

IRS e-file Signature Authorization for an Exempt Organization

For calendar year 2010, or fiscal year beginning 07/01, 2010, and ending 06/30, 2011

2010

Department of the Treasury
Internal Revenue Service

▶ Do not send to the IRS. Keep for your records.
▶ See instructions on back.

Name of exempt organization

MERCY MEDICAL CENTER

Employer identification number

52-0591658

Name and title of officer

JOHN TOPPER, SR VP/CFO/TREASURER

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

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

1a Form 990 check here ▶ <input checked="" type="checkbox"/>	b Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b <u>413922646.</u>
2a Form 990-EZ check here ▶ <input type="checkbox"/>	b Total revenue, if any (Form 990-EZ, line 9)	2b _____
3a Form 1120-POL check here ▶ <input type="checkbox"/>	b Total tax (Form 1120-POL, line 22)	3b _____
4a Form 990-PF check here ▶ <input type="checkbox"/>	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b _____
5a Form 8868 check here ▶ <input type="checkbox"/>	b Balance Due (Form 8868, Part I, line 3c or Part II, line 8c)	5b _____

Part II Declaration and Signature Authorization of Officer

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

Officer's PIN: check one box only

I authorize COHEN, RUTHERFORD + KNIGH to enter my PIN 1 4 2 1 9 as my signature
ERO firm name Enter five numbers, but do not enter all zeros

on the organization's tax year 2010 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer of the organization, I will enter my PIN as my signature on the organization's tax year 2010 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Officer's signature ▶ *John Topper*

Date ▶ 5/11/12

Part III Certification and Authentication

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

5 2 0 5 1 5 2 0 8 1 7

do not enter all zeros

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

ERO's signature ▶ *John Topper*

Date ▶ 05/04/2012

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

For Paperwork Reduction Act Notice, see back of form.

Return of Organization Exempt From Income Tax

2010

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

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

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

Form header section containing organization name (MERCY MEDICAL CENTER), address (301 ST. PAUL PLACE, BALTIMORE, MD 21202), telephone number (410) 332-9000, and tax-exempt status (501(c)(3)).

Part I Summary

Summary table with columns for Activities & Governance, Revenue, Expenses, and Net Assets or Fund Balances. Rows include mission statement, member counts, revenue (Total revenue: 387,518,381), expenses (Total expenses: 391,226,173), and net assets (Total assets: 798,086,962).

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.

Signature block area with fields for officer's signature and date.

Preparer information section including name (TINA ECKLOFF), date (05/04/2012), firm name (COHEN, RUTHERFORD + KNIGHT, PC), and firm address (6903 ROCKLEDGE DRIVE, SUITE 500 BETHESDA, MD 20817-1800).

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

For Paperwork Reduction Act Notice, see the separate instructions.

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:

ATTACHMENT 1

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 \$ 302,019,621. including grants of \$ _____) (Revenue \$ 396,315,583.)

ATTACHMENT 2

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 ▶ 302,019,621.

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

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question number, response box, and Yes/No checkboxes. Includes questions 1a through 14b regarding Form 1096, Form W-2G, backup withholding, Form W-3, federal employment tax returns, unrelated business gross income, foreign accounts, prohibited tax shelter transactions, annual gross receipts, deductible contributions, and Form 8899.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year; 1b Enter the number of voting members included in line 1a, above, who are independent; 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?; 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?; 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?; 5 Did the organization become aware during the year of a significant diversion of the organization's assets?; 6 Does the organization have members or stockholders?; 7a Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?; 7b Are any decisions of the governing body subject to approval by members, stockholders, or other persons?; 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body? b Each committee with authority to act on behalf of the governing body?; 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.

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Does the organization have local chapters, branches, or affiliates?; 10b 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?; 11a Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form?; 11b 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; 12b Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?; 12c Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done; 13 Does the organization have a written whistleblower policy?; 14 Does the organization have a written document retention and destruction policy?; 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; b Other officers or key employees of the organization; 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?; 16b 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?

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD,
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply. [] Own website [X] Another's website [X] Upon request
19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: JOHN TOPPER 301 ST. PAUL PLACE BALTIMORE, MD 21202 410-332-9313

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
ATTACHMENT 3										
(1) THOMAS MULLEN CHAIR, EX OFFICIO	15.00	X		X			0.	1,252,959.	33,264.	
(2) SAMUEL MOSKOWITZ EXEC VP/VICE CHAIR	34.00	X		X			1,277,842.	0.	31,571.	
(3) SCOTT SPIER MD SECRETARY	33.50	X		X			464,124.	0.	33,006.	
(4) JOHN TOPPER SR VP & CFO/TREASURER	15.00	X		X			0.	450,343.	28,015.	
(5) SUSAN FINLAYSON SR VP/DIRECTOR	38.00	X					423,685.	0.	18,807.	
(6) TOM MALIA DIRECTOR	40.00	X					0.	0.	0.	
(7) MICHAEL MULLANE SR VICE PRESIDENT CLINICAL PRG	25.00	X					131,353.	0.	2,199.	
(8) JUDITH WEILAND SENIOR VP	15.00					X	374,620.	0.	11,058.	
(9) ROBERT EDWARDS SENIOR VP	10.00					X	586,613.	0.	31,690.	
(10) JAMES LEVY MD PHYSICIAN	40.00					X	284,553.	0.	41,735.	
(11) WILMA A S ROWE MD PRESIDENT MEDICAL STAFF	39.00					X	658,186.	0.	32,154.	
(12) GARY MICHAEL SENIOR VP MARKETING/PLANNING	37.00					X	279,082.	0.	30,877.	
(13) AMY FREEMAN EXE VP/SECRETARY	0.00						634,642.	0.	6,735.	
(14)										
(15)										
(16)										

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)										
(18)										
(19)										
(20)										
(21)										
(22)										
(23)										
(24)										
(25)										
(26)										
(27)										
(28)										
1b Sub-total							5,114,700.	1,703,302.	301,111.	
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)							5,114,700.	1,703,302.	301,111.	

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 **126**

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

Section B. Independent Contractors

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

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **74**

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					
	b	Membership dues					
	c	Fundraising events					
	d	Related organizations	7,540,143.				
	e	Government grants (contributions)	918,655.				
	f	All other contributions, gifts, grants, and similar amounts not included above	3,689,687.				
	g	Noncash contributions included in lines 1a-1f: \$	1,794,963.				
	h	Total. Add lines 1a-1f	12,148,485.				
Program Service Revenue			Business Code				
	2a	PATIENT REVENUE		383,891,547.	383,891,547.		
	b	PEDIATRIC REVENUE		608,000.	608,000.		
	c						
	d						
	e						
	g	Total. Add lines 2a-2f		384,499,547.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts). ATTACHMENT 5		4,937,899.		4,937,899.	
	4	Income from investment of tax-exempt bond proceeds		0.			
	5	Royalties		0.			
	6a	Gross Rents	(i) Real	1,562,362.			
			(ii) Personal				
	b	Less: rental expenses		1,561,545.			
	c	Rental income or (loss)		817.			
	d	Net rental income or (loss)		817.	70,033.	-69,216.	
	7a	Gross amount from sales of assets other than inventory	(i) Securities				
			(ii) Other		26,014.		
	b	Less: cost or other basis and sales expenses		183,167.			
	c	Gain or (loss)		-157,153.			
d	Net gain or (loss)		-157,153.		-157,153.		
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	MANAGEMENT FEE		561000	6,041,107.	5,886,227.	154,880.	
b	TELEVISION SERVICE			20,707.	20,707.		
c	CAFETERIA REVENUE			2,023,368.	2,023,368.		
d	All other revenue		812930	4,407,869.	3,815,701.	592,168.	
e	Total. Add lines 11a-11d			12,493,051.			
12	Total revenue. See instructions			413,922,646.	396,315,583.	677,832.	
						4,780,746.	

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns.

All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21 . . .	0.			
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22	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	6,730,335.	0.	6,730,335.	0.
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.	0.	0.	0.
7 Other salaries and wages	144,254,310.	118,052,248.	26,202,062.	0.
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions).	4,310,015.	3,305,781.	1,004,234.	0.
9 Other employee benefits	13,679,816.	10,492,418.	3,187,398.	0.
10 Payroll taxes	10,616,059.	8,142,517.	2,473,542.	0.
11 Fees for services (non-employees):				
a Management	1,809,158.	0.	1,809,158.	0.
b Legal	821,966.	14,534.	807,432.	0.
c Accounting	434,124.	168,769.	265,355.	0.
d Lobbying	0.	0.	0.	0.
e Professional fundraising services. See Part IV, line 17	0.			0.
f Investment management fees	263,159.	0.	263,159.	0.
g Other	24,968,761.	17,564,826.	7,403,935.	0.
12 Advertising and promotion	1,153,781.	1,152,459.	1,322.	0.
13 Office expenses	83,416,804.	78,661,330.	4,755,474.	0.
14 Information technology	905,863.	905,863.	0.	0.
15 Royalties	0.	0.	0.	0.
16 Occupancy	10,087,858.	9,135,621.	952,237.	0.
17 Travel	438,302.	272,270.	166,032.	0.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.	0.	0.	0.
19 Conferences, conventions, and meetings	276,650.	75,588.	201,062.	0.
20 Interest	13,225,930.	13,225,930.	0.	0.
21 Payments to affiliates	0.	0.	0.	0.
22 Depreciation, depletion, and amortization	25,796,379.	0.	25,796,379.	
23 Insurance	6,607,661.	5,466,854.	1,140,807.	
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 REPAIRS AND MAINT	9,169,712.	8,106,597.	1,063,115.	0.
b OTHER	5,793,174.	4,082,607.	1,710,567.	0.
c DONATIONS	131,677.	131,677.	0.	0.
d BAD DEBT	23,061,732.	23,061,732.	0.	0.
e GARAGE TOWNE PARK EXPENSES	1,559,040.	0.	1,559,040.	0.
f All other expenses	1,713,907.		1,713,907.	0.
25 Total functional expenses. Add lines 1 through 24f	391,226,173.	302,019,621.	89,206,552.	0.
26 Joint Costs. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720). Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X Balance Sheet

		(A)		(B)	
		Beginning of year		End of year	
Assets	1	Cash - non-interest-bearing	58,933,702.	1	68,806,766.
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	21,652,316.	4	19,105,826.
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	75,000.	5	0.
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions)		6	
	7	Notes and loans receivable, net	201,120.	7	474,045.
	8	Inventories for sale or use	5,477,366.	8	6,739,569.
	9	Prepaid expenses and deferred charges	3,196,298.	9	3,449,102.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 721,853,773.		
	b	Less: accumulated depreciation	10b 209,343,451.	453,850,721.	10c 512,510,322.
	11	Investments - publicly traded securities	144,993,940.	11	34,283,252.
	12	Investments - other securities. See Part IV, line 11	51,670,718.	12	111,719,734.
	13	Investments - program-related. See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	58,035,781.	15	58,391,207.
16	Total assets. Add lines 1 through 15 (must equal line 34)	798,086,962.	16	815,479,823.	
Liabilities	17	Accounts payable and accrued expenses	48,512,885.	17	55,267,656.
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	440,856,541.	20	441,277,062.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities. Complete Part X of Schedule D	63,181,353.	25	43,549,176.
	26	Total liabilities. Add lines 17 through 25	552,550,779.	26	540,093,894.
Net Assets or Fund Balances	Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27	Unrestricted net assets	210,431,026.	27	245,850,569.
	28	Temporarily restricted net assets	33,981,727.	28	28,411,930.
	29	Permanently restricted net assets	1,123,430.	29	1,123,430.
	Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
33	Total net assets or fund balances	245,536,183.	33	275,385,929.	
34	Total liabilities and net assets/fund balances	798,086,962.	34	815,479,823.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	413,922,646.
2	Total expenses (must equal Part IX, column (A), line 25)	2	391,226,173.
3	Revenue less expenses. Subtract line 2 from line 1	3	22,696,473.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	245,536,183.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	7,153,273.
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	275,385,929.

Part XII Financial Statements and Reporting

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

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

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047

2010

Open to Public Inspection

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.

Department of the Treasury
Internal Revenue Service

Name of the organization

MERCY MEDICAL CENTER

Employer identification number

52-0591658

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

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

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E.)
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8 A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9 An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)
- 10 An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 11 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3)**. Check the box that describes the type of supporting organization and complete lines 11e through 11h.
 - a Type I
 - b Type II
 - c Type III - Functionally integrated
 - d Type III - Other
- e By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).
- f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box
- g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?
 - (i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?

	Yes	No
11g(i)		
11g(ii)		
11g(iii)		
 - (ii) A family member of a person described in (i) above?
 - (iii) A 35% controlled entity of a person described in (i) or (ii) above?
- h Provide the following information about the supported organization(s).

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

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

Schedule A (Form 990 or 990-EZ) 2010

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

Section A. Public Support

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

Section B. Total Support

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

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

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

Section C. Computation of Public Support Percentage

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

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

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

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

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

b **10%-facts-and-circumstances test - 2009.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the 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 section 501(c)(3) organization, check this box and stop here ▶ <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

15 Public support percentage for 2010 (line 10c, column (f) divided by line 13, column (f)).	15	%
16 Public support percentage from 2009 Schedule A, Part III, line 15.	16	%

Section D. Computation of Investment Income Percentage

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

- 19a **33 1/3% support tests - 2010.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization ▶
- b **33 1/3% support tests - 2009.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization ▶
- 20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶

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

Schedule of Contributors

2010

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

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
52-0591658

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), and received from any one contributor, during the year, a contribution of the greater of (1) \$5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h or (ii) Form 990-EZ, line 1. Complete Parts I and II.

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

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

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

Name of organization **MERCY MEDICAL CENTER**

Employer identification number
52-0591658

Part I Contributors (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
1	MERCY HEALTH FOUNDATION 301 ST. PAUL PLACE BALTIMORE, MD 21202	\$ 7,540,143.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
2	DEPARTMENT OF HEALTH AND HUMAN SERVICES 6820 DEERPATH ROAD ELKRIDGE, MD 21075	\$ 118,655.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
3	HEALTHCARE FOR THE HOMELESS 421 FALLS WAY BALTIMORE, MD 21202	\$ 1,184,142.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
4	FAMILY VIOLENCE RESPONSE 300 E JOPPA ROAD TOWSON, MD 21286-3016	\$ 9,453.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
5	SEXUAL ASSAULT FORENSIC EXAMINERS 300 E JOPPA ROAD TOWSON, MD 21286-3016	\$ 5,356.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
6	CHARLES C EDWARDS II MD 1826 CIRCLE RD RUXTON, MD 21204	\$ 1,794,963.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization **MERCY MEDICAL CENTER**

Employer identification number
52-0591658

Part I Contributors (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
7	SUPPORTIVE HOUSING PROGRAM 1966 GREENSPRING DR STE 200 TIMONIUM, MD 21093	\$ 452,531.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
8	NATIONAL INSTITUTE OF HEALTH 6120 EXECUTIVE BLVD STE 43 ROCKVILLE, MD 20892-7150	\$ 28,735.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
9	DOMESTIC DATING VIOLENCE INITIATIVE 300 E JOPPA RD TOWSON, MD 21286-3016	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
10	FORENSIC NURSE EXAMINER 300 E JOPPA RD TOWSON, MD 21286-3016	\$ 11,250.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
11	ADVOCACY SUPPORT AND EXPANSION PROJECT 300 E JOPPA RD TOWSON, MD 21286-3016	\$ 39,546.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
12	SUPPORTIVE HOUSING PROGRAM 417 E FAYETTE ST BALTIMORE, MD 21202	\$ 92,174.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization **MERCY MEDICAL CENTER**

Employer identification number
52-0591658

Part I Contributors (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
13	IPV FORENSIC EXAMINATION KITS 300 E JOPPA RD TOWSON, MD 21286-3016	\$ 21,787.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
14	SEXUAL ASSAULT RESPONSE ENHANCEMENT PROJ 300 E JOPPA RD TOWSON, MD 21286-3016	\$ 34,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
15	STATE OF MARYLAND 301 WEST PRESTON ST BALTIMORE, MD 21202-2305	\$ 800,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
			Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
			Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
			Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

Name of organization **MERCY MEDICAL CENTER**

Employer identification number
52-0591658

Part II Noncash Property (see instructions)

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
6	INTELLECTUAL PROPERTY	\$ 1,794,963.	

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2010

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990. See separate instructions.

Name of the organization MERCY MEDICAL CENTER

Employer identification number 52-0591658

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

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

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

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

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

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

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

- 3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):
- a Public exhibition
 - b Scholarly research
 - c Preservation for future generations
 - d Loan or exchange programs
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIV.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

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

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b If "Yes," explain the arrangement in Part XIV and complete the following table:
- | | Amount |
|---|--------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a Did the organization include an amount on Form 990, Part X, line 21? Yes No
- b If "Yes," explain the arrangement in Part XIV.

