PRICEWATERHOUSECOOPERS LLP 2001 MARKET STREET, 17TH FLOOR PHILADELPHIA, PA 19103

INSTRUCTIONS FOR FILING
MARCO ISLAND HOSPITAL, INC.
FORM 8453-EO - EXEMPT ORG. DECLARATION & SIGNATURE FOR E-FILING
FOR THE PERIOD ENDED SEPTEMBER 30, 2011

SIGNATURE...

THE ORIGINAL FORM 8453-EO SHOULD BE SIGNED (USE FULL NAME) AND DATED BY THE TAXPAYER.

FILING...

RETURN YOUR SIGNED FORM 8453-EO DECLARATION TO:

PRICEWATERHOUSECOOPERS LLP 2001 MARKET ST, SUITE 1700 PHILADELPHIA PA 19103

PAYMENT OF TAX...
NO PAYMENT OF TAX IS REQUIRED.

TO DOCUMENT THE TIMELY FILING OF YOUR TAX RETURN(S), WE SUGGEST THAT YOU OBTAIN AND RETAIN PROOF OF MAILING. PROOF OF MAILING CAN BE ACCOMPLISHED BY SENDING THE TAX RETURN(S) BY REGISTERED OR CERTIFIED MAIL (METERED BY THE U.S. POSTAL SERVICE) OR THROUGH THE USE OF AN IRS APPROVED DELIVERY METHOD PROVIDED BY AN IRS DESIGNATED PRIVATE DELIVERY SERVICE.

DO NOT SEPARATELY FILE FORM 990 WITH THE INTERNAL REVENUE SERVICE. DOING SO WILL DELAY THE PROCESSING OF YOUR RETURN.

WE MUST RECEIVE YOUR SIGNED FORM BEFORE WE CAN ELECTRONICALLY TRANSMIT YOUR RETURN WHICH IS DUE ON AUGUST 15, 2012. WE WOULD APPRECIATE YOUR RETURNING THIS FORM AS SOON AS POSSIBLE AS THIS WILL EXPEDITE THE PROCESSING OF YOUR RETURN. THE INTERNAL REVENUE SERVICE WILL NOTIFY US WHEN YOUR RETURN IS ACCEPTED. YOUR RETURN IS NOT CONSIDERED FILED UNTIL THE INTERNAL REVENUE SERVICE CONFIRMS THEIR ACCEPTANCE, WHICH MAY OCCUR AFTER THE DUE DATE OF YOUR RETURN.

Form **8453-EO**

Exempt Organization Declaration and Signature for Electronic Filing

OIVIB NO.	1545-1679

For calendar year 2010, or tax year beginning -10/01, 2010, and ending -09/30, 20 11For use with Forms 990, 990-EZ, 990-PF, 1120-POL, and 8868

Department of the Treasury Internal Revenue Service

► See instructions on back. Name of exempt organization

Employer identification number

59-2315435 MARCO ISLAND HOSPITAL, INC. Type of Return and Return Information (Whole Dollars Only) Part I

Check the box for the type of return being filed with 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 of the return being filed with this form was blank, then leave line 1b, 2b, 3b, 4b, or 5b, whichever is applicable, blank (do not enter -0-). 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. **5**7 1. **7**.4.1

1a	Form 990 check here ightharpoonup in any (Form 990, Part VIII, column (A), line 12)	1b	<u>3,591,676.</u>
2a	Form 990-EZ check here D Total revenue, if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here b total tax (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here b Lax based on investment income (Form 990-PF, Part VI, line 5)	4b	
5a	Form 8868 check here b Balance due (Form 8868, line 3c)	5b	

Declaration of Officer

3	I authorize the U.S. Treasury and its designated Financial Agent to initiate an Automated Clearing House (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 t	this return	is being f	iled with	a state a	gency(ies	s) regulating	g charities	as part of	the IR	S Fed/State	prograr	m, I certify	that
ш	executed	the	electronic	disclosure	consent	contained	d within	this return	allowing	disclosure b	y the	IRS of this	Form !	990/990-EZ	/990-
	PF (as spe	cific	ally identific	ed in Part I	above) to	the select	ted 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 2010 electronic return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund.

Sign			_	.				
Here	Signature of officer	Date		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 all 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		Date	Check if also paid		Check if self-		ERO's SSN or PTIN
ERO's	signature			preparer	X	employed		PO0858539
Use	Firm's name (or	PRICEWATERHOUSECOOF	PERS LLP				EIN	13-4008324
Only	yours if self-employed),	2001 MARKET ST, SUI	TE 1700					
	address, and ZIP code	PHILADELPHIA		PA	191	03	Pho	one no. 267-330-3000
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	Print/Type preparer's name	Preparer's signature	Date	Check	if d	PTIN
	Firm's name	Firm's EIN ▶				
Use Only	Firm's address ▶			Phone no.		

For Privacy Act and Paperwork Reduction Act Notice, see back of form.

Form **8453-EO** (2010)

0E1675 0.060

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

Open to Public Inspection

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

<u> </u>	OI III	e 2010	Calendar year, or tax ye	ear beginning		10/	01,2010,	and endi	iy			30,20		
В с	heck if ap	plicable:	C Name of organization							D Employer id		tion numbe	er	
_	Addre		MARCO ISLAND H	OSPITAL, I	NC.					59-231	5435			
	chang	je	Doing Business As		P 14 4									
	Name	change	Number and street (or P.O. I		livered to str	eet address)		Room/suite		E Telephone r				
	Initial	return	40 HEATHWOOD D							(239) 51	<u>.3 – 76</u>	30		
	Termi		City or town, state or country	/, and ZIP + 4										
	Amen return		MARCO ISLAND,							G Gross receip			32,	790.
	Applic pendi		F Name and address of prince	cipal officer:	VICKI	D. ORR				H(a) Is this a grown affiliates?	up return fo	or Y	res	X No
			P.O. BOX 41302	9, NAPLES,	FL 34	101-302	2.9			H(b) Are all affilia	ates include	ed? \	res	No
<u> </u>	Tax-ex	cempt st	tatus: X 501(c)(3)	501(c)()	(inserting)	t no.)	4947(a)(1) o	r 5	27	If "No," atta	ch a list. (s	ee instruction	ns)	
J	Websi	te: 🕨	WWW.NCHMD.ORG							H(c) Group exem	ption numb	ber >		
K	Form o	of organ	nization: X Corporation	Trust Asso	ciation	Other >		L Year	of format	tion: 1983 M	State of	legal domi	icile:	FL
Pa	rt I	Sui	mmary											
	1	Briefly	describe the organization's	mission or most	significant	activities:								
_			OUGH THE PROVISION				CARE, O	UR MISS	SION	IS TO				
nce		PRON	MOTE, MAINTAIN AN	ID RESTORE	HEALTI	H FOR T	HOSE WE	SERVE						
rna														
Governance	2	Check	k this box if the org	anization discon	tinued its o	perations or	disposed o	of more than	1 25% o	f its net assets.				
<u>ن</u> ھ	3	Numb	per of voting members of the	governing body	Part VI, lin	ie 1a)					3			17.
es S	4		er of independent voting me		•		41.5							17.
Activities	5	Total r	number of individuals employ	ved in calendar v	ear 2010 (Part V. line	O - \				· _			28.
\cti	6		number of volunteers (estima											110.
`	7a		gross unrelated business rev	• •							7a			0.
	b	•	nrelated business taxable inc			` ''					7b			0.
		110t ui	molated bacilloco taxable ille		000 1, 11110	0			1	Prior Year	1.0	Currer	nt Ye	
	8	Contri	ibutions and grants (Part VIII	line 1h)							0.			0.
Revenue	9		am service revenue (Part VII							3,301,1		3 4	25	621.
Ver	10	Invoct	tment income (Part VIII, colu	n, iii le 2y) mn (Λ) lines 3 /	and 7d)						94.	٥,٦	20,	613.
å	11					and 11a\			·	172,5		165,442		
			revenue (Part VIII, column (line 10\			3,474,02				676.
	12 13		revenue - add lines 8 through			2)				3,474,02	0.	3,3	· υ ⊥ ,	0.0.
			• • •	and similar amounts paid (Part IX, column (A), lines 1-3) s paid to or for members (Part IX, column (A), line 4)							0.			0.
	14						5 40)							
Expenses	15		es, other compensation, emp				-		•	1,900,7.		2,0	55,	002.
ens			ssional fundraising fees (Par	, ,	•				-		0.			0.
Ĕ			fundraising expenses (Part I	, ,				<u>.</u>		1 216 05	7.0	1 0	2.0	4 - 1
	17		expenses (Part IX, column (1,316,2				451.
	18		expenses. Add lines 13-17 (r		•	` '' '				3,271,99				453.
<u>, </u>	19	Reven	nue less expenses. Subtract	line 18 from line	12					202,0				223.
Net Assets or Fund Balances									Begir	nning of Current		End o		
sset	20									6,321,4				664.
ag P	21		liabilities (Part X, line 26)						-	333,0				297.
			ssets or fund balances. Subt	ract line 21 from	line 20 .				.	5,988,38	31.	6,1	95,	367.
	rt II		gnature Block											
cor	der per rect, a	naities of nd comp	of perjury, I declare that I have explete. Declaration of preparer (o	xamined this return ther than officer) is	i, including a s based on a	accompanying ill information	g schedules of which pre	and statemer eparer has ar	nts, and t ny knowle	o the best of my ledge.	knowleag	ge and belie	et, it is	s true,
_	_	Ι												
	ign													
Н	ere		Signature of officer							Date				
			Type or print name and title									T		
Dair		Print/	Type preparer's name	Pre	parer's signa	ature		Date		Check if self-		PTIN		
Paid	a parer									employed	-	P0085	585	39
	Only	Firm's	s name ▶ PRICEWATE	RHOUSECOOL	PERS LI	ıΡ				Firm's EIN		008324		
		Firm's	s address > 2001 MARKET S'	T, SUITE 1700	PHILADELP	HIA, PA 19	103			Phone no.	267-	330-30		
May	the II		cuss this return with the prep									X Yes	,	No

For Paperwork Reduction Act Notice, see the separate instructions.

Pa	rt III	Statement of Program Service A Check if Schedule O contains a re	Accomplishments esponse to any question in this Part III		
		escribe the organization's mission of CHA	on: ARITABLE HEALTHCARE, OUR MI	SSION IS TO	
			RE HEALTH FOR THOSE WE SERV		
	the prio		nificant program services during the your schedule O.		No
3	service	?	or make significant changes in how it		No
4	Describ Section	501(c)(3) and 501(c)(4) organiza	ents for each of the organization's three	required to report the amount of grants and	
4a	(Code:) (Expenses \$ 2	, ₉₀₉ , ₃₅₉ including grants of \$) (Revenue \$ 3,442,070.)	
			TES AN 11 1/2-HOUR/7-DAYS A		
	CARE	FACILITY AND SERVICES H	PATIENTS WITHOUT REGARD TO	THEIR	
	ABILI	Y TO PAY. DURING FYE	9/30/11, 8,054 PATIENTS WER	E TREATED.	
			ERE CLASSIFIED AS MEDICAID,		
	BAD D		·		
4b	(Code:) (Expenses \$	including grants of \$) (Revenue \$)	
4c	(Code:) (Expenses \$	including grants of \$) (Revenue \$)	
4d	-	ogram services. (Describe in Sch	edule O.)		
	(Expens)	
4e	Total p	ogram service expenses >	2,909,359.		

