

Exempt Organization Declaration and Signature for Electronic Filing

For calendar year 2009, or tax year beginning 07/01, 2009, and ending 06/30, 2010
For use with Forms 990, 990-EZ, 990-PF, 1120-POL, and 8868

2009

Department of the Treasury Internal Revenue Service

See instructions on back.

Name of exempt organization

SIERRA VISTA REGIONAL HEALTH CENTER, INC

Employer identification number

86-0186064

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

Check the box for the return for which you are using this Form 8453-EO and enter the applicable amount, if any, from the return. If you check the box on line 1a, 2a, 3a, 4a, or 5a below and the amount on that line for the return for which you are filing this form was blank, then leave line 1b, 2b, 3b, 4b, or 5b, whichever is applicable, blank (do not enter -0-). If you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

Table with 5 rows (1a-5a) and 2 columns (b). Row 1a: Form 990 check here [X] b Total revenue, if any (Form 990, Part VIII, column (A), line 12) 101813935.

Part II Declaration of Officer

6 I authorize the U.S. Treasury and its designated Financial Agent to initiate an ACH electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment.

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

Under penalties of perjury, I declare that I am an officer of the above named organization and that I have examined a copy of the organization's 2009 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) an indication of any refund offset, (c) the reason for any delay in processing the return or refund, and (d) the date of any refund.

Sign Here

Signature of officer [Handwritten Signature]

Date 05/11/2011

CFO Title

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

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

ERO's Use Only section with fields for signature, date (5-11-11), firm name (ERNST & YOUNG U.S. LLP), address (TWO NORTH CENTRAL AVENUE, STE 2300 PHOENIX AZ 85004), EIN (34-6565596), and phone number (602/322-3000).

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

Paid Preparer's Use Only section with fields for signature, date, firm name, EIN, and phone number.

Return of Organization Exempt From Income Tax

2009

Department of the Treasury
Internal Revenue Service

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

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

A For the 2009 calendar year, or tax year beginning 07/01, 2009, and ending 06/30, 2010

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	Please use IRS label or print or type. See Specific Instructions.	C Name of organization SIERRA VISTA REGIONAL HEALTH CENTER, INC. Doing Business As	D Employer identification number 86-0186064
	E Telephone number (520) 417-3911		G Gross receipts \$ 101,857,310.
F Name and address of principal officer: MARGARET HEPBURN, CEO 300 EL CAMINO REAL SIERRA VISTA, AZ 85635		H(a) Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c) (3) ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		J Website: ▶ WWW.SVRHC.ORG	
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		L Year of formation: 1963 M State of legal domicile: AZ	

Part I Summary

Activities & Governance	1	Briefly describe the organization's mission or most significant activities: SIERRA VISTA REGIONAL HEALTH CENTER WILL: BE COMMITTED TO CUSTOMER-FOCUSED QUALITY HEALTH CARE THROUGH EXCELLENCE IN PRACTICE, SERVICE, AND LEADERSHIP		
	2	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3	Number of voting members of the governing body (Part VI, line 1a)	3	12
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	10
	5	Total number of employees (Part V, line 2a)	5	908
	6	Total number of volunteers (estimate if necessary)	6	165
	7a	Total gross unrelated business revenue from Part VIII, column (C), line 12	7a	847,931.
7b	Net unrelated business taxable income from Form 990-T, line 34	7b	0.	
Revenue	8	Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9	Program service revenue (Part VIII, line 2g)	1,048,632.	394,315.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	93,606,328.	97,747,569.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	-334,303.	2,824,120.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	902,728.	847,931.
	12		95,223,385.	101,813,935.
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	52,083.	13,500.
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	44,267,906.	44,194,980.
	16 a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	16 b	Total fundraising expenses, Part IX, column (D), line 25 ▶	0.	
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24f)	43,100,871.	48,369,360.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	87,420,860.	92,577,840.	
19	Revenue less expenses. Subtract line 18 from line 12	7,802,525.	9,236,095.	
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	Beginning of Year	End of Year
	21	Total liabilities (Part X, line 26)	96,395,520.	106,188,978.
	22	Net assets or fund balances. Subtract line 21 from line 20	40,427,990.	40,985,353.
22		55,967,530.	65,203,625.	

Part II Signature Block

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

Sign Here	▶ Signature of officer		Date
	▶ BRUCE NORTON	CFO	
Type or print name and title			
Paid Preparer's Use Only	Preparer's signature ▶ <i>Morgan Hessemer</i>	Date 5-12-11	Check if self-employed <input type="checkbox"/>
	Firm's name (or yours if self-employed) address, and ZIP + 4 ▶ ERNST & YOUNG U.S. LLP TWO NORTH CENTRAL AVENUE, STE 2300 PHOENIX, AZ 85004	EIN ▶ 34-6565596	Phone no. ▶ 602/322-3000

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

For Privacy Act and Paperwork Reduction Act Notice, see the separate instructions. *

Part III Statement of Program Service Accomplishments

1 Briefly describe the organization's mission:
SIERRA VISTA REGIONAL HEALTH CENTER WILL:
BE COMMITTED TO CUSTOMER-FOCUSED QUALITY HEALTH CARE THROUGH
EXCELLENCE IN PRACTICE, SERVICE, AND LEADERSHIP

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 \$ 66,132,966. including grants of \$ _____) (Revenue \$ 97,849,322.)
SEE SCHEDULE O

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 ▶ 66,132,966.

Part IV Checklist of Required Schedules

Table with 3 main columns: Question, Yes, No. Rows 1-20 contain various questions about organizational activities and reporting requirements. Row 12A includes a sub-table with Yes/No columns.

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 question 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 of the organization (or a family member) 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)? <i>If "Yes," complete Schedule R, Part V, line 2.</i>	X	
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

Table with columns for question number, description, and Yes/No columns. Includes rows for 1a, 1b, 1c, 2a, 2b, 3a, 3b, 4a, 4b, 5a, 5b, 5c, 6a, 6b, 7a-7h, 8, 9a, 9b, 10a, 10b, 11a, 11b, 12a, 12b.

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.

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 (12); 1b Enter the number of voting members that are independent (10); 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? (X); 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? (X); 4 Did the organization make any significant changes to its organizational documents since the prior Form 990 was filed? (X); 5 Did the organization become aware during the year of a material diversion of the organization's assets? (X); 6 Does the organization have members or stockholders? (X); 7a Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body? (X); 7b Are any decisions of the governing body subject to approval by members, stockholders, or other persons? (X); 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: 8a The governing body? (X); 8b Each committee with authority to act on behalf of the governing body? (X); 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O (X).

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Does the organization have local chapters, branches, or affiliates? (X); 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?; 11 Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form? (X); 11A 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 (X); 12b Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (X); 12c Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done (X); 13 Does the organization have a written whistleblower policy? (X); 14 Does the organization have a written document retention and destruction policy? (X); 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? 15a The organization's CEO, Executive Director, or top management official (X); 15b Other officers or key employees of the organization (X); 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? (X); 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 AZ
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply.
[] Own website [] Another's website [X] Upon request
19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public.
20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: STEVEN CALABRESE, CPA 300 EL CAMINO REAL SIERRA VISTA, AZ 85635 520-417-4981

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

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. Use Schedule J-2 if additional space is needed.

- 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. 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 the organization did not compensate any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week	(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			
RONALD WAGNER TRUSTEE	4.00	X					540.	0.	0.	
MARI PETERSON TRUSTEE/VICE CHAIRMAN	4.00	X		X			540.	0.	0.	
LANNY KOPE TRUSTEE/CHAIR	4.00	X		X			2,400.	0.	0.	
BRUCE DOCKTER TRUSTEE/SECRETARY	4.00	X		X			540.	0.	0.	
ANDREA DUNLAP TRUSTEE	4.00	X					135.	0.	0.	
JOHN P HAUN MD TRUSTEE	4.00	X					540.	0.	0.	
DAVID KNAPP MD TRUSTEE	4.00	X					29,795.	0.	0.	
DIANE MCDANIEL TRUSTEE (THRU 6/10)	4.00	X					540.	0.	0.	
JOANNA MICHELICH PHD TRUSTEE	4.00	X					540.	0.	0.	
SUSAN A WARNE JD TRUSTEE	4.00	X					540.	0.	0.	
WILLIAM MILLER TRUSTEE	4.00	X					540.	0.	0.	
HARL PIKE TRUSTEE	4.00	X					540.	0.	0.	
RALPH MAYBERRY MD TRUSTEE	4.00	X					23,169.	0.	0.	
MARGARET HEPBURN PRESIDENT & CEO	40.00			X			561,655.	0.	53,760.	
BRUCE NORTON SR VICE PRESIDENT/CFO	40.00			X			260,609.	0.	52,586.	
REBECCA MCCALMONT VICE PRESIDENT	40.00				X		165,709.	0.	35,294.	

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

(A) Name and title	(B) Average hours per week	(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			
MARIE WURTH VICE PRESIDENT	40.00				X			187,928.	0.	19,401.
DIANE HEATH STAFF NURSE	40.00					X		137,957.	0.	6,498.
ANDREA WHITE CLINICAL EDUCATOR	40.00					X		124,798.	0.	19,085.
MARK FELTT FACILITIES MANAGER	40.00					X		122,927.	0.	16,626.
STEVEN CALABRESE CONTROLLER	40.00					X		112,485.	0.	23,792.
MATTHEW GENZ CHARGE NURSE	40.00					X		118,476.	0.	15,434.

1b Total								1,852,903.	0.	242,476.