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

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

- 2 Provide the estimated percentage of the year end balance held as:
- a Board designated or quasi-endowment ▶ _____ %
 - b Permanent endowment ▶ _____ %
 - c Term endowment ▶ _____ %
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|--------|----|
| (i) unrelated organizations | 3a(i) | |
| (ii) related organizations | 3a(ii) | |
| b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R? | 3b | |
- 4 Describe in Part XIV the intended uses of the organization's endowment funds.

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

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		8,067,791		8,067,791.
b Buildings		523,331,831	91,921,563	431,410,268.
c Leasehold improvements				
d Equipment		164,443,806	117,421,888	47,021,918.
e Other		26,010,345		26,010,345.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				512,510,322.

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) RESTRICTED INVESTMENTS	100,802,210.	FMV
(B) RESTRICTED CASH	10,917,524.	FMV
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
(I)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.)	111,719,734.	

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

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

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

(a) Description	(b) Book value
(1) INTEREST IN MERCY HEALTH FOUND	28,450,574.
(2) DUE FROM RELATED ENTITIES	14,064,786.
(3) OTHER RECEIVABLES	2,628,978.
(4) DEPOSITS	733,200.
(5) DEFERRED FINANCING COSTS	2,666,971.
(6) OTHER CURRENT ASSETS	302,160.
(7) OTHER ASSETS	193,408.
(8) INVEST UNCONSOLID SUBS	868,380.
(9) DEFERRED COMP PLAN ASSETS	6,647,882.
(10) CARDINAL SHEHAN SEC DEPOSIT	1,834,868.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.)	58,391,207.

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

1. (a) Description of liability	(b) Amount
(1) Federal income taxes	0.
(2) CONSTRUCTION RETAINAGE	780,113.
(3) POST RETIREMENT OBLIGATION	6,818,511.
(4) DEFERRED COMPENSATION	6,647,876.
(5) MERRILL LYNCH SWAP	22,788,921.
(6) MALPRACTICE TAIL LIABILITY	327,536.
(7) CARDINAL DEPOSIT	2,056,383.
(8) RETIREMENT ANNUITY PLAN OBLIGA	3,129,836.
(9) ESTIMATED TAIL LIAB GIC	1,000,000.
(10)	
(11)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	43,549,176.

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

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

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

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

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

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

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

Part XIV Supplemental Information

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

Part XIV Supplemental Information *(continued)*

**SCHEDULE F
(Form 990)**

Statement of Activities Outside the United States

OMB No. 1545-0047

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

2010

**Open to Public
Inspection**

▶ Attach to Form 990. ▶ See separate instructions.

Department of the Treasury
Internal Revenue Service

Name of the organization

MERCY MEDICAL CENTER

Employer identification number

52-0591658

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

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

2 For grantmakers. Describe in Part V the organization's procedures for monitoring the use of grant funds outside the United States.

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

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e.g., fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
(1) CENTRAL AMERICA/CARIBBEAN			INVESTMENTS		16,117,000.
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Sub-total					16,117,000.
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)					16,117,000.

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

Schedule F (Form 990) 2010

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

Part II can be duplicated if additional space is needed.

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

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

3 Enter total number of other organizations or entities.

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

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

Part IV Foreign Forms

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

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

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

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

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

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

Part V Supplemental Information

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

PART I, LINE 3

AMONG THE AMOUNTS INDICATED AS FOREIGN INVESTMENTS IN PART I WAS MERCY MEDICAL CENTER'S OWNERSHIP INTEREST IN GREENLEAF INSURANCE COMPANY, LTD ("GREENLEAF"), A CAYMAN ISLAND CORPORATION. GREENLEAF IS A WHOLLY-OWNED SUBSIDIARY OF MERCY MEDICAL CENTER THAT PROVIDES DIRECT COVERAGE FOR PROFESSIONAL, MALPRACTICE, AND COMPREHENSIVE GENERAL LIABILITY FOR MERCY MEDICAL CENTER AND ITS ASSOCIATED HEALTH CARE FACILITIES. AS OF THE END OF THE 2010 TAX YEAR, THE VALUE OF MERCY MEDICAL CENTER'S OWNERSHIP IN GREENLEAF WAS \$12,547,000.

SCHEDULE H
(Form 990)

Hospitals

OMB No. 1545-0047

2010

Open to Public Inspection

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

Department of the Treasury
Internal Revenue Service

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
52-0591658

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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)			10,440,830.		10,440,830.	2.84
b Unreimbursed Medicaid (from Worksheet 3, column a)						
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			10,440,830.		10,440,830.	2.84
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			3,988,308.	13,023.	3,975,285.	1.08
f Health professions education (from Worksheet 5)			13,818,636.		13,818,636.	3.76
g Subsidized health services (from Worksheet 6)			4,635,649.	261,073.	4,374,576.	1.19
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)			1,696,122.		1,696,122.	.46
j Total. Other Benefits			24,138,715.	274,096.	23,864,619.	6.49
k Total. Add lines 7d and 7j			34,579,545.	274,096.	34,305,449.	9.33

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

Schedule H (Form 990) 2010

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical Improvements and housing			12,000.		12,000.	
2 Economic development			968,623.	490,938.	477,685.	.13
3 Community support			20,192.		20,192.	
4 Environmental improvements						
5 Leadership development and training for community members			304,133.		304,133.	.08
6 Coalition building						
7 Community health improvement advocacy			214,085.		214,085.	.06
8 Workforce development						
9 Other						
10 Total			1,519,033.	490,938.	1,028,095.	.27

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Does the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		X
2 Enter the amount of the organization's bad debt expense (at cost)		
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		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts in community benefit.		
Section B. Medicare		
5 Enter total revenue received from Medicare (including DSH and IME)		
6 Enter Medicare allowable costs of care relating to payments on line 5		
7 Subtract line 6 from line 5. This is the surplus (or shortfall)		
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

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

Part V Facility Information

Section A. Hospital Facilities

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

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

Name and address

1 MERCY MEDICAL CENTER
 301 ST PAUL PLACE
 BALTIMORE MD 21202

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
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: MERCY MEDICAL CENTER

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

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

Part V Facility Information (continued) MERCY MEDICAL CENTER

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

Billing and Collections

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

Part V Facility Information (continued) **MERCY MEDICAL CENTER**

Policy Relating to Emergency Medical Care

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?

	Yes	No
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)

19		
20		
21		

20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?

If "Yes," explain in Part VI.

21 Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient?

If "Yes," explain in Part VI.

Part V Facility Information (continued)

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

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

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

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

Part VI Supplemental Information

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

MARYLAND HOSPITAL ASSOCIATION UNIFIED MARYLAND HOSPITAL RESPONSES

PART I, LINES 7A, 7B AND 7F

7A. CHARITY CARE AT COST AND 7F. HEALTH PROFESSIONS EDUCATION ARE

EXPLAINED IN THE FOLLOWING:

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

7B. UNREIMBURSED MEDICAID IS EXPLAINED IN THE FOLLOWING:

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

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

COST REVIEW COMMISSION, (HSCRC) DETERMINES PAYMENT THROUGH A RATE SETTING

PROCESS ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT

FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE

ALL PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN

EACH PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT

ANY DIRECTED OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. COMMUNITY

BENEFIT EXPENSES ARE EQUAL TO MEDICAID REVENUES IN MARYLAND, AS SUCH, THE

NET EFFECT IS ZERO. THE EXCEPTION TO THIS IS THE IMPACT ON THE HOSPITAL

OF ITS SHARE OF THE MEDICAID ASSESSMENT. IN RECENT YEARS, THE STATE OF

MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING

HOSPITALS THROUGH THE RATE SETTING SYSTEM. THE MARYLAND MEDICAID

ASSESSMENT FOR MERCY MEDICAL CENTER FOR THE 2010 TAX YEAR WAS \$989,402.

PART I, LINE 3C

FINANCIAL ASSISTANCE WILL BE PROVIDED AT NO CHARGE OR AT A REDUCED CHARGE

TO PATIENTS WHO ARE UNABLE TO PAY BASED ON A SLIDING SCALE THAT WILL BE

APPLIED FOR INCOMES UP TO APPROXIMATELY 400% ABOVE THE HHS POVERTY

GUIDELINES. THE POVERTY GUIDELINES ARE ISSUED EACH YEAR BY THE DEPARTMENT

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

OF HEALTH AND HUMAN SERVICES (HSS).

IN ORDER TO QUALIFY FOR FINANCIAL ASSISTANCE, A PATIENT MUST BE A U.S.

CITIZEN OR PERMANENT LEGAL RESIDENT WHO QUALIFIES UNDER AT LEAST ONE OF

THE FOLLOWING CONDITIONS:

1. A PATIENT WITH FAMILY INCOME AT OR BELOW 200% OF THE FEDERAL POVERTY LEVEL, WITH LESS THAN \$10,000 IN HOUSEHOLD MONETARY ASSETS QUALIFIES FOR FULL FINANCIAL ASSISTANCE IN THE FORM OF FREE MEDICALLY NECESSARY CARE.

2. A PATIENT NOT OTHERWISE ELIGIBLE FOR MEDICAID OR CHIP WHO IS A BENEFICIARY/RECIPIENT OF A MEANS-TESTED SOCIAL SERVICES PROGRAM, INCLUDING BUT NOT NECESSARILY LIMITED TO THE FOLLOWING PROGRAMS, IS DEEMED ELIGIBLE FOR FINANCIAL ASSISTANCE IN THE FORM OF FREE MEDICALLY NECESSARY CARE, PROVIDED THAT THE PATIENT SUBMITS PROOF OF ENROLLMENT WITHIN 30 DAYS UNLESS THE PATIENT OR THE PATIENT'S REPRESENTATIVE REQUESTS AN ADDITIONAL 30 DAYS:

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

A) HOUSEHOLDS WITH CHILDREN IN THE FREE OR REDUCED LUNCH PROGRAM

B) SUPPLEMENTAL NUTRITIONAL ASSISTANCE PROGRAM (SNAP)

C) LOW-INCOME-HOUSEHOLD ENERGY ASSISTANCE PROGRAM

D) PRIMARY ADULT CARE PROGRAM (PAC), UNTIL SUCH TIME AS INPATIENT

BENEFITS ARE ADDED TO THE PAC BENEFIT PACKAGE

E) WOMEN, INFANTS, AND CHILDREN (WIC)

3. A PATIENT WITH FAMILY INCOME AT OR BELOW 400% OF FEDERAL POVERTY
LEVEL, WITH LESS THAN \$10,000 IN HOUSEHOLD MONETARY ASSETS QUALIFIES FOR
PARTIAL FINANCIAL ASSISTANCE IN THE FORM OF REDUCED-COST MEDICALLY
NECESSARY CARE. THE AMOUNT OF FINANCIAL ASSISTANCE IN THIS CASE IS BASED
ON A SLIDING SCALE OF INCOME AND SHOWN IN THE ATTACHED TABLE AND OTHER
FACTORS.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

4. A PATIENT WITH: (I) FAMILY INCOME AT OR BELOW 500% OF FEDERAL POVERTY
LEVEL; (II) WITH MEDICAL DEBT INCURRED WITHIN THE 12 MONTH PERIOD PRIOR
TO APPLICATION THAT EXCEEDS 25% OF FAMILY INCOME FOR THE SAME PERIOD; AND
(III) WITH LESS THAN \$10,000 IN HOUSEHOLD MONETARY ASSETS WILL QUALIFY
FOR PARTIAL FINANCIAL ASSISTANCE IN THE FORM OF REDUCED-COST MEDICALLY
NECESSARY CARE. THE AMOUNT OF FINANCIAL ASSISTANCE IN THIS CASE IS BASED
ON A SLIDING SCALE OF INCOME, AMOUNT OF MEDICAL DEBT, AND OTHER FACTORS.

A) AN ELIGIBLE PATIENT OR ANY IMMEDIATE FAMILY MEMBER OF THE PATIENT
LIVING IN THE SAME HOUSEHOLD SHALL REMAIN ELIGIBLE FOR REDUCED-COST
MEDICALLY NECESSARY CARE WHEN SEEKING SUBSEQUENT CARE AT MERCY MEDICAL
CENTER DURING THE 12-MONTH PERIOD BEGINNING ON THE DATE ON WHICH THE
REDUCED-COST MEDICALLY NECESSARY CARE WAS INITIALLY RECEIVED.

B) TO AVOID AN UNNECESSARY DUPLICATION OF MERCY MEDICAL CENTER'S
DETERMINATIONS OF ELIGIBILITY FOR FINANCIAL ASSISTANCE, A PATIENT
ELIGIBLE FOR CARE UNDER PARAGRAPH 4.A SHALL INFORM THE HOSPITAL OF HIS OR
HER ELIGIBILITY FOR THE REDUCED-COST MEDICALLY NECESSARY CARE.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

5. AN UNINSURED PATIENT WITH FAMILY INCOME BETWEEN 200% AND 500% OF
FEDERAL POVERTY LEVEL WHO REQUESTS ASSISTANCE QUALIFIES FOR A PAYMENT
PLAN.

6. A HOMELESS PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE.

7. A DECEASED PATIENT, WITH NO PERSON DESIGNATED AS DIRECTOR OF FINANCIAL
AFFAIRS, OR NO ESTATE NUMBER ON FILE AT THE APPLICABLE REGISTRARS OF WILLS
DEPARTMENT, QUALIFIES FOR FINANCIAL ASSISTANCE.

8. A PATIENT WHO HAS A REMAINING BALANCE AFTER MEDICAL ASSISTANCE
QUALIFIES FOR FINANCIAL ASSISTANCE.

9. MERCY MEDICAL CENTER MAY ELECT TO GRANT PRESUMPTIVE CHARITY CARE TO
PATIENTS BASED ON INFORMATION GATHERED DURING A DEBT COLLECTION PROCESS.
FACTORS INCLUDE PROPENSITY TO PAY SCORING, ELIGIBILITY AND PARTICIPATION
IN OTHER FEDERAL PROGRAMS, AND OTHER RELEVANT INFORMATION.

Part VI Supplemental Information

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- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

10. A PATIENT WHO DOES NOT QUALIFY UNDER THE PRECEDING CATEGORIES MAY
STILL APPLY FOR FINANCIAL ASSISTANCE, AND MERCY MEDICAL CENTER WILL
REVIEW THE APPLICATION AND MAKE A DETERMINATION ON A CASE-BY-CASE BASIS
AS TO ELIGIBILITY FOR FINANCIAL ASSISTANCE. FACTORS THAT WILL BE
CONSIDERED INCLUDE:

A) FIXED INCOME SUCH AS SOCIAL SECURITY, RETIREMENT OR DISABILITY WITH NO
ADDITIONAL INCOME SOURCES AVAILABLE

B) MEDICAL EXPENSES AND/OR

C) EXPENSES RELATED TO NECESSITIES OF LIFE COMPARED TO INCOME.

IN DETERMINING ELIGIBILITY, THE SIZE OF THE PATIENT'S BILL RELATIVE TO
THE PATIENT'S ABILITY TO PAY WILL BE CONSIDERED. FINANCIAL ASSISTANCE
WILL BE GRANTED FOR NECESSARY HOSPITAL SERVICES AND IT WILL BE PROVIDED
TO THOSE WHO PROPERLY DOCUMENT ELIGIBILITY AND COOPERATE WITH MERCY

Part VI Supplemental Information

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

WITHIN TWO BUSINESS DAYS FOLLOWING A PATIENT'S INITIAL REQUEST FOR
FINANCIAL ASSISTANCE SERVICES, APPLICATION FOR MEDICAL ASSISTANCE, OR
BOTH, THE FACILITY MUST MAKE A DETERMINATION OF PROBABLE ELIGIBILITY.

NOTICE OF THE AVAILABILITY OF FINANCIAL ASSISTANCE IS TO BE POSTED IN THE
ADMISSIONS OFFICE, BUSINESS OFFICE, AND EMERGENCY AREAS OF THE HOSPITAL.
SUCH NOTICE IS POSTED IN ENGLISH, SPANISH AND/OR ANY OTHER LANGUAGE THAT
WILL BE UNDERSTANDABLE TO TARGET POPULATIONS OF PATIENTS UTILIZING
HOSPITAL SERVICES.

INDIVIDUAL NOTICE OF THE AVAILABILITY OF FINANCIAL ASSISTANCE, THE
POTENTIAL FOR MEDICAID ELIGIBILITY, AND THE AVAILABILITY OF ASSISTANCE
FROM OTHER GOVERNMENT FUNDED PROGRAMS SHALL BE PROVIDED TO EACH PERSON
WHO SEEKS SERVICES IN THE HOSPITAL AT THE TIME OF COMMUNITY OUTREACH
EFFORTS, PRENATAL SERVICES, PREADMISSION, OR ADMISSION. SUCH NOTICE WILL
BE PRINTED IN ENGLISH, SPANISH, AND/OR ANY OTHER LANGUAGE THAT WILL BE

Part VI Supplemental Information

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

UNDERSTANDABLE TO TARGET POPULATIONS OF PATIENTS UTILIZING HOSPITAL SERVICES.