Part	Checklist of Required Schedules		V	
			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes,"	_	37	
•	complete Schedule A	1	X	Х
2	Is the organization required to complete Schedule B, Schedule of Contributors? (see instructions)	2		Λ
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to	3		Х
	candidates for public office? If "Yes," complete Schedule C, Part I	3		Λ
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h)	4		Х
_	election in effect during the tax year? If "Yes," complete Schedule C, Part II	-		Λ
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C,			
		5		
6	Part III			
O	the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes,"			
	complete Schedule D, Part I	6		Х
7	Did the organization receive or hold a conservation easement, including easements to preserve open space,			
•	the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II.</i>	7		Х
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If</i> "Yes,"			
	complete Schedule D, Part III	8		Х
9	Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part			
	X; or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes,"			
	complete Schedule D, Part IV	9		Х
10	Did the organization, directly or through a related organization, hold assets in term, permanent, or			
	quasi-endowments? If "Yes," complete Schedule D, Part V	10		Х
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI,			
	VII, VIII, IX, or X as applicable.			
а	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete			
	Schedule D, Part VI	11a	Х	
b	Did the organization report an amount for investments—othersecurities in Part X, line 12 that is 5% or more			
	of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	11b		Х
С	Did the organization report an amount for investments-program related in Part X, line 13 that is 5% or more			
	of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII.	11c		Х
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets			
	reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	11d		Х
	Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses			
	the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	11f		Х
12 a	Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes,"	40.		37
	complete Schedule D, Parts XI, XII, and XIII.	12a		X
D	Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if	42h	Х	
12	the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional	12b 13	- 1	Х
13	Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i> Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
	Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising,	174		
b	business, and program service activities outside the United States? <i>If "Yes," complete Schedule F, Parts I and IV</i>	14b		Х
15	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any	- 		
	organization or entity located outside the United States? If "Yes," complete Schedule F, Parts II and IV	15		Х
16	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance			
-	to individuals located outside the United States? If "Yes," complete Schedule F, Parts III and IV	16		Х
17	Did the organization report a total of more than \$15,000 of expenses for professional fundraising services			
	on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)	17		Х
18	Did the organization report more than \$15,000 total of fundraising event gross income and contributions on			
	Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	18		Х
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a?			
	If "Yes," complete Schedule G, Part III	19		Х
20 a	Did the organization operate one or more hospitals? If "Yes," complete Schedule H	20a	Х	
b	If "Yes" to line 20a, did the organization attach its audited financial statements to this return? Note. Some Form			
	990 filers that operate one or more hospitals must attach audited financial statements (see instructions)	20b	X	

Part IV **Checklist of Required Schedules** (continued) Did the organization report more than \$5,000 of grants and other assistance to governments and organizations 21 Χ in the United States on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II 22 Did the organization report more than \$5,000 of grants and other assistance to individuals in the United States 22 Χ 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 Χ Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b 24a Χ 24b **b** Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? Did the organization maintain an escrow account other than a refunding escrow at any time during the year 24c d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? 25 a Section 501(c)(3) and 501(c)(4) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I Χ 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? 25b If "Yes," complete Schedule L, Part I 26 Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or Χ disqualified person outstanding as of the end of the organization's tax year? If "Yes," complete Schedule L, Part II, Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, 27 substantial contributor, or a grant selection committee member, or to a person related to such an individual? Χ 27 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): Χ a A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV...... b A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Χ An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV Χ 28c Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M 29 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified 30 Χ conservation contributions? If "Yes," complete Schedule M Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, 31 Χ Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," 32 Χ 33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations Χ 34 Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Parts II, III, 34 Χ Is any related organization a controlled entity within the meaning of section 512(b)(13)? Χ 35 Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes." complete Schedule R. Part V, line 2 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable 36 Χ 36 related organization? If "Yes," complete Schedule R, Part V, line 2 37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Χ Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and

Form 9	990 (2010) 59–2315435		ſ	Page \$
Part	t V Statements Regarding Other IRS Filings and Tax Compliance			
	Check if Schedule O contains a response to any question in this Part V			
			Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable 9			
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable 1b			
С	Did the organization comply with backup withholding rules for reportable payments to vendors and			
	reportable gaming (gambling) winnings to prize winners?	1c	Х	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax			
	Statements, filed for the calendar year ending with or within the year covered by this return . 28			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b	Х	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file. (see instructions)			

b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable 1b 0			
	Did the organization comply with backup withholding rules for reportable payments to vendors and			
	reportable gaming (gambling) winnings to prize winners?	1c	Χ	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax			
	Statements, filed for the calendar year ending with or within the year covered by this return 28			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b	Χ	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			
3 a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a		Χ
	If "Yes," has it filed a Form 990-T for this year? <i>If "No," provide an explanation in Schedule O</i>	3b		
	At any time during the calendar year, did the organization have an interest in, or a signature or other authority			
	over, a financial account in a foreign country (such as a bank account, securities account, or other financial			
	account)?	4a		Χ
b	If "Yes," enter the name of the foreign country:			
	See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.			
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		Χ
	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b		Χ
	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c		
	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the			
	organization solicit any contributions that were not tax deductible?	6a		Χ
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or			
	gifts were not tax deductible?	6b		
7	Organizations that may receive deductible contributions under section 170(c).			
	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods			
	and services provided to the payor?	7a		Χ
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b		
	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was			
	required to file Form 8282?	7c		Χ
d	If "Yes," indicate the number of Forms 8282 filed during the year			
е	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e		Χ
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f		Χ
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h		
8	Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting			
	organizations. Did the supporting organization, or a donor advised fund maintained by a sponsoring			
	organization, have excess business holdings at any time during the year?	8		
9	Sponsoring organizations maintaining donor advised funds.			
	Did the organization make any taxable distributions under section 4966?	9a		
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b		
10	Section 501(c)(7) organizations. Enter:			
	Initiation fees and capital contributions included on Part VIII, line 12			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities			
11	Section 501(c)(12) organizations. Enter:			
	Gross income from members or shareholders			
b	Gross income from other sources (Do not net amounts due or paid to other sources			
	against amounts due or received from them.)			
	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a		
	If "Yes," enter the amount of tax-exempt interest received or accrued during the year			
13	Section 501(c)(29) qualified nonprofit health insurance issuers.	120		
а	Is the organization licensed to issue qualified health plans in more than one state?	13a		
	Note. See the instructions for additional information the organization must report on Schedule O.			
a	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans			
-	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '			
		14a		X
	Did the organization receive any payments for indoor tanning services during the tax year? If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O	14a 14b		Λ
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0E1040 1.000	0 92699J 1467 V 10-8.3 NCH	i Oilli		AGE
	. 20 0.0			

Form 990 (2010) Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions. Check if Schedule O contains a response to any question in this Part VI Section A. Governing Body and Management Yes Nο 17 1a Enter the number of voting members of the governing body at the end of the tax year 17 **b** Enter the number of voting members included in line 1a, above, who are independent Did any officer, director, trustee, or key employee have a family relationship or a business relationship with Χ 2 any other officer, director, trustee, or key employee? Did the organization delegate control over management duties customarily performed by or under the direct 3 3 supervision of officers, directors or trustees, or key employees to a management company or other person? 4 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? 5 5 Did the organization become aware during the year of a significant diversion of the organization's assets? 6 Does the organization have members or stockholders? 6 7a Does the organization have members, stockholders, or other persons who may elect one or more members X 7a Χ 7b **b** Are any decisions of the governing body subject to approval by members, stockholders, or other persons? Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: X 8b **b** Each committee with authority to act on behalf of the governing body? Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.) Yes 10a Χ 10 a Does the organization have local chapters, branches, or affiliates? b If "Yes," does the organization have written policies and procedures governing the activities of such chapters, 10b Χ affiliates, and branches to ensure their operations are consistent with those of the organization? 11a Has the organization provided a copy of this Form 990 to all members of its governing body before filing the 11a **b** Describe in Schedule O the process, if any, used by the organization to review this Form 990. Χ 12a 12a Does the organization have a written conflict of interest policy? If "No," go to line 13 b Are officers, directors or trustees, and key employees required to disclose annually interests that could give Χ 12b rise to conflicts? c Does the organization regularly and consistently monitor and enforce compliance with the policy? 12c Χ describe in Schedule O how this is done Χ 13 13 Does the organization have a written whistleblower policy? Χ 14 14 Does the organization have a written document retention and destruction policy? 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? Χ 15a The organization's CEO, Executive Director, or top management official 15b If "Yes" to line 15a or 15b, describe the process in Schedule O. (See instructions.) 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement X with a taxable entity during the year? 16a b If "Yes," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken steps to safeguard the organization's exempt status with respect to such arrangements? Section C. Disclosure 17 List the states with which a copy of this Form 990 is required to be filed Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) 18 available for public inspection. Indicate how you make these available. Check all that apply. X Upon request X Own website Another's website Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest 19 policy, and financial statements available to the public.

organization: ►VICKI ORR, CFO/ASST TREASURER, 350 7TH STREET NORTH, NAPLES, FL 34102 (239)513-7630JSA 0E1042 1.000 Form **990** (2010)

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

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

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

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

- 1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.
- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
 - List all of the organization's current key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

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

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

(A) Name and Title	(B) Average	(C) Position (check all that apply)					lv)	(D) Reportable	(E) Reportable	(F) Estimated
ATTACHMENT 2	hours per week (describe hours for related organizations			Officer		Highest compensated employee	Former	compensation from the organization (W-2/1099-MISC)	compensation from related organizations (W-2/1099-MISC)	amount of other compensation from the organization and related organizations
(1) JAMES B. KAUFFMAN, JR.										
CHAIRMAN	2.00	X		Χ				0.	0.	. 0
(2) ALLEN S. "SKIP" MERRIAM III 1ST VICE CHAIRMAN	2.00	Х		Х				0.	0.	. 0
(3) JOHN L. (JACK) PATTERSON 2ND VICE CHAIRMAN	2.00	Х		Х				0.	0.	. 0
(4) BROOKS C.B. WOOD 3RD VICE CHAIRMAN	2.00	Х		Х				0.	0.	. 0
(5) RICHARD G. ADAMS SECRETARY/TREASURER	2.00	Х		Х				0.	0.	. 0
(6) GAIL CACCIOLA, R.N., EDD TRUSTEE	2.00	Х						0.	0.	. 0
(7) DAVID FENELON TRUSTEE	2.00	Х						0.	0.	. 0
(8) KEVIN FITZGERALD TRUSTEE	2.00	Х						0.	0.	. 0
(9) JUDY GERWIRTZ TRUSTEE	2.00	Х						0.	0.	. 0
(10)GEORGE R. BENSON TRUSTEE	2.00	Х						0.	0.	. 0
(11)MARY ANN (M.A.) KLINE TRUSTEE	2.00	Х						0.	0.	. 0
(12)MARGARET LANOIX TRUSTEE	2.00	Х						0.	0.	. 0
(13)ROBERT A. (BOB) MARKS TRUSTEE	2.00	Х						0.	0.	. 0
(14)MICHAEL STEPETIC TRUSTEE	2.00	Х						0.	0.	. 0
(15)SAL A. SOLDANO TRUSTEE	2.00	Х						0.	0.	. 0
(16)RALPH LOLLI TRUSTEE	2.00	Х						0.	0.	. 0

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Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees(continued)									ontinued)
(A)	(B)		(C)			(D)	(E)	(F)
Name and title	Average hours per week (describe hours for related organizations in Schedule O)	Individual trustee or director	Officer (c) Institutional trustee	Key employee	a Highest compensated employee	Former	Reportable compensation from the organization (W-2/1099-MISC)	Reportable compensation from related organizations (W-2/1099-MISC)	Estimated amount of other compensation from the organization and related organizations
(17) ELIZABETH (BONNIE) BOZZO									
TRUSTEE	2.00	Х					0.	0.	0.
(18) ALLEN S. WEISS, M.D.									
PRESIDENT/CEO	1.00		X				0.	643,511.	55,504.
(19) KEVIN D. COOPER									
GENERAL COUNSEL/CHIEF OF STAFF	1.00		X				0.	374,799.	18,113.
(20) PHILLIP DUTCHER	1 00							276 600	10 401
COO, NCH HEALTHCARE SYSTEM	1.00		X				0.	376,608.	10,431.
(21) AURORA ESTEVEZ, M.D. CHIEF MEDICAL OFFICER	1.00						0.	204 146	18,216.
(22) VICKI D. ORR	1.00		^				0.	394,146.	10,210.
CFO/ASSISTANT TREASURER	1.00						0.	369,494.	31,028.
(23) ELIZABETH MARTIN	1.00		1 21				0.	303, 434.	31,020.
ASSISTANT SECRETARY	1.00		X				0.	59,103.	14,080.
(24) BRIAN SETTLE	1.00		1					33,1331	
CHIEF HUMAN RESOURCES OFFICER	1.00		X				0.	254,326.	23,972.
(25) SUSAN WOLFF								,	· · · · · · · · · · · · · · · · · · ·
CHIEF INFORMATION OFFICER	1.00		X				0.	261,411.	17,919.
(26) MICHAEL RILEY									
CHIEF STRATEGY OFFICER	1.00		X				0.	189,961.	29 , 055.
(27) JAMES K. MARTIN									
CHIEF DEVELOP OFFICER	1.00		X				0.	298,520.	13,603.
(28) MICHELE THOMAN									
CNO	1.00		X				0.	242,658.	22,465.
1b Sub-total						>	0.	-,,	254,386.
c Total from continuation sheets to Part VII, Sec							118,603.		35,108.
d Total (add lines 1b and 1c)						<u> </u>	118,603.		289,494.
2 Total number of individuals (including but not lin reportable compensation from the organization				e) v	vno re	ceiv	red more than \$100	1,000 in	
Teportable compensation from the organization		-	L						Yes No
2 Did the exempleation list only former office				_			laaa aa biabaad		Tes No
3 Did the organization list any former offic employee on line 1a? If "Yes," complete Sched									3 X
4 For any individual listed on line 1a, is the									
the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual									
5 Did any person listed on line 1a receive or									
for services rendered to the organization? <i>If "Y</i>									5 X
Section B. Independent Contractors									
1 Complete this table for your five highest	compensat	ed in	depen	dent	conf	ract	tors that received	d more than \$10	0,000 of
componentian from the organization									

compensation from the organization.

