if no one recipient received more than $5,000. Part II can be duplicated if additional space is needed. . . . ▶ ☐

1 (a) Name and address of organization or government	(b) EIN	(c) IRC Code 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) ROCKING HORSE COMMUNITY HEALTH CENTER651 SOUTH LIMESTONE ST SPRINGFIELD,OH 45505	31-1593544	501(C)(3)	421,879				GENERAL PURPOSES
(2) SISTERS OF NOTRE DAME OF COVINGTON KY 1601 DIXIE HIGHWAY COVINGTON,KY 41011	61-0485643	501(C)(3)	16,720				GENERAL PURPOSES

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

3 Enter total number of other organizations . . . ▶ 0

Part III **Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 22. Use Schedule I-1 (Form 990) 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

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

Identifier	Return Reference	Explanation
Procedures for monitoring use of grant funds	Schedule I, Part I, Line 2	COMMUNITY MERCY HEALTH PARTNERS PERSONNEL REVIEW DOCUMENTATION SUBMITTED FOR THE INTENDED USE OF THE WITHDRAWALS MADE

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
COMMUNITY MERCY HEALTH PARTNERS

Employer identification number
31-0785684

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items ☐ First-class or charter travel ☐ Housing allowance or residence for personal use ☑ Travel for companions ☐ Payments for business use of personal residence ☐ Tax idemnification and gross-up payments ☐ Health or social club dues or initiation fees ☐ Discretionary spending account ☐ Personal services (e g , maid, chauffeur, chef)			
b	If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement orprovision of all the expenses described above? If "No," complete Part III to explain	**1b**	Yes	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	**2**	Yes	
3	Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director Check all that apply ☑ Compensation committee ☑ Written employment contract ☑ Independent compensation consultant ☑ Compensation survey or study ☐ Form 990 of other organizations ☑ Approval by the board or compensation committee			
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization			
a	Receive a severance payment or change-of-control payment from the organization or a related organization?	**4a**	Yes	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3) and 501(c)(4) organizations only must complete lines 5-9.			
5	For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," to line 5a or 5b, describe in Part III			
6	For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," to line 6a or 6b, describe in Part III			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**	Yes	
8	Were any amounts reported in Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regs section 53 4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	**9**		

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

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

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

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) MARK WIENER	(i)	351,931	84,186	5,885	26,317	25,192	493,511	0
	(ii)	0	0	0	0	0	0	0
(2) JOHN DEMPSEY	(i)	245,059	29,299	6,458	19,490	15,650	315,956	0
	(ii)	0	0	0	0	0	0	0
(3) SUSAN HAYES	(i)	61,890	24,430	105,178	74,865	16,903	283,266	0
	(ii)	0	0	0	0	0	0	0
(4) TERRANCE WEINBURGER	(i)	198,464	25,489	8,757	18,882	15,036	266,628	0
	(ii)	0	0	0	0	0	0	0
(5) KATRINA ENGLISH	(i)	198,575	34,059	1,707	16,697	22,842	273,880	0
	(ii)	0	0	0	0	0	0	0
(6) JAMES MAY	(i)	0	0	0	0	0	0	0
	(ii)	539,480	210,106	187,482	146,085	31,085	1,114,238	0
(7) GREGORY SMITH	(i)	153,549	125	350	7,796	10,901	172,721	0
	(ii)	0	0	0	0	0	0	0
(8) JAMES GOODRICH MD	(i)	194,292	125	1,221	5,942	13,614	215,194	0
	(ii)	0	0	0	0	0	0	0
(9) SANA WAIKHOM MD	(i)	171,563	125	992	6,948	11,605	191,233	0
	(ii)	0	0	0	0	0	0	0
(10) JENELLE ZELINSKI	(i)	164,342	15,816	611	9,181	10,976	200,926	0
	(ii)	0	0	0	0	0	0	0
(11) RON CONNOVICH	(i)	162,660	0	6,286	13,517	20,911	203,374	0
	(ii)	0	0	0	0	0	0	0
(12) D TERRY BOYS	(i)	173,726	20,859	14,911	17,058	2,945	229,499	0
	(ii)	0	0	0	0	0	0	0
(13) DONALD B JOHNSON MD	(i)	206,931	18,477	1,536	3,759	11,960	242,663	0
	(ii)	0	0	0	0	0	0	0
(14) ROBERT GONDOS	(i)	66,856	4,883	88,167	77,929	24,542	262,377	0
	(ii)	0	0	0	0	0	0	0
(15)								
(16)								