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 **▶** 16

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

Section B. Independent Contractors

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

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **▶** 60

Part VIII Statement of Revenue

86-0186064

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514	
Contributions, gifts, grants and other similar amounts	1a Federated campaigns	1a						
	b Membership dues	1b						
	c Fundraising events	1c						
	d Related organizations	1d	340,060.					
	e Government grants (contributions) . .	1e						
	f All other contributions, gifts, grants, and similar amounts not included above .	1f	54,255.					
	g Noncash contributions included in lines 1a-1f: \$							
	h Total. Add lines 1a-1f			394,315.				
Program Service Revenue		Business Code						
	2a NET PATIENT SERVICE (MEDICARE/MEDICAID)		446199	42,463,375.	42,463,375.			
	b NET PATIENT SERVICE (OTHER)		446199	54,405,029.	54,405,029.			
	c MOB/RENTAL		531120	168,071.		168,071.		
	d CAFETERIA		722210	399,944.	399,944.			
	e RADIOLOGY PRO FEE		541900	300,538.	300,538.			
	f All other program service revenue			10,612.	10,612.			
	g Total. Add lines 2a-2f			97,747,569.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			2,867,495.			2,867,495.	
	4 Income from investment of tax-exempt bond proceeds . . .			0.				
	5 Royalties			0.				
			(i) Real	(ii) Personal				
	6a Gross Rents							
	b Less: rental expenses							
	c Rental income or (loss)							
	d Net rental income or (loss)				0.			
			(i) Securities	(ii) Other				
	7a Gross amount from sales of assets other than inventory				0.			
	b Less: cost or other basis and sales expenses				43,375.			
	c Gain or (loss)				-43,375.			
	d Net gain or (loss)				-43,375.		-43,375.	
	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 MEDICAL SUPPLY SALES		446199		830,181.		830,181.		
b HOUSE RENTALS		900002		17,750.		17,750.		
c _____								
d All other revenue								
e Total. Add lines 11a-11d				847,931.				
12 Total Revenue. See instructions				101,813,935.	97,579,498.	847,931.	2,992,191.	

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).

<i>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</i>	(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.	0.		
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22	13,500.	13,500.		
3 Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16	0.	0.		
4 Benefits paid to or for members	0.	0.		
5 Compensation of current officers, directors, trustees, and key employees	2,526,826.	0.	2,526,826.	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	34,061,247.	24,836,572.	9,224,675.	0.
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions) . . .	649,509.	421,734.	227,775.	0.
9 Other employee benefits	4,369,786.	2,719,325.	1,650,461.	0.
10 Payroll taxes	2,587,612.	1,891,973.	695,639.	0.
11 Fees for services (non-employees):				
a Management	0.	0.	0.	0.
b Legal	517,065.	0.	517,065.	0.
c Accounting	274,279.	0.	274,279.	0.
d Lobbying	0.	0.	0.	0.
e Professional fundraising services. See Part IV, line 17	0.			0.
f Investment management fees	152,821.	0.	152,821.	0.
g Other	8,638,360.	5,505,943.	3,132,417.	0.
12 Advertising and promotion	288,206.	0.	288,206.	0.
13 Office expenses	15,456,128.	13,132,648.	2,323,480.	0.
14 Information technology	2,856,438.	1,826,554.	1,029,884.	0.
15 Royalties	0.	0.	0.	0.
16 Occupancy	1,542,216.	1,139,812.	402,404.	0.
17 Travel	92,450.	48,293.	44,157.	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	432,120.	70,083.	362,037.	0.
20 Interest	1,910,876.	1,528,701.	382,175.	0.
21 Payments to affiliates	0.	0.	0.	0.
22 Depreciation, depletion, and amortization . . .	6,531,300.	4,670,345.	1,860,955.	0.
23 Insurance	2,907,670.	2,721,471.	186,199.	0.
24 Other expenses. Itemize expenses not covered above. (Expenses grouped together and labeled miscellaneous may not exceed 5% of total expenses shown on line 25 below.)				
a <u>BAD DEBT</u>	2,685,398.	2,685,398.	0.	0.
b <u>EQUIPMENT REPAIRS & MAINT</u>	2,583,329.	2,131,603.	451,726.	0.
c <u>BLDG REPAIRS & MAINT</u>	906,955.	544,173.	362,782.	0.
d <u>MINOR EQUIPMENT & INSTRUMENT</u>	310,467.	206,187.	104,280.	0.
e <u>TAXES AND LICENSE FEES</u>	71,600.	0.	71,600.	0.
f All other expenses	211,682.	38,651.	173,031.	0.
25 Total functional expenses. Add lines 1 through 24f	92,577,840.	66,132,966.	26,444,874.	0.
26 Joint Costs. Check here <input type="checkbox"/> If following SOP 98-2. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X Balance Sheet

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	9,578,979.	1	12,838,651.
	2 Savings and temporary cash investments		2	
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	8,172,391.	4	7,837,953.
	5 Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6 Receivables from other disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B). Complete Part II of Schedule L		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	2,179,075.	8	2,099,777.
	9 Prepaid expenses and deferred charges	4,038,541.	9	4,134,325.
	10 a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 83,737,378.		
	b Less: accumulated depreciation	10b 46,863,677.	35,721,466.	10c 36,873,701.
	11 Investments - publicly traded securities	35,558,738.	11	41,128,832.
	12 Investments - other securities. See Part IV, line 11		12	
	13 Investments - program-related. See Part IV, line 11	236,990.	13	135,237.
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	909,340.	15	1,140,502.
16 Total assets. Add lines 1 through 15 (must equal line 34)	96,395,520.	16	106,188,978.	
Liabilities	17 Accounts payable and accrued expenses	4,517,675.	17	5,139,862.
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities	27,290,000.	20	26,400,000.
	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	848,144.	23	701,324.
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities. Complete Part X of Schedule D	7,772,171.	25	8,744,167.
	26 Total liabilities. Add lines 17 through 25	40,427,990.	26	40,985,353.
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	55,876,663.	27	65,182,728.
	28 Temporarily restricted net assets	90,867.	28	20,897.
	29 Permanently restricted net assets		29	
	Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
33 Total net assets or fund balances	55,967,530.	33	65,203,625.	
34 Total liabilities and net assets/fund balances	96,395,520.	34	106,188,978.	

Part XI Financial Statements and Reporting

	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
b Were the organization's financial statements audited by an independent accountant?	X	
c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	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 consolidated basis, separate 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
b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.		

Form **990** (2009)

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.)

Section A. Public Support

Table with 7 columns: (a) 2005, (b) 2006, (c) 2007, (d) 2008, (e) 2009, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2005, (b) 2006, (c) 2007, (d) 2008, (e) 2009, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 2 columns: Line number, Percentage. Rows include: 14 Public support percentage for 2009 (line 6, column (f) divided by line 11, column (f)); 15 Public support percentage from 2008 Schedule A, Part II, line 14; 16a 33 1/3 % support test - 2009; b 33 1/3 % support test - 2008; 17a 10%-facts-and-circumstances test - 2009; b 10%-facts-and-circumstances test - 2008; 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.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2005	(b) 2006	(c) 2007	(d) 2008	(e) 2009	(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) 2005	(b) 2006	(c) 2007	(d) 2008	(e) 2009	(f) Total
9 Amounts from line 6						
10 a 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 2009 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2008 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2009 (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from 2008 Schedule A, Part III, line 17	18	%

19 a 33 1/3 % support tests - 2009. 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 - 2008. 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 explanation required by Part II, line 10; Part II, line 17a or 17b; or Part III, line 12. Provide any other additional information. See instructions

Schedule of Contributors

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

2009

Name of the organization SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
--	---

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 SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
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Part I Contributors (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
1	SVRHC FOUNDATION 300 EL CAMINO REAL SIERRA VISTA, AZ 85635	\$ 230,060.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
2	AZ DEPT OF HEALTH SVCS 150 N 18TH AVE, STE 150 PHOENIX, AZ 85007	\$ 39,360.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
3	SVRHC AUXILIARY 300 EL CAMINO REAL SIERRA VISTA, AZ 85635	\$ 110,000.	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.)

SCHEDULE C
(Form 990 or 990-EZ)

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

OMB No. 1545-0047

2009

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

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

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

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

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

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax), then

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

Name of organization SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
- 2 Political expenditures ▶ \$ _____
- 3 Volunteer hours _____

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

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

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

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

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

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

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

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

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) Total
2 a Lobbying non-taxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

Table with 3 main columns: (a) Yes/No, (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation...; 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?; 2b If "Yes," enter the amount of any tax incurred under section 4912; 2c If "Yes," enter the amount of any tax incurred by organization managers under section 4912; 2d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?.

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

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

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

Table with 2 columns: Question, Amount. Rows include: 1 Dues, assessments and similar amounts from members; 2 Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid); 3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues; 4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?; 5 Taxable amount of lobbying and political expenditures (see instructions).

Part IV Supplemental Information

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

SEE PAGE 4

Series of horizontal dashed lines for providing supplemental information.

Part IV Supplemental Information (continued)

LOBBYING ACTIVITIES

SCHEDULE C, PART II-B

LINE 1 G - ACTIVITY CONSISTED OF DINNER IN PHOENIX AZ WITH STATE REPRESENTATIVES AND MEMBERS OF THE HOSPITAL STAFF AND TRUSTEES. THE PURPOSE OF THE MEETING WAS TO DISCUSS THE IMPACT OF STATE LEGISLATION UPON THE HOSPITAL.

LINE 1I- THIS AMOUNT REPRESENTS THE PORTION OF AMERICAN HOSPITAL ASSOCIATION DUES THAT HAVE BEEN ALLOCATED TO LOBBYING ACTIVITIES.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2009

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

SIERRA VISTA REGIONAL HEALTH CENTER, INC.