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

Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ▶ 0

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JSA

Par	t VIII	Statement of Revenue					
				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a b c d e f	Federated campaigns					
ont nd c	g	Noncash contributions included in lines 1a-1f: \$ _					
	h	Total. Add lines 1a-1f	<u></u>	0.			
nue			Business Code				
Program Service Revenue	2a b	NET PATIENT SERVICE REVENUE	622110	3,425,621.	3,425,621.		
ž	С						
J Se	d						
Izan	е	-					
roc	f	All other program service revenue Total. Add lines 2a-2f		2 405 601			
	<u>g</u>			3,425,621.			
	3	Investment income (including dividends, interother similar amounts) ATTACHMENT	est, and 3	613.	0.	0.	613.
			_	0.	0.	0.	013.
	4 5	Income from investment of tax-exempt bond p Royalties		0.			
	3	(i) Real	(ii) Personal	0.			
	6a	Gross Rents	7				
	b	Less: rental expenses 41,11					
	C	Rental income or (loss)					
	d	Net rental income or (loss)		148,993.			148,993.
		(i) Securities	(ii) Other	,			
	7a	Gross amount from sales of assets other than inventory					
	b	Less: cost or other basis					
		and sales expenses					
	С	Gain or (loss)					
	d	Net gain or (loss)		0.			
<u>•</u>	8a	Gross income from fundraising					
Other Revenue		events (not including \$					
ě		of contributions reported on line 1c).					
2		See Part IV, line 18					
he	b	Less: direct expenses					
ō	С	Net income or (loss) from fundraising events	. <u></u>	0.			
	9a	Gross income from gaming activities.					
		See Part IV, line 19					
	b	Less: direct expenses					
	4.	Net income or (loss) from gaming activities		0.			
	10a	Gross sales of inventory, less returns and allowances					
	<u>_</u>	Less: cost of goods sold					
	b	Net income or (loss) from sales of inventory		0.			
		Miscellaneous Revenue	Business Code	ÿ.			
	11a	AUXILIARY SALES REVENUE	900099	15,996.	15,996.		
	b	OTHER OPERATING REVENUE	900099	453.	453.		
	c						
	d	All other revenue					
	e	Total. Add lines 11a-11d		16,449.			
	12	Total revenue. See instructions		3,591,676.	3,442,070.	0.	149,606.

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).

	not include amounts reported on lines 6b, , 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1	Grants and other assistance to governments and	0.			
_	organizations in the U.S. See Part IV, line 21	0.			
2	Grants and other assistance to individuals in the U.S. See Part IV, line 22	0.			
•		0.			
3	Grants and other assistance to governments, organizations, and individuals outside the				
	U.S. See Part IV, lines 15 and 16	0.			
4	Benefits paid to or for members	0.			
5	Compensation of current officers, directors,				
3	trustees, and key employees	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.			
7	Other salaries and wages	1,660,897.	1,444,980.	215,917.	0.
8	Pension plan contributions (include section 401(k)	, ,	, ,		
·	and section 403(b) employer contributions)	58 , 270.	50,695.	7,575.	0.
9	Other employee benefits	214,423.	186,548.	27,875.	0.
10	Payroll taxes	121,412.	105,628.	15,784.	0.
11	Fees for services (non-employees):	,	,	·	
	Management	0.			
	Legal	0.			
	Accounting	0.			
	Lobbying	0.			
	Professional fundraising services. See Part IV, line 17	0.			
	Investment management fees	0.			
	Other	176,420.	153,485.	22,935.	0.
12	Advertising and promotion	9,961.	8,666.	1,295.	0.
13	Office expenses	292,794.	254,731.	38,063.	0.
14	Information technology	0.			
15	Royalties	0.			
16	Occupancy	154,808.	134,683.	20,125.	0.
17	Travel	3,331.	2,898.	433.	0.
18	Payments of travel or entertainment expenses				
	for any federal, state, or local public officials	0.			
19	Conferences, conventions, and meetings	0.			
20	Interest	0.			
21	Payments to affiliates	0.			
22	Depreciation, depletion, and amortization	222,173.	193,291.	28,882.	0.
23	Insurance	45,268.	39,383.	5,885.	0.
24	Other expenses. Itemize expenses not covered				
	above (List miscellaneous expenses in line 24f. If				
	line 24f amount exceeds 10% of line 25, column				
	(A) amount, list line 24f expenses on Schedule O.)				
	BAD DEBT EXPENSES	332,199.	332,199.	0.	0.
b	OTHER MISCELLANEOUS EXPENSES _	2,497.	2,172.	325.	0.
С					
d					
е					
	All other expenses				0.
	Total functional expenses. Add lines 1 through 24f	3,294,453.	2,909,359.	385,094.	0.
26	Joint Costs. Check here ▶ if following SOP 98-2 (ASC 958-720). Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				
JSA					Form 990 (2010)

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Part X Balance Sheet

Fe	irt X	Balance Sheet			
			(A) Beginning of year		(B) End of year
	1	Cash - non-interest-bearing	25,913.	1	24,616.
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	323,294.	4	435,183.
	5	Receivables from current and former officers, directors, trustees, key			
		employees, and highest compensated employees. Complete Part II of			
		Schedule L		5	
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons			
		described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of			
		section 501(c)(9) voluntary employees' beneficiary organizations (see instructions)		6	
Assets	7	Notes and loans receivable, net		7	
Ass	8	Inventories for sale or use		8	
	9	Prepaid expenses and deferred charges		9	
	10 a	Land, buildings, and equipment: cost or			
		other basis. Complete Part VI of Schedule D 10a 9,855,952.			
	b	Less: accumulated depreciation	5,952,034.	10c	5,964,623.
	11	Investments - publicly traded securities		11	
	12	Investments - other securities. See Part IV, line 11		12	
	13	Investments - program-related. See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	20,208.		12,242.
	16	Total assets. Add lines 1 through 15 (must equal line 34)	6,321,449.	16	6,436,664.
	17	Accounts payable and accrued expenses	280,712.	17	203,647.
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities		20	
es	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
Liabilities	22	Payables to current and former officers, directors, trustees, key			
jab		employees, highest compensated employees, and disqualified persons.			
_		Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties	50.056	24	
	25	Other liabilities. Complete Part X of Schedule D	52,356.		37,650.
_	26	Total liabilities. Add lines 17 through 25	333,068.	26	241,297.
		Organizations that follow SFAS 117, check here \(\subseteq \text{\$\subseteq \seteq \text{\$\subseteq \text{\$\subseteq \text{\$\subseteq \text{\$\subseteq \seteq \seteq \seteq \seteq \seteq \seteq \seteq \s			
Ses	27		5,988,381.	0.7	6 105 267
lan	27 28	Unrestricted net assets	3,900,301.	27	6,195,367.
Ba	29	Permanently restricted net assets		28	
pu	23	Organizations that do not follow SFAS 117, check here and		29	
Net Assets or Fund Balances		complete lines 30 through 34.			
ts c	30	Capital stock or trust principal, or current funds		30	
Se	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
Ą	32	Retained earnings, endowment, accumulated income, or other funds		32	
Š	33	Total net assets or fund balances	5,988,381.	33	6,195,367.
	34	Total liabilities and net assets/fund balances	6,321,449.	34	6,436,664.

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Pa	Reconciliation of Net Assets Check if Schedule O contains a response to any question in this Part XI		 	X	
1	Total revenue (must equal Part VIII, column (A), line 12)	1	3,5	91,6	576.
2	Total expenses (must equal Part IX, column (A), line 25)	2	3,2	94,4	153.
3	Revenue less expenses. Subtract line 2 from line 1	3	297,223.		
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	5,988,381.		
5	Other changes in net assets or fund balances (explain in Schedule O)	5	_	90,2	237.
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33,				
	column (B))	6	6,1	95 , 3	367.
Pa	Financial Statements and Reporting Check if Schedule O contains a response to any question in this Part XII		 		
				Yes	No
1	Accounting method used to prepare the Form 990: Cash X Accrual Other				
	If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.				
2a			2a		Х
b		• •	 2b	X	
C	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight or	F			
-	the audit, review, or compilation of its financial statements and selection of an independent accountant?		2c	X	
	If the organization changed either its oversight process or selection process during the tax year, explain in				
	Schedule O.				
d					
	issued on a separate basis, consolidated basis, or both:				
	Separate basis X Consolidated basis 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?		3a		Х
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the	• •			
	required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.		3b		

SCHEDULE A (Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047
2010

Department of the Treasury Internal Revenue Service

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

► Attach to Form 990 or Form 990-EZ. ► See separate instructions.