Part III Supplemental Information

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

Identifier	Return Reference	Explanation
Travel for companions	Schedule J, Part I, Line 1a	TRAVEL FOR COMPANIONS WAS PROVIDED FOR THE FOLLOWING LISTED INDIVIDUALS JAMES N DOYLE, RICHARD W FURAY, M D , KATHLEEN M HUGHES, JOSEPH R JACKSON, E'LISE DELANGLADE SPRIGGS, AND PAMELA YOUNG, PH D THE ENTIRE BENEFIT WAS TREATED AS TAXABLE COMPENSATION
Severance or change-of-control payment	Schedule J, Part I, Line 4a	SEVERANCE BENEFITS CONSISTING OF CONTINUATION OF BASE SALARY AND INSURANCE BENEFITS WERE PROVIDED TO LISTED INDIVIDUALS FOR SPECIFIED PERIODS THE LISTED INDIVIDUALS EXECUTED RELEASES AND WAIVERS OF CLAIMS IN EXCHANGE FOR THE SEVERANCE BENEFITS SALARY CONTINUATION AMOUNTS PROVIDED DURING THE YEAR TO LISTED INDIVIDUALS WERE AS FOLLOWS SUSAN HAYES $85,991, ROBERT GONDOS $64,397
Supplemental nonqualified retirement plan	Schedule J, Part I, Line 4b	THE COMMUNITY MERCY HEALTH PARTNERS (CMHP) SERP PLAN IS A DEFERRED COMPENSATION PLAN WHICH PROVIDES SUPPLEMENTAL RETIREMENT BENEFITS TO PERSONS SELECTED BY THE CMHP COMMITTEE IT PROVIDES ANNUAL CREDITS OF A SPECIFIED PERCENTAGE OF COMPENSATION AND ANNUAL INVESTMENT RETURNS AND/OR LOSSES PARTICIPANTS VEST THE LATER OF FIVE YEARS OF ACTIVE SERVICE OR THE SECOND ANNIVERSARY OF HIS OR HER SEPARATION FROM SERVICE WITH THE EMPLOYER VESTING OCCURS EARLIER FOR DEATH OR TOTAL DISABILITY PAYMENTS DURING EMPLOYMENT ARE MADE FOR REQUIRED TAX WITHHOLDING PAYMENT OF THE VESTED ACCOUNT BALANCE IN A LUMP SUM OCCURS AFTER TERMINATION OF EMPLOYMENT AMOUNTS INCLUDABLE AS TAXABLE COMPENSATION FOR LISTED INDIVIDUALS DUE TO SERP PARTICIPATION IN THE REPORTING YEAR WERE AS FOLLOWS MARK WIENER $0, JOHN DEMPSEY $0, SUSAN HAYES $0, TERRANCE WEINBURGER $0, KATRINA ENGLISH $0, RON CONNOVICH $0, D TERRY BOYS $0
Non-fixed payments	Schedule J, Part I, Line 7	THE ORGANIZATION PROVIDES ANNUAL INCENTIVE COMPENSATION FOR LISTED INDIVIDUALS THE ORGANIZATION'S BOARD OF TRUSTEES ESTABLISHES OBJECTIVE THRESHOLDS FOR QUALITY, COMMUNITY BENEFIT, AND FINANCIAL PERFORMANCE WHICH MUST BE ACHIEVE FOR INCENTIVES TO BE AWARDED THE BOARD ALSO ESTABLISHES THRESHOLD, TARGET AND MAXIMUM LEVELS FOR INCENTIVE AWARDS WITHIN THESE ESTABLISHED PARAMETERS, THE BOARD DETERMINES THE CEO'S INCENTIVE AWARD AND INCENTIVE AWARDS FOR OTHER LISTED INDIVIDUALS ARE DETERMINED BY THE CEO AND DISCLOSED TO THE BOARD THE BOARD MAY AUTHORIZE MODIFIED INCENTIVE AWARDS WHEN APPROPRIATE IN ITS JUDGMENT
THE CHP EXECUTIVE RETENTION PLAN	SCHEDULE J, PART I, LINE 4B	THE CHP EXECUTIVE RETENTION PLAN IS A DEFERRED COMPENSATION PLAN WHICH PROVIDES EMPLOYMENT CONTINUATION INCENTIVES TO PERSONS SELECTED BY THE BOARD OF TRUSTEES OR ITS DELEGATE IT PROVIDES ANNUAL CREDITS OF A SPECIFIED PERCENTAGE OF COMPENSATION AND ANNUAL INTEREST CREDITS PARTICIPANTS VEST AND CEASE TO RECEIVE CREDITS AFTER 5 YEARS OF PLAN PARTICIPATION PROVIDED THEY REMAIN EMPLOYED VESTING AND CESSATION OF CREDITS OCCUR EARLIER FOR DEATH OR TOTAL DISABILITY WHILE EMPLOYED, INVOLUNTARY TERMINATION OF EMPLOYMENT WITHIN 24 MONTHS AFTER A CHANGE IN CONTROL OF THE ORGANIZATION, OR, FOR CERTAIN PARTICIPANTS, UPON BEING OFFERED A SPECIFIED PROMOTION PAYMENT OF THE VESTED ACCOUNT BALANCE IN A LUMP SUM OCCURS UPON VESTING AMOUNTS INCLUDIBLE AS TAXABLE COMPENSATION FOR LISTED INDIVIDUALS DUE TO RETENTION PLAN PARTICIPATION IN THE REPORTING YEAR WERE AS FOLLOWS JAMES MAY $0
THE CHP SERP PLAN	SCHEDULE J, PART I, LINE 4B	THE CHP SERP PLAN IS A DEFERRED COMPENSATION PLAN WHICH PROVIDES SUPPLEMENTAL RETIREMENT BENEFITS TO PERSONS SELECTED BY THE BOARD OF TRUSTEES OR ITS DELEGATE IT PROVIDES ANNUAL CREDITS OF A SPECIFIED PERCENTAGE OF COMPENSATION AND ANNUAL INTEREST CREDITS PARTICIPANTS VEST 50%, 75%, AND 100% IN THEIR ACCOUNTS AFTER 5, 6, AND 7 YEARS OF SERVICE, RESPECTIVELY, VESTING OCCURS EARLIER FOR DEATH OR TOTAL DISABILITY OR REACHING AGE 60 WHILE EMPLOYED, OR INVOLUNTARY TERMINATION OF EMPLOYMENT WITHIN 24 MONTHS AFTER A CHANGE IN CONTROL OF THE ORGANIZATION OR DUE TO POSITION ELIMINATION, PAYMENTS DURING EMPLOYMENT ARE MADE FOR REQUIRED TAX WITHHOLDINGS PAYMENT OF THE VESTED ACCOUNT BALANCE IN A LUMP SUM OCCURS AFTER TERMINATION OF EMPLOYMENT AMOUNTS INCLUDIBLE AS TAXABLE COMPENSATION FOR LISTED INDIVIDUALS DUE TO SERP PARTICIPATION IN THE REPORTING YEAR WERE AS FOLLOWS JAMES MAY $132,881

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

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

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

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
COMMUNITY MERCY HEALTH PARTNERS

Employer identification number
31-0785684

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

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

1	(a) Name of disqualified person	(b) Description of transaction	(c) Corrected? Yes	(c) Corrected? No

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

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

Part II Loans to and/or From Interested Persons.

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

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

Part III Grants or Assistance Benefitting Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of grant or type of assistance

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) SPRINGFIELD HEMATOLOGY AND ONCOLOGY ASSOCIATES	RAVI KHANNA, M D (BOARD MEMEBER) IS AN OWNER	145,975	INDEPENDENT CONTRACTOR		No
(2) MERCY ANESTHESIOLOGY	FAMILY MEMBER OF PLATO PAVLATOS (BOARD MEMBER) HAS A REPORTABLE OWNERSHIP INTEREST	553,893	INDEPENDENT CONTRACTOR		No
(3) SPRINGFIELD HEMATOLOGY AND ONCOLOGY ASSOCIATES	RAVI KHANNA M D (BOARD MEMBER) HAS A REPORTABLE OWNERSHIP INTEREST	118,390	RENTAL PAYMENTS		No

Part V **Supplemental Information**

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

Identifier	Return Reference	Explanation

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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 to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
COMMUNITY MERCY HEALTH PARTNERS

Employer identification number
31-0785684

Identifier	Return Reference	Explanation
Family/business relationships amongst interested persons	Form 990, Part VI, Section A, Line 2	JAMES N DOYLE, MARK B ROBERTSON, AND PAMELA YOUNG, PH D - BUSINESS RELATIONSHIP, JOSEPH R JACKSON, JAMES N DOYLE - BUSINESS RELATIONSHIP

Identifier	Return Reference	Explanation
Classes of members or stockholders	Form 990, Part VI, Section A, Line 6	COMMUNITY MERCY HEALTH SYSTEM IS THE MEMBER OF COMMUNITY MERCY HEALTH PARTNERS

Identifier	Return Reference	Explanation
Members or stockholders electing members of governing body	Form 990, Part VI, Section A, Line 7a	COMMUNITY MERCY HEALTH SYSTEM HAS THE ABILITY TO ELECT AND REMOVE BOARD MEMBERS

Identifier	Return Reference	Explanation
Decisions requiring approval by members or stockholders	Form 990, Part VI, Section A, Line 7b	COMMUNITY MERCY HEALTH SYSTEM HAS THE AUTHORITY TO APPROVE THE FOLLOWING AMENDMENTS TO GOVERNING DOCUMENTS, CHANGES TO THE MISSION, VISION AND VALUE STATEMENTS THAT DETERMINE THE ACTIVITIES OF THE CORPORATION, TO FIX THE NUMBER OF AND ELECT MEMBERS TO THE GOVERNING BODY, TO REMOVE AT WILL, WITH OR WITHOUT CAUSE, ANY MEMBER OF THE GOVERNING BOARD