MERCY MEDICAL CENTER WILL MAKE AN EFFORT TO PROVIDE THE FINANCIAL ASSISTANCE APPLICATION, POLICIES, PROCEDURES, AND INFORMATION AVAILABLE IN ENGLISH, SPANISH, AND/OR ANY OTHER LANGUAGE THAT WILL BE UNDERSTANDABLE TO TARGET POPULATIONS OF PATIENTS UTILIZING HOSPITAL SERVICES.

PART I, LINE 6A

COMMUNITY BENEFIT REPORT IS MADE AVAILABLE ON ANOTHER'S WEBSITE, SPECIFICALLY THE WEBSITE FOR THE MARYLAND HSCRC. MERCY MEDICAL CENTER PREPARES ITS COMMUNITY BENEFIT REPORT ANNUALLY AND ITS MADE AVAILABLE TO THE PUBLIC.

PART I, LINE 7G

THERE ARE NO COSTS REPORTED THAT ARE ATTRIBUTABLE TO A PHYSICIAN CLINIC.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 7, COLUMN F

THE BAD DEBT EXPENSE AS REPORTED ON FORM 990, PART IX, IS

\$23,061,732.

PART I, LINE 7

IN TABLE 7, A COST-TO-CHARGE RATIO WAS USED IN ALL CALCULATIONS.

PART III, LINE 4

THE COST OF BAD DEBTS ON LINE 2 AND 3 OF SCHEDULE H WAS DETERMINED BASED
ON THE COST TO CHARGE RATIO FORM MERCY MEDICAL CENTER'S ANNUAL FILING
WITH THE HSCRC.

PART III, LINE 8

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

Part VI Supplemental Information

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- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, LINE 9B

ONCE THE COLLECTION PROCESS HAS BEGUN, THE ORGANIZATION CONTINUES TO
 MONITOR WHETHER THE PATIENT QUALIFIES FOR CHARITY CARE UNDER THE
 FINANCIAL ASSISTANCE POLICY. IF THE ORGANIZATION DETERMINES THAT A
 PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE, INCLUDING ONCE THE COLLECTION
 PROCESS HAS BEGUN, THE ORGANIZATION WILL APPROVE THE PATIENT FOR CHARITY
 CARE. ONCE CHARITY CARE HAS BEEN APPROVED, THERE IS NO FURTHER ATTEMPT
 MADE BY THE ORGNANIZATION TO COLLECT. COLLECTION EFFORTS WILL BE STOPPED
 AT ANY TIME DURING THE COLLECTION PROCESS IF THE PATIENT QUALIFIES FOR
 CHARITY CARE UNDER THE FINANCIAL ASSISTANCE POLICY. FURTHERMORE, IF A
 PATIENT'S FINANCIAL SITUATION CHANGES AT ANY POINT DURING THE COLLECTION
 PROCESS, THE PATIENT MAY QUALIFY FOR FINANCIAL ASSISTANCE AT SUCH POINT.

PART V

MERCY MEDICAL CENTER (MMC) IS A LICENCED HOSPITAL. MMC PROVIDES
 INPATIENT, OUTPATIENT AND EMERGENCY CARE SERVICES PRIMARILY FOR THE
 CITIZENS OF THE BALTIMORE METROPOLITAN AREA.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

NEEDS ASSESSMENT

PART VI, QUESTION 2

MERCY MEDICAL CENTER EMPLOYED A MULTI-PRONGED APPROACH IN IDENTIFYING

COMMUNITY NEEDS. THESE APPROACHES ARE AS FOLLOWS:

1. ACCESSING EXISTING DATA SOURCES ON HEALTH CARE STATUS IN PRIMARY

SERVICE AREA (PSA) AS PREVIOUSLY REFERENCED, "BALTIMORE CITY'S HEALTH STATUS REPORT: 2008" WAS THE MAIN STATISTICAL DOCUMENT THAT PROVIDED THE HOSPITAL WITH KEY DATA ON THE MOST CRITICAL HEALTH CARE CONDITIONS AFFECTING THE POPULATION.

ACCESSED AND REVIEWED OTHER STATE OF MARYLAND HEALTH CARE DATA BASES RELATED TO HEALTH CARE NEEDS OF COMMUNITIES THAT MERCY MEDICAL CENTER SERVES IN ITS PSA.

PUBLICATIONS AND DATA AVAILABLE FROM ORGANIZATIONS IN WHICH MERCY MEDICAL CENTER PHYSICIAN AND ADMINISTRATIVE LEADERSHIP ARE ACTIVE PARTICIPANTS AND MEMBERS SUCH AS B'MORE FOR HEALTHY BABIES, JOURNEY HOME, FAMILY

Part VI Supplemental Information

Complete this part to provide the following information.

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

OTHERS.

2. PARTNERSHIPS, WORKGROUPS, AND MEMBERSHIP IN ORGANIZATIONS THROUGH THE

WORKGROUPS AND PARTNERSHIPS THAT HAVE BEEN ESTABLISHED WITH KEY

ORGANIZATIONS SUCH AS HEALTH CARE FOR THE HOMELESS, BALTIMORE HOMELESS

SERVICES, THE WEINBERG HOUSING AND RESOURCE CENTER, MAYOR'S OFFICE ON

EMEGENCY MANAGEMENT, SEX AND FAMILY CRIMES DIVISION OF THE BALTIMORE CITY

POLICE DEPARTMENT, TURN AROUND HOUSE OF RUTH, FAMILY CRISIS CENTER OF

BALTIMORE, DOMESTIC VIOLENCE COORDINATING COUNCIL, B'MORE FOR HEALTHY

BABIES AND FAMILY HEALTH CENTERS OF BALTIMORE, THE HOSPITAL RECEIVED

SIGNIFICANT INPUT AND FEEDBACK ON THE HEALTH CARE NEEDS OF ITS IMMEDIATE

SURROUNDING NEIGHBORHOODS AND COMMUNITIES. THIS WAS ACHIEVED THROUGH

REGULAR MEETINGS AND DISCUSSIONS THROUGHOUT FY11.

THROUGH PARTICIPATION OF THE HOSPITAL'S EXECUTIVE LEADERSHIP TEAM IN

BUSINESS FORUMS SUCH AS THE DOWNTOWN PARTNERSHIP AND MEMBERSHIP IN OTHER

ORGANIZATIONS, SIGNIFICANT FEEDBACK AND INFORMATION ON HEALTH CARE NEEDS

Part VI Supplemental Information

Complete this part to provide the following information.

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

3. MERCY HEALTH SERVICES MISSION AND COPORATE ETHICS COMMITTEE THE
MISSION AND COPORATE ETHICS COMMITTEE OF THE BOARD OF TRUSTEES MEETS
REGULARLY TO REVIEW AND COORDINATE ISSUES RELATED TO MISSION INTEGRATION
AND COORDINATION. THIS BOARD COMMITTEE IS INFORMED AND CLEARLY
UNDERSTANDS THE SCOPE AND DEPTH OF THE HOSPITAL'S COMMUNITY BENEFIT AND
INITIATIVES.

IN SUMMARY, THROUGH A QUANTITATIVE ASSESSMENT OF NEEDS BASED ON REVIEW OF
CURRENT DATA SOURCES AND ACTIVE PARTICIPANTS IN SEVERAL COMMUNITY BASED
ORGANIZATIONS, MERCY MEDICAL CENTER WAS ABLE TO DETERMINE AND PRIORITIZE
ITS COMMUNITY NEED FOCUS.

PLANNING IS UNDERWAY TO PERFORM A FORMAL COMMUNITY NEEDS ASSESSMENT BY
JUNE 30, 2013.

Part VI Supplemental Information

Complete this part to provide the following information.

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

PART VI, QUESTION 3

MERCY ATTEMPTS TO BE VERY PROACTIVE IN COMMUNICATING ITS CHARITY CARE

POLICY AND FINANCIAL ASSISTANCE CONTACT INFORMATION TO PATIENTS. THE

CHARITY CARE POLICY AND FINANCIAL ASSISTANCE CONTACT INFORMATION IS

POSTED IN ALL ADMISSIONS AREAS, INCLUDING THE EMERGENCY ROOM. A COPY OF

THE POLICY AND FINANCIAL ASSISTANCE CONTACT INFORMATION IS ALSO PROVIDED

TO PATIENTS OR THEIR FAMILIES DURING THE PRE-ADMISSION, PRE-SURGERY AND

ADMISSIONS PROCESS.

MERCY UTILIZES A THIRD PARTY, AS WELL AS IN-HOUSE FINANCIAL COUNSELING

STAFF, TO CONTACT AND SUPPORT PATIENTS IN UNDERSTANDING AND COMPLETING

THE FINANCIAL ASSISTANCE REQUIREMENTS. THEY ALSO DISCUSS WITH PATIENTS OR

THEIR FAMILIES THE AVAILABILITY OF VARIOUS GOVERNMENT BENEFITS AND ASSIST

PATIENTS WITH UNDERSTANDING THE QUALIFICATIONS FOR SUCH PROGRAMS.

EVEN AFTER THE PATIENT IS DISCHARGED, EACH BILLING STATEMENT CONTAINS AN

OVERVIEW OF MERCY'S FINANCIAL ASSISTANCE POLICY, A PATIENT'S RIGHTS AND

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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OBLIGATIONS, AND CONTACT NUMBERS FOR FINANCIAL ASSISTANCE, FINANCIAL
 COUNSELING, AND MARYLAND MEDICAID. FOLLOW-UP PHONE CALLS BY HOSPITAL
 BILLING/COLLECTION STAFF MADE TO PATIENTS WITH UNPAID BALANCES ALSO
 STRESS THE AVAILABILITY OF FINANCIAL ASSISTANCE AND CHARITY CARE
 AVAILABILITY.

MERCY MEDICAL CENTER PROVIDES AND PROMOTES HEALTH SERVICES FOR THE PEOPLE
 OF BALTIMORE OF EVERY CREED, RACE, ECONOMIC, AND SOCIAL CONDITION. IN THE
 SPIRIT OF THE SISTERS OF MERCY WHO ARE ITS SPONSORS, MERCY CONTINUES A
 SPECIAL COMMITMENT TO THE UNDERSERVED AND THE UNINSURED.

CONSISTENT WITH THIS MISSION, IT HAS BEEN THE POLICY OF MERCY MEDICAL
 CENTER TO ACCEPT, WITHIN THE LIMITS OF ITS FINANCIAL RESOURCES, ALL
 PATIENTS WHO REQUIRE ITS SERVICES, WITHOUT REGARD TO THEIR ABILITY TO PAY
 FOR SUCH SERVICES. EMERGENCY CARE WILL BE RENDERED TO ALL PATIENTS
 WITHOUT REGARD TO THE LIMITATION OF FINANCIAL RESOURCES. THIS POLICY,
 HOWEVER, DOES NOT PRECLUDE AN ATTEMPT TO REVIEW:

1. THE PATIENT'S ABILITY TO PAY

Part VI Supplemental Information

Complete this part to provide the following information.

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2. THE AVAILABILITY OF INSURANCE BENEFITS

3. THE ELIGIBILITY OF MEDICAL ASSISTANCE FOR THE PATIENT

COMMUNITY INFORMATION

PART VI, QUESTION 4

LOCATED IN THE HEART OF DOWNTOWN BALTIMORE, MERCY MEDICAL CENTER DRAWS

PATIENTS FROM THE GREATER BALTIMORE METROPOLITAN AREA FOR ITS

LONGSTANDING TRADITION OF COMPASSIONATE CARE, COMMITMENT TO QUALITY AND

PATIENT SAFETY, AS WELL AS ITS PRIMARY CARE AND SPECIALIST PHYSICIANS.

MERCY MEDICAL CENTER'S PRIMARY SERVICE AREA WHICH COMPRISES 17 ZIP CODES

IN BALTIMORE CITY, ACCOUNTS FOR 60% OF ITS TOTAL ADMISSIONS. KEY

DEMOGRAPHIC CHARACTERISTICS OF THE PSA ARE AS FOLLOWS:

POPULATION

1. THE PSA 2009 POPULATION IS 535,038

2. PSA POPULATION GROWTH IS PROJECTED TO DECLINE BY 1.2% FROM 2009 TO

2014. THIS IS IN CONTRAST TO A 3.1% PROJECTED GROWTH FOR THE STATE

Part VI Supplemental Information

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OF MARYLAND.

3. SINCE 1990, THE DISTRIBUTION OF BALTIMORE CITY RESIDENTS HAS SHIFTED TOWARDS OLDER AGE GROUPS WITH A 6% INCREASE IN THE 40 YEARS AND OLDER POPULATION. THIS TREND OF AN INCREASING OLDER POPULATION GROWTH IS EXPECTED THROUGH 2020.

ETHNICITY AND AGE

1. 64% BLACK; 32% CAUCASIAN IN PSA. BALTIMORE CITY'S BLACK POPULATION HAS INCREASED BY 5% SINCE 1990.

2. APPROXIMATELY 59% OF PATIENTS SERVED BY MERCY MEDICAL CENTER ARE MEMBERS OF A RACIAL OR ETHNIC MINORITIES; 66% ARE WOMEN AND 51% ARE MEDICAID AND/OR MEDICARE BENEFICIARIES.

3. 12% OF THE POPULATION IS 65 YEARS IN AGE AND OLDER.

INCOME

1. PSA MEDIAN HOUSEHOLD INCOME \$35,656

2. 40% OF BALTIMORE CITY HOUSEHOLDS REPORTED AN INCOME OF LESS THAN \$30,000. THIS IS ONLY 44% OF THE STATEWIDE MEDIAN INCOME OF \$68,080

Part VI Supplemental Information

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3. THREE TIMES AS MANY FAMILIES LIVING IN BALTIMORE CITY HAD INCOME THAT
 WAS BELOW THE POVERTY LEVEL COMPARED TO ALL FAMILIES IN MARYLAND.

OF NOTE, THE MAJOR COMMUNITY BENEFIT PROGRAMS THAT ARE IDENTIFIED IN
 QUESTION #4 DIRECTLY ADDRESS KEY HEALTH CARE NEEDS OF THE POPULATION IN
 MERCY MEDICAL CENTER'S PSA.

KEY FINDINGS FORM THE "BALTIMORE CITY HEALTH STATUS REPORT 2008"
 BALTIMORE CITY VS. STATE OF MARYLAND ON KEY HEALTH OUTCOME MEASURES

- 1. OVERALL MORTALITY RATE: BALTIMORE IS 37% HIGHER
- 2. LIFE EXPECTANCY: BALTIMORE IS 8% LOWER
- 3. INFANT MORTALITY: BALTIMORE IS 41% HIGHER
- 4. LOW BIRTH WEIGHT: BALTIMORE IS 36% HIGHER
- 5. TEEN BIRTH RATE: BALTIMORE IS TWICE AS HIGH
- 6. HIV/AIDS MORTALITY: BALTIMORE IS FIVE TIMES HIGHER

AS SHOWN BY THESE SELECT INDICATORS, THERE IS A SIGNIFICANT HEALTH STATUS
 DISPARITY BETWEEN BALTIMORE CITY'S RESIDENTS AND THE REST OF THE STATE OF

Part VI Supplemental Information

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MARYLAND.

DUE TO ITS LOCATION IN CENTER CITY, MERCY MEDICAL CENTER CARES FOR MANY OF THE AT-RISK, LOW INCOME POPULATION IN THE COMMUNITIES THAT IMMEDIATELY SURROUND THE HOSPITAL. THIS IS BEST EVIDENCED BY THE LARGE PERCENTAGE OF EMERGENCY ROOM VISITS BY THE MEDICAID, UNINSURED, AND MEDICARE PATIENTS.

MERCY MEDICAL CENTER'S COMMUNITY BENEFIT SERVICE AREA (CBSA) IS DEFINED BY 15 OF THE 17 PSA ZIP CODES. THESE ZIP CODES WERE IDENTIFIED AND DETERMINED BASED ON EMERGENCY DEPARTMENT (ED) VISITS DURING FY11. KEY DEMOGRAPHIC CHARACTERISTICS OF THE CBSA ARE AS FOLLOWS:

1. THE CBSA POPULATION IS 487,000
2. 53% FEMALE AND 32% MALE
3. 90% BLACK OR AFRICAN AMERICAN; 5% WHITE; 5% ALL OTHER
4. MEDIAN HOUSEHOLD INCOME \$21,000
5. PERCENTAGE OF HOUSEHOLDS WITH INCOME BELOW FEDERAL POVERTY GUIDELINES
43%

Part VI Supplemental Information

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6. ESTIMATE PERCENTAGE OF UNINSURED PEOPLE 39%

7. PERCENTAGE OF MEDICAID RECIPIENTS 30%

MEDICAID COVERED AND UNINSURED PATIENTS ACCOUNTED FOR MORE THAN 50% OF
THE FY11 EMERGENCY ROOM VISITS.