Open to Public Inspection

Nan	ame of the organization Employer identification number												
MA	RCO	ISLAND HOSPITA	AL, INC.							59	-2315	435	
	rt I			s (All organizations mus		•			e instru	ıctions			
The	orga	· · · · · · · · · · · · · · · · · · ·		use it is: (For lines 1 throu	-		-	-					
1		A church, convention	n of churches, or a	ssociation of churches des	scribed	in s	ection	170(b)(1	I)(A)(i).				
2	Ш			1)(A)(ii). (Attach Schedule									
3	X		· · · · · · · · · · · · · · · · · · ·	vice organization describe			-		-				
4				erated in conjunction wi	th a h	ospita	I descri	ibed in	sectio	n 170(b	o)(1)(A)(i	iii). Ente	er the
_		hospital's name, cit		. – – . – . – . – . – . –									
5		An organization op section 170(b)(1)(A		nefit of a college or universely.	ersity	owned	or ope	erated b	by a go	vernme	ntal uni	t describ	ed in
6				·	ned in	sect	ion 170	(b)(1)(A)(v).				
7		A federal, state, or local government or governmental unit described in section 170(b)(1)(A)(v). An organization that normally receives a substantial part of its support from a governmental unit or from the general public											
-		described in sectio	= = = = = = = = = = = = = = = = = = =	•	o oupp							900.0.	
8				on 170(b)(1)(A)(vi). (Com	plete F	Part II.)							
9				es: (1) more than 33 1/3 %				contrib	utions.	membe	ership fe	ees. and	aross
		=	=	exempt functions - subj							-		-
		•		ome and unrelated busin									
				e 30, 1975. See section							,		
10				ed exclusively to test for pu						-			
11		An organization or	ganized and oper	rated exclusively for the	benef	fit of,	to perf	orm the	e functi	ions of	, or to	carry ou	it the
	purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See section												
		509(a)(3). Check th	ne box that describ	es the type of supporting	organi	zation	and co	mplete	lines 11	le th <u>rou</u>	<u>ıg</u> h 11h		
		a Type I	b Type				•	-		d		III - Other	
e	<u> </u>	By checking this I	box, I certify that	the organization is not	contro	olled o	directly	or indi	rectly	by one	or moi	re disqua	alified
		•		gers and other than one	or mo	re pub	licly su	pported	organi	izations	descri	bed in se	ection
		509(a)(1) or section	`										
f		_		n determination from the	e IRS	that it	is a T	ype I, 1	ype II,	or Typ	e III sup	oporting	
		organization, check											
ć	J	=	006, has the organi	zation accepted any gift or	contri	oution	from an	y of the					
		following persons?	directly or indire	atly controls sither class		o a o th o	طائند س		a daga	سنام مان	· /::\	Yes	No
			=	ctly controls, either alor ly of the supported organ		_	ei witti	person	s desci	ibed iii		11g(i)	110
		(ii) A family memb		• •	ization	٠					⊢	11g(ii)	+
		• •	•	n described in (i) or (ii) abo	ove?						· · · ⊢	1g(iii)	+
ŀ	,		-	t the supported organization								-5()	
		ame of supported	(ii) EIN	(iii) Type of organization		Is the	(v) Did v	ou notify	(vi)	ls the	(vii)	Amount o	
	(-,	organization	(,	(described on lines 1-9	organiz	ation in	the orga	anization	organiz	ation in		support	
				above or IRC section (see instructions))	your go			. (i) of upport?		rganized U.S.?			
					Yes	No	Yes	No	Yes	No	1		
(A)													
(B)													
(C)													
(D)													
(E)													
_	_												
Tot	al												

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

Schedule A (Form 990 or 990-EZ) 2010

Part II

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

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

Sec	tion A. Public Support				_		
Caler	ndar year (or fiscal year beginning in)	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3	The value of services or facilities furnished by a governmental unit to the organization without charge						
4	Total . Add lines 1 through 3						
5	The portion of total contributions by each						
	person (other than a governmental unit or publicly supported organization) included						
	on line 1 that exceeds 2% of the amount						
6	shown on line 11, column (f) Public support. Subtract line 5 from line 4.						
	tion B. Total Support						
	ndar year (or fiscal year beginning in)	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
7	Amounts from line 4	. ,				. ,	
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar						
	sources						
9	Net income from unrelated business activities, whether or not the business is regularly carried on						
10	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11	Total support. Add lines 7 through 10						
12	Gross receipts from related activities, etc. (se	ee instructions) .				12	
13	First five years. If the Form 990 is forganization, check this box and stop here	or the organizat	ion's first, secor	nd, third, fourth,	or fifth tax ye	ar as a section	501(c)(3)
Sec	tion C. Computation of Public Sup	port Percenta	age				
14	Public support percentage for 2010 (line	e 6, column (f) d	ivided by line 11	, column (f))		14	<u>%</u>
15	Public support percentage from 2009 S	chedule A, Part	II, line 14			15	<u></u>
16a	33 1/3 % support test - 2010. If the o	-					re, check
	this box and stop here . The organization						▶ □
b	33 1/3 % support test - 2009. If the c						
	check this box and stop here . The orga						
17a	10%-facts-and-circumstances test - 2						
	or more, and if the organization me						
	Part IV how the organization meets to			_			supported
	organization						
b	10%-facts-and-circumstances test - 15 is 10% or more and if the organ	-	=				
	15 is 10% or more, and if the organization in Part IV how the organization						
	Explain in Part IV how the organization						publicly
10	supported organization Private foundation. If the organizatio						and soc
18	_						
	instructions						<u> </u>

Schedule A (Form 990 or 990-EZ) 2010

92699J 1467 V 10-8.3 NCH PAGE 15

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Schedule A (Form 990 or 990-EZ) 2010

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Sec	tion A. Public Support						
C	alendar year (or fiscal year beginning in) 🕨	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1	Gifts, grants, contributions, and membership fees						
	received. (Do not include any "unusual grants.")						
2	Gross receipts from admissions, merchandise						
	sold or services performed, or facilities						
	furnished in any activity that is related to the						
	organization's tax-exempt purpose						
3	Gross receipts from activities that are not an						
	unrelated trade or business under section 513						
4	Tax revenues levied for the organization's						
	benefit and either paid to or expended on						
	its behalf						
5	The value of services or facilities						
-	furnished by a governmental unit to the						
	organization without charge						
6	Total. Add lines 1 through 5						
	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						
•	Add lines 7a and 7b						
R	Public support (Subtract line 7c from						
·	line 6.)						
Sec	tion B. Total Support						
	alendar year (or fiscal year beginning in)	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
9	Amounts from line 6						
	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						
С	Add lines 10a and 10b						
11	Net income from unrelated business						
	activities not included in line 10b,						
	whether or not the business is regularly						
40	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 vear a	as a section 501	c)(3)
• •	organization, check this box and stop here	•			•	•	
Sec	tion C. Computation of Public Sup						
15	Public support percentage for 2010 (line 8, co			(f))		15	%
16	Public support percentage from 2009 Schedu	ıle A, Part III, line	15			16	%
Sec	tion D. Computation of Investment						
17	Investment income percentage for 2010 (lir			, column (f))		17	%
18	Investment income percentage from 2009 S					18	%
	33 1/3 % support tests - 2010. If the org						
	17 is not more than 331/3 %, check thi						
b	33 1/3 % support tests - 2009. If the orga		-	-		• • •	
-	line 18 is not more than 331/3 %, check						. —
20	Private foundation. If the organization		-				

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Schedule A (Form 990 or 990-EZ) 2010 Page **4**

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

Schedule A (Form 990 or 990-EZ) 2010

SCHEDULE D (Form 990)

Supplemental Financial Statements

2010

OMB No. 1545-0047

Department of the Treasury Internal Revenue Service

Name of the organization

► 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.

Open to Public Inspection

Employer identification number

MAF	CO ISLAND HOSPITAL, INC.	59-2315435
Par	Organizations Maintaining Donor Advised Funds or Other Similar Funds or organization answered "Yes" to Form 990, Part IV, line 6.	r Accounts Complete if the
	(a) Donor advised funds	(b) Funds and other accounts
4		(-).
1 2	Total number at end of year	
3	Aggregate contributions to (during year)	
4	Aggregate yelve at and of year	
5	Aggregate value at end of year	advised
3		Yes No
6	Did the organization inform all grantees, donors, and donor advisors in writing that grant funds ca	
•	used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any	
	purpose conferring impermissible private benefit?	
Par	Conservation Easements. Complete if the organization answered "Yes" to Fo	rm 990, Part IV, line 7.
1	Purpose(s) of conservation easements held by the organization (check all that apply).	, ,
	Preservation of land for public use (e.g., recreation or education)	an historically important land area
		a certified historic structure
	Preservation of open space	
2	Complete lines 2a through 2d if the organization held a qualified conservation contribution in the	form of a conservation
	easement on the last day of the tax year.	
		Held at the End of the Tax Year
а	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
С	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a	
	historic structure listed in the National Register	2d
3	Number of conservation easements modified, transferred, released, extinguished, or terminated	by the organization during the
	tax year ▶	
4	Number of states where property subject to conservation easement is located	
5	Does the organization have a written policy regarding the periodic monitoring, inspection, handlir violations, and enforcement of the conservation easements it holds?	-
6	violations, and enforcement of the conservation easements it holds? Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easeme	
0	Translation volunteer flours devoted to floring firspecting, and emoting conservation easement	nts during the year
7	Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements d	luring the year
•	►\$	ianing the year
8	Does each conservation easement reported on line 2(d) above satisfy the requirements of section	n 170(h)(4)(B)
	(i) and 170(h)(4)(B)(ii)?	
9	In Part XIV, describe how the organization reports conservation easements in its revenue and ex	pense statement, and
	balance sheet, and include, if applicable, the text of the footnote to the organization's financial st	atements that describes the
	organization's accounting for conservation easements.	
Par		r Similar Assets.
	Complete if the organization answered "Yes" to Form 990, Part IV, line 8.	
1a	If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its rworks of art, historical treasures, or other similar assets held for public exhibition, educ	revenue statement and balance sheet
	public service, provide, in Part XIV, the text of the footnote to its financial statements that des	cribes these items.
b	If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its re-	evenue statement and balance sheet
	works of art, historical treasures, or other similar assets held for public exhibition, educe public service, provide the following amounts relating to these items:	cation, or research in furtherance of
	(i) Revenues included in Form 990, Part VIII, line 1	▶ \$
	(ii) Assets included in Form 990, Part X	
2	If the organization received or held works of art, historical treasures, or other similar a	
	following amounts required to be reported under SFAS116 (ASC958) relating to these items	s:
а	Revenues included in Form 990, Part VIII, line 1	
<u>b</u>	Assets included in Form 990, Part X	▶ \$

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Schedule D (Form 990) 2010 59-2315435 Page **2**

Par	t III Organizations Maintaining Co	llections of Art, Histo	rical Treasures	, or Other Similar	Assets(continued)
3	Using the organization's acquisition, according to the collection items (check all that apply):	ession, and other recor	ds, check any of	the following that	are a significant use of its
_		4 -] Loop or eyek	ango programa	
a	Public exhibition	d _		ange programs	
b	Scholarly research	e	Other		
С	Preservation for future generation				
4	Provide a description of the organization	s collections and expla	ain how they furth	ner the organization	's exempt purpose in Part
	XIV.				
5	During the year, did the organization solici				
	assets to be sold to raise funds rather than	<u> </u>			
Par	t IV Escrow and Custodial Arrange line 9, or reported an amount or			inswered "Yes" to	Form 990, Part IV,
	Letter consideration on another tracks and	diaman and the contrate one and the			
та	Is the organization an agent, trustee, custo		-		□ vaa □ Na
	included on Form 990, Part X?				Yes No
b	If "Yes," explain the arrangement in Part XI	v and complete the folic	wing table:		
	D : : 1 1		-		Amount
C	Beginning balance			1c	
d	Additions during the year			1d	
е	Distributions during the year			1e	
ţ	Ending balance		_	1f	
2a	Did the organization include an amount on		21?		Yes No
	If "Yes," explain the arrangement in Part XI				
Par	•				
		urrent year (b) Prior ye	ar (c) Two year	s back (d) Three ye	ears back (e) Four years back
1a	Beginning of year balance				
b	Contributions				
С	Net investment earnings, gains,				
_	and losses				
d	Grants or scholarships				
е	Other expenditures for facilities .				
	and programs				
f	Administrative expenses				
g	End of year balance				
2	Provide the estimated percentage of the y				
а	Board designated or quasi-endowment	%			
b		6			
	Term endowment ▶%				
3a	Are there endowment funds not in the pos	session of the organizat	ion that are held a	nd administered for t	
	organization by:				Yes No
	(i) unrelated organizations				
	(ii) related organizations				
b	If "Yes" to 3a(ii), are the related organization	•			3b
4	Describe in Part XIV the intended uses of t				
Par		ntSee Form 990, Par	t X, line 10.		
	Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basi (other)	s (c) Accumulated depreciation	(d) Book value
1a	Land		2,375,830).	2,375,830.
b	Buildings	0.	5,840,22	5. 2,682,100	. 3,158,126.
С	Leasehold improvements	•			
d	Equipment	0.	1,639,89	5. 1,209,229	430,667.
е	Other			0. 0	0.
Tota	I. Add lines 1a through 1e. (Column (d) mus	st equal Form 990, Part 2	K, column (B), line	10(c).) ▶	5,964,623.