Employer identification number

86-0186064

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... Yes No, 6 Did the organization inform all grantees... Yes No.

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 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..., 3 Number of conservation easements modified..., 4 Number of states where property subject to conservation easement is located, 5 Does the organization have a written policy..., 6 Staff and volunteer hours devoted to monitoring..., 7 Amount of expenses incurred..., 8 Does each conservation easement reported on line 2(d) above satisfy the requirements..., 9 In Part XIV, describe how the organization reports 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: Amount. Rows include: 1a If the organization elected, as permitted under SFAS 116, not to report..., 1b If the organization elected, as permitted under SFAS 116, to report..., 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 relating to these items: a Revenues included..., b Assets included...

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

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

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

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

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

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

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

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

b If "Yes," explain the arrangement in Part XI V.

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

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

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

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

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

- (i) unrelated organizations
(ii) related organizations

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

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

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

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

Table with 4 columns: (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows: 1a Land, b Buildings, c Leasehold improvements, d Equipment, e Other, Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)

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

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

Table with 5 main rows and sub-rows. Row 1: Total revenue, gains, and other support per audited financial statements - 1. Row 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). Row 3: Subtract line 2e from line 1 - 3. Row 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). Row 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

Table with 5 main rows and sub-rows. Row 1: Total expenses and losses per audited financial statements - 1. Row 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). Row 3: Subtract line 2e from line 1 - 3. Row 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). Row 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 X, LINE 2

FIN 48 FOOTNOTE

THE AUDITED FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2010 DO NOT

CONTAIN A FIN 48 FOOTNOTE. MANAGEMENT HAS DETERMINED THAT THERE ARE NO

UNCERTAIN TAX POSITIONS THAT REQUIRE ACCRUAL OR DISCLOSURE.

Part XIV Supplemental Information *(continued)*

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2009

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

SIERRA VISTA REGIONAL HEALTH CENTER, INC.

Employer identification number

86-0186064

Part I Charity Care and Certain Other Community Benefits at Cost

	Yes	No
1a Does the organization have a charity care policy? If "No," skip to question 6a	X	
b If "Yes," is it a written policy?	X	
2 If the organization has multiple hospitals, indicate which of the following best describes application of the charity care policy to the various hospitals. <input checked="" type="checkbox"/> Applied uniformly to all hospitals <input type="checkbox"/> Applied uniformly to most hospitals <input type="checkbox"/> Generally tailored to individual hospitals		
3 Answer the following based on the charity care eligibility criteria that applies to the largest number of the organization's patients.		
a Does the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing free care to low income individuals? If "Yes," indicate which of the following is the 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 Does the organization use FPG to determine eligibility for providing discounted care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other 800.0000 %	X	
c If the organization does not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization uses an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.		
4 Does the organization's policy provide free or discounted care to the "medically indigent"?	X	
5a Does the organization budget amounts for free or discounted care provided under its charity care policy?	X	
b If "Yes," did the organization's charity care expenses exceed the budgeted amount?	X	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a Does the organization prepare an annual community benefit report?	X	
b If "Yes," does the organization make it available to the public?	X	

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

7 Charity Care and Certain Other Community Benefits at Cost

	(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
Charity Care and Means-Tested Government Programs						
a Charity care at cost (from Worksheets 1 and 2)			1,124,124.	0.	1,124,124.	1.25
b Unreimbursed Medicaid (from Worksheet 3, column a)			0.	0.	0.	0.00
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)			156,109.	113,184.	42,925.	.05
d Total Charity Care and Means-Tested Government Programs			1,280,233.	113,184.	1,167,049.	1.30
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			188,085.	0.	188,083.	.21
f Health professions education (from Worksheet 5)			1,377,065.	864,029.	513,036.	.57
g Subsidized health services (from Worksheet 6)			867,978.	843,604.	24,374.	.03
h Research (from Worksheet 7)			0.	0.	0.	0.00
i Cash and in-kind contributions to community groups (from Worksheet 8)			48,358.	1,914.	46,444.	.05
j Total Other Benefits			2,481,486.	1,709,547.	771,937.	.86
k Total. Add lines 7d and 7j			3,761,719.	1,822,731.	1,938,986.	2.16

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

Schedule H (Form 990) 2009

Part II Community Building Activities Complete this table if the organization conducted any community building activities.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development			2,000.		2,000.	0.00
3 Community support			13,500.		13,500.	.01
4 Environmental improvements						
5 Leadership development and training for community members			37,791.		37,791.	.04
6 Coalition building			8,125.		8,125.	.01
7 Community health improvement advocacy			2,758.		2,758.	0.00
8 Workforce development			136,629.		136,629.	.15
9 Other						
10 Total			200,803.		200,803.	.21

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

- 1 Does the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? **1**
- 2 Enter the amount of the organization's bad debt expense (at cost) **2** 892,895.
- 3 Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's charity care policy **3**
- 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 other bad debt amounts in community benefit.

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

Section B. Medicare

- 5 Enter total revenue received from Medicare (including DSH and IME) **5** 22,038,661.
- 6 Enter Medicare allowable costs of care relating to payments on line 5 **6** 25,857,951.
- 7 Subtract line 6 from line 5. This is the surplus or (shortfall) **7** -3,819,290.
- 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:
 Cost accounting system Cost to charge ratio Other

Section C. Collection Practices

- 9a Does the organization have a written debt collection policy? **9a** X
- b If "Yes," does the organization's collection policy contain provisions on the collection practices to be followed for patients who are known to qualify for charity care or financial assistance? Describe in Part VI. **9b** 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					
14					

Part V Facility Information

Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)
SIERRA VISTA REGIONAL HLTH CNTR 300 EL CAMINO REAL SIERRA VISTA AZ 85635	X	X		X			X		
MOORMAN AVE OUTPATIENT SVCS 185 S MOORMAN AVE SIERRA VISTA AZ 85635									LAB/INFUSION/HOSPICE
SIERRA VISTA REGIONAL HLTH CNTR 151 COLONIA DE SALUD SIERRA VISTA AZ 85635									OUT PATIENT SURGERY CENTER
SIERRA VISTA REGIONAL HLTH CNTR 1840 PASEO SAN LUIS SIERRA VISTA AZ 85635									DIABETES EDUCATION/OUT REACH
SIERRA VISTA REGIONAL HLTH CNTR 302 06 EL CAMINO REAL SIERRA VISTA AZ 85635									MRI
SIERRA VISTA REGIONAL HLTH CNTR 1967 FRONTAGE RD SIERRA VISTA AZ 85635									DURABLE MEDICAL SUPPLIES
SIERRA VISTA REGIONAL HLTH CNTR 2151 S HWY 92 SIERRA VISTA AZ 85635									REHABILITATION SVCS
SIERRA VISTA REGIONAL HLTH CNTR 2151 S HWY 92 SIERRA VISTA AZ 85635									HOSPICE

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves.
- 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 charity care policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Community building activities.** Describe how the organization's community building activities, as reported in Part II, promote the health of the communities the organization serves.
- 6 Provide any other information important to describing how the organization's hospitals 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.).
- 7 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.
- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 3C:

SELF PAY DISCOUNTS & UNCOMPENSATED CARE (CHARITY) POLICY

POLICY:

1. PHILOSOPHY: IN KEEPING WITH SIERRA VISTA REGIONAL HEALTH CENTERS

VISION TO BE A LEADER IN IMPROVING THE COMMUNITY'S HEALTH CARE

STATUS, IT IS CONSIDERED NOT ONLY NECESSARY BUT ALSO APPROPRIATE TO

MAKE ADJUSTMENT TO PATIENT CARE CHARGES UNDER CERTAIN CIRCUMSTANCES.

IT IS NOT THE INTENT OF THIS POLICY TO RESTRICT THIS PRACTICE, BUT TO

ESTABLISH CLEAR GUIDELINES BY WHICH TO ACCOMPLISH THE TASK.

2. DEFINITIONS: BECAUSE ADJUSTMENTS CAN OCCUR FOR SEVERAL REASONS, IT

IS NECESSARY TO DEFINE CERTAIN TYPES OF ADJUSTMENTS.

A. UNCOMPENSATED CARE: UNCOMPENSATED CARE/CHARITY CARE IS DEFINED

AS SERVICES PROVIDED TO PATIENTS WHO ARE UNABLE TO PAY BASED ON

INCOME LEVEL, FINANCIAL ANALYSIS, DEMOGRAPHIC INDICATORS AND/OR

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
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- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

FURTHER HEALTHCARE NEEDS BASED ON DIAGNOSIS OR CATASTROPHIC

CIRCUMSTANCES.

B. SELF-PAY DISCOUNT: A PAYMENT ADJUSTMENT MAY OCCUR WHEN THE

PATIENT AGREES TO MAKE IMMEDIATE OR PROMPT PAYMENT IN RETURN FOR A

REDUCTION IN THE AMOUNT DUE.

C. PROCESS: ALL ADJUSTMENTS OF PATIENT CARE CHARGES REQUESTED SHALL

BE APPROVED BY PERSONS DESIGNATED AS FOLLOWS:

- \$25,000 + CFO

- \$5,000 TO \$24,999 DIRECTOR OF REVENUE MANAGEMENT

- \$101 TO \$4999 ASSISTANT MANAGER OF A/R

- \$1.00 TO \$100 A/R STAFF

- SELF PAY DISCOUNTS. : A SELF PAY DISCOUNT OF 50% WILL BE APPLIED

AT THE TIME OF BILLING.