Identifier	Return Reference	Explanation
Review of form 990 by governing body	Form 990, Part VI, Section B, Line 11b	THE FORM 990 IS PREPARED BY CHP'S TAX DEPARTMENT AND REVIEWED BY AN INDEPENDENT ACCOUNTING FIRM A COPY OF THE FORM 990 IS THEN REVIEWED BY MANAGEMENT UPON REVIEW, THE FORM 990 IS THEN FORWARDED TO THE AUDIT & CORPORATE RESPONSIBILITY COMMITTEE FOR APPROVAL ADDITIONALLY, THE COMPENSATION COMMITTEE REVIEWS ALL COMPENSATION RELATED SCHEDULES AND DISCLOSURES BOTH THE AUDIT & CORPORATE RESPONSIBILITY COMMITTEE AND THE COMPENSATION COMMITTEE ARE INDEPENDENT OF THE FILING ORGANIZATION ONCE THE FORM 990 IS REVIEWED BY ALL APPLICABLE PARTIES A COPY OF THE FINAL VERSION IS PROVIDED TO ALL MEMBERS OF THE GOVERNING BODY PRIOR TO FILING

Identifier	Return Reference	Explanation
Conflict of interest policy	Form 990, Part VI, Section B, Line 12c	ALL BOARD MEMBERS ARE COVERED BY THE CATHOLIC HEALTH PARTNERS (CHP) CONFLICT OF INTEREST POLICY WHICH REQUIRES DISCLOSURE ON AN ANNUAL BASIS ALL POTENTIAL CONFLICTS OF INTEREST ARE REVIEWED BY CHP CORPORATE COMPLIANCE OFFICER AT THE BEGINNING OF EACH BOARD MEETING ALL BOARD MEMBERS ARE REQUIRED TO DISCLOSE ANY CONFLICTS OF INTEREST BOARD MEMBERS DETERMINED TO HAVE A CONFLICT OF INTEREST ARE PROHIBITED FROM PARTICIPATING IN DELIBERATIONS AND DECISION-MAKING FOR THE TRANSACTION IN WHICH THE CONFLICT EXISTS

Identifier	Return Reference	Explanation
Process used to establish compensation of top management official	Form 990, Part VI, Section B, Line 15a	THE ORGANIZATION'S FORMAL PROCESS FOR DETERMINING TOTAL COMPENSATION FOR THE CEO AND OTHER OFFICERS AND KEY EMPLOYEES IS INTENDED TO PROVIDE REASONABLE COMPENSATION FOR ACCOMPLISHING THE ORGANIZATION'S MISSION, TO RECOGNIZE PERFORMANCE, AND TO OPERATE IN KEEPING WITH THE ORGANIZATION'S OBLIGATIONS AS A TAX-EXEMPT CHARITABLE ORGANIZATION THE COMPENSATION & EVALUATION COMMITTEE OF THE ORGANIZATION'S BOARD OF TRUSTEES CONDUCTS AN ANNUAL REVIEW OF THE COMPENSATION AND PERFORMANCE OF THE CEO AND OTHER OFFICERS AND KEY EMPLOYEES IN DOING SO, THE COMMITTEE RETAINS A QUALIFIED INDEPENDENT COMPENSATION CONSULTANT TO CONDUCT A COMPETITIVE MARKET ANALYSIS ANNUALLY OF THE MARKET RANGES OF BASE, INCENTIVE, AND TOTAL CASH COMPENSATION THE COMMITTEE UTILIZES THAT ANALYSIS AND OTHER APPROPRIATE INFORMATION IN CONNECTION WITH ITS ANNUAL REVIEW AND ADJUSTMENT OF COMPENSATION RANGES IT ALSO REVIEWS AND RECOMMENDS TO THE FULL BOARD THE THRESHOLD, TARGET, AND MAXIMUM INCENTIVE AWARDS FOR WHICH THE LISTED INDIVIDUALS MAY BE ELIGIBLE, BASED UPON THE ORGANIZATION'S PERFORMANCE RESULTS FOR COMMUNITY BENEFIT, QUALITY, AND FINANCIAL PERFORMANCE THE COMMITTEE'S RECOMMENDATIONS CONCERNING SALARY RANGE ADJUSTMENTS AND INCENTIVE AWARDS GO TO THE FULL BOARD FOR APPROVAL THE COMMITTEE, WITH FULL BOARD APPROVAL, DETERMINES THE ADJUSTMENT TO THE CEO'S BASE COMPENSATION AND INCENTIVE AWARD, WITHIN SUCH ESTABLISHED PARAMETERS FOR THE COO, CAO, EVP, AND SVP POSITIONS, ADJUSTMENTS AND INCENTIVE AWARDS ARE APPROVED BY THE ORGANIZATION'S CEO WITHIN SUCH PARAMETERS ADJUSTMENTS AND AWARDS FOR OTHER LISTED INDIVIDUALS ARE RECOMMENDED BY THE SUPERVISING EXECUTIVE BASE SALARY ADJUSTMENTS AND INCENTIVE AWARDS ARE DISCLOSED TO THE COMMITTEE A FORMAL PERFORMANCE APPRAISAL PROCESS IS INCORPORATED IN THE COMPENSATION ADJUSTMENT AND AWARD PROCESS IT UTILIZES A MULTI-PERSPECTIVE APPROACH AND PERFORMANCE MEASURES WHICH ARE LINKED TO THE ORGANIZATION'S LONG-TERM STRATEGIC PLAN, ACHIEVEMENT OF ANNUAL SYSTEM OBJECTIVES, AND PERSONAL OBJECTIVES

Identifier	Return Reference	Explanation
Process used to establish compensation of other officers/key employees	Form 990, Part VI, Section B, Line 15b	COMPENSATION-RELATED DETERMINATIONS ARE CONDUCTED IN ACCORDANCE WITH APPLICABLE REQUIREMENTS OF THE INTERNAL REVENUE CODE AND REGULATIONS TO QUALIFY FOR THE PRESUMPTION THAT THE COMPENSATION IS REASONABLE, INCLUDING BUT NOT LIMITED TO APPROVAL BY AN AUTHORIZED BODY COMPOSED OF INDIVIDUALS WHO DO NOT HAVE A CONFLICT OF INTEREST, OBTAINING AND RELYING ON APPROPRIATE DATA AS TO COMPARABILITY, AND CONCURRENT DOCUMENTATION OF THE BASIS FOR THE COMPENSATION DETERMINATIONS

Identifier	Return Reference	Explanation
Public Disclosure	Form 990, Part VI, Section C, Line 19	THE CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS ARE POSTED ON THE CATHOLIC HEALTH PARTNERS WEBSITE

Identifier	Return Reference	Explanation
AVERAGE HOURS PER WEEK DEVOTED TO RELATED ORGANIZATIONS BY LISTED PERSONS	FORM 990 PART VII SECTION A COLUMN (B)	JAMES MAY 40 MARK WEINER 5 JOHN DEMPSEY 3 JAMES N DOYLE 2 RICHARD W FURAY, M D 2 SR DORIS A GOTTEMOELLER, RSM 3 PIUS KURIAN, M D 2 MICHAEL S MCKEE, M D 2 PLATO N PAVLATOS 2 PAMELA R YOUNG, PH D 2 JOSEPH R JACKSON 2 RAVI C KHANNA, M D 2 MARK B ROBERTSON 2 HOMER A SMITH 2 E'LISE DELANGLADE SPRIGGS 2 REV DARRYL L GRAYSON 2 KATHLEEN M HUGHES 2

Identifier	Return Reference	Explanation
Other changes in net assets or fund balances	Form 990, Part XI, Line 5	NET UNREALIZED GAINS (LOSSES) ON INVESTMENTS - 3191933, NET ASSETS RELEASED FROM RESTRICTIONS - -8806, EQUITY TRANSFERS BETWEEN REGIONS - -1073995, RESIDENT TRUST ACCOUNT ADJUSTMENTS - -71780, INCOME REPORTED IN CH HEALTH SERVICES COMPANY - 199393,