Schedule D (Form 990) 2010 59-2315435 Page **3**

Part VII	Investments - Other Securities. See Fo	rm 990, Part X, lin	e 12.		Ţ.
	(a) Description of security or category (including name of security)	(b) Book value		(c) Method of valuate Cost or end-of-year mar	
(1) Financia	al derivatives				
(2) Closely	-held equity interests				
(3) Other_					
<u>(A)</u>					
(B)					
<u>(C)</u>					
(D)					
(E)					
(F)					
<u>(G)</u>					
(11)					
	n (b) must equal Form 990, Part X, col. (B) line 12.)				
Part VIII	Investments - Program Related. See Fo	rm 990. Part X. lin	e 13.		
	(a) Description of investment type	(b) Book value		(c) Method of valuate Cost or end-of-year mar	
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
	in (b) must equal Form 990, Part X, col. (B) line 13.)	. 45			
Part IX	Other Assets. See Form 990, Part X, lin				(h) Dook value
(1)	(a) L	Description			(b) Book value
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
				<u> </u>	
Part X	Other Liabilities. See Form 990, Part X,				
1.	(a) Description of liability	(b) Amount			
	ral income taxes RUED EXP-PROF/GEN LIAB INSU	1.0	115.		
	RUED EXP-WORKER'S COMP		010.		
	PAID RENT		525.		
(5)	ALD KUNI	1,	323.		
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
	mn (b) must equal Form 990, Part X, col. (B) line 25.)	▶ 37,	650.		
• EIN 40 /	100 740 F + + + D + + 1 + + + + +	- 6 41 644- 1 11			

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

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Schedule D (Form 990) 2010 59-2315435

	e D (Form 990) 2010	39-2313433	Page 4
Part	=	ed Financial Statemen	ts
1			
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	
3	Excess or (deficit) for the year. Subtract line 2 from line 1		
4	Net unrealized gains (losses) on investments	4	
5	Donated services and use of facilities		
6	Investment expenses	6	
7	Prior period adjustments		
8	Other (Describe in Part XIV.)		
9	Total adjustments (net). Add lines 4 through 8	l -	
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3)
Part :			n
1	Total revenue, gains, and other support per audited financial statements	•	1
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
а	Net unrealized gains on investments	2a	
b	Donated services and use of facilities	2b	
C	Recoveries of prior year grants		
d	Other (Describe in Part XIV.)	2d	
e	Add lines 2a through 2d		2e
3	Subtract line 2e from line 1		3
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
	1 1 1 1 1 5 000 B 11/11 B 71	4a	
a b	Other (Describe in Part XIV.)		
			40
C E	Add lines 4a and 4b Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)		4c 5
5 Dovt	Reconciliation of Expenses per Audited Financial Statements V		
	Tatal appropriate and leaves non-codited financial statements		
1			1
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:	20	
a	Donated services and use of facilities	2a	-
b	Prior year adjustments	2b	-
C	Other losses	2c	-
d	Other (Describe in Part XIV.)	2d	
e	Add lines 2a through 2d		2e
3	Subtract line 2e from line 1		3
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	-
b	Other (Describe in Part XIV.)	4b	
	Add lines 4a and 4b		4c
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)		5
Part V	Supplemental Information ete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Paline 4; Part X, line 2; Part XI, line 8; Part XII, lines 2d and 4b; and Part XIII, lines ditional information.	2d and 4b. Also complete	

Schedule D (Form 990) 2010 59-2315435 Page **5**

Part XIV Supplemental Information (continued)

Schedule D (Form 990) 2010

JSA 0E1226 1.000

SCHEDULE H (Form 990)

Hospitals

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

OMB No. 1545-0047

2010

Open to Public Inspection

Department of the Treasury Internal Revenue Service Name of the organization

Employer identification number

59-2315435 MARCO ISLAND HOSPITAL, INC. Financial Assistance and Certain Other Community Benefits at Cost Part I Yes No Χ 1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a 1a Χ 1b If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. Applied uniformly to all hospital facilities Applied uniformly to most hospital facilities Generally tailored to individual hospital facilities Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. Did 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 was the FPGfamily income limit for eligibility for free care: 3a X 200% 150% Other Did the organization use FPG to determine eligibility for providing discounted care to low income individuals? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: Χ 3h X 400% 300% 350% Other _ c If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care. Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? X 4 Χ 5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? 5b If "Yes," did the organization's financial assistance 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?..... 5c X 6a **6a** Did the organization prepare a community benefit report during the tax year? Χ 6b **b** If "Yes," did the organization make it available to the public? Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H Financial Assistance and Certain Other Community Benefits at Cost (b) Persons (c) Total community benefit expense (d) Direct offsetting (e) Net community (f) Percent (a) Number of activities or Financial Assistance and benefit expense revenue Means-Tested Government programs (optional) (optional) expense **Programs** a Financial Assistance at cost 8054 9,532 0 9,532. .32 (from Worksheets 1 and 2) b Unreimbursed Medicaid (from 84,850. 67,915. 16,935. .57 Worksheet 3, column a) Unreimbursed costs - other meanstested government programs (from Worksheet 3, column b) Total Financial Assistance and Means-Tested Government 67,915. 8054 94,382. 26,467. .89 Other Benefits Community health improvement services and community benefit 2 3025 0 11,000. 11,000. .37 operations (from Worksheet 4) Health professions education (from Worksheet 5) Subsidized health services (from

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2

2

3025

11079

Total, Other Benefits

Total. Add lines 7d and 7j

Schedule H (Form 990) 2010

. 37

1.26

11,000.

37,467.

0

67,915.

11,000.

105,382

Schedule H (Form 990) 2010 59-2315435 Page **2**

Part II

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and						
training for community members						
6 Coalition building						
7 Community health improvement						
advocacy						
8 Workforce development						
9 Other						
I0 Total						
Part III Bad Debt, Me	edicare. &	Collection	Practices	•	•	•

Sec	tion A. Bad Debt Expense		Yes	No
4	Door the organization report had dobt expense in accordance with Healtheare Financial Management		162	NO
•	Does the organization report bad debt expense in accordance with Healthcare Financial Management	4	Х	
	Association Statement No. 15?	1	Λ	
2	Enter the amount of the organization's bad debt expense (at cost)			
3	Enter the estimated amount of the organization's bad debt expense (at cost) attributable			
	to patients eligible under the organization's financial assistance policy			
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt			
	expense. In addition, describe the costing methodology used in determining the amounts reported on lines			
	2 and 3, and rationale for including a portion of bad debt amounts in community benefit.			
Sec	tion B. Medicare			
5	Enter total revenue received from Medicare (including DSH and IME) 5 1,238,070.			
6	Enter Medicare allowable costs of care relating to payments on line 5 6 1,657,274.			
7	Subtract line 6 from line 5. This is the surplus (or shortfall)			
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit.			
	Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6.			
	Check the box that describes the method used:			
	Cost accounting system X Cost to charge ratio Other			
Sec	tion C. Collection Practices			
9a	Does the organization have a written debt collection policy during the tax year?	9a	Х	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the			
	collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	Х	

Part IV Management Companies and Joint Ventures

Wanagement Compa	ines 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				

JSA 0E1285 2.0902 699J 1467 Schedule H (Form 990) 2010 59-2315435 Page **3**

Part V Facility Information									
Section A. Hospital Facilities		0	0	⊣	C	מ	Ш	т	
(list in order of size, measured by total revenue per facility, from largest to smallest)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	
How many hospital facilities did the organization operate during the tax year? $\underline{}$	<u>ta</u>	al & surgio	oital	ital	hospital	₹			
Name and address		<u>a</u>							Other (describe)
1 MARCO ISLAND HOSPITAL, INC.									11 1/2 HOURS/
40 HEATHWOOD DRIVE	1								7 DAYS A WEEK
MARCO ISLAND FL 34145	1							Х	URGENT CARE FACILITY
2									
3	-								
	-								
4									
	1								
	1								
5									
6									
	4								
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	-								
8									
	1								
9									
10	-								
	-								
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	1								
12									
13	4								
	-								
44									
14	-								
	1								
15									
	1								
16									
	1								

Page 4

Schedule H (Form 990) 2010 Facility Information (continued) Part V Section B. Facility Policies and Practices (Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

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

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Part V	Facility Information (continued) MARCO ISLAND HOSPITAL, INC.			
I alt v	ruding information (commuca) - Trace Tolling modified inc.		Yes	No
10 Us	sed FPG to determine eligibility for providing discounted care to low income individuals?	10		
	'Yes," indicate the FPG family income limit for eligibility for discounted care:			
	cplained the basis for calculating amounts charged to patients?	11		
	'Yes," indicate the factors used in determining such amounts (check all that apply):			
a	Income level			
b	Asset level			
c	Medical indigency			
d	Insurance status			
е	Uninsured discount			
f	Medicaid/Medicare			
g	State regulation			
h	Other (describe in Part VI)			
12 Ex	xplained the method for applying for financial assistance?	12		
	cluded measures to publicize the policy within the community served by the hospital facility?	13		
I <u>f</u> "	'Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a _	The policy was posted on the hospital facility's website			
b	The policy was attached to billing invoices			
С	The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	The policy was posted in the hospital facility's admissions offices			
е	The policy was provided, in writing, to patients on admission to the hospital facility			
f	The policy was available on request			
g	Other (describe in Part VI)			
	and Collections		1	
	d the hospital facility have in place during the tax year a separate billing and collections policy, or a written ancial assistance policy that explained actions the hospital facility may take upon non-payment?	14		
	neck all of the following collection actions against a patient that were permitted under the hospital facility's	14		
	licies at any time during the tax year:			
a	Reporting to credit agency			
b	Lawsuits			
С	Liens on residences			
d	Body attachments			
е	Other actions (describe in Part VI)			
16 Did	d the hospital facility engage in or authorize a third party to perform any of the following collection actions			
du	ring the tax year?	16		
If "	'Yes," check all collection actions in which the hospital facility or a third party engaged (check all that			
ар	pply):			
a _	Reporting to credit agency			
b _	Lawsuits			
°. –	Liens on residences			
d _	Body attachments Other patients (describe in Part VI)			
e	Other actions (describe in Part VI)			
	dicate which actions the hospital facility took before initiating any of the collection actions checked in line (check all that apply):			
a To	Notified patients of the financial assistance policy on admission			
b _	Notified patients of the financial assistance policy prior to discharge			
c	Notified patients of the financial assistance policy in communications with the patients regarding the			
• _	patients' bills			
d	Documented its determination of whether a patient who applied for financial assistance under the			
_	financial assistance policy qualified for financial assistance			
е	Other (describe in Part VI)			

Part \	Facility Information (continued) MARCO ISLAND HOSPITAL, INC.			
Polic	y Relating to Emergency Medical Care			
	_	- 1	Yes	No
18	, , , , , , , , , , , , , , , , , , , ,	18		
a b c	If "No," indicate the reasons why (check all that apply): The hospital facility did not provide care for any emergency medical conditions The hospital facility did not have a policy relating to emergency medical care The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
Char	Other (describe in Part VI)			
	ges for Medical Care			
19 a	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply): The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b c d	The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility The hospital facility used the Medicare rate for those services Other (describe in Part VI)			
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?.	20		
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service	21		

Page **7**

Schedule H (Form 990) 2010 Part V Facility Information (continued)

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

Schedule H (Form 990) 2010

10

Part VI Supplemental Information

Complete this part to provide the following information.

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

- 2 Needs assessment. Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
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- **6** Affiliated health care system. If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- **7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

Part VI Supplemental Information

Complete this part to provide the following information.

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SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGES REPORTED ON THE
SCHEDULE H, PART I, LINE 7 TABLE.
THE COSTING METHODOLOGY USED IN CALCULATING THE AMOUNTS REPORTED ON THE
LINE 7 TABLE ARE BASED ON A COST TO CHARGE RATIO. THE COST TO CHARGE
RATIO WAS DERIVED FROM WORKSHEET 2.
BAD DEBT EXPENSE
PART III, SECTION A, LINE 4
UNCOMPENSATED CARE REPRESENTS EITHER CHARGES FOREGONE OR CHARGES IN
EXCESS OF PAYMENT RECEIVED FOR SERVICES PROVIDED TO PATIENTS WHO ARE NOT
COVERED UNDER CONTRACTS WITH THIRD-PARTY PAYORS. THE MAJOR COMPONENTS OF
UNCOMPENSATED CARE ARE CATEGORIZED AS CHARITY, WELFARE, AND BAD DEBT.
CHARITY CARE REPRESENTS SERVICES AND SUPPLIES FURNISHED AT NO CHARGE TO
PATIENTS WHO HAVE QUALIFIED UNDER THE INCOME CRITERIA PROMULGATED BY THE
STATE OF FLORIDA. PATIENTS WHO WOULD OTHERWISE BE DEEMED AS CHARITY CARE

Part VI Supplemental Information

Complete this part to provide the following information.