D. PLEASE NOTE ON SELF PAY AFTER INSURANCE, THERE IS NO DISCOUNT ON

DEDUCTIBLES OR CO-PAYS AS THIS IS PART OF THE CONTRACTUAL

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
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- 7 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.
- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

RELATIONSHIP BETWEEN THE PAYER AND THE SUBSCRIBER. ONLY COINSURANCE

BALANCES ARE ELIGIBLE FOR DISCOUNTS.

E. A COINSURANCE DISCOUNT OF 30% WILL BE APPLIED AT THE TIME OF

BILLING.

F. UNCOMPENSATED CARE - CHARITY CARE POLICY REQUEST FOR CHARITY

CARE (FINANCIAL ASSISTANCE): FINANCIAL ASSISTANCE REQUEST MAY BE

MADE BY THE PATIENT, OUTSIDE HEALTH CARE PROVIDERS, COMMUNITY OR

RELIGIOUS GROUPS, SOCIAL SERVICES, FAMILY MEMBERS, AND SVRHC

PERSONNEL. THE FINANCIAL COUNSELOR WILL KEEP ON FILE (AND FOR

REFERENCE) AN ANNUAL "POVERTY GUIDELINES" AS PUBLISHED BY THE FEDERAL

REGISTRY.

1. ELIGIBILITY CONSIDERATIONS FOR FINANCIAL ASSISTANCE:

- FINANCIAL ASSISTANCE IS SECONDARY TO ALL OTHER FINANCIAL

RESOURCES AVAILABLE TO THE PATIENT INCLUDING INSURANCE, GOVERNMENT

PROGRAMS, THIRD PARTY LIABILITY, AND PERSONAL ASSETS.

- FULL FINANCIAL ASSISTANCE WILL BE PROVIDED TO A PATIENT/GUARANTOR

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
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- 6 Provide any other information important to describing how the organization's hospitals 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.).
- 7 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.
- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

WITH A GROSS FAMILY INCOME 200% OF THE FEDERAL POVERTY GUIDELINES.

DEPENDENT UPON THE ELIGIBILITY CRITERIA FOR THE AHCCCS PROGRAMS

- MOST PROGRAMS AHCCCS ELIGIBILITY 100% FPL (FEDERAL POVERTY LEVEL)

- A PATIENT /GUARANTOR WILL BE GIVEN PARTIAL FINANCIAL ASSISTANCE BASED ON HIS OR HER INCOME LEVEL UP TO 800% OF THE POVERTY

GUIDELINES.

- COSMETIC AND OTHER SERVICES THAT ARE NOT MEDICALLY NECESSARY ARE NOT ELIGIBLE FOR FINANCIAL ASSISTANCE

- OTHER CATASTROPHIC CIRCUMSTANCES MAY BE CONSIDERED IN THE CHARITY DECISION.

- AHCCCS ELIGIBILITY WITHIN 60 DAYS OF SERVICE WILL BE PROOF OF INDIGENCE

- MEDICAL INDIGENCE -EVALUATE ADDITIONAL CIRCUMSTANCE

- MEDICAL BILLS (COMBINED) GREATER THAN 1 YEAR TIMES ANNUAL INCOME

- CATASTROPHIC EVENT/DIAGNOSIS

- ASSET AVAILABILITY

- PATIENTS/GUARANTORS WILL BE ASKED TO COMPLETE AN APPLICATION FOR ASSISTANCE AND PROVIDE PROOF OF INCOME SUCH AS EMPLOYER PAYMENTS

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
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- 7 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.
- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

STUBS, BANK STATEMENTS AND/OR TAX RETURN.

2. DETERMINATION:

- PATIENTS/GUARANTORS WILL BE NOTIFIED OF FINANCIAL ASSISTANCE

DETERMINATION BY PHONE OR IN WRITING.

- PATIENTS/GUARANTORS MAY APPEAL A FINANCIAL ASSISTANCE

DETERMINATION BY PROVIDING ADDITIONAL INFORMATION SUCH AS INCOME

VERIFICATION OR AN EXPLANATION OF EXTENUATING CIRCUMSTANCES TO THE

FINANCIAL COUNSELOR FOR REVIEW.

- SVRHC'S DECISION TO PROVIDE FINANCIAL ASSISTANCE IN NO WAY

AFFECTS THE PATIENTS/GUARANTOR FINANCIAL OBLIGATION TO THEIR

PHYSICIAN OR OTHER HEALTH CARE PROVIDERS.

PART I, LINE 6A:

THE COMMUNITY BENEFIT REPORT IS CONTAINED IN A SEPARATE REPORT,

PREPARED BY AN UNRELATED ORGANIZATION.

PART I, LINE 7G:

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
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- 7 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.
- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SVRHC PROVIDES SUBSIDIZED HEALTH SERVICES FOR NON-MEDICARE/MEDICAID

CARDIAC CATH PATIENTS AT LESS THAN HOSPITAL COST.

PART I, LINE 7, COLUMN F:

BAD DEBT INCLUDED ON PART IX LINE 25 IS \$2,685,398. THIS AMOUNT HAS BEEN BACKED OUT OF TOTAL EXPENSE USED IN THE DENOMINATOR FOR THE PERCENTAGES IN COLUMN F.

PART I, LINE 7:

COSTING METHODOLOGY USED TO CALCULATE THE AMOUNTS REPORTED IN THE TABLE IS PRIMARILY THE COST TO CHARGE RATIO CALCULATED IN WORKSHEET 2 OF SCHEDULE H. OTHER COSTS COME FROM OUR FY2010 COST REPORT.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
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PART III, LINE 4:

THE BAD DEBT EXPENSE (AT COST) WAS CALCULATED USING THE COST TO

CHARGE RATIO CALCULATED IN WORKSHEET 2 OF SCHEDULE H. THE BAD DEBT

EXPENSE IS RECORDED ON THE FINANCIALS AT GROSS CHARGES. EVERY EFFORT

IS MADE TO IDENTIFY CHARITY PATIENTS AT THE POINT OF SERVICE SO NONE

OF THE PATIENTS WRITTEN OFF TO BAD DEBT SHOULD HAVE BEEN ELIGIBLE FOR

CHARITY CARE. IT IS POSSIBLE THAT SOME PATIENTS REFUSED TO COMPLETE

THE CHARITY APPLICATION SO THAT NEED COULD NOT BE DETERMINED.

PART III, LINE 8:

MEDICARE ALLOWABLE COSTS WERE CALCULATED USING THE COST TO CHARGE

RATIO CALCULATED IN WORKSHEET 2 OF SCHEDULE H. MEDICARE CHARGES FOR

CATH LAB WERE EXCLUDED SINCE THEY WERE REPORTED AS PART OF THE

SUBSIDIZED HEALTH SERVICES. EXPENSE FOR HEALTH PROFESSIONAL

EDUCATION WAS THEN EXCLUDED FROM RESULTING COST. THE ENTIRE

SHORTFALL CALCULATED SHOULD BE ATTRIBUTABLE TO COMMUNITY BENEFIT,

SINCE THERE ARE NO OTHER HOSPITALS IN THE AREA THAT COULD PROVIDE

CARE FOR THESE PATIENTS.

PART III, LINE 9B:

Part VI Supplemental Information

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ALL LOCATIONS ARE LICENSED BY THE STATE.

NEEDS ASSESSMENT:

A COMMUNITY HEALTH ASSESSMENT WAS PERFORMED BY HMS ASSOCIATES, A NATIONAL COMPANY, FOR SIERRA VISTA REGIONAL HEALTH CENTER IN JULY, 2007. ANOTHER COMMUNITY HEALTH CARE NEEDS ASSESSMENT IS SCHEDULED FOR THE SUMMER OF 2011. THE COMPANY CONDUCTED THE SURVEY UTILIZING THREE TYPES OF INFORMATION:

- A. STATISTICS ON DEATHS, BIRTHS, SERVICE USE
- B. COMMUNITY SURVEYS
- C. OPINIONS OF KEY ORGANIZATIONS

THE ASSESSMENT COVERED ALL OF THE HOSPITAL'S SERVICE AREAS WITHIN THE COUNTY AND KEY EFFORTS INCLUDED DURING THE ANALYSIS WERE: GATHERING DATA, ASSIGNING DATA TO HEALTHY PEOPLE PROGRAM CATEGORIES, COMPARING DATA TO BENCHMARKS, ANALYZING DATA AND SELECTING PRIORITIES, AND SUMMARIZING FINDINGS. THE ASSESSMENT WAS THE FOUNDATION FOR SVRHC'S COMMUNITY BENEFIT PLAN WHICH INCLUDES ACTIVITIES AND PROGRAMS TO

Part VI Supplemental Information

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IMPROVE THE COMMUNITY HEALTH OF OUR CITIZENS.

COLLECTION METHODS:

ASSESSMENT CAPITALIZED ON EXTENSIVE EXISTING INFORMATION ABOUT

COCHISE COUNTY RESIDENTS' HEALTH RELATED NEEDS

KEY EFFORTS INCLUDE:

- GATHERING DATA
- ASSIGNING DATA TO HEALTHY PEOPLE PROGRAM CATEGORIES
- COMPARING DATA TO BENCHMARKS
- ANALYZING DATA AND SELECTING PRIORITIES
- SUMMARIZING FINDINGS

THE ASSESSMENT COVERS THE COUNTY AS A WHOLE AND ALSO SIX DIFFERENT
 COMMUNITIES WITHIN THE COUNTY. OFTEN TIMES, COUNTY PROBLEMS ARE MORE
 RELATED TO SPECIFIC COMMUNITIES. COMMUNITY ANALYSES HELP TO PINPOINT
 PROBLEMS AS WELL AS TARGET AND DEFINE THE MOST APPROPRIATE
 INTERVENTIONS.