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
COMMUNITY MERCY HEALTH PARTNERS

Employer identification number
31-0785684

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

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) SPRINGFIELD REGIONAL CANCER CENTER 148 W NORTH STREET SPRINGFIELD, OH 45502 35-2216018	CANCER CENTER	OH	3,656,423	8,535,716	NA

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 organization	
						Yes	No
See Additional Data Table							

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

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
See Additional Data Table							

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

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

		Yes	No
1 During the tax year, did the orgranization 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 **(iv)** rent from a controlled entity	1a		No
b Gift, grant, or capital contribution to other organization(s)	1b		No
c Gift, grant, or capital contribution from other organization(s)	1c	Yes	
d Loans or loan guarantees to or for other organization(s)	1d		No
e Loans or loan guarantees by other organization(s)	1e	Yes	
f Sale of assets to other organization(s)	1f		No
g Purchase of assets from other organization(s)	1g		No
h Exchange of assets	1h		No
i Lease of facilities, equipment, or other assets to other organization(s)	1i		No
j Lease of facilities, equipment, or other assets from other organization(s)	1j		No
k Performance of services or membership or fundraising solicitations for other organization(s)	1k		No
l Performance of services or membership or fundraising solicitations by other organization(s)	1l		No
m Sharing of facilities, equipment, mailing lists, or other assets	1m		No
n Sharing of paid employees	1n	Yes	
o Reimbursement paid to other organization for expenses	1o		No
p Reimbursement paid by other organization for expenses	1p		No
q Other transfer of cash or property to other organization(s)	1q	Yes	
r Other transfer of cash or property from other organization(s)	1r	Yes	

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

(a) Name of other organization	(b) Transaction type(a-r)	(c) Amount involved	(d) Method of determining amount involved
(1) THE COMMUNITY MERCY FOUNDATION	C	874,305	GAAP
(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) Are all partners section 501(c)(3) organizations?		(e) Share of end-of-year assets	(f) Disproprtionate allocations?		(g) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(h) General or managing partner?	
			Yes	No		Yes	No		Yes	No

Part VII Supplemental Information

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

Identifier	Return Reference	Explanation

Additional Data Return to Form

Software ID: 10000128
Software Version: v2010.1.0
EIN: 31-0785684
Name: COMMUNITY MERCY HEALTH PARTNERS

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(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 organization	
						Yes	No
CATHOLIC HEALTH PARTNERS 615 ELSINORE PLACE CINCINNATI, OH45202 31-1161086	HEALTHCARE SYSTEM PARENT	OH	501(C)(3)	11 - Type III - FI	NA		
CATHOLIC HEALTHCARE PARTNERS FOUNDATION 615 ELSINORE PLACE CINCINNATI, OH45202 20-1072726	FUNDRAISING	OH	501(C)(3)	7	CATHOLIC HEALTH PARTNERS		
CATHOLIC HEALTHCARE PARTNERS HOUSING DEVELOPMENT 615 ELSINORE PLACE CINCINNATI, OH45202 20-8943658	HUD PARENT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
CATHOLIC HEALTHCARE PARTNERS RETIREMENT TRUST 615 ELSINORE PLACE CINCINNATI, OH45202 31-6046304	RETIREMENT TRUST	OH	501(C)(3)	8	CATHOLIC HEALTH PARTNERS		
SISTERS OF MERCY WORKERS COMPENSATION SELF-INSURANCE TRUST 615 ELSINORE PLACE CINCINNATI, OH45202 31-0990309	TRUST ADMINISTRATION	OH	501(C)(3)	11 - Type I	CATHOLIC HEALTH PARTNERS		
COMMUNITY HEALTH PARTNERS REGIONAL HEALTH SYSTEM 3700 KOLBE ROAD LORAIN, OH44053 27-0071694	REGIONAL PARENT	OH	501(C)(3)	11 - Type II	CATHOLIC HEALTH PARTNERS		
COMMUNITY HEALTH PARTNERS REGIONAL MEDICAL CENTER 3700 KOLBE ROAD LORAIN, OH44053 34-0714704	HOSPITAL	OH	501(C)(3)	3	COMMUNITY HEALTH PARTNERS REGIONAL HEALTH SYSTEM		
ALLEN MEDICAL CENTER 200 WEST LORAIN ST OBERLIN, OH44074 34-0864230	HOSPITAL	OH	501(C)(3)	3	COMMUNITY HEALTH PARTNERS REGIONAL HEALTH SYSTEM		
COMMUNITY HEALTH PARTNERS REGIONAL FOUNDATION 3700 KOLBE ROAD LORAIN, OH44053 34-1504558	FOUNDATION	OH	501(C)(3)	11 - Type III - FI	COMMUNITY HEALTH PARTNERS REGIONAL MEDICAL CENTER		
COMMUNITY HEALTH PARTNERS PHYSICIANS OFFICE BUILDINGS 3700 KOLBE ROAD LORAIN, OH44053 34-1268828	MEDICAL OFFICE RENTAL	OH	501(C)(3)	9	COMMUNITY HEALTH PARTNERS REGIONAL MEDICAL CENTER		
ALLEN MEDICAL CENTER FOUNDATION 200 WEST LORAIN ST OBERLIN, OH44074 34-1675592	FOUNDATION	OH	501(C)(3)	11 - Type I	ALLEN MEDICAL CENTER		
ALLEN MEDICAL CENTER MEDICAL OFFICE BUILDING 200 WEST LORAIN ST OBERLIN, OH44074 36-4504991	MEDICAL OFFICE RENTAL	OH	501(C)(3)	11 - Type II	ALLEN MEDICAL CENTER		