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

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CAN SOMETIMES QUALIFY UNDER THE COLLIER COUNTY WELFARE PROGRAM. PAYMENTS
UNDER THE COUNTY WELFARE PROGRAM ARE LIMITED BY THE AMOUNT APPROPRIATED
BY THE COUNTY.
FINALLY, BAD DEBTS REPRESENT CHARGES DEEMED UNCOLLECTIBLE DUE TO EITHER
(A) A PATIENT'S INABILITY TO QUALIFY AS CHARITY, WELFARE, OR MEDICAID,
YET CLEAR FINANCIAL INDICATIONS EXIST THAT DEMONSTRATE AN INABILITY TO
PAY, OR (B) A PATIENT'S REFUSAL TO PAY FOR SERVICES PROVIDED AND THE
HOSPITAL'S DECISION TO CEASE FURTHER COLLECTION EFFORTS.
THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNTS REPORTED ON LINES
2 AND 3 ARE BASED ON A COST TO CHARGE RATIO.
COSTING METHODOLOGY, MEDICARE SHORTFALL
PART III, SECTION B, LINE 8
THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNT REPORTED ON LINE 6
IS BASED ON A COST TO CHARGE RATIO.

Part VI Supplemental Information

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CONSISTENT WITH THE CHARITABLE HEALTHCARE MISSION OF MARCO ISLAND
HOSPITAL, INC. AND THE COMMUNITY BENEFIT STANDARD SET FORTH IN IRS
HOSPITAL, INC. AND THE COMMONITE BENEFIT STANDARD SET FORTH IN TRS
REVENUE RULING 69-545, THE HOSPITAL PROVIDES CARE FOR ALL PATIENTS
COVERED BY MEDICARE SEEKING MEDICAL CARE. SUCH CARE IS PROVIDED
REGARDLESS OF WHETHER THE REIMBURSEMENT PROVIDED FOR SUCH SERVICES MEETS
OR EXCEEDS THE COSTS INCURRED BY THE HOSPITAL TO PROVIDE SUCH SERVICES.
AS A RESULT, MARCO ISLAND HOSPITAL, INC. VIEWS ANY SHORTFALL REPORTED IN
LINE 7 AS AN ADDITIONAL ITEM OF COMMUNITY BENEFIT PROVIDED BY THE
ORGANIZATION.
COLLECTION PRACTICES
PART III, LINE 9B
MARCO ISLAND HOSPITAL, INC. PROVIDES CARE WITHOUT CHARGE OR AT AMOUNTS
IDAA MUAN IMA DAMAA DAAGA MA DAMIDAMA MUA MUA MUA ADDATITA ADIMBATA
LESS THAN ITS ESTABLISHED RATES TO PATIENTS WHO MEET SPECIFIC CRITERIA
UNDER THE STATE'S CHARITY CARE GUIDELINES. BECAUSE MARCO ISLAND
HOSPITAL, INC. DOES NOT PURSUE COLLECTION OF ACCOUNTS DETERMINED TO

Part VI Supplemental Information

Complete this part to provide the following information.

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QUALIFY AS CHARITY CARE, THESE AMOUNTS ARE NOT REPORTED AS REVENUE.
NEEDS ASSESSMENT
PART VI, LINE 2
THE ORGANIZATION ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITIES IT
SERVES IN VARIOUS WAYS. IN 2011, WE PARTICIPATED IN THE 2011 COLLIER
COUNTY SUSTAINING EXCELLENCE CONFERENCE. THIS CONFERENCE PARTNERED KEY
PARTICIPANTS FROM THE COUNTY INCLUDING THE COLLIER COUNTY PUBLIC SCHOOLS,
COLLIER COUNTY HEALTH DEPARTMENT, COLLIER COUNTY PARKS AND RECREATION
DEPARTMENT, UNITED WAY OF COLLIER COUNTY, YMCA, POLICE, EMS AND FIRE
DEPARTMENTS, NUTRITION FOOD SERVICE COMPANIES, PINE RIDGE MEDICAL CENTER
AND NAPLES COMMUNITY HOSPITAL.
THE GROUP FOCUSED ON HEALTH AND COMMUNITY ISSUES IN COLLIER COUNTY AND
FLORIDA SUCH AS TOBACCO USE, ADULT OBESITY, BINGE DRINKING, UNSAFE SEX,
ACCESS TO CARE, QUALITY OF CARE, EDUCATION, UNEMPLOYMENT, CHILDREN IN
POVERTY, INADEQUATE SOCIAL SUPPORT, COMMUNITY SAFETY, BUILT ENVIRONMENT

Part VI Supplemental Information

Complete this part to provide the following information.

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AND MORBIDITY. THE GROUP WAS ABLE TO FOCUS ON SOLUTIONS TO SOME OF THE
ISSUES DISCUSSED AS WELL AS CREATE OPPORTUNITIES TO BETTER SERVE THE
COMUNITY'S NEEDS.
INFORMATION REGARDING PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE
PART VI, LINE 3
MARCO ISLAND HOSPITAL, INC. RECOGNIZES ITS RESPONSIBILITY TO COMMUNICATE
ITS FINANCIAL POLICIES AND EXPECTATIONS TO PATIENTS. THE HOSPITAL
INFORMS AND EDUCATES PATIENTS BY PROVIDING PATIENTS WITH THE NCH
HEALTHCARE SYSTEM PATIENT RIGHTS AND RESPONSIBILITIES. INCLUDED IN THESE
RIGHTS IS THE RIGHT TO BE GIVEN, UPON REQUEST, FULL MEDICAL INFORMATION
AND FINANCIAL COUNSELING. IN ADDITION, A PATIENT REPRESENTATIVE WILL
CONTACT PATIENTS PRIOR TO SERVICES TO EVALUATE THE PATIENT'S ABILITY TO
PAY. THIS PROCESS INCLUDES OBTAINING THE PATIENT'S CURRENT FINANCIAL
INFORMATION, OBTAINING A CREDIT REPORT AND REVIEWING THE PATIENT'S
PAYMENT HISTORY WITH MARCO ISLAND HOSPITAL, INC. PERSONS REQUIRING
ASSISTANCE WITH THE UNFUNDED PORTION OF THEIR BILLS ARE ENCOURAGED TO

Part VI Supplemental Information

Complete this part to provide the following information.

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

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

REQUEST A CHARITY EVALUATION.
MARCO ISLAND HOSPITAL, INC. ALSO PROVIDES ASSISTANCE FOR PATIENTS TO
APPLY FOR MEDICAID COVERAGE OR OTHER STATE OR LOCAL ASSISTANCE PROGRAMS
WHICH MAY ASSIST WITH PAYMENT FOR MEDICAL SERVICES.
COMMUNITY INFORMATION
PART VI, LINE 4
MARCO ISLAND HOSPITAL, INC. SERVES AN OLDER COMMUNITY. THE MEDIAN AGE IS
64. THE ESTIMATED MEDIAN HOUSEHOLD INCOME IS \$85,504. THE UNEMPLOYMENT
RATE IS APPROXIMATELY 7.8%. THE PERCENTAGE OF RESIDENTS BELOW 50% OF THE
POVERTY LEVEL IS APPROXIMATELY 5.4%.
INFORMATION REGARDING PROMOTION OF COMMUNITY HEALTH

Part VI Supplemental Information

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PART VI, LINE 5
MARCO ISLAND HOSPITAL, INC. EMPLOYEES ARE INVOLVED IN A WIDE VARIETY OF
ACTIVITIES AND ESSENTIAL SERVICES THAT ARE GEARED TOWARDS POSITIVELY
AFFECTING OUR COMMUNITY'S HEALTH STATUS. THE FOLLOWING IS A SUMMARY OF
TWO SUCH ACTIVITIES PROVIDED DURING THE YEAR:
MARCO ISLAND HOSPITAL, INC. OFFERED FREE BLOOD PRESSURE CHECKS TO THE
COMMUNITY MONDAY THRU FRIDAY FROM 9:00AM TO 4:00PM (9:00AM TO NOON IN THE
SUMMER MONTHS). FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2011, 3,013
COMPLIMENTARY BLOOD PRESSURE CHECKS WERE GIVEN TO THE PUBLIC.
IN NOVEMBER 2010, THE MARCO CAMPUS HOSTED THELEADERSHIP MARCO WITH 12
MEMBERS IN ATTENDANCE. GROUP TOURS WERE GIVEN OF THE CENTER AND THREE
"MOCK TRAUMA" UNITS (I.V. INSERTION, USE OF THE AED AND SPLINTING) WERE
DISPLAYED. THREE MARCO RN'S AS WELL AS THE ADMINISTRATIVE ASSISTANT
PARTICIPATED. KEVIN COOPER, CHIEF OF STAFF/GENERAL COUNSEL ADDRESSED THE
GROUP.

Part VI Supplemental Information

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AFFILIATED HEALTHCARE SYSTEM INFORMATION
PART VI, LINE 6
MARCO ISLAND HOSPITAL, INC. IS AN AFFILIATE OF THE NCH HEALTHCARE SYSTEM,
INC. THE NCH HEALTHCARE SYSTEM, INC. PROVIDES HEALTH-ENHANCING
EDUCATIONAL PROGRAMS AND RESOURCES IN PROMOTING THE HEALTH OF OUR
COMMUNITY. THE TYPES OF PROGRAMS/RESOURCES PROVIDED INCLUDE: HEALTH
SEMINARS, COMMUNITY HEALTH FAIRS & TESTING, RN'S EDUCATING FUTURE
PATIENTS, SUPPORTING THE NEIGHBORHOOD HEALTH CLINIC, PHYSICIAN LED ACCESS
NETWORK OF COLLIER C OUNTY, HEART PROGRAMS, CANCER SURVIVAL AWARENESS,
SUPPORT OF PATIENT FAMILIES, THE SPIRIT OF WOMEN, DR. JOHN BRIGGS
WELLNESS CENTER, SHARING OUR SPACE AT NO COST TO NEEDY, NOT-FOR-PROFIT
ORGANIZATIONS. THE ORGANIZATION ALSO SPONSORS AND SUPPORTS THE CLINICAL
NURSING SCHOOLS IN OUR COMMUNITY.
THE ORGANIZATIONS'S CIVIC INVOLVEMENT INCLUDES OPENING OUR DOORS TO THE
COLLIER COUNTY SUPERVISOR OF ELECTIONS FOR BOTH VOTER REGISTRATION AND TO
ACT AS A POLLING PLACE. NUMEROUS NCH STAFF VOLUNTEER TO MAN THE POLLS.

Part VI Supplemental Information

Complete this part to provide the following information.