FINDINGS OF THE COUNTY'S MOST IMPORTANT COMMUNITY NEEDS:

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NINETEEN HEALTH PROGRAM AREAS WERE CLOSELY STUDIED AND THREE LEVELS

OF PRIORITIES EMERGED.

ACCESS TO HEALTH CARE IN GENERAL WAS A SIGNIFICANT CONCERN AS WELL.

COMMUNITY NEEDS HIGH PRIORITIES:

- ACCESS TO CARE
- CANCER
- CHRONIC DISEASE
- HEART DISEASE
- INJURY PREVENTION
- MATERNAL CHILD HEALTH
- SUBSTANCE ABUSE-DRUGS

COMMUNITY NEEDS MODERATE PRIORITIES:

- DIABETES/OBESITY
- HIV
- MENTAL HEALTH
- ORAL HEALTH
- RESPIRATORY DISEASE

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- SUBSTANCE ABUSE - ALCOHOL

- SUICIDE

COMMUNITY NEEDS LOW PRIORITIES:

- BLOOD RELATED ILLNESSES

- CEREBROVASCULAR DISEASE

- IMMUNIZATION OR VACCINATION PREVENTABLE DISEASES

- NEPHRITIS

- RESPONSIBLE SEXUAL BEHAVIOR

- VIOLENCE PREVENTION

- CANCER

- CHRONIC DISEASE

- HEART DISEASE

- INJURY PREVENTION

- MATERNAL CHILD HEALTH

- SUBSTANCE ABUSE-DRUGS

THE FEDERAL POVERTY GUIDELINES CAN BE FOUND AT:

[HTTPS://WWW.CMS.GOV/MEDICAIDELIGIBILITY/DOWNLOADS/POV10COMBO.PDF.](https://www.cms.gov/MedicaidEligibility/downloads/POV10COMBO.pdf)

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SIERRA VISTA REGIONAL HEALTH CENTER INFORMS AND EDUCATES OUR PATIENTS

AND COMMUNITY MEMBERS WHO MAY BE BILLED FOR PATIENT CARE ABOUT THEIR

ELIGIBILITY FOR ASSISTANCE UNDER FEDERAL, STATE, AND LOCAL GOVERNMENT

PROGRAMS AND UNDER THE HOSPITAL'S CHARITY CARE POLICY IN THE

FOLLOWING WAYS:

A. INFORMATION ON ELIGIBILITY ASSISTANCE IS PROVIDED ON THE

WEBSITE, AT THE HOSPITAL'S WELLNESS DEPOT, AND IN PAMPHLETS.

B. EACH PATIENT IS VISITED BY AN ELIGIBILITY SPECIALIST TO DISCUSS

ONE-ON-ONE ELIGIBILITY ASSISTANCE.

C. THERE ARE POSTED SIGNS WITHIN THE HOSPITAL NOTIFYING

PATIENTS/COMMUNITY MEMBERS ON ASSISTANCE.

D. FOR PATIENTS UNABLE TO INTERACT WITH AN ELIGIBILITY SPECIALIST

AT THE TIME OF ARRIVAL THROUGH THE EMERGENCY ROOM, THE DEMOGRAPHICS

AND INFORMATION SHEET IS VIEWED BY THE SPECIALIST AND CONTACT IS MADE

WITH EACH ONE TO DISCUSS ELIGIBILITY.

E. THERE IS A STATEMENT ON EACH BILL SENT TO ALL PATIENTS ABOUT

ELIGIBILITY ASSISTANCE.

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COMMUNITY INFORMATION:

 THE HOSPITAL UTILIZED THE DEMOGRAPHIC INFORMATION PROVIDED BY THE

 ASSESSMENT ON THE POPULATIONS OF THE CITIES WITHIN COCHISE COUNTY AND

 INFUSED THESE FINDINGS INTO OUR PLAN. WE LOOKED AT THE POPULATION

 SIZE AND DENSITY, DISTRIBUTION, AND VITAL STATISTICS OF EACH CITY

 COUPLED WITH THE HEALTH NEED FINDINGS TO ESTABLISH EDUCATION AND

 PROGRAMS FOR THE POPULACE. SOME OF THE DEMOGRAPHIC INFLUENCES UNIQUE

 TO OUR SERVICE AREA INCLUDE THE FOLLOWING:

 A. DUE TO ANTICIPATED POPULATION GROWTH, THE NEED FOR SERVICES WILL

 GROW BY 50% OVER THE NEXT 20 YEARS

 B. THE POPULACE OF 50+ YEARS IS PROJECTED TO GROW BY 54% OVER THE

 NEXT 20 YEARS

 C. RETIREE GROWTH IS ALSO PROJECTED TO GROW BY 18% OVER THE NEXT 20

 YEARS

 D. POPULATIONS DENSITY VARIES (FROM 500 TO 65,000) DUE TO MOST OF

 OUR SERVICE AREA BEING RURAL

 E. ALL OF OUR SERVICE AREA HAS CULTURAL SENSITIVITY

 CHARACTERISTICS

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F. THE POPULACE HAS SPECIAL POPULATIONS WITHIN OF GROUP HOMES,

ARMED FORCES, CIVILIAN VETERANS (TWO AGE GROUPS - 18 TO 64 AND OVER

64)

G. DEMOGRAPHICS SHOW HIGH HEALTH RISK BEHAVIOR LEVELS, POOR HEALTH

STATUS, AND CONSIDERABLE CONCERN BY COMMUNITY LEADERS AND KEY HEALTH

CARE PROVIDERS WITHIN THE COUNTY

H. ACCESS TO CARE WAS A MAJOR CONCERN IDENTIFIED FOR THE COUNTY

I. THE COUNTY RELIES ON THE EMERGENCY ROOM FOR CARE MORE THAN ANY

OTHER COUNTY IN THE STATE

COMMUNITY BUILDING ACTIVITIES:

IN ACCORDANCE WITH OUR MISSION AND PHILOSOPHY, SIERRA VISTA REGIONAL

HEALTH CENTER COMMITS SUBSTANTIAL RESOURCES TO SPONSOR A BROAD RANGE

OF SERVICES TO BOTH THE POOR AND UNDERSERVED. OUR COMMUNITY BENEFIT

INCLUDES THE COST OF PROVIDING SERVICES TO PERSONS WHO CANNOT AFFORD

HEALTH CARE DUE TO INADEQUATE RESOURCES, UNDOCUMENTED PATIENTS,

AND/OR WHO ARE UNINSURED OR UNDERINSURED. THIS TYPE OF COMMUNITY

BENEFIT INCLUDES THE COST OF TRADITIONAL CHARITY CARE, UNPAID

PORTIONS OF ACCHHS AND SUPPLIES OR STAFF TIME VOLUNTEERED ON BEHALF

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OF THE COMMUNITY.

COMMUNITY BENEFIT PROVIDED TO THE COMMUNITY INCLUDES THE COST OF PROVIDING SERVICES TO OTHER POPULATIONS WHO MAY NOT QUALIFY AS POOR; BUT MAY NEED SPECIAL SERVICES AND SUPPORT. THIS TYPE OF COMMUNITY BENEFIT INCLUDES THE COST OF UNPAID PORTIONS OF MEDICARE AND OTHER PROGRAMS FOR SENIOR CITIZENS SUCH AS HEALTH PROMOTION AND EDUCATION, HEALTH CLINICS, AND SCREENINGS. ALL OF THESE ARE NOT BILLED OR CAN BE PROVIDED ON A DEFICIT BASIS. IT ALSO INCLUDES UNPAID PORTIONS OF TRAINING HEALTH PROFESSIONALS SUCH AS MEDICAL RESIDENTS, NURSING STUDENTS, AND STUDENTS IN ALLIED HEALTH PROFESSIONALS.

SIERRA VISTA REGIONAL HEALTH CENTER ALSO COMMITS SIGNIFICANT TIME AND RESOURCES TO ENDEAVORS AND CRITICAL SERVICES WHICH MEET OTHERWISE UNFILLED COMMUNITY NEEDS. MANY OF THESE ACTIVITIES ARE SPONSORED WITH THE KNOWLEDGE THAT THEY WILL NOT BE FINANCIALLY VIABLE. THE DEVELOPMENT OF THESE PROGRAMS IS BASED ON A COMMUNITY HEALTH CARE ASSESSMENT PERFORMED BY AN INDEPENDENT COMPANY. THE CURRENT COMMUNITY OUTREACH PROGRAMS ARE:

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- FOOD DRIVES

- HEALTH FAIRS

- HOSPICE BEREAVEMENT GROUP

- MALL WALKERS PROGRAM

- PARISH NURSE PROGRAM

- PERINATAL GRIEF SUPPORT

- POISON

- SAFETY CLASSES

- POSTPARTUM DEPRESSION INFORMATION

- POWER OF PINK BREAST CANCER

- PRENATAL CLASSES

- PULMONARY REHABILITATION

- SPEAKERS BUREAU

- SMART TEEN EATING PROGRAM

- SMOKE SUPPORT GROUP

- TELECARE HOME BOUND

- VIRTUAL TOUR KITS FOR ALL SCHOOLS

- WEIGHT MANAGEMENT PROGRAM

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- CHOLESTEROL TESTING

- WELLNESS DEPOT

- OLD MEDICATION DISPOSAL

- H1N1 AWARENESS

- VICAP

- SPACE AND SUPPLIES

- CHAIR YOGA

- ARTHRITIS PROGRAMS

- WATER SAFETY

- MRSA AWARENESS

- FLU PRECAUTION PROGRAMS

- KIDS SPORTS TEAMS 1ST AIDE KITS

- MUSIC THERAPY

- LIVING WILLS

- ADVANCED DIRECTIVES

- SUN SAFETY

- IMMUNIZATION INFORMATION

- BONE MARROW COLLECTION

- PULSE OXYGEN TESTS

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- BODY MASS INDEX

- SW SNAKE SAFETY

- SW INSECT SAFETY

- ARRHYTHMIC DEATH SYNDROME

- HEART SAFETY

THE HOSPITAL ALSO SPONSORS EVENTS IN THE COMMUNITY WHICH PROMOTE HEALTHY LIFE STYLES AND/OR DISEASE PREVENTION/INFORMATION. THESE EVENTS ARE:

- AMERICAN CANCER SOCIETY

- FORGACH HOUSE (BATTERED WOMEN/CHILDREN)

- LITTLE LEAGUE

- GOOD NEIGHBOR ALLIANCE (MEN'S SHELTER)

- UNITED WAY (NUMEROUS PROGRAMS)

- MARCH OF DIMES

- JUST KIDS (CLOTHING PROGRAM)

- RUNNING CLUB

- YOUTH SOCCER CLUB

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- SENIOR OLYMPICS

- HIGH SCHOOL SCHOLARSHIPS

- COLLEGE SCHOLARSHIPS

- STATE OF ARIZONA KIDS CARE

- AMERICAN HEART ASSOCIATION

- AMERICAN RED CROSS BLOOD DRIVES

- VICAP

- PROJECT GRADUATION (DRUG/ALCOHOL FREE EVENING FOR GRADUATING

SENIORS)

SIERRA VISTA REGIONAL HEALTH CENTER PROVIDES MANY OPPORTUNITIES FOR

COMMUNITY MEMBERS TO PROVIDE US FEEDBACK ON THE PROGRAMS AND SERVICES

DELIVERED BY THE HOSPITAL. THESE PROGRAMS INCLUDE:

- SVRHC AUXILIARY

- SVRHC FOUNDATION

- FOCUS GROUPS

- FACILITY TOURS

- VOLUNTEER SERVICES

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves.
- 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 charity care policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Community building activities.** Describe how the organization's community building activities, as reported in Part II, promote the health of the communities the organization serves.
- 6 Provide any other information important to describing how the organization's hospitals 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.).
- 7 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.
- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

- COMMUNITY BREAKFASTS

- ON LINE SURVEYS

- PRESS GANEY SURVEYS

- COMMUNITY ASSESSMENTS

- WEB SITE

- HEALTH BEAT COMMUNICATION

IN ADDITION, THE HOSPITAL HOSTS EMT, NURSING, REHABILITATION, PHARMACY, LABORATORY, DIAGNOSTIC IMAGING, NUTRITION, AND RESIDENT STUDENTS. THESE STUDENTS RECEIVE FREE MEALS IN OUR CAFETERIA. THE REHAB AND RESIDENT STUDENTS RECEIVED "DORM" TYPE HOUSING FOR \$100 PER MONTH. IN ADDITION, THE HOSPITAL HAS A RESIDENT PROGRAM. THE RESIDENTS RECEIVE FREE MEALS IN THE CAFETERIA AND FREE HOUSING WHEN THEY TRAVEL TO TUCSON FOR CERTAIN ROTATIONS. THE HOSPITAL ALSO SPONSORS A COMPASSION FUND WHICH ALLOWS US TO PURCHASE CLOTHING OR PAY FOR RIDES FOR PATIENTS THAT NEED THESE ITEMS.

OTHER INFORMATION:

THE HOSPITAL HAS AN OPEN MEDICAL STAFF AND A COMMUNITY BOARD OF

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves.
- 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 charity care policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Community building activities.** Describe how the organization's community building activities, as reported in Part II, promote the health of the communities the organization serves.
- 6 Provide any other information important to describing how the organization's hospitals 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.).
- 7 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.
- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

TRUSTEES. THE HOSPITAL PLACES SURPLUS FUNDS BACK INTO THE
 ORGANIZATION THROUGH OPERATIONS AND ALSO THROUGH THE MANY COMMUNITY
 BENEFIT PROGRAMS AND CLASSES PROVIDED TO THE COMMUNITY MEMBERS WE
 SERVE.

AFFILIATED HEALTH CARE SYSTEM ROLES:

FROM APRIL 17, 2010 THROUGH JUNE 30, 2010 FOR FISCAL YEAR 6-30-10,
 THE HOSPITAL WAS NOT PART OF AN AFFILIATED HEALTH CARE SYSTEM. THE
 HOSPITAL DID ENJOY AN INTEGRATIVE NETWORK AGREEMENT WITH CARONDELET
 HEALTH NETWORK TO FACILITATE WORKING ON PROJECTS. BOTH ORGANIZATIONS
 RAN COMPLETELY SEPARATE AND THERE WERE NO FINANCIAL COLLABORATIONS.
 THE AGREEMENT IS NO LONGER IN FORCE.

LINE 8:

THE ORGANIZATION OPERATES SOLELY IN ARIZONA. ARIZONA DOES NOT
 CURRENTLY REQUIRE COMMUNITY BENEFIT REPORTING.

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
SCHOLARSHIPS		13,500.			

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

PROCEDURES FOR MONITORING FUNDS

PART I, LINE 2

SCHOLARSHIP FUNDS (<\$5,000) ARE PROVIDED TO COCHISE COLLEGE, AND THE COLLEGE ADMINISTERS THE PROGRAM.

**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

2009

Open to Public Inspection

Name of the organization

SIERRA VISTA REGIONAL HEALTH CENTER, INC.

Employer identification number

86-0186064

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 is checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

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

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

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

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

- a** Receive a severance payment or change-of-control payment? **4a** Yes No
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b** Yes No
- c** Participate in, or receive payment from, an equity-based compensation arrangement? **4c** Yes No
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

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

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

- a** The organization? **5a** Yes No
- b** Any related organization? **5b** Yes No
- If "Yes" to line 5a or 5b, describe in Part III.

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

- a** The organization? **6a** Yes No
- b** Any related organization? **6b** Yes No
- If "Yes" to line 6a or 6b, describe in Part III.

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

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 Regs. 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		<input checked="" type="checkbox"/>
4b		<input checked="" type="checkbox"/>
4c		<input checked="" type="checkbox"/>
5a		<input checked="" type="checkbox"/>
5b		<input checked="" type="checkbox"/>
6a		<input checked="" type="checkbox"/>
6b		<input checked="" type="checkbox"/>
7	<input checked="" type="checkbox"/>	
8		<input checked="" type="checkbox"/>
9		

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

Schedule J (Form 990) 2009

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees Use Schedule J-1 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				
MARGARET HEPBURN	(i)	385,902.	135,505.	40,248.	28,302.	25,458.	615,415.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
BRUCE NORTON	(i)	209,583.	47,222.	3,804.	29,444.	23,142.	313,195.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
REBECCA MCCALMONT	(i)	130,045.	33,599.	2,065.	15,385.	19,909.	201,003.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
MARIE WURTH	(i)	150,589.	35,401.	1,938.	0.	19,401.	207,329.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

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

SCHEDULE J, PART I, LINE 7

BONUS PROGRAM

THE EXECUTIVE TEAM, WHICH CONSISTS OF THE CEO, CFO, VICE PRESIDENTS,

DIRECTORS, AND MANAGERS, ARE ELIGIBLE FOR PARTICIPATION IN THE BONUS

PROGRAM. THE AMOUNT OF BONUS IS DETERMINED BY A BONUS MATRIX, ONE OF THE

COMPONENTS OF WHICH IS AN EARNINGS TRIGGER.

**SCHEDULE K
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

SIERRA VISTA REGIONAL HEALTH CENTER, INC.

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

2009

**Open to Public
Inspection**

Employer identification number

86-0186064

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	
							Yes	No	Yes	No
A	THE INDUSTRIAL DEV AUTHORITY OF COUNTY OF COCHISE	86-0445518	191320BL3	06/05/2003	2,670,000.	REFUND BONDS ISSUED ON 12/31/1996		X		X
B										
C										
D										
E										

Part II Proceeds

	A		B		C		D		E	
1 Total proceeds of issue	2,670,000.									
2 Gross proceeds in reserve funds	0.									
3 Proceeds in refunding or defeasance escrows	0.									
4 Other unspent proceeds	0.									
5 Issuance costs from proceeds	53,400.									
6 Working capital expenditures from proceeds	0.									
7 Capital expenditures from proceeds	0.									
8 Year of substantial completion	2003									
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
9 Were the bonds issued as part of a current refunding issue?	X									
10 Were the bonds issued as part of an advance refunding issue?		X								
11 Has the final allocation of proceeds been made?	X									
12 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X									

Part III Private Business Use

	A		B		C		D		E	
	Yes	No	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?										
2 Are there any lease arrangements with respect to the financed property which may result in private business use?										

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

Schedule K (Form 990) 2009

Part III Private Business Use (Continued)

	A		B		C		D		E	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts with respect to the financed property which may result in private business use?										
b Are there any research agreements with respect to the financed property which may result in private business use?										
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		E	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1 Has a Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate, been filed with respect to the bond issue?		X								
2 Is the bond issue a variable rate issue?		X								
3a Has the organization or the governmental issuer identified a hedge with respect to the bond issue on its books and records?		X								
b Name of provider										
c Term of hedge										
4a Were gross proceeds invested in a GIC?		X								
b Name of provider										
c Term of GIC										
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?										
5 Were any gross proceeds invested beyond an available temporary period?		X								
6 Did the bond issue qualify for an exception to rebate?	X									

SCHEDULE L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

OMB No. 1545-0047

2009

Open To Public Inspection

Name of the organization SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
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Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

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

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

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

Part II Loans to and/or From Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 26, or Form 990-EZ, Part V, line 38a.