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(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 organization	
						Yes	No
MERCY HEALTH PARTNERS OF SOUTHWEST OHIO 4600 MCAULEY PLACE CINCINNATI, OH45242 31-1063783	REGIONAL PARENT	OH	501(C)(3)	11 - Type III - FI	CATHOLIC HEALTH PARTNERS		
MERCY HEALTH PARTNERS OF SOUTHWEST OHIO FOUNDATION 4600 MCAULEY PLACE CINCINNATI, OH45242 31-1217563	FOUNDATION	OH	501(C)(3)	7	MERCY HEALTH PARTNERS OF SOUTHWEST OHIO		
MERCY HOSPITALS WEST 2446 KIPLING AVENUE CINCINNATI, OH45239 31-1091597	HOSPITAL	OH	501(C)(3)	3	MERCY HEALTH PARTNERS OF SOUTHWEST OHIO		
MERCY HOSPITAL ANDERSON 7500 STATE ROAD CINCINNATI, OH45255 31-0537085	HOSPITAL	OH	501(C)(3)	3	MERCY HEALTH PARTNERS OF SOUTHWEST OHIO		
THE SISTERS OF MERCY OF HAMILTON OHIO 3000 MACK ROAD FAIRFIELD, OH45014 31-0538532	HOSPITAL	OH	501(C)(3)	3	MERCY HEALTH PARTNERS OF SOUTHWEST OHIO		
THE SISTERS OF MERCY OF CLERMONT COUNTY OHIO 3000 HOSPITAL DRIVE BATAVIA, OH45103 31-0830955	HOSPITAL	OH	501(C)(3)	3	MERCY HEALTH PARTNERS OF SOUTHWEST OHIO		
CLERMONT MERCY FOUNDATION 3000 HOSPITAL DRIVE BATAVIA, OH45103 31-1514749	FOUNDATION	OH	501(C)(3)	11 - Type III - FI	THE SISTERS OF MERCY OF CLERMONT COUNTY OHIO		
MERCY FRANCISCAN SENIOR HEALTH AND HOUSING SERVICES INC 7010 ROWAN HILLS DR CINCINNATI, OH45227 31-1308729	RETIREMENT HOME	OH	501(C)(3)	9	MERCY HEALTH PARTNERS OF SOUTHWEST OHIO		
MERCY SACRED HEART INC 2120 PAYNE STREET LOUISVILLE, KY40206 61-1318326	RETIREMENT HOME	KY	501(C)(3)	9	MERCY HEALTH PARTNERS OF SOUTHWEST OHIO		
MERCY LONG TERM CARE INITIATIVE 4915 CHARLESTOWN RD NEW ALBANY, IN47150 31-1332491	RETIREMENT HOME	IN	501(C)(3)	9	MERCY HEALTH PARTNERS OF SOUTHWEST OHIO		
PROVIDENCE RETIREMENT HOME AUXILIARY 4915 CHARLESTOWN RD NEW ALBANY, IN47150 20-4664839	SUPPORTING ORG	IN	501(C)(3)	11 - Type II	MERCY LONG TERM CARE INITIATIVE		
MERCY FRANCISCAN SOCIAL MINISTRIES INC 1800 LOGAN STREET CINCINNATI, OH45210 31-1222942	LOW INCOME HOUSING	OH	501(C)(3)	7	MERCY HEALTH PARTNERS OF SOUTHWEST OHIO		

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(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 organization	
						Yes	No
MERCY FRANCISCAN AT ST RAPHAEL INC 610 HIGH STREET HAMILTON, OH45011 20-2934871	SERVICES TO THE POOR	OH	501(C)(3)	7	MERCY HEALTH PARTNERS OF SOUTHWEST OHIO		
COMMUNITY MERCY HEALTH SYSTEM ONE S LIMESTONE ST SPRINGFIELD, OH45502 30-0272454	REGIONAL PARENT	OH	501(C)(3)	11 - Type III - FI	CATHOLIC HEALTH PARTNERS		
THE COMMUNITY MERCY FOUNDATION 1343 N FOUNTAIN BLVD SPRINGFIELD, OH45504 31-1443778	FOUNDATION	OH	501(C)(3)	7	COMMUNITY MERCY HEALTH SYSTEM		
COMMUNITY HOSPITAL HEALTH SERVICES COMPANY ONE S LIMESTONE ST SPRINGFIELD, OH45502 31-1181984	HOSPITAL	OH	501(C)(3)	3	COMMUNITY MERCY HEALTH SYSTEM		
CLARKE & CHAMPAIGN COUNTIES HEALTH INFORMATION EXCHANGE 1150 E HOME ROAD SPRINGFIELD, OH45503 26-0698515	MEDICAL INFORMATION EXCHANGE	OH	501(C)(3)	9	COMMUNITY MERCY HEALTH SYSTEM		
THE WALLACE S MURRAY AND FRANCES RABBITTS MURRAY MEMORIAL TRUST ONE S LIMESTONE ST SPRINGFIELD, OH45502 34-6827136	INDIGENT MEDICAL CARE	OH	501(C)(3)	11 - Type I	NA		
MERCY HEALTH SYSTEM - NORTHERN REGION 2200 JEFFERSON AVENUE TOLEDO, OH43604 34-1344482	REGIONAL PARENT	OH	501(C)(3)	11 - Type III - FI	CATHOLIC HEALTH PARTNERS		
ST CHARLES MERCY HOSPITAL OF OREGON OHIO 2600 NAVARRE AVENUE OREGON, OH43616 34-4445373	HOSPITAL	OH	501(C)(3)	3	MERCY HEALTH SYSTEM - NORTHERN REGION		
ST CHARLES MERCY HEALTH FOUNDATION 2600 NAVARRE AVENUE OREGON, OH43616 34-1414900	FOUNDATION	OH	501(C)(3)	11 - Type III - FI	ST CHARLES MERCY HOSPITAL OF OREGON OHIO		
RIVERSIDE MERCY HOSPITAL 3404 W SYLVANIA AVE TOLEDO, OH43623 31-1556401	HOSPITAL	OH	501(C)(3)	3	MERCY HEALTH SYSTEM - NORTHERN REGION		
MERCY HOME CARE INC 2200 JEFFERSON AVENUE TOLEDO, OH43604 34-1587572	HOME HEALTHCARE	OH	501(C)(3)	9	MERCY HEALTH SYSTEM - NORTHERN REGION		
MERCY COLLEGE OF NORTHWEST OHIO 2221 MADISON AVENUE TOLEDO, OH43604 34-1726619	MEDICAL COLLEGE	OH	501(C)(3)	2	MERCY HEALTH SYSTEM - NORTHERN REGION		

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						Yes	No
MERCY COLLEGE OF NORTHWEST OHIO FOUNDATION INC 2221 MADISON AVENUE TOLEDO, OH43604 14-1963204	FOUNDATION	OH	501(C)(3)	11 - Type I	MERCY COLLEGE OF NORTHWEST OHIO		
MERCY HOSPITAL OF TIFFIN OHIO 45 ST LAWRENCE DRIVE TIFFIN, OH44883 34-4431174	HOSPITAL	OH	501(C)(3)	3	MERCY HEALTH SYSTEM - NORTHERN REGION		
MERCY TIFFIN HEALTH FOUNDATION 45 ST LAWRENCE DRIVE TIFFIN, OH44883 34-1499894	FOUNDATION	OH	501(C)(3)	11 - Type III - FI	MERCY HOSPITAL OF TIFFIN OHIO		
THE SISTERS OF MERCY OF WILLARD OHIO 110 EAST HOWARD ST WILLARD, OH44890 34-1577110	HOSPITAL	OH	501(C)(3)	3	MERCY HEALTH SYSTEM - NORTHERN REGION		
MERCY HOSPITAL OF WILLARD FOUNDATION 110 EAST HOWARD ST WILLARD, OH44890 11-3742347	FOUNDATION	OH	501(C)(3)	11 - Type III - FI	THE SISTERS OF MERCY OF WILLARD OHIO		
ST VINCENT MERCY MEDICAL CENTER 2213 CHERRY STREET TOLEDO, OH43608 34-4428250	HOSPITAL	OH	501(C)(3)	3	MERCY HEALTH SYSTEM - NORTHERN REGION		
ST VINCENT MERCY MEDICAL CENTER FOUNDATION 2213 CHERRY STREET TOLEDO, OH43608 23-7393213	FOUNDATION	OH	501(C)(3)	11 - Type III - FI	ST VINCENT MERCY MEDICAL CENTER		
LIFESTAR AMBULANCE INC 2200 JEFFERSON AVENUE TOLEDO, OH43604 34-1354653	MEDICAL TRANSPORTATION	OH	501(C)(3)	11 - Type II	MERCY HEALTH SYSTEM - NORTHERN REGION		
RSM MEDICAL FOUNDATION 2200 JEFFERSON AVENUE TOLEDO, OH43624 34-1693671	HOSPITAL	OH	501(C)(3)	3	MERCY HEALTH SYSTEM - NORTHERN REGION		
ST MARGUERITE D'YOUVILLE FOUNDATION II 2213 CHERRY STREET TOLEDO, OH43608 13-4350655	FOUNDATION	OH	501(C)(3)	11 - Type II	CATHOLIC HEALTH PARTNERS		
SIMON OUTREACH SERVICES 2600 NAVARRE AVENUE OREGON, OH43616 34-1383325	MEDICAL OFFICE RENTAL	OH	501(C)(3)	11 - Type II	ST CHARLES MERCY HOSPITAL OF OREGON OHIO		
FARLEY HEALTHCARE CORPORATION 2200 JEFFERSON AVENUE TOLEDO, OH43604 34-1363204	HEALTH SERVICES	OH	501(C)(3)	9	MERCY HEALTH SYSTEM - NORTHERN REGION		