1. BALTIMORE CITY'S LARGEST HOMELESS SHELTER AT GUILFORD AVENUE IS
WITHIN THREE BLOCKS OF THE HOSPITAL

2. MERCY MEDICAL CENTER PROVIDES ALL OF THE MEDICAL STAFF (PHYSICIANS AND
NURSING PERSONNEL) FOR HEALTHCARE FOR THE HOMELESS (HCH), A
FEDERALLY QUALIFIED HEALTH CENTER, WHICH DELIVERS OUTPATIENT CARE
TO A LARGE NUMBER OF HOMELESS PERSONS IN BALTIMORE CITY. THE HCH
CLINIC IS LOCATED TWO BLOCKS FROM THE HOSPITAL.

COMMUNITY BUILDING ACTIVITIES

PART VI, QUESTION 4

MERCY SUPPORTIVE HOUSING PROGRAM

THE SUPPORTIVE HOUSING PROGRAM AT MERCY MEDICAL CENTER HAS A STAFF OF

Part VI Supplemental Information

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- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
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- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

EIGHT EXPERIENCED HUMAN SERVICES PERSONNEL WHO WORK IN CONJUNCTION WITH
 OTHER HOMELESS AND HUMAN SERVICES PROVIDERS TO COORDINATE SERVICES FOR
 HOMELESS FAMILIES AND FAMILIES AT RISK FOR HOMELESSNESS. THE PROGRAM'S
 GOAL IS TO HOUSE HOMELESS FAMILIES AND TO PROVIDE SUPPORTIVE SERVICES FOR
 A DEFINED PERIOD TO PREVENT A RETURN TO HOMELESSNESS.

IN FY 2011, THE SUPPORTIVE HOUSING PROGRAM AT MERCY PROVIDED A
 COMPREHENSIVE RANGE OF COUNSELING SERVICES AND COMMUNITY RESOURCE
 LINKAGES TO 207 CLIENTS. THESE SERVICES INCURRED DIRECT COSTS OF \$568,441
 DURING FY2011, OR ABOUT \$3,000 PER CLIENT.

MERCY FAMILY VIOLENCE RESPONSE PROGRAM

THE MERCY FAMILY VIOLENCE RESPONSE PROGRAM WAS DEVELOPED BY A
 MULTIDISCIPLINARY STAFF TASK FORCE AT MERCY MEDICAL CENTER TO PROVIDE
 CRISIS INTERVENTION AND SAFETY PLANNING FOR VICTIMS OF FAMILY VIOLENCE
 (DOMESTIC VIOLENCE, CHILD ABUSE, ELDER AND VULNERABLE ADULT ABUSE) AND
 SEXUAL ASSAULT WHO COME TO MERCY MEDICAL CENTER AND ITS PHYSICIANS FOR

Part VI Supplemental Information

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TREATMENT.

THIS PROGRAM IMPROVES BALTIMORE'S COORDINATED COMMUNITY RESPONSE TO
 VICTIMS OF VIOLENCE, AND CREATES AN ALERT WORKFORCE AT MERCY MEDICAL
 CENTER, SKILLED AT IDENTIFYING AND RESPONDING TO VICTIMS OF FAMILY
 VIOLENCE.

DUE TO ITS LOCATION WITHIN THREE BLOCKS OF THE CITY'S LARGEST HOMELESS
 SHELTER AT GUILFORD AVENUE AND CLOSE PROXIMITY TO HCH, MERCY MEDICAL
 CENTER'S ER RECEIVES MANY VISITS FORM HOMELESS PERSONS. WITH DECADES OF
 EXPERIENCE IN PROVIDING EMERGENT AND URGENT CARE TO POOR AND HOMELESS
 POPULATIONS, THE HOSPITAL HAS ESTABLISHED KEY SERVICES FOR THE MEDICALLY
 UNDERSERVED INCLUDING THE FOLLOWING:

A FULL TIME SOCIAL WORKER IS A PART OF THE ER TEAM TO COORDINATE CARE AND
 OTHER SERVICES FOR HOMELESS PATIENTS WHO ARRIVE AT THE ER.

ER PHYSICIANS AND NURSES MAKE VISITS TO BALTIMORE CITY SHELTERS TO

Part VI Supplemental Information

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PROVIDE THE FOLLOWING SERVICES:

1. ADMINISTRATION OF FLU VACCINATIONS TO RESIDENTS
2. PRESENTATIONS ON PARASITES AND INFECTIOUS DISEASE
3. INFECTIOUS DISEASE PREVENTION

THE FORENSIC NURSE EXAMINER PROGRAM (FNE) IS HOUSED AT THE HOSPITAL'S ER AND PROVIDES 24/7 CARE TO PATIENTS WHO ARE VICTIMS OF SEXUAL, DOMESTIC, CHILD, ELDER AND INSTITUTIONAL VIOLENCE. FORENSIC NURSES PROVIDE COMPREHENSIVE FORENSIC MEDICAL INTERVIEWS, MEDICAL ASSESSMENTS, AND EVIDENCE COLLECTION, AND ASSURE CRISIS INTERVENTION TO AN EVER INCREASING VOLUME OF UNDERSERVED PATIENTS.

DURING FY 2011, THE FNE PROGRAM CONDUCTED 554 EXAMINATIONS AND IS THE DESIGNATED SITE FOR PATIENTS IN BALTIMORE CITY.

LOW BIRTH WEIGHT PROGRAM - DEPARTMENT OF OBSTETRICS

Part VI Supplemental Information

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MERCY MEDICAL CENTER DELIVERED MORE BABIES, 2,886 THAN ANY OTHER HOSPITAL

IN BALTIMORE CITY IN FY 2011. OF THESE BABIES, 10.6% WERE OF LOW BIRTH

WEIGHT AND 13.7% WERE PREMATURE. LOW BIRTH WEIGHT AND PREMATUREITY ARE

INTERTWINED AND CORRELATED. AS CITED IN QUESTION #2, LOW BIRTH WEIGHT IS

A KEY HEALTH STATUS INDICATOR THAT IS MEASURED AND TRACKED BY THE

BALTIMORE CITY DEPARTMENT OF HEALTH THAT MUST BE DECREASED IN INCIDENCE.

THE HOSPITAL HAS TAKEN A LEADERSHIP ROLE THROUGH ITS ACTIVE PARTICIPATION

IN "B'MORE FOR HEALTHY BABIES", A LONG TERM INITIATIVE LED BY THE MAYOR'S

OFFICE AND MANAGED BY THE BALTIMORE CITY HEALTH DEPARTMENT TO REDUCE THE

INCIDENTS OF LOW BIRTH WEIGHT. DR. ROBERT ATLAS, CHAIRMAN OF MERCY

MEDICAL CENTER'S DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, HAS A

LEADERSHIP ROLE WITHIN THIS WORKGROUP. THE GOALS OF "B'MORE FOR HEALTHY

BABIES" ARE REDUCTION IN THE FOLLOWING:

1. RATE OF PRE-TERM BIRTHS BY AT LEAST 10%

2. RATE OF LOW BIRTH WEIGHT INFANTS BY AT LEAST 10%

3. THE NUMBER OF DEATHS FROM UNSAFE SLEEP BY AT LEAST 10%

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OF NOTE, 60% OF THE PATIENTS WHO DELIVERED BABIES AT MERCY MEDICAL CENTER
 WERE EITHER MEDICAID BENEFICIARIES OR UNINSURED/SELF PAY. THIS POPULATION
 IS ESPECIALLY LINKED WITH LOW BIRTH RATE AND PREMATUREITY DUE TO POVERTY
 THAT CLOSELY RELATES TO UNHEALTHY LIFESTYLES, PARTICULARLY, POOR
 NUTRITION AND INADEQUATE PRENATAL CARE.

IN ORDER TO ENSURE 24/7 COVERAGE FOR ITS OBSTERICAL PATIENTS, REGARDLESS
 OF THEIR ABLILITY TO PAY, MERCY MEDICAL CENTER PROVIDED \$1,397,137 IN
 PHYSICIAN SUBSIDY FOR THIS SPECIALTY.

DETERMINING THE NEEDS IN THE COMMUNITY TO BE ADDRESSED
 SINCE THE INCEPTION OF COMMUNITY BENEFIT REPORTING TO THE HSCRC, MERCY
 MEDICAL CENTER HAS CONSISTENTLY RANKED AMONG THE TOP FIVE HOSPITALS IN
 THE STATE OF MARYLAND IN TERMS OF THE PERCENTAGE OF OPERATING REVENUE
 DEVOTED TO COMMUNITY NEEDS PROGRAMS.

Part VI Supplemental Information

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

PART VI, QUESTION 5

ACCESS TO CARE FOR AT-RISK, UNDERSERVED POPULATIONS HAS LONG BEEN A
 CORNERSTONE MISSION FOR MERCY MEDICAL CENTER. MAJOR PROGRAMS TO SERVE
 THIS NEED INCLUDE OUR FUNDING OF DIRECT PHYSICIAN CHARITY CARE ACROSS ALL
 SPRECIALTIES AND THE PHARMACY CHARITY FUND TO PATIENTS WHO ARE UNINSURED
 AND UNABLE TO PAY. IN ADDITION, THE FAMILY HEALTH CENTERS OF BALTIMORE
 (FCHB) IS A FEDERALLY QUALIFIED HEALTH CENTER (FQHC), WHICH RECEIVES
 SIGNIFICANT FINANCIAL SUPPORT FROM THE HOSPITAL. FCHB, WITH A CLINIC
 LOCATED ADJACENT TO THE MERCY CAMPUS, LARGELY SERVES THE MEDICAID AND
 UNINSURED POPULATIONS IN SURROUNDING COMMUNITIES.

BASED UPON THE NEEDS ASSESSMENT, MERCY MEDICAL CENTER IDENTIFIED THREE
 KEY AREAS OF FOCUS FOR "MISSION DRIVEN HEALTH SERVICES" IN FY 2011: THEY
 ARE AS FOLLOWS:

HOMELESSNESS: THE NEED TO RESPOND TO AND ACTIVELY SUPPORT THE MEDICAL
 PROFESSIONAL NEEDS OF ORGANIZATIONS THAT SERVE THE HOMELESS POPULATION OF

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BALTIMORE.

EMERGENCY SERVICES: AS PROVIDED THROUGH THE EMERGENCY DEPARTMENT, GIVEN
THE LARGE PERCENTAGE OF POOR AND UNINSURED PATIENTS WHO ACCESS THIS
SERVICE.

LOW BIRTH WEIGHT: MERCY MEDICAL CENTER DELIVERS MORE BABIES TO WOMEN AT
OR BELOW THE POVERTY LINE THAN ANY OTHER HOSPITAL IN BALTIMORE. A
SIGNIFICANT PERCENTAGE (>10%) OF THESE BIRTHS ARE PREMATURE AND OF LOW
BIRTH WEIGHT.

ALL OF THESE PROGRAMS ARE INTERTWINED AS THEY SHARE A COMMON THREAD IN
THAT THE UNDERSERVED AND POOR POPULATIONS OF BALTIMORE ARE THE PRIMARY
RECIPIENTS OF MEDICAL SERVICES PROVIDED BY MERCY MEDICAL CENTER ON AND
OFF ITS CAMPUS.

HOMELESSNESS

Part VI Supplemental Information

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THE NUMBER OF PEOPLE EXPERIENCING HOMELESSNESS HAS GROWN STEADILY OVER
 THE PAST 20 YEARS IN BALTIMORE AND THROUGHOUT THE ENTIRE NATION. THIS
 NUMBER IS EXPECTED TO CONTINUE TO RISE GIVEN THE DETERIORATING ECONOMIC
 CONDITIONS LOCALLY AND NATIONALLY THAT CAUSE HIGH UNEMPLOYMENT, LOSS OF
 HOMES, REDUCED FEDERAL ASSISTANCE TO MEDICAID AND OTHER SAFETY NET
 PROGRAMS. BALTIMORE'S HOMELESS POPULATION EXTENDS GREATLY BEYOND THOSE
 WHO CAN FIND BEDS IN CITY AND OTHER NONPROFIT RUN SHELTERS. MERCY MEDICAL
 CENTER IS DIRECTLY INVOLVED IN THE PROVISION OF MEDICAL SERVICES TO THE
 HOMELESS POPULATION THROUGH THREE AREAS.

HEALTH CARE FOR THE HOMELESS

HEALTH CARE FOR THE HOMELESS (HCH) WAS ESTABLISHED IN 1985 AND PROVIDES
 ADULT, PEDIATRIC, AND GERIATRIC MEDICAL CARE, DENTAL CARE, MENTAL HEALTH,
 HIV SERVICES, SOCIAL WORK AND CASE MANAGEMENT, ADDICTION TREATMENT,
 OUTREACH, PRISON RE-ENTRY, SUPPORTIVE HOUSING, AND ACCESS TO EDUCATION
 AND EMPLOYMENT.

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IN 2011, HCH SAW 17,421 PATIENTS A THREEFOLD INCREASE FROM THE PRIOR YEAR
 PRIMARILY DUE TO ITS NEW LOCATION AND EXPANDED PROGRAMS.

SINCE ITS INCEPTION IN 1985 (A 25-YEAR PARTNERSHIP), MERCY MEDICAL CENTER
 HAS DIRECTLY EMPLOYED AND PROVIDED ALL OF THE PHYSICIAN AND NURSING STAFF
 TO HCH FOR MEDICAL SERVICES. WHILE THE HOSPITAL IS REIMBURSED FOR THE
 DIRECT COSTS OF ITS EMPLOYED CLINICIANS FROM HCH, INDIRECT AND OTHER NON
 COMPENSATED COSTS CONTRIBUTED TO HCH WERE \$1,297,938 IN FY 2011.

THE HOSPITAL EMPLOYS AND PROVIDES FOUR PRIMARY CARE PHYSICIANS, TWO NURSE
 PRACTITIONERS, ONE PHYSICIAN ASSISTANT, AND THREE REGISTERED NURSES TO
 WORK AT HCH.

MERCY MEDICAL CENTER, THROUGH ITS SOLE MEMBER, MHS, IS GOVERNED BY A
 COMMUNITY BOARD COMPRISED OF CIVIC LEADERS WHO ARE COMMITTED TO AND
 REPRESENT THE HEALTHCARE NEEDS OF THE COMMUNITY. MERCY MEDICAL CENTER
 EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS FOR ALL OF
 ITS DEPARTMENTS. ALL FINANCIAL SURPLUSES MERCY MEDICAL CENTER GENERATES

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ARE USED EXCLUSIVELY TO FURTHER THE MISSION OF THE ORGANIZATION.

MERCY SUPPORTIVE HOUSING PROGRAM

THE SUPPORTIVE HOUSING PROGRAM AT MERCY MEDICAL CENTER HAS A STAFF OF
EIGHT EXPERIENCED HUMAN SERVICES PERSONNEL WHO WORK IN CONJUNCTION WITH
OTHER HOMELESS AND HUMAN SERVICE PROVIDERS TO COORDINATE SERVICES FOR
HOMELESS FAMILIES AND FAMILIES AT RISK FOR HOMELESSNESS. THE PROGRAM'S
GOAL IS TO HOUSE HOMELESS FAMILIES AND TO PROVIDE SUPPORTIVE SERVICES FOR
A DEFINED PERIOD TO PREVENT A RETURN TO HOMELESSNESS.

IN FY 2011, THE SUPPORTIVE HOUSING PROGRAM AT MERCY PROVIDED A
COMPREHENSIVE RANGE COUNSELING SERVICES AND COMMUNITY RESOURCE LINKAGES
TO 207 CLIENTS. THESE SERVICES INCURRED DIRECT COSTS OF \$477,629 DURING
FY 2011, OR ABOUT \$3,000 PER CLIENT.

MERCY FAMILY VIOLENCE RESPONSE PROGRAM

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 (DOMESTIC VIOLENCE, CHILD ABUSE, ELDER AND VULNERABLE ADULT ABUSE) AND
 SEXUAL ASSAULT WHO COME TO MERCY MEDICAL CENTER AND ITS PHYSICIANS FOR
 TREATMENT.

THIS PROGRAM IMPROVES BALTIMORE'S COORDINATED COMMUNITY RESPONSE TO
 VICTIMS OF VIOLENCE, AND CREATES AN ALERT WORKFORCE AT MERCY MEDICAL
 CENTER, SKILLED AT IDENTIFYING AND RESPONDING TO VICTIMS OF FAMILY
 VIOLENCE.