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

Total ▶ \$ _____

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

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

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
OFFICE SMART	TRUSTEE MCDANIEL, OWNER	323,936.	PURCHASE/SALE OF GOODS		X

**SCHEDULE O
(Form 990)**

Department of the Treasury
Internal Revenue Service

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

OMB No. 1545-0047

2009

**Open to Public
Inspection**

Name of the organization

SIERRA VISTA REGIONAL HEALTH CENTER, INC.

Employer identification number

86-0186064

ATTACHMENT 1

FORM 990, PART I, LINE 6

VOLUNTEER SERVICES

VOLUNTEERS IMPACT EVERY DEPARTMENT AND ARE A SOURCE OF COMFORT TO PATIENTS AND FAMILY MEMBERS. THE QUALITY OF CARE THAT SVRHC PROVIDES IS NOT JUST A RESULT OF THE OUTSTANDING STAFF AND PHYSICIANS, BUT ALSO A DIRECT IMPACT FROM THE FRIENDLINESS AND CHEERY ATTITUDES EACH VOLUNTEER GIVES TO THE HOSPITAL. VOLUNTEERS SACRIFICE THEIR TIME AND ENERGY AS AMBASSADORS FOR SVRHC AND ARE TRUE GEMS IN THE COMMUNITY.

WE UTILIZE VOLUNTEERS IN MOST OF THE DEPARTMENTS HERE AT THE HOSPITAL. THESE AREAS INCLUDE CLINICAL DEPARTMENTS SUCH AS MATERNAL CHILD, MED. SURGICAL, ICU/TELE, EMERGENCY DEPARTMENTS AND REHABILITATION SERVICES. OUR VOLUNTEERS WORK CLOSELY WITH OUR NURSING STAFF AND TECHNICIANS TO LEND ASSISTANCE WHENEVER NEEDED. THEY HELP GREET PATIENTS AND FAMILY MEMBERS, ANSWER PHONES, STOCK SMALL SUPPLIES, CREATE PACKETS, HELP WITH CHARTS AND TAKE ITEMS TO PATIENTS' ROOMS SUCH AS FLOWERS OR MAIL.

OUR NON-CLINICAL DEPARTMENTS INCLUDE MEDICAL RECORDS, CLIENT SERVICES, HUMAN RESOURCES, PATIENT ACCOUNTS AND NUTRITION & FOOD SERVICES. OUR VOLUNTEERS HELP OUT IN THESE AREAS BY MAKING COPIES, DATA ENTRY, PUTTING TOGETHER PACKETS, ANSWERING PHONES, COVERING THE OFFICE FOR MEETINGS, MAKING FILES AND DOING FOOD PREPARATION.

Name of the organization SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
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ATTACHMENT 1 (CONT'D)

TRAINING IS REQUIRED WHICH PROVIDES VOLUNTEERS THE NECESSARY TRAINING AND TOOLS TO ASSIST THESE SPECIAL CLIENTS IN THEIR DAILY LIVES. WE ARE REQUIRED TO HAVE A CERTAIN PERCENTAGE OF VOLUNTEER HOURS TO STAFF HOURS TO MAINTAIN OUR STATUS AND MEET MEDICARE GUIDELINES.

FORM 990, PART III, LINE 4A

EXEMPT PURPOSE ACHIEVEMENTS

SIERRA VISTA REGIONAL HEALTH CENTER (SVRHC) OPERATES AN 84 BED SHORT-TERM PRIMARY CARE FACILITY IN RURAL ARIZONA. SVRHC PROVIDES A FULL RANGE OF INPATIENT, OUTPATIENT, DIAGNOSTIC AND REHABILITATION SERVICES. SERVICES PROVIDED FOR YEAR ENDED JUNE 30, 2010 INCLUDED 17,845 INPATIENT PATIENT DAYS, 96,199 OUTPATIENT REGISTRATIONS AND 25,268 EMERGENCY ROOM VISITS.

IN SUPPORT OF ITS MISSION AND PHILOSOPHY THE HOSPITAL PROVIDES CARE TO ALL PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES. THE HOSPITAL DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE AND ACCORDINGLY THEY ARE NOT RECORDED AS REVENUE. CHARITY CARE SERVICES TOTALED APPROXIMATELY \$1,166,000 WHEN MEASURED AT THE HOSPITAL'S ESTABLISHED RATES.

THE HOSPITAL PROVIDES CARE TO PATIENTS WHO HAVE ENTERED THE COMMUNITY ILLEGALLY. THE CHARGES FOR THESE PATIENTS ARE PARTIALLY REIMBURSED UNDER SECTION 1011 OF THE MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003. THE UNREIMBURSED COSTS FOR SERVING THESE PATIENTS WERE APPROXIMATELY \$49,000.

Name of the organization SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
<u>ATTACHMENT 1 (CONT'D)</u>	

PUBLIC PROGRAMS SUCH AS AHCCCS AND MEDICARE PROVIDE FOR THE POOR, INDIGENT AND ELDERLY. PUBLIC PROGRAMS DO NOT ALWAYS COVER THE COSTS OF PROVIDING THESE SERVICES; THE UNREIMBURSED COSTS OF THE MEDICARE PROGRAM WERE APPROXIMATELY \$10,789,000.

BENEFITS PROVIDED TO THE COMMUNITY INCLUDE THE COST OF PROVIDING SERVICES TO OTHER POPULATIONS WHO MAY QUALIFY AS POOR BUT MAY NEED SPECIAL SERVICES AND SUPPORT. THIS TYPE OF COMMUNITY BENEFIT INCLUDES THE COST OF PROGRAMS FOR SENIOR CITIZENS SUCH AS HEALTH PROMOTION AND EDUCATION, HEALTH CLINICS AND SCREENINGS, IT ALSO INCLUDES COSTS INCURRED BY THE HOSPITAL FOR TRAINING HEALTH PROFESSIONALS SUCH AS MEDICAL RESIDENTS, NURSING STUDENTS IN ALLIED HEALTH PROFESSIONALS.

THE HOSPITAL ALSO COMMITS SIGNIFICANT TIME AND RESOURCES TO ENDEAVORS AND CRITICAL SERVICES WHICH MEET OTHERWISE UNFILLED COMMUNITY NEEDS. MANY OF THESE ACTIVITIES ARE SPONSORED WITH THE KNOWLEDGE THAT THEY WILL NOT BE FINANCIALLY VIABLE. THE DEVELOPMENT OF THESE PROGRAMS IS BASED UPON A COMMUNITY ASSESSMENT PERFORMED BY AN INDEPENDENT COMPANY. SUCH ENDEAVORS INCLUDE LOCAL CHARITIES, NOT-FOR-PROFIT ORGANIZATIONS, YOUTH GROUPS AND OTHER PATIENT SUPPORT GROUPS SUCH AS BUT NOT INCLUSIVE OF: HEALTH SCREENINGS AND ASSESSMENTS, CANCER AND OTHER SUPPORT GROUPS, FREE TRANSPORTATION, MEALS AND MEDICATIONS FOR TRANSIENT PATIENTS WHEN NEEDED, THE AMERICAN HEART ASSOCIATION, MARCH OF DIMES, CANCER SOCIETY, AMERICAN RED CROSS, PRENATAL CLASSES, SENIOR OLYMPICS, HEALTH FAIRS, BLOOD

Name of the organization SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
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ATTACHMENT 1 (CONT'D)

PRESSURE CHECKS, HEALTH CAREER SCHOLARSHIPS FOR HIGH SCHOOL AND COLLEGE STUDENTS, BOY SCOUTS OF AMERICA, LITTLE LEAGUE AND PARTICIPATION IN REGULAR BLOOD DRIVES.

FORM 990, PART VI, LINE 2

FAMILY/BUSINESS RELATIONSHIPS

DIANE MCDANIELS, TRUSTEE, AND MARI PETERSON, TRUSTEE, HAVE A BUSINESS RELATIONSHIP.

FORM 990, PART VI, LINE 11A

PROCESS USED BY MANAGEMENT &/OR GOVERNING BODY TO REVIEW 990

THE 990 IS PREPARED BY THE CONTROLLER CAREFULLY CONSIDERING THE ORGANIZATION'S ENTRIES ON THE RETURN. THOSE QUESTIONS CONCERNING COMPENSATION HAVE BEEN REVIEWED WITH THE VICE PRESIDENT OF HUMAN RESOURCES AND ALL COMPENSATION HAS BEEN SUPPLIED BY THE HUMAN RESOURCES DEPARTMENT. THE ENTIRE RETURN HAS BEEN REVIEWED FOR CORRECTNESS WITH THE CFO. ONCE COMPLETED THE RETURN WAS THEN REVIEWED BY ERNST AND YOUNG TAX DEPARTMENT. BEFORE THE FINAL RETURNS ARE FILED, THE COMPLETED 990 AND 990-T ARE REVIEWED WITH THE AUDIT COMMITTEE OF THE BOARD HIGHLIGHTING THE AREAS OF INTEREST TO A GOVERNING BODY. A COMPLETED COPY IS MADE AVAILABLE FOR ALL TRUSTEES TO REVIEW PRIOR TO FILING. ANSWERS ARE PROVIDED TO ANY QUESTIONS OR CONCERNS.

FORM 990, PART VI, LINE 12C

Name of the organization SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
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ATTACHMENT 1 (CONT'D)

PROCESS TO MONITOR TRANSACTIONS FOR CONFLICT OF INTEREST

THE ORGANIZATION HAS A CONFLICT OF INTEREST POLICY. THE FOLLOWING PROCEDURES ARE EMPLOYED.