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

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						Yes	No
ST RITA'S MEDICAL CENTER 730 W MARKET STREET LIMA, OH45801 34-1105619	HOSPITAL	OH	501(C)(3)	3	CATHOLIC HEALTH PARTNERS		
SRHC FOUNDATION 730 W MARKET STREET LIMA, OH45801 34-1368429	FOUNDATION	OH	501(C)(3)	11 - Type III - FI	ST RITA'S MEDICAL CENTER		
NEW VISION MEDICAL LABORATORIES INC 750 W HIGH ST STE 400 LIMA, OH45801 34-1937267	MEDICAL LAB SERVICES	OH	501(C)(3)	11 - Type III - FI	ST RITA'S MEDICAL CENTER		
HUMILITY OF MARY HEALTH PARTNERS 1044 BELMONT AVENUE YOUNGSTOWN, OH44501 34-0505560	HOSPITAL	OH	501(C)(3)	3	CATHOLIC HEALTH PARTNERS		
THE ASSUMPTION VILLAGE 9800 N MARKET STREET NORTH LIMA, OH44452 34-1013695	NURSING HOME	OH	501(C)(3)	9	HUMILITY OF MARY HEALTH PARTNERS		
HOSPICE OF THE VALLEY 5190 MARKET STREET YOUNGSTOWN, OH44512 34-1288745	HOSPICE SERVICES	OH	501(C)(3)	9	HUMILITY OF MARY HEALTH PARTNERS		
HUMILITY OF MARY DEVELOPMENT FOUNDATION 1044 BELMONT AVENUE YOUNGSTOWN, OH44501 34-1826978	FOUNDATION	OH	501(C)(3)	11 - Type III - FI	HUMILITY OF MARY HEALTH PARTNERS		
HUMILITY OF MARY INFORMATION SYSTEMS 250 FEDERAL PLAZA EAST YOUNGSTOWN, OH44501 34-1452943	INFORMATION SERVICES	OH	501(C)(3)	11 - Type II	HUMILITY OF MARY HEALTH PARTNERS		
HUMILITY HOUSE 755 OHLTOWN ROAD AUSTINTOWN, OH44515 34-1894783	NURSING HOME	OH	501(C)(3)	9	HUMILITY OF MARY HEALTH PARTNERS		
LAUREL LAKE RETIREMENT COMMUNITY INC 200 LAUREL LAKE DRIVE HUDSON, OH44236 34-1481142	NURSING HOME	OH	501(C)(3)	9	HUMILITY OF MARY HEALTH PARTNERS		
LAUREL LAKE RETIREMENT COMMUNITY FOUNDATION INC 200 LAUREL LAKE DRIVE HUDSON, OH44236 34-1779303	FOUNDATION	OH	501(C)(3)	7	LAUREL LAKE RETIREMENT COMMUNITY INC		
ST JOSEPH HEALTH CENTER AUXILIARY 677 EASTLAND SE WARREN, OH44484 34-6556121	FUNDRAISING	OH	501(C)(3)	9	HUMILITY OF MARY HEALTH PARTNERS		

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						Yes	No
MERCY HEALTH PARTNERS - LOURDES INC 1530 LONE OAK ROAD PADUCAH, KY42003 61-0600313	HOSPITAL	KY	501(C)(3)	3	CATHOLIC HEALTH PARTNERS		
LOURDES FOUNDATION INC 1530 LONE OAK ROAD PADUCAH, KY42003 61-1258960	FOUNDATION	KY	501(C)(3)	7	MERCY HEALTH PARTNERS - LOURDES INC		
LOURDES HOSPITAL AUXILIARY GIFT SHOP 1530 LONE OAK ROAD PADUCAH, KY42003 61-0927805	FUNDRAISING	KY	501(C)(3)	11 - Type III - FI	LOURDES FOUNDATION INC		
MARCUM AND WALLACE MEMORIAL HOSPITAL INC 60 MERCY COURT IRVINE, KY40336 61-0927491	HOSPITAL	KY	501(C)(3)	3	MERCY HEALTH PARTNERS - LOURDES INC		
MARCUM AND WALLACE HOSPITAL FOUNDATION INC 60 MERCY COURT IRVINE, KY40336 32-0026557	FOUNDATION	KY	501(C)(3)	11 - Type III - FI	MARCUM AND WALLACE MEMORIAL HOSPITAL INC		
MERCY HEALTH PARTNERS INC 900 EAST OAK HILL AVE KNOXVILLE, TN37917 73-1627534	REGIONAL PARENT	TN	501(C)(3)	11 - Type I	CATHOLIC HEALTH PARTNERS		
MERCY HEALTH SYSTEM INC 900 EAST OAK HILL AVE KNOXVILLE, TN37917 62-0480068	HOSPITAL	TN	501(C)(3)	3	MERCY HEALTH PARTNERS INC		
ST MARY'S MEDICAL CENTER OF CAMPBELL COUNTY INC 923 EAST CENTRAL AVE LAFOLLETTE, TN37766 62-1817376	HOSPITAL	TN	501(C)(3)	3	MERCY HEALTH PARTNERS INC		
MERCY HEALTH PARTNERS FOUNDATION INC 900 EAST OAK HILL AVE KNOXVILLE, TN37917 62-1247676	FOUNDATION	TN	501(C)(3)	7	MERCY HEALTH PARTNERS INC		
JEFFERSON MEMORIAL HOSPITAL INC 110 HOSPITAL DRIVE JEFFERSON CITY, TN37760 62-1660663	HOSPITAL	TN	501(C)(3)	3	MERCY HEALTH PARTNERS INC		
JEFFERSON MEMORIAL FOUNDATION INC 110 HOSPITAL DRIVE JEFFERSON CITY, TN37760 62-1660666	FOUNDATION	TN	501(C)(3)	11 - Type III - FI	JEFFERSON MEMORIAL HOSPITAL INC		
ST MARY'S MEDICAL CENTER OF SCOTT COUNTY INC 18797 ALBERTA STREET ONEIDA, TN37841 26-1535503	HOSPITAL	TN	501(C)(3)	3	MERCY HEALTH PARTNERS INC		