AFFILIATED HEALTH CARE SYSTEM

PART VI, QUESTION 6

KEY MERCY HEALTH SERVICES (MHS) PARTNERSHIPS/WORK GROUPS

MERCY MEDICAL CENTER IS A PART OF AN AFFILIATED HEALTH CARE SYSTEM, WHICH
 INCLUDES A NUMBER OF ORGANIZATIONS THAT ARE UNDER THE COMMON GOVERNANCE

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

OF MERCY HEALTH SERVICES. THESE AFFILIATED ORGANIZATIONS WORK TOGETHER
 TO PROVIDE A RANGE OF HEALTHCARE SERVICES TO THEIR COMMUNITIES. AMONG
 MERCY MEDICAL CENTER'S AFFILIATES ARE SAINT PAUL PLACE SPECIALISTS, INC.
 ("SPPS), MARYLAND FAMILY CARE, INC. ("MFC"), AND STELLA MARIS, INC.
 ("SM"). SPPS PROVIDES SPECIALTY PHYSICIAN SERVICES TO PATIENTS OF MERCY
 MEDICAL CENTER'S INPATIENT SERVICES AND OUTPATIENT CLINICS AND TO OTHER
 MEMBERS OF THE COMMUNITY THROUGHOUT CENTRAL MARYLAND AND BEYOND. DURING
 THE 2010 TAX YEAR, SPPS PROVIDED SEVERAL COMMUNITY BENEFIT ACTIVITIES.
 FIRST, SPPS PROVIDED \$1,926,771 OF CHARITY CARE TO PATIENTS SEEN BY SPPS
 PHYSICIANS. SECOND, SPPS INCURRED DIRECT AND INDIRECT UNREIMBURSED COSTS
 OF \$3,458,657 AS A RESULT OF PROVIDING PHYSICIAN SERVICES TO PATIENTS IN
 THE EMERGENCY DEPARTMENT OF MERCY MEDICAL CENTER. THIRD, SPPS PROVIDES
 AN ANTEPARDUM DIAGNOSTIC PHYSICIAN SUBSIDY WITH A NET COST OF \$6,658 TO
 SPPS. FINALLY, SPPS PHYSICIANS UNDERTAKE DISEASE AND PREVENTION RESEARCH
 AT AN UNREIMBURSED COST TO SPPS OF \$583,985.

SM OWNS AND OPERATES A NURSING HOME, A RESIDENTIAL AND HOME HOSPICE
 SERVICE AND A HOME HEALTH AGENCY. DURING THE 2010 TAX YEAR, SM PROVIDED

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

\$471,000 OF CHARITY CARE TO ITS PATIENTS. MFC PROVIDES PRIMARY CARE

SERVICES ON THE CAMPUS OF MERCY MEDICAL CENTER, THROUGHOUT BALTIMORE

CITY, AND IN ANNE ARUNDEL AND BALTIMORE COUNTIES. ADDITIONALLY, MFC

EMPLOYS A NUMBER OF PHYSICIANS TO SERVE AS HOSPITALS, WHO CARE FOR

PATIENTS ADMITTED TO MERCY MEDICAL CENTER. DURING THE 2010 TAX YEAR, MFC

PROVIDED \$81,116 OF CHARITY CARE TO PATIENTS SEEN BY MMC PHYSICIANS.

GROUP NAME: HEALTH CARE FOR THE HOMELESS

PURPOSE AND MMC PARTICIPATION: HCH PROVIDES HEALTH-RELATED SERVICES TO

REDUCE THE INCIDENCE AND BURDENS OF HOMELESSNESS. ITS HEADQUARTERS/CLINIC

IS LOCATED THREE BLOCKS FROM MERCY. CATHERINE KELLY, DIRECTOR OF

COMMUNITY OUTREACH AT MERCY, SERVES ON THE HCH BOARD OF DIRECTORS.

GROUP NAME: BALTIMORE HOMELESS SERVICES

PURPOSE AND MMC PARTICIPATION: A PROGRAM WITHIN THE MAYOR'S OFFICE OF

HUMAN SERVICES RESPONSIBLE FOR MANAGING THE CONTINUUM OF CARE OF PROVIDED

TO THE CITY'S HOMELESS POPULATION. MERCY SUPPORTIVE HOUSING PROGRAM

PROVIDES HOUSING COUNSELING AND CASE MANAGEMENT FOR HOMELESS FAMILIES

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

UNDER GRANTS FROM THIS AGENCY.

GROUP NAME: THE WEINBERG HOUSING AND RESOURCE CENTER

PURPOSE AND MMC PARTICIPATION: BALTIMORE CITY'S FACILITY PROVIDING 274

EMERGENCY SHELTER BEDS AND 25 BEDS FOR THE MEDICALLY FRAGILE AS WELL AS

PROGRAMS AND SERVICES FOR THE HOMELESS. MERCY EMPLOYEES ASSIST WITH THE

PROGRAM.

GROUP NAME: MAYOR'S OFFICE ON EMERGENCY MANAGEMENT

PURPOSE AND MMC PARTICIPATION: MERCY SERVES ON THE EMERGENCY PREPAREDNESS

TASK FORCE FOR BALTIMORE CITY.

GROUP NAME: SEX AND FAMILY CRIMES DIVISION OF THE BALTIMORE CITY POLICE

DEPARTMENT

PURPOSE AND MMC PARTICIPATION: MERCY'S FORENSIC NURSE EXAMINER PROGRAM

WORKS COLLABORATIVELY WITH THE BALTIMORE CITY POLICE DEPARTMENT. MERCY

PROVIDES THE FORENSIC NURSE EXAMINER PROGRAM IN THE METROPOLITAN AREA.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
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- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

GROUP NAME: TURN AROUND, HOUSE OF RUTH

PURPOSE AND MMC PARTICIPATION: MERCY'S FAMILY VIOLENCE RESPONSE PROGRAM

WORKS WITH TURN AROUND, HOUSE OF RUTH, AND OTHER ORGANIZATIONS. MERCY

ALSO IS TAKING A LEADERSHIP ROLE IN ESTABLISHING HOSPITAL-BASED FAMILY

VIOLENCE RESPONSE PROGRAMS AT OTHER MARYLAND HOSPITALS.

GROUP NAME: FAMILY CRISIS CENTER OF BALTIMORE (FCCB)

PURPOSE AND MMC PARTICIPATION: FCCB IS A MAJOR REFERRAL PARTNER TO MERCY'S

FORENSIC NURSE EXAMINER AND SUPPORTIVE HOUSING PROGRAMS.

GROUP NAME: DOMESTIC VIOLENCE COORDINATING COUNCIL

PURPOSE AND MMC PARTICIPATION: COLLEEN MOORE, COORDINATOR OF MERCY'S

FAMILY VIOLENCE RESPONSE PROGRAM, SERVES ON THE ORGANIZATION'S STEERING

COMMITTEE.

GROUP NAME: B'MORE FOR HEALTHY BABIES (BHB)

PURPOSE AND MMC PARTICIPATION: BHB IS A COALITION OF PHYSICIANS AMONG

BALTIMORE CITY'S MAJOR HOSPITALS THAT ADDRESSES WAYS TO REDUCE INFANT

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

MORTALITY, PREMATUREITY AND LOW BIRTH WEIGHT. ROBERT ATLAS, M.D., CHAIRMAN
 OF THE DEPARTMENT OF OBSTETRICS AND GYNECOLOGY AT MERCY AND A RECOGNIZED
 EXPERT IN AT-RISK PREGNANCY IS A LEADER WITHIN BHB.

GROUP NAME: FAMILY HEALTH CENTERS OF BALTIMORE (FCHB)
 PURPOSE AND MMC PARTICIPATION: SAMUEL MOSKOWITZ, MERCY'S EXECUTIVE VICE
 PRESIDENT AND CHIEF OPERATING OFFICER SERVES ON THE BOARD OF DIRECTORS OF
 FCHB, A FEDERALLY QUALIFIED HEALTH CENTER THAT SERVES CENTRAL AND SOUTH
 BALTIMORE CITY.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
 ▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.
 ▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
52-0591658

Part I Questions Regarding Compensation

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

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

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

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

3 Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director. Check all that apply.

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

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

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

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

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

- a** The organization?
- b** Any related organization?
- 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?
- b** Any related organization?
- 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

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

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

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

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

Schedule J (Form 990) 2010

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

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

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

	(A) Name	(B) Breakdown of W-2 and/or 1099-MISC compensation:			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	THOMAS MULLEN	(i) 0.	(ii) 0.	(iii) 0.	11,025.	0.	0.	262,774.
		723,183.	106,500.	423,276.	11,025.	0.	1,286,223.	521,363.
2	AMY FREEMAN	(i) 108,941.	(ii) 0.	(iii) 525,701.	0.	0.	641,377.	0.
		458,879.	46,200.	772,763.	7,350.	0.	1,309,413.	703,350.
3	SAMUEL MOSKOWITZ	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
		370,785.	37,300.	56,039.	11,025.	0.	497,130.	0.
4	SCOTT SPIER MD	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
		361,341.	35,500.	53,502.	7,350.	0.	478,358.	0.
5	JOHN TOPPER	(i) 303,860.	(ii) 23,250.	(iii) 96,575.	7,350.	0.	442,492.	0.
		285,987.	20,700.	67,933.	7,350.	0.	385,678.	16,233.
7	JUDITH WEILAND	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
		274,263.	20,775.	291,575.	11,025.	0.	618,303.	250,675.
8	ROBERT EDWARDS	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
		247,153.	29,400.	8,000.	14,700.	0.	326,288.	0.
9	JAMES LEVY MD	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
		463,163.	195,023.	0.	8,683.	0.	690,340.	0.
10	WILMA A S ROWE MD	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
		225,393.	16,875.	36,814.	10,229.	0.	309,959.	0.
11	GARY MICHAEL	(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
12		(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
13		(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
14		(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
15		(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.
16		(i) 0.	(ii) 0.	(iii) 0.	0.	0.	0.	0.

Part III Supplemental Information

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

NONQUALIFIED RETIREMENT PLAN

SCH J LINE 4B

THE CORPORATION MAINTAINED A NONQUALIFIED PLAN OF DEFERRED COMPENSATION FOR CERTAIN EMPLOYEES. THE PLAN ONLY PERMITTED DEFERRALS (THAT IS, NO CONTRIBUTIONS WERE MADE BY THE CORPORATION). DUE TO THE CHANGES IN TAX LAWS, THE PLAN WAS TERMINATED AND PARTICIPATING EMPLOYEES ARE BEING PAID AND TAXED ON THE WITHDRAWALS FROM THEIR ACCOUNTS. SCHEDULE J REPORTS THE AMOUNTS DISTRIBUTED, WHICH AMOUNTS WERE REFLECTED AS CONTRIBUTIONS IN PRIOR PERIODS. THE FOLLOWING INDIVIDUALS RECEIVED DISTRIBUTIONS FROM THE

NONQUALIFIED DEFERRED COMPENSATION PLAN IN THE FOLLOWING AMOUNTS:

THOMAS MULLEN	\$262,774
SAMUEL MOSKOWITZ	\$703,350
AMY FREEMAN	\$521,363
JUDITH WEILAND	\$ 16,233
ROBERT EDWARDS	\$250,675

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.

NON-FIXED PAYMENTS

SCH J LINE 7

THE COMPENSATION COMMITTEE APPROVES NON-FIXED PAYMENTS FOR MANAGEMENT BASED ON THE DEGREE OF MEETING CORPORATE PRIORITIES ESTABLISHED BY THE BOARD OF TRUSTEES. THE CORPORATE OBJECTIVES ARE DESIGNED TO ADVANCE THE ORGANIZATION IN THE AREAS OF QUALITY CARE, PATIENT SAFETY, PATIENT SATISFACTION, BUSINESS DEVELOPMENT AND FINANCIAL STRENGTH.

CEO'S COMPENSATION

SCHEDULE J, LINES 1 - 3

THE ORGANIZATION RELIED ON A RELATED ORGANIZATION AND THAT RELATED ORGANIZATION USED THE FOLLOWING METHODS TO ESTABLISH THE TOP MANAGEMENT

OFFICIAL COMPENSATION:

- 1) COMPENSATION COMMITTEE
- 2) INDEPENDENT COMPENSATION CONSULTANT
- 3) COMPENSATION SURVEY OR STUDY
- 4) APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE

**SCHEDULE K
(Form 990)**

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

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

OMB No. 1545-0047

2010

Open to Public
Inspection

Name of the organization
MERCY MEDICAL CENTER
Employer identification number
52-0591658

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Deceased		(h) On behalf of issuer		(i) Pooled Financing	
						Yes	No	Yes	No	Yes	No
A MARYLAND HEALTH & HIGHER EDUCATIONAL FAC AUTHORITY	52-0936091	574217XX8	08/03/2006	35,000,000.	2006 REPLACEMENT GARAGE AND RO		X		X		X
B MARYLAND HEALTH & HIGHER EDUCATIONAL FAC AUTHORITY	52-0936091	574217L29	11/08/2007	155,000,000.	2007 A REPLACEMENT TOWER AND R		X		X		X
C MARYLAND HEALTH & HIGHER EDUCATIONAL FAC AUTHORITY	52-0936091	574217L45	11/08/2007	150,000,000.	2007 B C D REPLACEMENT PATIENT		X		X		X
D MARYLAND HEALTH & HIGHER EDUCATIONAL FAC AUTHORITY	52-0936091	574217Y41	07/16/2008	35,325,000.	2008 REFUNDING OF 2003 BONDS		X		X		X

Part II Proceeds

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Amount of bonds retired		1,090,000.		2,500,000.		100,000,000.		33,340,000.
2 Amount of bonds legally defeased								
3 Total proceeds of issue		35,952,865.		170,176,129.		155,267,784.		35,457,518.
4 Gross proceeds in reserve funds				12,557,037.				
5 Capitalized interest from proceeds		1,492,333.		18,613,677.		10,489,674.		
6 Proceeds in refunding escrows				8,812,500.				
7 Issuance costs from proceeds		330,107.		1,508,050.		896,739.		387,518.
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds		34,130,425.		128,742,923.		143,880,161.		
11 Other spent proceeds				0.				35,070,000.
12 Other unspent proceeds								
13 Year of substantial completion		2008		2010		2010		2008
14 Were the bonds issued as part of a current refunding issue?	Yes	No	Yes	No	Yes	No	Yes	No
15 Were the bonds issued as part of an advance refunding issue?		X		X		X		X
16 Has the final allocation of proceeds been made?		X		X		X		X
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?		X		X		X		X

Part III Private Business Use

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		X
2 Are there any lease arrangements that may result in private business use of bond-financed property?	X		X		X		X	

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

**SCHEDULE K
(Form 990)**

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

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

OMB No. 1545-0047

2010

Open to Public
Inspection

Name of the organization
MERCY MEDICAL CENTER
Employer identification number
52-0591658

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled Financing	
						Yes	No	Yes	No	Yes	No
A MARYLAND HEALTH & HIGHER EDUCATIONAL FAC AUTHORITY	52-0936091	5742174Z5	12/16/2009	30,000,000.	2009 PARTIAL CONVERSION 2008 BONDS		X		X		X
B MARYLAND HEALTH & HIGHER EDUCATIONAL FAC AUTHORITY	52-0936091	5742176K6	04/01/2010	30,000,000.	2010 PARTIAL CONVERSION 2007 BONDS		X		X		X
C MARYLAND HEALTH & HIGHER EDUCATIONAL FAC AUTHORITY	52-0936091	574218AM5	02/11/2011	40,770,000.	2011 BONDS REFUNDING 2007 B AND C		X		X		X
D MARYLAND HEALTH & HIGHER EDUCATIONAL FAC AUTHORITY	52-0936091		06/09/2011	34,890,000.	2011 B BONDS REFUNDING 2007 B AND C		X		X		X

Part II Proceeds

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Amount of bonds retired								
2 Amount of bonds legally defeased								
3 Total proceeds of issue		30,000,000.		30,000,000.		39,509,163.		34,890,000.
4 Gross proceeds in reserve funds						4,875,902.		
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows						409,830.		
7 Issuance costs from proceeds								
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds								
11 Other spent proceeds		30,000,000.		30,000,000.		35,110,419.		34,890,000.
12 Other unspent proceeds								
13 Year of substantial completion		2008		2011		2011		2011
14 Were the bonds issued as part of a current refunding issue?	X		X		X		X	
15 Were the bonds issued as part of an advance refunding issue?		X		X		X		X
16 Has the final allocation of proceeds been made?	X		X		X		X	
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III Private Business Use

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		X
2 Are there any lease arrangements that may result in private business use of bond-financed property?	X		X		X		X	

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

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X		X		X	
b Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
c Does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts or research agreements relating to the financed property?	X		X		X		X	
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government.		0.0000 %		0.0000 %		0.0000 %		0.0000 %
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government.		0.0000 %		0.0000 %		0.0000 %		0.0000 %
6 Total of lines 4 and 5		0.0000 %		0.0000 %		0.0000 %		0.0000 %
7 Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?	X		X		X		X	

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has a Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate, been filed with respect to the bond issue?		X		X		X		X
2 Is the bond issue a variable rate issue?		X		X		X		X
3a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X		X		X		X	
b Name of provider.		MERRILL LYNCH		MERRILL LYNCH		MERRILL LYNCH		MERRILL LYNCH
c Term of hedge.		30.000		30.000		35.000		35.000
d Was the hedge superintegrated?								
e Was the hedge terminated?								
4a Were gross proceeds invested in a GIC?		X		X		X		X
b Name of provider.				GE FUNDING		GE FUNDING		GE FUNDING
c Term of GIC.				4.250		2.000		2.000
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?			X		X		X	
5 Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
6 Did the bond issue qualify for an exception to rebate?	X			X		X		X

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

SCHEDULE K
 BOND ISSUE A - 2006 REPLACEMENT GARAGE - BOND ISSUE OF \$35,000,000
 RESULTED IN TOTAL PROCEEDS OF \$35,952,865 AS A RESULT OF INVESTMENT
 EARNINGS OF \$952,865.