ALL OFFICERS, LEADERS OR IDENTIFIED OTHERS SHALL COMPLETE A CONFLICT OF INTEREST QUESTIONNAIRE AND SUBMIT IT TO THE HOSPITAL ANNUALLY.

THE TERM "CONFLICT OF INTEREST" MEANS THOSE CIRCUMSTANCES WHERE THE BEST INTERESTS OF SIERRA VISTA REGIONAL HEALTH CENTER (SVRHC) CONFLICT WITH EITHER THE ECONOMIC, PROFESSIONAL, POLITICAL OR PERSONAL INTERESTS OF ONE OR MORE OFFICERS, LEADERS OR IDENTIFIED OTHER OF SVRHC.

THE RELATIONSHIP BETWEEN SVRHC AND ITS OFFICERS, LEADERS AND IDENTIFIED OTHERS IS ONE WHICH IS COMPLEX AND CHANGING. THERE ARE CIRCUMSTANCES WHICH MAY EXIST WHICH MAY INTERTWINE THE INTERESTS OF SVRHC AND ITS OFFICERS, LEADERS AND IDENTIFIED OTHERS. IN ORDER TO RECOGNIZE AND EFFECTIVELY DEAL WITH CIRCUMSTANCES OF THIS NATURE THE FOLLOWING POLICY HAS BEEN ADOPTED.

ANY AND ALL CONFLICTS OF INTEREST SHALL BE DISCLOSED TO THE HOSPITAL EITHER AT THE TIME OF HIRE, INCEPTION OF RELATIONSHIP AND/OR AT THE TIME OF AN INITIAL AGREEMENT/CONTRACT OR AT ANY TIME A CONFLICT OF INTEREST OCCURS.

A CONFLICT OF INTEREST QUESTIONNAIRE IS SUBMITTED TO THE HOSPITAL.

Name of the organization SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
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ATTACHMENT 1 (CONT'D)

FAILURE TO COMPLETE AND SUBMIT A QUESTIONNAIRE WILL RESULT IN THE OFFICER, LEADER OR IDENTIFIED OTHER BEING REMOVED FROM THEIR RELATIONSHIP WITH THE HOSPITAL. WHILE THIS IS AN ANNUAL REQUIREMENT, IT IS NOT MEANT TO TAKE THE PLACE OF IMMEDIATE AND APPROPRIATE DISCLOSURE OF A CONFLICT OF INTEREST BY AN OFFICER, LEADER OR IDENTIFIED OTHER TO THE HOSPITAL WHEN CIRCUMSTANCES OCCUR.

ANY POTENTIAL CONFLICT OF INTEREST SHALL BE DISCLOSED TO THE HOSPITAL. THE POTENTIAL CONFLICT WILL BE REVIEWED EITHER BY THE CEO/PRESIDENT OR HIS/HER DESIGNEE(S) OR BY THE BOARD OF TRUSTEES' CHAIRPERSON OR HIS/HER DESIGNEE(S) DEPENDING ON THE NATURE OF THE POTENTIAL CONFLICT. A DECISION PERTAINING TO THE CONFLICT OF INTEREST AND THE OFFICER'S, LEADER'S AND IDENTIFIED OTHER'S ABILITY TO CONTINUE IN HIS/HER POSITION AND/OR RELATIONSHIP WILL BE DETERMINED AND SHARED WITH THE OFFICER, LEADER OR IDENTIFIED OTHER.

FORM 990, PART VI, LINES 15A AND 15B
PROCEDURES USED TO DETERMINE COMPENSATION

IT IS THE POLICY OF SIERRA VISTA REGIONAL HEALTH CENTER THAT AN EXECUTIVE'S BASE SALARY WILL BE MAINTAINED AT OR ABOVE THE 50TH PERCENTILE AND THAT ANNUALLY THE BOARD OF TRUSTEES WILL DEVELOP A COMPENSATION PLAN UTILIZING A THIRD PARTY CONSULTANT AND CURRENT MARKET DATA.

IT IS THE POLICY OF SIERRA VISTA REGIONAL HEALTH CENTER THAT EXECUTIVES WILL BE PAID AN INCENTIVE BONUS BASED UPON AN ANNUAL PLAN COMPRISED OF

Name of the organization SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
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ATTACHMENT 1 (CONT'D)

FINANCIAL AND NON-FINANCIAL METRICS APPROVED BY THE BOARD OF TRUSTEES,
THE PLAN WILL BE APPROPRIATELY ALIGNED WITH THE PROBABILITY OF
ACHIEVEMENT.

PROCEDURE:

- ENGAGE AN INDEPENDENT COMPANY TO CONDUCT A COMPENSATION VALUATION STUDY OF COMPENSATION ARRANGEMENTS IN TAX- EXEMPT ORGANIZATIONS UNDER THE INTERMEDIATE SANCTIONS LEGISLATION.
- THE INDEPENDENT COMPANY WILL PROVIDE THE SVRHC BOARD OF TRUSTEES' EXECUTIVE COMPENSATION COMMITTEE COMPETITIVE MARKET DATA TO INCLUDE: A CONFIRMATION OF THE SCOPE, DATA CUTS AND SURVEY SOURCES WITH THE HUMAN RESOURCE TEAM. PROVIDE MARKET COMPARABILITY DATA IN ORDER TO REVIEW THE COMPETITIVENESS OF SVRHC'S PROGRAM. RESEARCH MARKET PRACTICES FOR BOTH SHORT AND LONG TERM PLANS TO DETERMINE ALIGNMENT. REVIEW EXECUTIVE BENEFIT AND PERQUISITE PREVALENCE DATA.
- THE INDEPENDENT COMPANY WILL SELECT RELEVANT DATA AND ADJUST THE DATA TO ACCURATELY REFLECT THE SIZE AND SCOPE OF SVRHC'S ROLES AND MEDIAN REVENUE SIZE.
- THE INDEPENDENT COMPANY WILL UTILIZE THE SAME METHODOLOGY TO CONDUCT A REVIEW OF INCENTIVE BONUS PLANS FOR THE EXECUTIVE STAFF.
- THE INDEPENDENT COMPANY WILL CONSIDER THE FOLLOWING WHEN REVIEWING A PARTICULAR INDIVIDUAL'S COMPENSATION: PRIOR SKILLS AND EXPERIENCE OF INCUMBENTS IN THE ROLE. THE MIX OF COMPENSATION ELEMENTS AND OTHER REWARD COMPONENTS. THE HOSPITAL'S PERFORMANCE VERSUS COMPARABLE PEER PERFORMANCE. THE ABILITY OF THE HOSPITAL TO PAY AT COMPETITIVE LEVELS.

Name of the organization SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
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ATTACHMENT 1 (CONT'D)

- THE INDEPENDENT COMPANY WILL MAKE RECOMMENDATIONS FOR COMPENSATION AND BONUS PERCENTAGES FOR THE EXECUTIVE STAFF TO THE SVRHC BOARD OF TRUSTEES EXECUTIVE COMPENSATION COMMITTEE.
- THE COMMITTEE WILL REVIEW THE RECOMMENDATIONS AND FORWARD THEM TO THE ENTIRE SVRHC BOARD OF TRUSTEES FOR APPROVAL.

FORM 990, PART VI, LINE 19

AVAILABILITY OF CERTAIN DOCUMENTS TO GENERAL PUBLIC

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

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

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
CPS INC PO BOX 10000 DEPT 176 MEMPHIS, TN 38148	PHARMACY MANAGEMENT	1,342,403.
CERNER CORPORATION PO BOX 412702 KANSAS CITY, MO 64141	SOFTWARE MAINTENANCE	1,676,560.
ARAMARK HEALTHCARE MANAGEMENT 12483 COLLECTION CENTER DR CHICAGO, IL 60693	BIO MED/MGT CONTRACT	2,371,008.
TL ROOF AND ASSOCIATES CONSTRUCTION CO 710 S CAMPBELL AVENUE TUCSON, AZ 85719	CONSTRUCTION	1,947,362.
MIDWESTERN UNIVERSITY 19555 N 59TH AVE GLENDALE, AZ 85308	RESIDENTS	826,065.

Name of the organization SIERRA VISTA REGIONAL HEALTH CENTER, INC.	Employer identification number 86-0186064
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ATTACHMENT 2 (CONT'D)

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

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
TOTAL COMPENSATION		<u>8,163,398.</u>

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2009

**Open to Public
Inspection**

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

Name of the organization

SIERRA VISTA REGIONAL HEALTH CENTER, INC.

Employer identification number

86-0186064

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
SVRHC PROPERTIES LLC 86-0186064 300 EL CAMINO REAL SIERRA VISTA, AZ 85635	MOB	AZ	0.	0.	N/A

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
SVRHC FOUNDATION 86-0729397 300 EL CAMINO REAL SIERRA VISTA, AZ 85625	FUND RAISING	AZ	9	509 (A) (2)	N/A
SIERRA VISTA COMMUNITY HOSPITAL AUX, INC 86-0431251 300 EL CAMINO REAL SIERRA VISTA, AZ 85625	FUND RAISING	AZ	9	509 (A) (2)	N/A

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

Schedule R (Form 990) 2009

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?	
							Yes	No		Yes	No

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
ARIZONA FAMILY CARE ASSOCIATES 6 SOUTH 2ND ST SIERRA VISTA, AZ 85635	PHYSICIANS GROUP	AZ	N/A	C CORP	0.	0.	58.1400

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

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

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

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

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved
(1) SVRHC FOUNDATION	C	230,060.
(2)		
(3)		
(4)		
(5)		
(6)		