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						Yes	No
THE BAPTIST HEALTH SYSTEM FOUNDATION INC 101 BLOUNT AVE BOX 1788 KNOXVILLE, TN37920 58-1565290	FOUNDATION	TN	501(C)(3)	7	MERCY HEALTH PARTNERS INC		
BAPTIST HOSPITAL OF EAST TENNESSEE INC 137 BLOUNT AVE KNOXVILLE, TN37920 62-0506166	HOSPITAL	TN	501(C)(3)	3	MERCY HEALTH PARTNERS INC		
BAPTIST HOSPITAL WEST INC 10820 PARKSIDE DRIVE KNOXVILLE, TN37934 62-1870324	HOSPITAL	TN	501(C)(3)	3	MERCY HEALTH PARTNERS INC		
BAPTIST HOSPITAL OF COCKE COUNTY INC 435 SECOND STREET NEWPORT, TN37821 62-1133149	HOSPITAL	TN	501(C)(3)	3	MERCY HEALTH PARTNERS INC		
MERCY HEALTH AND REHABILITATION CENTER INC 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN37917 62-1592992	REHAB CENTER	TN	501(C)(3)	9	MERCY HEALTH PARTNERS INC		
MERCY HEALTH PARTNERS - NORTHEAST REGION INC 746 JEFFERSON AVENUE SCRANTON, PA18510 23-2813196	REGIONAL PARENT	PA	501(C)(3)	11 - Type III - FI	CATHOLIC HEALTH PARTNERS		
MERCY HEALTHCARE FOUNDATION 746 JEFFERSON AVENUE SCRANTON, PA18510 23-2972928	FOUNDATION	PA	501(C)(3)	11 - Type III - FI	MERCY HEALTH PARTNERS - NORTHEAST REGION INC		
MERCY HOSPITAL SCRANTON PA 746 JEFFERSON AVENUE SCRANTON, PA18510 24-0795456	HOSPITAL	PA	501(C)(3)	3	MERCY HEALTH PARTNERS - NORTHEAST REGION INC		
MERCY COMMUNITY CARE CORPORATION 746 JEFFERSON AVENUE SCRANTON, PA18510 23-2310566	MEDICAL CARE	PA	501(C)(3)	9	MERCY HEALTH PARTNERS - NORTHEAST REGION INC		
MERCY MED-CARE INC 746 JEFFERSON AVENUE SCRANTON, PA18510 23-2261991	HOSPITAL	PA	501(C)(3)	3	MERCY HEALTH PARTNERS - NORTHEAST REGION INC		
MERCY HOSPITAL NANTICOKE 128 W WASHINGTON ST NANTICOKE, PA18634 23-2604818	HOSPITAL	PA	501(C)(3)	3	MERCY HEALTH PARTNERS - NORTHEAST REGION INC		
MERCY HOSPITAL OF WILKES-BARRE 746 JEFFERSON AVENUE SCRANTON, PA18510 24-0795625	HOSPITAL	PA	501(C)(3)	3	MERCY HEALTH PARTNERS - NORTHEAST REGION INC		

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

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						Yes	No
MERCY HEALTH CARE CENTER 746 JEFFERSON AVENUE SCRANTON, PA18510 23-2322809	HOSPITAL	PA	501(C)(3)	3	MERCY HEALTH PARTNERS - NORTHEAST REGION INC		
MERCY TYLER HEALTH SYSTEMS 880 SR 6W TUNKHANNOCK, PA18657 23-2772476	SUPPORTING ORG	PA	501(C)(3)	11 - Type II	MERCY HEALTH PARTNERS - NORTHEAST REGION INC		
MERCY TYLER HOSPITAL 880 SR 6W TUNKHANNOCK, PA18657 24-0779665	HOSPITAL	PA	501(C)(3)	3	MERCY TYLER HEALTH SYSTEMS		
MERCY TYLER HOME HEALTH SERVICES 880 SR 6W TUNKHANNOCK, PA18657 23-2723529	IN-HOME MEDICAL CARE	PA	501(C)(3)	9	MERCY TYLER HEALTH SYSTEMS		
SIENA SPRINGS 615 ELSINORE PLACE CINCINNATI, OH45202 31-1052772	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
SIENA SPRINGS II 615 ELSINORE PLACE CINCINNATI, OH45202 31-1591780	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
CHARLES MEADOW CORPORATION 615 ELSINORE PLACE CINCINNATI, OH45202 34-1552671	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
CHARLES CREST CORPORATION 615 ELSINORE PLACE CINCINNATI, OH45202 34-1399869	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
CHARLES CREST II CORPORATION 615 ELSINORE PLACE CINCINNATI, OH45202 34-1714407	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
ST THERESA VILLAGE INC 615 ELSINORE PLACE CINCINNATI, OH45202 31-1411529	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
SACRED HEART VILLAGE INC 615 ELSINORE PLACE CINCINNATI, OH45202 31-1411531	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
SACRED HEART VILLAGE II INC 615 ELSINORE PLACE CINCINNATI, OH45202 61-1339396	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(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 organization	
						Yes	No
SACRED HEART VILLAGE III INC 615 ELSINORE PLACE CINCINNATI, OH45202 61-1367719	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
MCAULEY MANOR INC 615 ELSINORE PLACE CINCINNATI, OH45202 31-1548500	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
DUBLIN MANOR INC 615 ELSINORE PLACE CINCINNATI, OH45202 02-0655254	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
MERCY MANOR INC 615 ELSINORE PLACE CINCINNATI, OH45202 61-1344092	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
ST MARY'S VILLA INC 615 ELSINORE PLACE CINCINNATI, OH45202 31-1548512	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
RIVERVIEW ST MARY'S INC 615 ELSINORE PLACE CINCINNATI, OH45202 62-1782683	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		
ST MARY'S VILLA AT RIVERVIEW II INC 615 ELSINORE PLACE CINCINNATI, OH45202 31-1723287	HUD HOUSING PROJECT	OH	501(C)(3)	9	CATHOLIC HEALTH PARTNERS		

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(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) Disproprtionate allocations?		(i) Code V-UBI amount on Box 20 of K-1 ($)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
NWO INTEGRATED LABORATORIES MERCY LLC 2200 JEFFERSON AVENUE TOLEDO, OH43624 34-1898285	LABORATORY SERVICES	OH	NA	N/A								
TIFFIN AMBULATORY SURGICAL ASSOCIATES 45 ST LAWRENCE DRIVE TIFFIN, OH44833 37-1567866	AMBULATORY SURGERY CENTER	OH	NA	N/A								
MERCY HOSPITAL OF DEFIANCE LLC 1404 E SECOND ST DEFIANCE, OH43512 02-0701635	HOSPITAL	OH	NA	N/A								
WEST CENTRAL OHIO REGIONAL HEALTHCARE ALLIANCE FORT AMANDA ROAD LIMA, OH45804 34-1817078	REG HOSPITALS	OH	NA	N/A								
WEST CENTRAL OHIO SURGERY & ENDO CENTER 770 W HIGH ST SUITE 100 LIMA, OH45801 34-1868154	AMBULATORY SURGERY CENTER	OH	NA	N/A								
NEW VISION MEDICAL LAB LLC 750 W HIGH STREET LIMA, OH45801 34-1913433	LAB SERVICES	OH	NA	N/A								
WEST CENTRAL OHIO GROUP LTD 801 MEDICAL DRIVE LIMA, OH45804 34-1848147	ORTHOPEDIC HOSPITAL	OH	NA	N/A								
KIDNEY SERVICES OF WEST CENTRAL OHIO 750 W HIGH STREET SUITE 100 LIMA, OH45801 06-1644264	DIALYSIS CENTER	OH	NA	N/A								