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

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

IN ADDITION, MEMBERS OF NCH MANAGEMENT SERVE ON COMMUNITY BOARDS IN
VARIOUS CAPACITIES. THE HOSPITALS HAVE ALWAYS PROVIDED EXEMPLARY
PASTORAL CARE SEVICES. NCH IS ENCOURAGING THEIR OWN HEALTHCARE
PROFESSION BY SPONSORING CAREER DAYS, JOB SHADOWING, AND LECTURES AT
LOCAL MIDDLE AND HIGH SCHOOLS ON THE MANY OPPORTUNITIES IN THE HEALTHCARE
FIELD. IN ADDITION TO MARCO ISLAND HOSPITAL, INC. THE NCH HEALTHCARE
SYSTEM ALSO INCLUDES THE FOLLOWING NON-PROFIT ORGANIZATIONS:
> NAPLES COMMUNITY HOSPITAL, LOCATED IN COLLIER COUNTY, FLORIDA, THE
HOSPITAL CONSISTS OF NAPLES COMMUNITY HOSPITAL, A 420-BED ACUTE CARE
FACILITY, AND NORTH NAPLES HOSPITAL, A 261-BED ACUTE CARE FACILITY. THE
HOSPITAL ALSO HAS A BLOOD CENTER AND MAINTAINS VARIOUS OTHER OUTPATIENT
CENTERS LOCATED THROUGHOUT THE COUNTY.
> COLLIER HEALTH CARE, INC. OWNS AND LEASES HEALTHCARE FACILITIES IN
NAPLES AND IMMOKALEE, FLORIDA. THIS ORGANIZATION ALSO OPERATES
CHILDREN'S MEDICAL SERVICES, A PROGRAM SERVING CHRONICALLY ILL AND
SPECIAL NEEDS CHILDREN UNDER TITLE V AND THE FLORIDA KIDCARE PROGRAM

Part VI Supplemental Information

THROUGH TITLE XXI

Complete this part to provide the following information.

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

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

11111000011 1111	LD 21211 •							
> NCHMD, IN	C. OWNS AND	OPERATES	PHYSICIAN	N MEDICAL	PRACTIC	ES IN COI	LIER	
AND LEE COU								

Part VI Supplemental Information

Complete this part to provide the following information.

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

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

STATE	FILING	OF	COMMUNI	ΤY	BENEFIT	REPORT				
FL,										

SCHEDULE J (Form 990)

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 **Open to Public** Inspection

Internal Revenue Service Name of the organization

Department of the Treasury

MARCO ISLAND HOSPITAL, INC.

Employer identification number 59-2315435

Part	Questions Regarding Compensation			
			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	First-class or charter travel X Housing allowance or residence for personal use			
	Travel for companions Payments for business use of personal residence			
	Tax indemnification and gross-up payments Health or social club dues or initiation fees			
	Discretionary spending account Personal services (e.g., maid, chauffeur, chef)			
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to			
	explain	1b	X	
2	explain			
	directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	2	X	
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.			
	X Compensation committee X Written employment contract			
	X Independent compensation consultant X Compensation survey or study			
	Form 990 of other organizations X 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:			
а	Receive a severance payment or change-of-control payment from the organization or a related organization?	4a	Х	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	Х	
С	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		Х
	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:			
а	The organization?	5a		Х
b	Any related organization?	5b		Х
	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:			
а	The organization?	6a		Х
b	Any related organization?	6b		Х
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed			
	payments not described in lines 5 and 6? If "Yes," describe in Part III	7	X	
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject			1
	to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe			1
	in Part III	8		Х
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in			1
	Regulations section 53.4958-6(c)?	9	1	1

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

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

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

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

(A) Name		(B) Breakdown	of W-2 and/or 1099-MISC	compensation	(C) Retirement and	(D) Nontaxable	(E) Total of columns	(F) Compensation
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	other deferred compensation	benefits	(B)(i)-(D)	reported in prior Form 990 or Form 990-EZ
	(i)	0.			0.	0.	0.	0.
1 ALLEN S. WEISS, M.D.	(ii)	598,143.	28,868.	16,500.	40,671.	14,833.	699,015.	0.
	(i)	0.	0.	0.	0.	0.	0.	0.
2 KEVIN D. COOPER	(ii)	343,159.	15,140.	16,500.	9,800.	8,313.	392,912.	0.
	(i)	0.	0.	0.	0.	0.	0.	0.
3 PHILLIP DUTCHER	(ii)	361,468.	15,140.	0.	9,800.	631.	387,039.	0.
	(i)	0.	0.	0.	0.	0.	0.	0.
4 AURORA ESTEVEZ, M.D.	(ii)	360,652.	16,994.	16,500.	9,800.	8,416.	412,362.	0.
	(i)	0.	0.	0.	0.	0.	0.	0.
5 VICKI D. ORR	(ii)	337,854.	15,140.	16,500.	9,800.	21,228.	400,522.	0.
	(i)	0.	0.	0.	0.	0.	0.	0.
6 BRIAN SETTLE	(ii)	226,108.	11,718.	16,500.	9,800.	14,172.	278,298.	0.
	(i)	0.	0.	0.	0.	0.	0.	0.
7 SUSAN WOLFF	(ii)	232,727.	12,184.		9,800.	8,119.	279,330.	0.
	(i)	0.	0.	0.	0.	0.	0.	0.
8 MICHAEL RILEY	(ii)	189,893.	68.	0.	7,753.	21,302.	219,016.	0.
	(i)	0.	0.	0.	0.	0.	0.	0.
9 JAMES K. MARTIN	(ii)	208,452.	90,068.	0.	1,177.	12,426.	312,123.	0.
	(i)	0.	0.	0.	0.	0.	0.	0.
10 MICHELE THOMAN	(ii)	232,585.		0.	6,743.	15,722.	265,123.	0.
	(i)	0.	0.	0.	0.	0.	0.	0.
11 GARY PARSONS, MD	(ii)	69,158.	80,068.	4,125.	1,467.	1,859.	156,677.	0.
	(i)							
12	(ii)							
	(i)							
13	(ii)							
	(i)							
14	(ii)							
	(i)							
15	(ii)							
	(i)							
16	(ii)							dulo 1 (Form 990) 2010

NCH

Schedule J (Form 990) 2010 59-2315435 Page **3**

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.

SUPPLEMENTAL NON QUALIFIED RETIREMENT PLAN PARTICIPATION FORM 990, SCHEDULE J, PART I, PART I, LINE 4B

IN 1996, THE NCH HEALTHCARE SYSTEM, INC. BOARD OF TRUSTEES APPROVED A RECOMMENDATION OF THE EXECUTIVE COMPENSATION COMMITTEE THAT CERTAIN EXECUTIVES OF THE NCH HEALTHCARE SYSTEM WOULD BE PROVIDED WITH A SERP THAT WAS SUPPORTED THROUGH THE USE OF LIFE INSURANCE PROGRAMS. DUE TO CHANGES IN THE IRS TAX CODE, EFFECTIVE OCTOBER 1, 2003, THE FUNDING MECHANISM FOR ACTIVE EMPLOYEES WAS CHANGED FROM USING LIFE INSURANCE TO FUNDING RABBI TRUSTS. HOWEVER, THE PLAN DESIGN WAS NOT CHANGED.

THE TRUST IS OWNED BY NCH AND IS SUBJECT TO THE RISK OF CREDITORS OF NCH.

CONSEQUENTLY, DEPOSITS MADE TO THE TRUSTS REMAIN AS ASSETS OF NCH UNTIL

THE PARTICIPANT VESTS IN ACCORDANCE WITH THE PLAN. THE SERP HAS BEEN

DISCONTINUED WITH THE EXCEPTION OF DR. ALLEN WEISS, PRESIDENT & CEO, WHO

IS NO LONGER RECEIVING CONTRIBUTIONS TO THE PLAN, BUT WHOSE PLAN

CONTINUES TO REALIZE INVESTMENT INCOME/LOSSES ON PREVIOUS CONTRIBUTIONS

WHICH HAVE BEEN REPORTED ON PRIOR YEAR FORMS 990.

Schedule J (Form 990) 2010 59-2315435 Page **3**

Part | | 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.

THE ACCOUNT OF ALLEN S. WEISS, MD REALIZED INVESTMENT INCOME OF \$30,871

FOR THE CALENDAR YEAR 2010. THIS INVESTMENT INCOME IS INCLUDED IN

SCHEDULE J, PART II, COLUMN C.

PROVISION OF NON-FIXED PAYMENTS

FORM 990, SCHEDULE J, PART I, LINE 7

THIS ORGANIZATION IS AN AFFILIATE OF NAPLES COMMUNITY HOSPITAL, INC.

("NCH"). ALL COMPENSATION ARRANGEMENTS ARE DETERMINED AND PAID THROUGH

NCH. NCH MAY PROVIDE DISCRETIONARY BONUS AND/OR INCENTIVE COMPENSATION

PAYMENTS TO ELIGIBLE EMPLOYEES. PAYMENTS MADE TO ANY DISQUALIFIED PERSON

IS APPROVED BY THE NCH COMPENSATION COMMITTEE THROUGH THE PROCESS

DESCRIBED IN FORM 990, PART VI, SECTION B, LINE 15.

Schedule J (Form 990) 2010 59-2315435 Page **3**

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.

PROVISION OF HOUSING ALLOWANCE

FORM 990, SCHEDULE J, PART I, LINE 1A

HOUSING WAS PROVIDED FOR OUR CHIEF DEVELOPMENT OFFICER, JAMES MARTIN.

THE VALUE OF SUCH HOUSING (\$4,500) WAS INCLUDED AS A COMPONENT OF HIS

REPORTABLE COMPENSATION LISTED ON FORM 990, PART VII.

DETAIL OF SEVERANCE PAYMENTS

FORM 990, SCHEDULE J, PART I, LINE 4A

WILLIAM EDWARDS, CHIEF ADMINISTRATIVE OFFICER, NCHMD, INC., RESIGNED

6/4/11 AND RECEIVED A SEVERANCE PAYMENT OF \$146,505 FOR CALENDAR YEAR

2011.

SCHEDULE O (Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

OMB No. 1545-0047

2010

Open to Public Inspection

Department of the Treasury Internal Revenue Service Name of the organization

MARCO ISLAND HOSPITAL, INC.

Employer identification number 59-2315435

FORM 990 REVIEW PROCESS

FORM 990, PART VI, SECTION B, LINE 11A

INFORMATION RELATED TO MARCO ISLAND HOSPITAL INC.'S ("MIH") FORM 990

FILING IS GATHERED BY FINANCE STAFF AND PROVIDED TO

PRICEWATERHOUSECOOPERS LLP FOR REVIEW AND RETURN PREPARATION. THE 2010

FORM 990 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2011 WAS REVIEWED AND APPROVED BY THE CHAIRMAN OF THE NCH AUDIT AND FINANCE COMMITTEES,

RESPECTIVELY, SENIOR LEADERSHIP TEAM AND OUTSIDE COUNSEL FOR THE BOARD PRIOR TO FILING WITH THE IRS.

GOVERNING BODY AND MANAGEMENT

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

THE BOARD OF DIRECTORS OF NCH HEALTHCARE SYSTEM, INC., SOLE MEMBER OF
THIS ORGANIZATION, ELECTS THIS ORGANIZATION'S DIRECTORS. THE DECISIONS OF
THIS ORGANIZATION'S BOARD ARE SUBJECT TO THE APPROVAL OF THE NCH
HEALTHCARE SYSTEM, INC. BOARD.

CONFLICT OF INTEREST POLICY

FORM 990, PART VI, SECTION B, LINE 12

ANNUALLY, ALL MIH OFFICERS, DIRECTORS, TRUSTEES, AND KEY EMPLOYEES ARE REQUIRED TO DISCLOSE INTERESTS THAT COULD POTENTIALLY GIVE RISE TO

NCH

Schedule O (Form 990 or 990-EZ) 2010 Page 2

Name of the organization

MARCO ISLAND HOSPITAL, INC.

59-2315435

CONFLICTS.

COMPENSATION PROCESS

FORM 990, PART VI, SECTION B, LINE 15

THIS ORGANIZATION IS AN AFFILIATE OF NAPLES COMMUNITY HOSPITAL, INC.

("NCH"). ALL COMPENSATION ARRANGEMENTS ARE DETERMINED BY AND PAID THROUGH

NCH. COMPENSATION ARRANGEMENTS INVOLVING OUR CEO AND SENIOR LEADERSHIP

TEAM ARE ESTABLISHED BY NCH PURSUANT TO A PROCESS THAT SATISFIES THE

REBUTTABLE PRESUMPTION PROCEDURE AVAILABLE FOR SECTION 4958 EXCESS

BENEFIT TRANSACTION TAX PURPOSES (WHICH REQUIRES A REVIEW OF COMPENSATION

DETERMINATIONS BY DISINTERESTED PERSONS, USE OF APPROPRIATE COMPARABILITY

DATA, AND CONTEMPORANEOUS DOCUMENTATION OF THE PROCESS). WRITTEN

EMPLOYMENT CONTRACTS ARE ALSO UTILIZED.