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?								
b Are there any research agreements that may result in private business use of bond-financed property?								
c Does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts or research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government.		%		%		%		%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government.		%		%		%		%
6 Total of lines 4 and 5		%		%		%		%
7 Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?								

Part IV Arbitrage

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

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

BOND ISSUE B - 2007 REPLACEMENT TOWER - BOND ISSUE OF \$155,000,000 RESULTED IN TOTAL PROCEEDS OF \$170,176,129 AS A RESULT OF INVESTMENT EARNINGS OF \$15,176,129.

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3 a Are there any management or service contracts that may result in private business use of bond-financed property?								
b Are there any research agreements that may result in private business use of bond-financed property?								
c Does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts or research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government.		%		%		%		%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government.		%		%		%		%
6 Total of lines 4 and 5		%		%		%		%
7 Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?								

Part IV Arbitrage

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

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

BOND ISSUE C - 2007 B,C&D REPLACEMENT TOWER - BOND ISSUE OF \$150,000,000
 RESULTED IN TOTAL PROCEEDS OF \$155,268,784 AS A RESULT OF INVESTMENT EARNINGS OF \$5,267,784.

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?								
b Are there any research agreements that may result in private business use of bond-financed property?								
c Does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts or research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government.		%		%		%		%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government.		%		%		%		%
6 Total of lines 4 and 5		%		%		%		%
7 Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?								

Part IV Arbitrage

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

Part V Supplemental Information. Complete this part to provide additional information for responses to questions on Schedule K (see instructions).
 BOND ISSUE D - 2008 REFUNDING OF 2003 BONDS - BOND ISSUE OF \$35,457,518
 AS A RESULT OF \$132,518 CARRIED FORWARD FROM THE 2003 SINKING FUND.

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X		X		X	
b Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
c Does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts or research agreements relating to the financed property?	X		X		X		X	
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government.		.5000 %		0.0000 %				%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government.		.1000 %		0.0000 %				%
6 Total of lines 4 and 5		.6000 %		0.0000 %				%
7 Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?	X		X		X		X	

Part IV Arbitrage

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

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

**SCHEDULE M
(Form 990)**

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶ **Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.**
▶ **Attach to Form 990.**

OMB No. 1545-0047

2010

**Open To Public
Inspection**

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
52-0591658

Part I Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art				
2 Art - Historical treasures				
3 Art - Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property	X	1.	1,794,963.	COST SAVINGS
9 Securities - Publicly traded				
10 Securities - Closely held stock				
11 Securities - Partnership, LLC, or trust interests				
12 Securities - Miscellaneous				
13 Qualified conservation contribution - Historic structures				
14 Qualified conservation contribution - Other				
15 Real estate - Residential				
16 Real estate - Commercial				
17 Real estate - Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (_____)				
26 Other ▶ (_____)				
27 Other ▶ (_____)				
28 Other ▶ (_____)				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement **29**

	Yes	No
30 a During the year, did the organization receive by contribution any property reported in Part I, line 1-28 that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?		X
b If "Yes," describe the arrangement in Part II.		
31 Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?		X
32 a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?		X
b If "Yes," describe in Part II.		
33 If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.		

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule M (Form 990) (2010)

Part II **Supplemental Information.** Complete this part to provide the information required by Part I, lines 30b, 32b, and 33. Also complete this part for any additional information.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

MERCY MEDICAL CENTER

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2010

**Open to Public
Inspection**

Employer identification number

52-0591658

DESCRIPTION OF 990 REVIEW PROCESS

PART VI, LINE 11

MERCY HEALTH SERVICES, INC. ("MHS), THE SOLE PARENT OF THE CORPORATION, HAS A POLICY WHICH REQUIRES THE CORPORATION'S 990 TO BE MADE AVAILABLE FOR REVIEW BY THE MHS BOARD AND/OR THE MHS BOARD EXECUTIVE COMMITTEE PRIOR TO ITS FILING. AT ITS MARCH 21, 2012 MEETING, MHS BOARD EXECUTIVE COMMITTEE MEMBERS RECEIVED A COPY OF THE CORPORATION'S DRAFT FORM 990. THE MHS CFO PROVIDED A POWER POINT PRESENTATION REGARDING THE DRAFT AND THERE WAS AN OPPORTUNITY FOR QUESTIONS AND DISCUSSION. FOLLOWING FURTHER REVISION OF THE DRAFT 990 AND PRIOR TO ITS FILING, IT WAS MADE AVAILABLE IN FINAL FORM TO ALL MEMBERS OF THE MHS BOARD AND THE CORPORATION'S BOARD.

CONFLICTS OF INTEREST MONITORING AND ENFORCEMENT

PART VI, LINE 12C

MHS HAS A WRITTEN CONFLICT OF INTEREST POLICY THAT COVERS MHS AND ALL OF ITS DIRECT AND INDIRECT SUBSIDIARIES. THE INDIVIDUALS COVERED UNDER THE POLICY INCLUDE ALL TRUSTEES, DIRECTORS, OFFICERS (INCLUDING ALL SENIOR AND EXECUTIVE VICE PRESIDENTS) AND MEMBERS OF ANY COMMITTEE WITH BOARD-DELEGATED POWERS. UNDER THE POLICY, EACH SUCH PERSON IS REQUIRED TO COMPLETE AN ANNUAL DISCLOSURE FORM REGARDING BUSINESS RELATIONSHIPS THAT HE OR SHE, OR ANY FAMILY MEMBER, HAS WITH ANY OTHER ORGANIZATION THAT DOES BUSINESS WITH MHS OR ITS SUBSIDIARIES AND RELATIONSHIPS BETWEEN AND AMONG OFFICERS, TRUSTEES AND DIRECTORS. THE COMPLETED DISCLOSURE FORMS

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MERCY MEDICAL CENTER

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ARE REVIEWED BY THE MHS BOARD CHAIR AND BY THE MHS CEO OR A DESIGNEE.

IN ADDITION TO THE ANNUAL DISCLOSURE, ANY PERSON WHO IS COVERED BY THE CONFLICT OF INTEREST POLICY HAS AN ONGOING OBLIGATION TO DISCLOSE THE EXISTENCE OF ANY ACTUAL OR POTENTIAL CONFLICT TO THE BOARD OR THE BOARD COMMITTEE IN WHICH THE MATTER ARISES. FOLLOWING THE DISCLOSURE, THE PERSON MAY MAKE A PRESENTATION, BUT MUST THEN LEAVE THE MEETING AND THE OTHER MEMBERS OF THE BOARD OR COMMITTEE SHALL DETERMINE WHETHER A CONFLICT EXISTS. UNDER THE POLICY, A CONFLICT OF INTEREST EXISTS WHEN AN INDIVIDUAL'S OWN PERSONAL INTEREST WOULD, OR MAY, INTERFERE WITH HIS OR HER IMPARTIALITY REGARDING THE MATTER. IF A CONFLICT EXISTS, THE PERSON MAY NOT BE PRESENT DURING DELIBERATIONS ON THE MATTER OR VOTE ON IT. THE BOARD OR COMMITTEE, AFTER CONDUCTING SUCH ADDITIONAL DUE DILIGENCE AS IT DETERMINES IS APPROPRIATE, SHALL MAKE A DECISION ON THE MATTER BASED UPON WHETHER THE PARTICULAR PROPOSAL IS FAIR, REASONABLE AND IN THE BEST INTEREST OF THE ORGANIZATION.

PROCESS OF DETERMINING COMPENSATION

PART VI, LINE 15

THE ORGANIZATION'S BOARD HAS ADOPTED A COMPENSATION POLICY (THE "POLICY") FOR COVERED INDIVIDUALS. PURSUANT TO THE POLICY, A COMPENSATION COMMITTEE OF INDEPENDENT DIRECTORS OF THE BOARD OF THE ORGANIZATION'S PARENT CORPORATION WAS ESTABLISHED TO REVIEW THE COMPENSATION OF ALL EMPLOYEES SPECIFIED AS HAVING A SUBSTANTIAL INFLUENCE OVER THE ORGANIZATION AND WHO RECEIVE REMUNERATION FROM THE ORGANIZATION. THE COMPENSATION COMMITTEE IS ADVISED BY AN INDEPENDENT COMPENSATION

Name of the organization MERCY MEDICAL CENTER	Employer identification number 52-0591658
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CONSULTANT, WHICH OPINES TO THE COMPENSATION COMMITTEE THAT THE LEVEL OF COMPENSATION PAID AND THE PROCESS BY WHICH COMPENSATION IS ESTABLISHED MEET APPLICABLE IRS REASONABLENESS AND "SAFE HARBOR" STANDARDS. THE OUTSIDE COMPENSATION CONSULTANT PROVIDES DATA OF COMPENSATION PROVIDED AT SIMILAR ORGANIZATIONS TO ENSURE THAT THE ORGANIZATION DOES NOT COMPENSATE IN EXCESS OF MARKET NORMS. MERCY HEALTH SERVICES, INC. (THE CORPORATION'S SOLE MEMBER) HAS A WRITTEN POLICY REGARDING THE REVIEW OF PHYSICIAN COMPENSATION TITLED "AMENDED AND RESTATED PHYSICIAN COMPENSATION REVIEW." THE POLICY APPLIES TO ALL MHS SUBSIDIARIES, INCLUDING THE CORPORATION, AND IT SETS OUT THE PROCESS AND PROCEDURES FOR ENSURING THAT PHYSICIAN COMPENSATION IS APPROPRIATELY REVIEWED AND DETERMINED TO BE CONSISTENT WITH FAIR MARKET VALUE. UNDER THE POLICY THE REVIEW AND DETERMINATION MUST BE DOCUMENTED IN WRITING. THE POLICY ADDRESSES INTERNAL REVIEWS THROUGH BENCHMARKING OF PHYSICIAN COMPENSATION AGAINST NATIONALLY RECOGNIZED COMPENSATION SURVEY DATA, THE USE OF INDEPENDENT COMPENSATION CONSULTANTS AND REVIEW BY THE MHS BOARD COMPENSATION COMMITTEE. THE POLICY FURTHER REQUIRES THAT ALL COMPENSATION REVIEWS BE PERFORMED IN ACCORDANCE WITH THE MHS CONFLICT OF INTEREST POLICY.

DOCUMENT AVAILABILITY

PART VI, LINE 19

THE GOVERNING DOCUMENTS OF THE ORGANIZATION, ITS CONFLICTS OF INTEREST POLICY, AND ITS FINANCIAL STATEMENTS ARE AVAILABLE FROM THE ORGANIZATION UPON REQUEST.

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MERCY MEDICAL CENTER

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AUDITS

PART XI, QUESTIONS 2 AND 3

MERCY HEALTH SYSTEM, INC. AND ITS SUBSIDIARIES INCLUDING THE ORGANIZATION FILING THIS FORM 990, UNDERGO A CONSOLIDATED AUDIT OF THEIR FINANCIAL STATEMENT THAT COMPLIES WITH SINGLE AUDIT ACT/OMB CIRCULAR A-133 REQUIREMENTS DUE TO THE EXPENDITURE OF FEDERAL AWARDS. THE ACCOUNTING FIRM OF COHEN, RUTHERFORD + KNIGHT P.C. HAS ISSUED AN UNQUALIFIED OPINION REGARDING THE CONSOLIDATED FINANCIAL STATEMENTS IN CONFORMANCE WITH GENERALLY ACCEPTED AUDIT STANDARDS AND THE SINGLE AUDIT ACT/OMB CIRCULAR A-133 REQUIREMENTS FOR THE FISCAL YEAR THAT CORRESPONDS TO THE TAX REPORTING YEAR GOVERNED BY THIS FORM 990.

PART VI, LINE 1B

MERCY HEALTH SERVICES, INC. ("MHS"), A 501(C)(3) CORPORATION, IS THE SOLE MEMBER OF MERCY MEDICAL CENTER, INC. ("MMC"). MHS IS GOVERNED BY A 28-PERSON BOARD OF TRUSTEES, OF WHOM 21 ARE INDEPENDENT BOARD MEMBERS. THE BOARD OF DIRECTORS OF MMC IS CURRENTLY MADE OF 7 DIRECTORS. THE PRESIDENT OF MHS SERVES AS AN EX OFFICIO MEMBER OF MMC'S BOARD AND THE BALANCE OF THE MMC BOARD MEMBERS ARE ELECTED BY, AND SUBJECT TO REMOVAL BY, THE BOARD OF TRUSTEES OF MHS. ONE OF THE MEMBERS OF THE MFC BOARD IS INDEPENDENT. SEVEN OF THE BOARD MEMBERS ARE COMPENSATED AS EMPLOYEES EITHER OF MFC OR A RELATED ORGANIZATION LISTED IN SCHEDULE R, PART II.

PART VI, LINE 6

MHS IS THE SOLE MEMBER OF MMC.

Name of the organization
MERCY MEDICAL CENTER

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52-0591658

PART VI, LINE 7A

THE PRESIDENT OF MHS SERVES AS AN EX OFFICIO VOTING MEMBER OF THE BOARD OF DIRECTORS OF MMC. AS THE MEMBER OF MMC, THE BOARD OF TRUSTEES OF MHS ELECTS ALL OF THE OTHER MEMBERS OF THE BOARD OF MMC. ALL OF THE MEMBERS OF THE MMC BOARD SERVE AT THE PLEASURE OF THE BOARD OF TRUSTEES OF MHS AND ARE SUBJECT TO REMOVAL BY THE MHS BOARD.

PART VI, LINE 7B

THE BOARD OF TRUSTEES OF MHS EXERCISES AUTHORITY OVER MMC THROUGH ITS RIGHT TO APPOINT AND REMOVE MMC BOARD MEMBERS.

IN ADDITION, MHS, AS THE MEMBER, IS RESPONSIBLE FOR THE FOLLOWING ACTIONS:

- A) TO APPOINT MEMBERS TO MMC'S BOARD OF DIRECTORS;
- B) TO REVIEW AND APPROVE OR DISAPPROVE THE STRATEGIC PLAN, ANNUAL BUDGET AND THE ANNUAL OPERATING GOALS AND OBJECTIVES OF MMC AS RECOMMENDED TO MHS BY MMC'S BOARD OF DIRECTORS;
- C) TO EVALUATE THE PERFORMANCE OF MMC'S BOARD OF DIRECTORS, OFFICERS, AND OPERATING MANAGEMENT;
- D) TO REMOVE BOARD MEMBERS OF MMC IN ITS DISCRETION AT ANY TIME;
- E) TO APPROVE THE MISSION AND VISION THAT GOVERN MMC'S OPERATIONS;
- F) TO HAVE ULTIMATE RESPONSIBILITY FOR MMC'S QUALITY ASSURANCE, PERFORMANCE IMPROVEMENT, UTILIZATION REVIEW AND RISK MANAGEMENT; AND
- G) TO APPOINT, REAPPOINT AND TAKE ANY CORRECTIVE ACTION RELATED TO THE MEDICAL STAFF OF MMC (THE "MEDICAL STAFF") IN ACCORDANCE WITH THE

Name of the organization
MERCY MEDICAL CENTER

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MEDICAL STAFF BYLAWS OF MMC.

THE FOLLOWING ACTIONS REQUIRE THE APPROVAL OF AND AFFIRMATIVE CORPORATE ACTION BY MHS:

- A) ANY DISPOSITION OF ALL OR SUBSTANTIALLY ALL OF MMC'S ASSETS, DISSOLUTION, LIQUIDATION, WINDING UP OR ABANDONMENT OF MMC;
- B) ANY AMENDMENT OF THE ARTICLES OF INCORPORATION OR BYLAWS OF MMC OR OF THE MEDICAL STAFF BYLAWS OF MMC;
- C) ANY BORROWING OR LENDING BY MMC OR THE ISSUANCE OF ANY GUARANTEE BY MMC IN AN AMOUNT IN EXCESS OF AN AMOUNT SPECIFIED BY MHS FROM TIME TO TIME;
- D) ANY MERGER, CONSOLIDATION OR INSTITUTIONAL AFFILIATION WITH ANY OTHER CORPORATION OR OTHER ENTITY; AND
- E) THE PURCHASE OR SALE OF ASSETS FOR AN AMOUNT IN EXCESS OF AN AMOUNT SPECIFIED FROM TIME TO TIME BY MHS.

ULTIMATELY, THE CORPORATION IS CONTROLLED BY MHS'S 26-PERSON COMMUNITY BOARD, WHICH INCLUDES 21 INDEPENDENT DIRECTORS AS NOTED ABOVE.