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(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) Disproprtionate allocations?		(i) Code V-UBI amount on Box 20 of K-1 ($)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
ST ELIZABETH CARDIAC CATH LAB LLC 1044 BELMONT AVE YOUNGSTOWN, OH44501 30-0023795	CARDIAC CATH LAB	OH	NA	N/A								
ST ELIZABETH SOUTHWOODS IMAGING 250 DEBARTOLO PLACE BLDG B YOUNGSTOWN, OH44512 26-1626482	DIAGNOSTIC IMAGING	OH	NA	N/A								
UROLOGIC ONCOLOGY OF MAHONING VALLEY LLC 1044 BELMONT AVE YOUNGSTOWN, OH44501 26-2989686	RADIATION THERAPY	OH	NA	N/A								
HMHPUSP SURGERY CENTERS LLC 15305 DALLAS PKWY STE 1600 ADDISON, TX75001 27-1953122	SURGERY CENTER	TX	NA	N/A								
OSC-HMHP LLC 6505 MARKET ST BLDG B STE 101 BOARDMAN, OH44512 01-0724836	ORTHOPEDIC SURGERY CENTER	OH	NA	N/A								
MERCY HEALTHPLEX ANDERSON LLC 7495 STATE ROAD CINCINNATI, OH45255 31-1589865	FITNESS FACILITY	OH	NA	N/A								
MERCY HEALTHPLEX FAIRFIELD LLC 3050 MACK ROAD FAIRFIELD, OH45014 31-1589867	FITNESS FACILITY	OH	NA	N/A								
LOURDES AMBULATORY SURGERY CENTER 225 MEDICAL CENTER DRIVE PADUCAH, KY42003 61-1258960	SURGERY CENTER	KY	NA	N/A								

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(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) Disproprtionate allocations?		(i) Code V-UBI amount on Box 20 of K-1 ($)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
TOMOGRAPHY ASSOCIATES LLC 2000 CHAPMAN HWY KNOXVILLE, TN37920 74-2034927	EQUIPMENT LEASING	TN	NA	N/A								
EAST TENNESSEE DIAGNOSTIC CENTER LLC 1450 DOWELL SPRINGS BLVD SUITE 250 KNOXVILLE, TN37909 20-4773300	DIAGNOSTIC SERVICES	TN	NA	N/A								
LACKAWANNA SURGERY CENTER LLC 415 ADAMS AVENUE SCRANTON, PA18503 20-5360014	AMBULATORY SURGERY CENTER	PA	NA	N/A								

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

(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
CHP INSURANCE LTD 615 ELSINORE PLACE CINCINNATI, OH45202 98-0621978	INSURANCE	CJ	NA	C CORPORATION			
HEALTHSPAN INC 225 PICTORIA DRIVE STE 320 CINCINNATI, OH45246 31-1431434	PPO	OH	NA	C CORPORATION			
MHSWO HEALTH VENTURES INC 1 S LIMESTONE ST SPRINGFIELD, OH45502 31-1072139	PHYSICIAN PRACTICES	OH	COMMUNITY MERCY HEALTH PARTNERS	C CORPORATION	-6,434	0	1 00 %
NORTHPARKE MEDICAL COMMONS CONDO ASSN 333 N LIMESTONE ST SPRINGFIELD, OH45503 31-1391230	REAL PROPERTY MGMNT	OH	COMMUNITY MERCY HEALTH PARTNERS	C CORPORATION	18,917	2,397	55 %
MERCY HEALTH AFFILIATES INC 2200 JEFFERSON AVENUE TOLEDO, OH43604 34-1372633	PHYSICIAN SERVICES	OH	NA	C CORPORATION			
PHYSICIAN'S HEALTH COLLABORATIVE 2200 JEFFERSON AVENUE TOLEDO, OH43604 20-3986844	MEDICAL & HOSPITAL SERVICES	OH	NA	C CORPORATION			
NORTHSIDE CORPORATION 2200 JEFFERSON AVENUE TOLEDO, OH43604 34-1318438	RESIDENT RENTALS	OH	NA	C CORPORATION			
MERCY WORK SOLUTIONS 2200 JEFFERSON AVENUE TOLEDO, OH43604 30-0066340	WORKERS COMPENSATION	OH	NA	C CORPORATION			
GENESIS HEALTH PLAN OF OHIO INC 2200 JEFFERSON AVENUE TOLEDO, OH43604 34-1819975	HMO	OH	NA	C CORPORATION			
MERCY HEALTH SYSTEM PHO 2200 JEFFERSON AVENUE TOLEDO, OH43604 34-1778321	MEDICAL SERVICES	OH	NA	C CORPORATION			
PHYSICIAN MANAGED CARE INC 2200 JEFFERSON AVENUE TOLEDO, OH43604 34-1565320	HEALTH SERVICES	OH	NA	C CORPORATION			
MCAULEY MANAGEMENT SERVICES INC 730 W MARKET STREET LIMA, OH45801 34-1379037	PROPERTY RENTAL	OH	NA	C CORPORATION			
LIMA MEDICAL SUPPLIES INC 730 W MARKET STREET LIMA, OH45801 34-0944477	MEDICAL EQUIPMENT	OH	NA	C CORPORATION			
COMMUNITY HEALTH PARTNERS ENTERPRISES INC 3700 KOLBE ROAD LORAIN, OH44053 34-1455525	HOLDING COMPANY	OH	NA	C CORPORATION			
COMMUNITY HEALTH PARTNERS PHYSICIANS INC 3700 KOLBE ROAD LORAIN, OH44053 34-1803352	PHYSICIAN PRACTICES	OH	NA	C CORPORATION			
AMC PHYSICIANS INC 200 W LORAIN STREET OBERLIN, OH44074 37-1439554	PHYSICIAN SERVICES	OH	NA	C CORPORATION			
MERCY HEALTH VENTURES INC 4600 MCAULEY PLACE CINCINNATI, OH45242 31-1185477	DIVERSIFIED ACTIVITIES	OH	NA	C CORPORATION			
FRANCISCAN HOMES I INC 1300 MAIN STREET CINCINNATI, OH45210 31-1313185	LOW-INCOME HOUSING	OH	NA	C CORPORATION			
FRANCISCAN HOMES II INC 1300 MAIN STREET CINCINNATI, OH45210 31-1336890	LOW-INCOME HOUSING	OH	NA	C CORPORATION			
FRANCISCAN HOMES III INC 1300 MAIN STREET CINCINNATI, OH45210 31-1394510	LOW-INCOME HOUSING	OH	NA	C CORPORATION			
FRANCISCAN HOMES IV INC 1300 MAIN STREET CINCINNATI, OH45210 31-1483370	LOW-INCOME HOUSING	OH	NA	C CORPORATION			
MERCY FRANCISCAN AT WINTON WOODS I INC 10290 MILL ROAD CINCINNATI, OH45231 31-1658668	LOW-INCOME HOUSING	OH	NA	C CORPORATION			
MERCY HEALTH MANAGEMENT INC 1530 LONE OAK ROAD PADUCAH, KY42003 61-1086762	MEDICAL OFFICES	KY	NA	C CORPORATION			
HEALTH DYNAMICS INC 900 E OAK HILL AVENUE KNOXVILLE, TN37917 62-1247729	MEDICAL EQUIPMENT SALES	TN	NA	C CORPORATION			
HEALTH VENTURES INC & SUBSIDIARIES P O BOX 1788 KNOXVILLE, TN37901 62-1175587	MEDICAL SERVICES	TN	NA	C CORPORATION			