DOCUMENTS AVAILABILITY TO PUBLIC

FORM 990, PART VI, SECTION C, LINE 19

THE FORMS 1023 AND 990, GOVERNING DOCUMENTS, AUDITED FINANCIAL STATEMENTS, AND CONFLICT OF INTEREST POLICY OF MARCO ISLAND HOSPITAL INC.

ARE AVAILABLE TO THE PUBLIC UPON REQUEST. FINANCIAL STATEMENTS ARE ALSO AVAILABLE VIA OUR WEBSITE: WWW.NCHMD.ORG.

DETAIL OF OTHER CHANGES IN NET ASSETS

FORM 990, PART XI, LINE 5

Name of the organization Employer identification number
MARCO ISLAND HOSPITAL, INC. 59-2315435

TRANSFERS TO AFFILIATES

\$(90,237)

ATTACHMENT 1

PART VII - CONTINUATION OF OFFICERS, DIRECTORS, TRUSTEES,
KEY EMPLOYEES AND HIGHEST COMPENSATED EMPLOYEES

(1)=IND.TRUSTEE/DIR. (2)=INS.TRUSTEE (3)=OFFICER (4)=KEY EMP. (5)=HIGHEST COMP. (6)=FORMER

			(C) POSITION	COMPEN	SATION FROM	
	(A) NAME AND TITLE	(B) HOURS	(1)(2)(3)(4)(5)(6)	(D) ORG. (E	E) REL. ORG.	(F)OTHER
29	ZACH BOSTOCK (START 9/19/11)					
	CHIEF ADMINISTRATIVE OFFICER	1.00	X	0.	0.	0.
30	GARY PARSONS, MD					
	CHIEF MEDICAL OFFICER	1.00	X	0.	153,351.	3,326.
31	WILLIAM EDWARDS (TERM 06/4/11)					
	CHIEF ADMINISTRATIVE OFFICER	1.00	X	0.	107,111.	6,012.
32	CINDILEE LUKACS					
	OPERATIONS DIRECTOR	40.00	X	118,603.	0.	25 , 770.

ATTACHMENT 2

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

NAME AND TITLE	HOURS DEVOTED	FOR RELATED	ORGANIZATION
ALLEN S. WEISS, M.D.			
PRESIDENT/CEO	44.00		
KEVIN D. COOPER	44.00		
GENERAL COUNSEL/CHIEF OF STAFF	44.00		
PHILLIP DUTCHER	44.00		
COO, NCH HEALTHCARE SYSTEM	44.00		
AURORA ESTEVEZ, M.D.	44.00		
CHIEF MEDICAL OFFICER	44.00		
	44.00		
VICKI D. ORR	44.00		
CFO/ASSISTANT TREASURER	44.00		
ELIZABETH MARTIN	44.00		
ASSISTANT SECRETARY	44.00		
BRIAN SETTLE	4.4.00		
CHIEF HUMAN RESOURCES OFFICER	44.00		
SUSAN WOLFF	4.4.00		
CHIEF INFORMATION OFFICER	44.00		
MICHAEL RILEY			
CHIEF STRATEGY OFFICER	44.00		
JAMES K. MARTIN			
CHIEF DEVELOP OFFICER	44.00		
MICHELE THOMAN			
CNO	44.00		
ZACH BOSTOCK (START 9/19/11)			
CHIEF ADMINISTRATIVE OFFICER	44.00		

Schedule O (Form 990 or 990-EZ) 2010 Page **2**

Name of the organization		Employer identification number
MARCO ISLAND HOSPITAL, INC.		59-2315435
		ATTACHMENT 2 (CONT'D)
GARY PARSONS, MD		
CHIEF MEDICAL OFFICER	44.00	
WILLIAM EDWARDS (TERM 06/4/11)		
CHIEF ADMINISTRATIVE OFFICER	44.00	

FORM 990, PART VIII - INVESTMENT INCOME			ATTACHMENT 3	
	(A) TOTAL	(B) RELATED OR	(C) UNRELATED	(D) EXCLUDED
DESCRIPTION	REVENUE	EXEMPT REVENUE	BUSINESS REV.	REVENUE
INTEREST	61	3. 0.	0.	613.
TOTALS -	61	3. 0.	0.	613.

SCHEDULE R (Form 990)

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

Department of the Treasury Internal Revenue Service

▶ 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.

Open to Public Inspection

Name of the organization MARCO ISLAND HOSPITAL, INC. Employer identification number 59-2315435

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

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	Section 5 conti	g) 12(b)(13) rolled tity?
							Yes	No
(1) NCH HEALTHCARE SYSTEM, INC.	59-2314655							
P.O. BOX 413029	NAPLES, FL 34101	HOLDING CO	FL	501(C)3	11,B	N/A		X
(2) NAPLES COMMUNITY HOSPITAL, INC.	59-0694358							
P.O. BOX 413029	NAPLES, FL 34101	HEALTHCARE	FL	501(C)3	3	NCH SYSTEM		X
(3) NCHMD, INC.	33-1075317							
P.O. BOX 413029	NAPLES, FL 34101	HEALTHCARE	FL	501(C)3	9	NCH SYSTEM		X
(4) COMMUNITY HOME SERVICES, INC.	59-2440516							
P.O. 413029	NAPLES, FL 34101	SUPPORT ORG	FL	501(C)3	11,B	NCH SYSTEM		X
(5) COLLIER HEALTH CARE, INC.	65-0244276							
P.O. BOX 413029	NAPLES, FL 34101	HEALTHCARE	FL	501(C)3	3	NCH SYSTEM		X
<u></u>								
(7)								
_(7)		-						

NCH

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

Schedule R (Form 990) 2010 59-2315435 Page **2**

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	Share of total Sh	(g) Share of end-of-year assets	Disprope	(h) (coations? (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)		Gene mana	i) eral or aging ner?	(k) Percentage ownership						
		,		,			Yes	No	(* 3 1333)	Yes	No								
_(1)																			
<u>(2)</u>																			
<u>(3)</u>																			
(4)																			
<u>(5)</u>																			
(6)																			
(7)																			

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) COUNSELING & EMPLOYEE ASSISTANCE PROGRAM 65-037498	9						
350 7TH STREET NORTH NAPLES, FL 34102	EMPLOYEE ASSIT	FL	NCH SYSTEM	C CORP			
(2) HEALTH RESOURCES CORPORATION 59-256800	13						
350 7TH STREET NORTH NAPLES, FL 34102	HOLDING COMPANY	FL	NCH SYSTEM	C CORP			
(3) AMBULATORY SURGICAL CARE CENTER, INC. 59-256802	9						
350 7TH STREET NORTH NAPLES, FL 34102	OUTPAT. SURGERY	FL	HRC	C CORP			
(4) COMMUNITY HOME CARE, INC. 59-237296	i <u>6</u>						
350 7TH STREET NORTH NAPLES, FL 34102	HOME HEALTH	FL	HRC	C CORP			
(5) COMMUNITY IMAGING, INC. 59-244633	6						
350 7TH STREET NORTH NAPLES, FL 34102	RADIOLOGY LAB	FL	HRC	C CORP			
(6) GULFCOAST LINEN SERVICE, INC. 65-021454	6						
350 7TH STREET NORTH NAPLES, FL 34102	LINEN SERVICE	FL	HRC	C CORP			

NCH

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

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

1	During the tax year, did the organization engage in any of the following transactions with one or more related org	ganizations listed in	Parts II–IV?				
а	Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity				1a	Х	
b	Gift, grant, or capital contribution to other organization(s)				1b	X	
С	Gift, grant, or capital contribution from other organization(s)				1c	X	
d	Loans or loan guarantees to or for other organization(s)				1d		Χ
e	Loans or loan guarantees by other organization(s)				1e		Χ
·	Estants of four guarantees by other organization(o)						
f	Sale of assets to other organization(s)				1f		Х
-	Purchase of assets from other organization(s)				1g		Х
g	Exchange of assets				1h	Х	_
h					1i	X	_
1	Lease of facilities, equipment, or other assets to other organization(s)					21	
					1j	Х	
J	Lease of facilities, equipment, or other assets from other organization(s)				1k	X	
k	Performance of services or membership or fundraising solicitations for other organization(s)				-	Х	
ı	Performance of services or membership or fundraising solicitations by other organization(s)				11	_	
m	Sharing of facilities, equipment, mailing lists, or other assets				1m	Х	
n	Sharing of paid employees				1n	Х	
0	Reimbursement paid to other organization for expenses				10	Х	
р	Reimbursement paid by other organization for expenses				1p	Х	_
q	Other transfer of cash or property to other organization(s)				1q	Х	
<u>r</u>	Other transfer of cash or property from other organization(s)				1r	Х	
2	If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, inc	ncluding covered rela	ationships and transaction th	resholds.			
	(a)	(b)	(c)		(d)		
	Name of other organization	Transaction type (a-r)	Amount involved	Method o	it deteri nt invol		
		type (u 1)		amou	1111101	, ou	
(1)							
(2)							
(3)							
(4)							
							_
(5)							
(6)							
104		L		Schedule R	(Form	990) 20)10

NCH

Yes No

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	omicile Are all p		(e) Share of end-of-year assets	Disprop	ortionate ations?			(h) neral or naging rtner?
			Yes	No		Yes	No	(1 61111 1000)	Yes	s No
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										\top
(7)										
(8)										
(9)										
(10)										
(11)										
(12)										
(13)										+
(14)										+
(15)										+
(16)										+

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Part VII Supplemental Information

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

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RENT AND ROYALTY INCOME

Taxpayer's Name							1		ing Number
MARCO ISLAND HOS	PITAL, INC						5	<u>9-23</u>	15435
DESCRIPTION OF PROPERTY									
5400 5100 RENTAL									
	tively participate in the	e operation of	of the act	ivity du	uring the tax year?				
REAL RENTAL INCC)ME		-					\dashv	
OTHER INCOME						100	400		
RENTAL INCOME						190	<u>,107</u>	-	
								\dashv	100 100
TOTAL GROSS INCOME						<u> </u>		-	190,107.
OTHER EXPENSES:									
SEE ATTACHMENT								_	
								\dashv	
								_	
								_	
								_	
								\dashv	
								\dashv	
								\dashv	
DEPRECIATION (SHOWN BELOW	n								
LESS: Beneficiary's Portion	<i>'</i>								
AMORTIZATION									
LESS: Beneficiary's Portion									
DEPLETION									
LESS: Beneficiary's Portion									
TOTAL EXPENSES									41,114.
TOTAL RENT OR ROYALTY INCO	ME (LOSS)								148,993.
Less Amount to								'	•
Rent or Royalty									
Depreciation									
Depletion									
Investment Interest Expense									
Other Expenses									
Net Income (Loss) to Others									
Net Rent or Royalty Income (Loss	s)								148,993.
Deductible Rental Loss (if Applica	able)								
SCHEDULE FOR DEPREC	IATION CLAIME	D				T			
() 5	(b) Cost or	(c) Date	(d) ACRS	(e) Bus.	(f) Basis for	(g) Depreciation in	(h)	(i) Life or	(j) Depreciation
(a) Description of property	unadjusted basis	acquired	des.	%	depreciation	prior years	Method	rate	for this year
JSA Totals									
	1								

SUPPLEMENT TO RENT AND ROYALTY SCHEDULE

OTHER INCOME

OTHER DEDUCTIONS

RENTAL EXPENSES 41,114.

41,114.

RENT AND ROYALTY SUMMARY

PROPERTY	TOTAL INCOME	DEPLETION/ DEPRECIATION	OTHER EXPENSES	ALLOWABLE NET <u>INCOME</u>
5400 5100 RENTAL INC	190,107.		41,114.	148,993.
TOTALS	190,107.		41,114.	148,993.

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