OTHER CHANGES TO NET ASSETS

PART XI, LINE 5

UNREALIZED GAIN	\$ 6,015,986
INTEREST RATE SWAP	9,811,012
NET ASSETS RELEASED FOR CAPITAL EXP	950,110
CONTRIBUTIONS	(8,879,019)

Name of the organization MERCY MEDICAL CENTER	Employer identification number 52-0591658
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MHF NET BENEFIT	(944,974)
CHANGES TO POST RETIREMENT	
PLAN OBLIGATIONS	200,158

TOTAL	\$ 7,153,273

ATTACHMENT 1FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

MERCY IS DEDICATED TO CARRYING FORWARD THE 136 - YEAR TRADITION OF THE SISTER'S HEALING MINISTRY IN BALTIMORE. GROUNDED IN A VISION OF GOD'S HEALING LOVE FOR ALL PEOPLE, WE ARE COMMITTED TO PROVIDING HEALTHCARE FOR PERSONS OF EVERY CREED, COLOR, AND ECONOMIC AND SOCIAL CONDITION IN BALTIMORE CITY, CENTRAL MARYLAND AND BEYOND. IN THE TRADITION OF CATHOLIC HEALTHCARE AND OF THE SISTERS OF MERCY, WE CONTINUE OUR SPECIAL COMMITMENT TO POOR AND UNDERSERVED PERSONS. MERCY IS DRIVEN BY ITS MISSION TO SERVE AND WILL REMAIN STEADFAST IN ITS COMMITMENT TO UPHOLD ITS HIGHEST STANDARDS FOR CARE, ITS COMMITMENT OT THE POOR AND ITS COMMITMENT OT BALTIMORE. WE ARE HERE TO PROVIDE EXCELLENT HEALTHCARE, WITH COMPASSION AND RESPECT, TO ALL WHO COME TO US FOR HELP.

ATTACHMENT 2FORM 990, PART III - PROGRAM SERVICE, LINE 4A

TO PROVIDE HEALTHCARE TO PATIENTS WITHOUT REGARD TO ABILITY TO PAY. MERCY STRIVES TO PROVIDE EXCELLENT CLINICAL SERVICES ACROSS THE LIFE SPAN WITHIN A COMMUNITY OF COMPASSIONATE CARE. MERCY MEDICAL CENTER (MMC) HAS 226 LICENSED BEDS AND HAD 17,455

Name of the organization MERCY MEDICAL CENTER	Employer identification number 52-0591658
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ATTACHMENT 2 (CONT'D)

INPATIENT ADMISSIONS FOR THE FISCAL YEAR ENDING JUNE 30, 2011.

MERCY MEDICAL CENTER'S PRIMARY SERVICE AREA (PSA) WHICH COMPRISES 17 ZIP CODES IN BALTIMORE CITY, ACCOUNTS FOR ALMOST 60% OF ITS TOTAL ADMISSIONS. THE KEY DEMOGRAPHIC CHARACTERISTICS OF THE PSA ARE AS FOLLOWS:

64% OF THE POPULATION IS BLACK

59% OF PATIENTS SERVED BY MMC ARE MEMBERS OF A RACIAL OR ETHNIC MINORITY

66% ARE WOMEN

51% ARE MEDICAID AND/OR MEDICARE BENEFICIARIES

12% OF THE POPULATION IS 65 YEAR IN AGE AND OLDER

THE MEDIAN HOUSEHOLD INCOME OF THE POPULATION IS \$35,656

40% OF BALTIMORE CITY HOUSEHOLDS REPORTED A INCOME OF LESS THAN \$30,000

THREE TIMES AS MANY FAMILIES LIVING IN BALTIMORE CITY HAD INCOME THAT WAS BELOW THE POVERTY LEVEL COMPARED TO ALL FAMILIES IN MARYLAND.

WITHIN THE HOSPITAL'S 17 ZIP CODES THAT COMPRISE THE PSA 35% OF FAMILIES LIVE BELOW THE FEDERAL POVERTY LEVEL DEFINITION. DUE TO ITS LOCATION IN CENTER CITY, MMC CARES FOR MANY OF THE AT-RISK, LOW INCOME POPULATION IN THE COMMUNITIES THAT IMMEDIATELY SURROUND THE HOSPITAL. THIS IS BEST EVIDENCED BY THE LARGE PERCENTAGE OF EMERGENCY ROOM VISITS BY MEDICAID, UNINSURED, AND MEDICARE PATIENTS. MEDICAID COVERED AND UNISURED PATIENTS ACCOUNTED FOR MORE THAN 50% OF FY2011 EMERGENCY ROOM VISITS. IN FY 2011, THE

Name of the organization MERCY MEDICAL CENTER	Employer identification number 52-0591658
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ATTACHMENT 2 (CONT'D)

SUPPORTIVE HOUSING PROGRAM PROVIDED A COMPREHENSIVE RANGE
 COUSELING SERVICES AND COMMUNITY RESOURCE LINKAGES TO 207 CLIENTS.
 THESE SERVICES INCURRED A DIRECT COSTS OF \$568,441 DURING FY 2011,
 OR ABOUT \$3,000 PER CLIENT. MMC DELIVERED MORE BABIES, 2,886, THAN
 ANY OTHER HOSPITAL IN BALTIMORE CITY IN FY 2011. OF THESE BABIES,
 10.6% WERE OF LOW BIRTH WEIGHT AND 13.7% WERE PREMATURE. 60% OF
 THE PATIENTS WHO DELIVERED BABIES AT MMC WERE EITHER MEDICAID
 BENEFICIARIES OR UNISURED/SELF PAY. THIS POPULATION IS ESPECIALLY
 LINKED WITH LOW BIRTH WEIGHT AND PREMATUREITY DUE TO POVERTY THAT
 CLOSELY RELATED TO UNHEALTHY LIFESTYLES, PARTICULARLY, POOR
 NUTRITION AND INADEQUATE PRENATAL CARE.

ATTACHMENT 3FORM 990, PART VII, COLUMN B - ESTIMATED AVERAGE PER WEEK

NAME AND TITLE	HOURS DEVOTED FOR RELATED ORGANIZATION
THOMAS MULLEN CHAIR, EX OFFICIO	25.00
SAMUEL MOSKOWITZ EXEC VP/VICE CHAIR	6.00
SCOTT SPIER MD SECRETARY	6.50
JOHN TOPPER SR VP & CFO/TREASURER	25.00
SUSAN FINLAYSON SR VP/DIRECTOR	2.00
MICHAEL MULLANE SR VICE PRESIDENT CLINICAL PRG	15.00
JUDITH WEILAND SENIOR VP	0.00
ROBERT EDWARDS SENIOR VP	30.00
JAMES LEVY MD PHYSICIAN	0.00
WILMA A S ROWE MD PRESIDENT MEDICAL STAFF	1.00

Name of the organization MERCY MEDICAL CENTER	Employer identification number 52-0591658
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ATTACHMENT 3 (CONT'D)

GARY MICHAEL SENIOR VP MARKETING/PLANNING	3.00
AMY FREEMAN EXE VP/SECRETARY	0.00

ATTACHMENT 4

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

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
WHITTING TURNER PO BOX 17596 BALTIMORE, MD 21297	CONSTRUCTION	75,948,029.
CURA HOSPITALITY PO BOX 827276 PHILADELPHIA, PA 19182	FOOD SERVICES	3,853,453.
RADAMERICA II LLC 9105 FRANKLIN SQUARE DR BALTIMORE, MD 21237	RADIATION THERAPY	2,876,206.
UNIVERSITY OF MARYLAND MEDICAL SYSTEMS 22 SOUTH GREENE ST BALTIMORE, MD 21201	MEDICAL SERVICES	2,515,473.
ELLERBE BECKET 1001 G ST NW WASHINGTON, DC 20001	ARCHITECT	2,237,555.
TOTAL COMPENSATION		<u>87,430,716.</u>

ATTACHMENT 5

FORM 990, PART VIII - INVESTMENT INCOME

<u>DESCRIPTION</u>	(A) <u>TOTAL</u> <u>REVENUE</u>	(B) <u>RELATED OR</u> <u>EXEMPT REVENUE</u>	(C) <u>UNRELATED</u> <u>BUSINESS REV.</u>	(D) <u>EXCLUDED</u> <u>REVENUE</u>
INTEREST INCOME	1,145,971.			1,145,971.
INVESTMENT INCOME	3,791,928.			3,791,928.
TOTALS	<u>4,937,899.</u>			<u>4,937,899.</u>

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
52-0591658

ATTACHMENT 6

FORM 990, PART X - NOTES AND LOANS RECEIVABLE

BORROWER: ERICA NICHELSON DO
ORIGINAL AMOUNT: 43,166.
DATE OF NOTE: 12/01/2007
PURPOSE OF LOAN: PRACTICE DEVELOPMENT

BEGINNING BALANCE DUE 21,697.
ENDING BALANCE DUE 11,817.

BORROWER: MARK KIM MD
ORIGINAL AMOUNT: 40,000.
DATE OF NOTE: 08/01/2008
PURPOSE OF LOAN: PRACTICE DEVELOPMENT

BEGINNING BALANCE DUE 26,372.
ENDING BALANCE DUE 18,437.

Name of the organization MERCY MEDICAL CENTER	Employer identification number 52-0591658
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ATTACHMENT 6 (CONT'D)

BORROWER: METROPOLITAN OBGYN ASSOCIATES
ORIGINAL AMOUNT: 100,000.
DATE OF NOTE: 10/15/2008
PURPOSE OF LOAN: PRACTICE DEVELOPMENT

BEGINNING BALANCE DUE 56,700.
ENDING BALANCE DUE 26,667.

BORROWER: TERESA HOFFMAN
ORIGINAL AMOUNT: 60,022.
DATE OF NOTE: 11/01/2008
PURPOSE OF LOAN: PRACTICE DEVELOPMENT LOAN

BEGINNING BALANCE DUE 34,182.
ENDING BALANCE DUE 25,011.

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
52-0591658

ATTACHMENT 6 (CONT'D)

BORROWER: TERESA HOFFMAN
ORIGINAL AMOUNT: 30,000.
DATE OF NOTE: 06/07/2010
PURPOSE OF LOAN: PRACTICE DEVELOPMENT LOAN

BEGINNING BALANCE DUE 28,943.
ENDING BALANCE DUE 23,732.

BORROWER: DR FARRIOR
DATE OF NOTE: 12/10/2009
PURPOSE OF LOAN: PRACTICE DEVELOPEMNT LOAN

BEGINNING BALANCE DUE 16,613.
ENDING BALANCE DUE 1.

Name of the organization
MERCY MEDICAL CENTER

Employer identification number
52-0591658

ATTACHMENT 6 (CONT'D)

BORROWER: DR HOPKINS LUNA
DATE OF NOTE: 12/10/2009

BEGINNING BALANCE DUE 16,613.
ENDING BALANCE DUE 9,874.

BORROWER: HATEM ABDO

BEGINNING BALANCE DUE 0.
ENDING BALANCE DUE 190,111.

Name of the organization MERCY MEDICAL CENTER	Employer identification number 52-0591658
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ATTACHMENT 6 (CONT'D)

BORROWER:	DR HOPKINS LUNA	
BEGINNING BALANCE DUE		0.
ENDING BALANCE DUE		<u>168,395.</u>
TOTAL BEGINNING NOTES AND LOANS RECEIVABLE		<u>201,120.</u>
TOTAL ENDING NOTES AND LOANS RECEIVABLES		<u>474,045.</u>

ATTACHMENT 7

FORM 990, PART X - PREPAID EXPENSES AND DEFERRED CHARGES

<u>DESCRIPTION</u>	<u>ENDING BOOK VALUE</u>
PREPAID EXPENSES	3,449,102.
TOTALS	<u>3,449,102.</u>

ATTACHMENT 8

FORM 990, PART X - INVESTMENTS - PUBLICLY TRADED SECURITIES

<u>DESCRIPTION</u>	<u>ENDING BOOK VALUE</u>	<u>COST OR FMV</u>
FUNDS HELD BY TRUSTEE	34,283,252.	FMV
TOTALS	<u>34,283,252.</u>	

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

MERCY MEDICAL CENTER

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**

Employer identification number
52-0591658

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) MERCY HEALTH SERVICES INC 301 ST PAUL PLACE BALTIMORE, MD 21202 52-2173382	SUPPORT	MD	501(C)(3)	509(A)(3)	N/A		X
(2) MERCY HEALTH FOUNDATION INC 301 ST PAUL PLACE BALTIMORE, MD 21202 52-2173656	FOUNDATION	MD	501(C)(3)	170(B)(1)VI	MERCY HEALTH	X	
(3) SAINT PAUL PLACE SPECIALISTS INC 301 ST PAUL PLACE BALTIMORE, MD 21202 52-1495113	SPEC CARE	MD	501(C)(3)	170(B)1 III	MERCY HEALTH	X	
(4) MARYLAND FAMILY CARE INC 301 ST PAUL PLACE BALTIMORE, MD 21202 52-2046586	PRIMARY CARE	MD	501(C)(3)	170(B)1 III	MERCY HEALTH	X	
(5) STELLA MARIS INC 2300 DULANEY VALLEY TIMONID, MD 21093 52-1419602	NURSING FACILT	MD	501(C)(3)	509(A)(2)	MERCY HEALTH	X	
(6) MERCY TRANSITIONAL CARE SERVICES INC 301 ST PAUL PLACE BALTIMORE, MD 21202 52-1968440	SKILLED NURSE	MD	501(C)(3)	509(A)(2)	MERCY MEDICA	X	
(7) -----							

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

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) GREENLEAF INSURANCE CO LTD PO BOX 1363 KY1-1106 GRAND CAYMAN, CAYMAN ISLANDS CJ 52-0591658	INSURANCE	CJ	MERCY MEDICAL LTD		11,924,419.	45,364,089.	100.0000
(2) -----							
(3) -----							
(4) -----							
(5) -----							
(6) -----							
(7) -----							

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

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

- 1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?
 - a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity **1a**
 - b Gift, grant, or capital contribution to other organization(s) **1b**
 - c Gift, grant, or capital contribution from other organization(s) **1c**
 - d Loans or loan guarantees to or for other organization(s) **1d**
 - e Loans or loan guarantees by other organization(s) **1e**
 - f Sale of assets to other organization(s) **1f**
 - g Purchase of assets from other organization(s) **1g**
 - h Exchange of assets **1h**
 - i Lease of facilities, equipment, or other assets to other organization(s) **1i**
 - j Lease of facilities, equipment, or other assets from other organization(s) **1j**
 - k Performance of services or membership or fundraising solicitations for other organization(s) **1k**
 - l Performance of services or membership or fundraising solicitations by other organization(s) **1l**
 - m Sharing of facilities, equipment, mailing lists, or other assets **1m**
 - n Sharing of paid employees **1n**
 - o Reimbursement paid to other organization for expenses **1o**
 - p Reimbursement paid by other organization for expenses **1p**
 - q Other transfer of cash or property to other organization(s) **1q**
 - r Other transfer of cash or property from other organization(s) **1r**

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

	(a) Name of other organization	(b) Transaction type (a-f)	(c) Amount involved	(d) Method of determining amount involved
(1)	MERCY TRANSITIONAL CARE SERVICES	Q	3,373,085.	FMV
(2)	MERCY TRANSITIONAL CARE SERVICES	R	1,182,317.	FMV
(3)	MERCY TRANSITIONAL CARE SERVICES	M	24,523.	FMV
(4)	MERCY TRANSITIONAL CARE SERVICES	N	2,112,682.	FMV
(5)	MERCY TRANSITIONAL CARE SERVICES	H	275,922.	FMV
(6)	STELLA MARIS INC	R	30,504.	FMV

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

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

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

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

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)	STELLA MARIS INC	N	895,394.	FMV
(2)	STELLA MARIS INC	H	51,012.	FMV
(3)	STELLA MARIS INC	M	387,692.	FMV
(4)	STELLA MARIS INC	O	806,766.	FMV
(5)	SAINT PAUL PLACE SPECIALISTS INC	R	7,899,550.	FMV
(6)	SAINT PAUL PLACE SPECIALISTS INC	M	67,375,745.	FMV

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

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

- 1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?
 - a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity
 - b Gift, grant, or capital contribution to other organization(s)
 - c Gift, grant, or capital contribution from other organization(s)
 - d Loans or loan guarantees to or for other organization(s)
 - e Loans or loan guarantees by other organization(s)
 - f Sale of assets to other organization(s)
 - g Purchase of assets from other organization(s)
 - h Exchange of assets
 - i Lease of facilities, equipment, or other assets to other organization(s)
 - j Lease of facilities, equipment, or other assets from other organization(s)
 - k Performance of services or membership or fundraising solicitations for other organization(s)
 - l Performance of services or membership or fundraising solicitations by other organization(s)
 - m Sharing of facilities, equipment, mailing lists, or other assets
 - n Sharing of paid employees
 - o Reimbursement paid to other organization for expenses
 - p Reimbursement paid by other organization for expenses
 - q Other transfer of cash or property to other organization(s)
 - r Other transfer of cash or property from other organization(s)

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-f)	(c) Amount involved	(d) Method of determining amount involved	Yes	No
(1) SAINT PAUL PLACE SPECIALISTS INC	N	65,137,359.	FMV		
(2) SAINT PAUL PLACE SPECIALISTS INC	G	77,186.	FMV		
(3) SAINT PAUL PLACE SPECIALISTS INC	P	2,236,866.	FMV		
(4) SAINT PAUL PLACE SPECIALISTS INC	I	7,869.	FMV		
(5) SAINT PAUL PLACE SPECIALISTS INC	Q	1,297,496.	FMV		
(6) VASCULAR SERVICES	R	499,597.	FMV		

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

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

		Yes	No
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a	Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity		1a
b	Gift, grant, or capital contribution to other organization(s)		1b
c	Gift, grant, or capital contribution from other organization(s)		1c
d	Loans or loan guarantees to or for other organization(s)		1d
e	Loans or loan guarantees by other organization(s)		1e
f	Sale of assets to other organization(s)		1f
g	Purchase of assets from other organization(s)		1g
h	Exchange of assets		1h
i	Lease of facilities, equipment, or other assets to other organization(s)		1i
j	Lease of facilities, equipment, or other assets from other organization(s)		1j
k	Performance of services or membership or fundraising solicitations for other organization(s)		1k
l	Performance of services or membership or fundraising solicitations by other organization(s)		1l
m	Sharing of facilities, equipment, mailing lists, or other assets		1m
n	Sharing of paid employees		1n
o	Reimbursement paid to other organization for expenses		1o
p	Reimbursement paid by other organization for expenses		1p
q	Other transfer of cash or property to other organization(s)		1q
r	Other transfer of cash or property from other organization(s)		1r
2	If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.		

	(a) Name of other organization	(b) Transaction type (a-f)	(c) Amount involved	(d) Method of determining amount involved
(1)	VASCULAR SERVICES	M	674,515.	FMV
(2)	VASCULAR SERVICES	N	609,741.	FMV
(3)	VASCULAR SERVICES	P	185,748.	FMV
(4)	VASCULAR SERVICES	Q	129,736.	FMV
(5)	MARYLAND FAMILY CARE	Q	92,141.	FMV
(6)	MARYLAND FAMILY CARE	R	491,195.	FMV

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

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

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

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

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-f)	(c) Amount involved	(d) Method of determining amount involved	Yes	No
(1) MARYLAND FAMILY CARE	M	31,605,780.	FMV		
(2) MARYLAND FAMILY CARE	N	27,619,633.	FMV		
(3) MARYLAND FAMILY CARE	G	1,951,297.	FMV		
(4) MARYLAND FAMILY CARE	P	352,761.	FMV		
(5) MARYLAND FAMILY CARE	I	82,988.	FMV		
(6) MERCY HEALTH FOUNDATION	R	1,169,307.	FMV		

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

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

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

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

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-f)	(c) Amount involved	(d) Method of determining amount involved
(1)	MERCY HEALTH FOUNDATION	N	1,001,629.	FMV
(2)	MERCY HEALTH FOUNDATION	M	1,110,220.	FMV
(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) Disproportionate allocations?		(g) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(h) General or managing partner?	
			Yes	No		Yes	No		Yes	No
(1) _____										
(2) _____										
(3) _____										
(4) _____										
(5) _____										
(6) _____										
(7) _____										
(8) _____										
(9) _____										
(10) _____										
(11) _____										
(12) _____										
(13) _____										
(14) _____										
(15) _____										
(16) _____										

Part VII **Supplemental Information**

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

RENT AND ROYALTY INCOME

Taxpayer's Name
MERCY MEDICAL CENTER

Identifying Number
52-0591658

DESCRIPTION OF PROPERTY
RENTAL PROPERTIES

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

REAL RENTAL INCOME	1,562,362.	
OTHER INCOME		
TOTAL GROSS INCOME		1,562,362.
OTHER EXPENSES: SEE ATTACHMENT		
DEPRECIATION (SHOWN BELOW)	707,542.	
LESS: Beneficiary's Portion		
AMORTIZATION		
LESS: Beneficiary's Portion		
DEPLETION		
LESS: Beneficiary's Portion		
TOTAL EXPENSES		1,561,545.
TOTAL RENT OR ROYALTY INCOME (LOSS)		817.

Less Amount to

Rent or Royalty	_____
Depreciation	_____
Depletion	_____
Investment Interest Expense	_____
Other Expenses	_____
Net Income (Loss) to Others	_____
Net Rent or Royalty Income (Loss)	817.

SCHEDULE FOR DEPRECIATION CLAIMED

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

SUPPLEMENT TO RENT AND ROYALTY SCHEDULE

OTHER DEDUCTIONS

REPAIRS	21,555.
TAXES	156,680.
RENT	675,768.
	<u>854,003.</u>

RENT AND ROYALTY SUMMARY

<u>PROPERTY</u>	<u>TOTAL INCOME</u>	<u>DEPLETION/ DEPRECIATION</u>	<u>OTHER EXPENSES</u>	<u>ALLOWABLE NET INCOME</u>
RENTAL PROPERTIES	1,562,362.	707,542.	854,003.	817.
TOTALS	<u>1,562,362.</u>	<u>707,542.</u>	<u>854,003.</u>	<u>817.</u>

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

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

Name(s) shown on return MERCY MEDICAL CENTER	Identifying number 52-0591658
---	--------------------------------------

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

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

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

3 Gain, if any, from Form 4684, line 42 **3**
 4 Section 1231 gain from installment sales from Form 6252, line 26 or 37 **4**
 5 Section 1231 gain or (loss) from like-kind exchanges from Form 8824 **5**
 6 Gain, if any, from line 32, from other than casualty or theft **6**
 7 Combine lines 2 through 6. Enter the gain or (loss) here and on the appropriate line as follows: **7**

Partnerships (except electing large partnerships) and S corporations. Report the gain or (loss) following the instructions for Form 1065, Schedule K, line 10, or Form 1120S, Schedule K, line 9. Skip lines 8, 9, 11, and 12 below.
Individuals, partners, S corporation shareholders, and all others. If line 7 is zero or a loss, enter the amount from line 7 on line 11 below and skip lines 8 and 9. If line 7 is a gain and you did not have any prior year section 1231 losses, or they were recaptured in an earlier year, enter the gain from line 7 as a long-term capital gain on the Schedule D filed with your return and skip lines 8, 9, 11, and 12 below.

8 Nonrecaptured net section 1231 losses from prior years (see instructions) **8**
 9 Subtract line 8 from line 7. If zero or less, enter -0-. If line 9 is zero, enter the gain from line 7 on line 12 below. If line 9 is more than zero, enter the amount from line 8 on line 12 below and enter the gain from line 9 as a long-term capital gain on the Schedule D filed with your return (see instructions) **9**

Part II Ordinary Gains and Losses (see instructions)

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

ATTACHMENT 1	-157,153.

11 Loss, if any, from line 7 **11** ()
 12 Gain, if any, from line 7 or amount from line 8, if applicable **12**
 13 Gain, if any, from line 31 **13**
 14 Net gain or (loss) from Form 4684, lines 34 and 41a **14**
 15 Ordinary gain from installment sales from Form 6252, line 25 or 36 **15**
 16 Ordinary gain or (loss) from like-kind exchanges from Form 8824 **16**
 17 Combine lines 10 through 16 **17** -157,153.

18 For all except individual returns, enter the amount from line 17 on the appropriate line of your return and skip lines a and b below. For individual returns, complete lines a and b below:
a If the loss on line 11 includes a loss from Form 4684, line 38, column (b)(ii), enter that part of the loss here. Enter the part of the loss from income-producing property on Schedule A (Form 1040), line 28, and the part of the loss from property used as an employee on Schedule A (Form 1040), line 23. Identify as from "Form 4797, line 18a." See Instructions **18a**
b Redetermine the gain or (loss) on line 17 excluding the loss, if any, on line 18a. Enter here and on Form 1040, line 14 **18b**

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

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

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

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

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

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

MERCY MEDICAL CENTER
 Supplement to Form 4797 Part II Detail

52-0591658
 ATTACHMENT 1

Description	Date Acquired	Date Sold	Gross Sales Price	Depreciation Allowed or Allowable	Cost or Other Basis	Gain or (Loss) for entire year
SALE OF FIXED ASSETS			26,014.		183,167.	-157,153.
Totals						-157,153.

Form **990-T**

Department of the Treasury
Internal Revenue Service

Exempt Organization Business Income Tax Return (and proxy tax under section 6033(e))

For calendar year 2010 or other tax year beginning 07/01, 2010, and
ending 06/30, 2011 See separate instructions.

OMB No. 1545-0087

2010

Open to Public Inspection
for 601(c)(3) Organizations Only

A Check box if address changed

B Exempt under section
 501(C)(3) 220(e)
 408(e) 530(a)
 408A 529(a)

C Book value of all assets at end of year

815,479,823.

Name of organization (Check box if name changed and see instructions.)
MERCY MEDICAL CENTER
Number, street, and room or suite no. If a P.O. box, see page 8 of instructions.
301 ST. PAUL PLACE
City or town, state, and ZIP code
BALTIMORE, MD 21202

D Employer identification number
(Employees' trust, see instructions for Block D on page 9.)

52-0591658

E Unrelated business activity codes
(See instructions for Block E on page 9.)

531120 561000

F Group exemption number (See instructions for Block F on page 9.)

G Check organization type 501(c) corporation 501(c) trust 401(a) trust Other trust

H Describe the organization's primary unrelated business activity. **ATTACHMENT 1**

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? Yes No
If "Yes," enter the name and identifying number of the parent corporation. **ATTACHMENT 2**

J The books are in care of **JOHN TOPPER** Telephone number **410-332-9313**

Part I Unrelated Trade or Business Income		(A) income	(B) Expenses	(C) Net
1a	Gross receipts or sales <u>747,048.</u>			
b	Less returns and allowances			
c	Balance ▶ 1c	747,048.		
2	Cost of goods sold (Schedule A, line 7)			
3	Gross profit. Subtract line 2 from line 1c	747,048.		747,048.
4a	Capital gain net income (attach Schedule D)			
4b	Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)			
4c	Capital loss deduction for trusts			
5	Income (loss) from partnerships and S corporations (attach statement)			
6	Rent income (Schedule C)	32,585.	101,801.	-69,216.
7	Unrelated debt-financed income (Schedule E)			
8	Interest, annuities, royalties, and rents from controlled organizations (Schedule F)			
9	Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)			
10	Exploited exempt activity income (Schedule I)			
11	Advertising income (Schedule J)			
12	Other income (See page 10 of the instructions; attach schedule.)			
13	Total. Combine lines 3 through 12.	779,633.	101,801.	677,832.

Part II Deductions Not Taken Elsewhere (See page 11 of the instructions for limitations on deductions.) (Except for contributions, deductions must be directly connected with the unrelated business income.)				
14	Compensation of officers, directors, and trustees (Schedule K)			
15	Salaries and wages			157,752.
16	Repairs and maintenance			
17	Bad debts			
18	Interest (attach schedule)			
19	Taxes and licenses			
20	Charitable contributions (See page 13 of the instructions for limitation rules.)			
21	Depreciation (attach Form 4562)		0.	
22	Less depreciation claimed on Schedule A and elsewhere on return	22a		22b 0.
23	Depletion			
24	Contributions to deferred compensation plans			
25	Employee benefit programs			
26	Excess exempt expenses (Schedule I)			
27	Excess readership costs (Schedule J)			
28	Other deductions (attach schedule) ATTACHMENT 3			955,868.
29	Total deductions. Add lines 14 through 28			1,113,620.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13			-435,788.
31	Net operating loss deduction (limited to the amount on line 30)			
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30			-435,788.
33	Specific deduction (Generally \$1,000, but see line 33 instructions for exceptions.)			1,000.
34	Unrelated business taxable income. Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32.			-435,788.

Part III Tax Computation

35 Organizations Taxable as Corporations. See instructions for tax computation on page 15.
36 Trusts Taxable at Trust Rates. See instructions for tax computation on page 16.
37 Proxy tax. See page 16 of the instructions.
38 Alternative minimum tax.
39 Total. Add lines 37 and 38 to line 35c or 36, whichever applies.

Part IV Tax and Payments

40 a Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)
40 b Other credits (see page 16 of the instructions)
40 c General business credit. Attach Form 3800.
40 d Credit for prior year minimum tax (attach Form 8801 or 8827)
41 Subtract line 40e from line 39.
42 Other taxes. Check if from: Form 4255 Form 8611 Form 8697 Form 8866 Other (attach schedule).
43 Total tax. Add lines 41 and 42.
44 a Payments: A 2009 overpayment credited to 2010
44 b 2010 estimated tax payments
44 c Tax deposited with Form 8868
44 d Foreign organizations: Tax paid or withheld at source (see instructions)
44 e Backup withholding (see instructions)
44 f Credit for small employer health insurance premiums (Attach Form 8941)
44 g Other credits and payments: Form 2439 Other Total
45 Total payments. Add lines 44a through 44g.
46 Estimated tax penalty (see page 4 of the instructions). Check if Form 2220 is attached.
47 Tax due. If line 45 is less than the total of lines 43 and 46, enter amount owed.
48 Overpayment. If line 45 is larger than the total of lines 43 and 46, enter amount overpaid.
49 Enter the amount of line 48 you want: Credited to 2011 estimated tax Refunded

Part V Statements Regarding Certain Activities and Other Information (see instructions on page 17)

1 At any time during the 2010 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country?
2 During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust?
3 Enter the amount of tax-exempt interest received or accrued during the tax year

Schedule A - Cost of Goods Sold. Enter method of inventory valuation

1 Inventory at beginning of year
2 Purchases
3 Cost of labor
4 a Additional section 263A costs (attach schedule)
4 b Other costs (attach schedule)
5 Total. Add lines 1 through 4b.
6 Inventory at end of year
7 Cost of goods sold. Subtract line 6 from line 5. Enter here and in Part I, line 2.
8 Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?

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 taxpayer) is based on all information of which preparer has any knowledge.

Sign Here: Signature of officer, Date, Title
Paid Preparer Use Only: Print/Type preparer's name, Preparer's signature, Date, Check self-employed, PTIN, Firm's name, Firm's address, Firm's EIN, Phone no.

Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property)

(see instructions on page 18)

1. Description of property

(1) MEDI SPA
(2)
(3)
(4)

2. Rent received or accrued

(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
	32,585.	ATTACHMENT 4 101,801.
(1)		
(2)		
(3)		
(4)		
Total	Total 32,585.	
(c) Total income. Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A).		(b) Total deductions. Enter here and on page 1, Part I, line 6, column (B).
32,585.		101,801.

Schedule E - Unrelated Debt-Financed Income (see instructions on page 19)

1. Description of debt-financed property	2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property		4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5. Average adjusted basis of or allocable to debt-financed property (attach schedule)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
		(a) Straight line depreciation (attach schedule)	(b) Other deductions (attach schedule)					
(1)						%		
(2)						%		
(3)						%		
(4)						%		
Totals							Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
Total dividends-received deductions included in column 8								

Schedule F - Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions on page 20)

1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations			
		3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)					
(2)					
(3)					
(4)					

Nonexempt Controlled Organizations

7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)				
(2)				
(3)				
(4)				
Totals			Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).

Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization (see instructions on page 20)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
Totals		Enter here and on page 1, Part I, line 9, column (A).		Enter here and on page 1, Part I, line 9, column (B).

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income (see instructions on page 21)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals		Enter here and on page 1, Part I, line 10, col. (A).	Enter here and on page 1, Part I, line 10, col. (B).			Enter here and on page 1, Part II, line 26.

Schedule J - Advertising Income (see instructions on page 21)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5))						

Part II Income From Periodicals Reported on a Separate Basis (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
(5) Totals from Part I	Enter here and on page 1, Part I, line 11, col. (A).	Enter here and on page 1, Part I, line 11, col. (B).				Enter here and on page 1, Part II, line 27.
Totals, Part II (lines 1-5)						

Schedule K - Compensation of Officers, Directors, and Trustees (see instructions on page 21)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)			%
(2)			%
(3)			%
(4)			%
Total. Enter here and on page 1, Part II, line 14.			

ORGANIZATION'S PRIMARY UNRELATED BUSINESS ACTIVITY.

LEASE REAL ESTATE PROPERTY, PROVIDE MANAGEMENT SERVICES TO TAXABLE AFFILIATES, PROVIDE LAB SERVICES TO NON-HOSPITAL PATIENTS, PROVIDE ANSWERING SERVICE, PROVIDE PARKING TO NON-HOSPITAL PATRONS

MERCY MEDICAL CENTER

52-0591658

ATTACHMENT 2

NAME AND FEIN OF PARENT CORPORATION

MERCY HEALTH SERVICES, INC. 52-2173382

FORM 990T - PART II - LINE 28 - TOTAL OTHER DEDUCTIONS

OTHER
PARKING

8,302.
947,566.

PART II - LINE 28 - OTHER DEDUCTIONS

955,868.

SCHEDULE C - RENT INCOME DEDUCTIONS

ATTACHMENT 4

MEDI SPA

RENTAL EXPENSES

101,801.

TOTAL

101,801.