

PUBLIC DISCLOSURE COPY

# Return of Organization Exempt From Income Tax

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

2020

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

▶ **Do not enter social security numbers on this form as it may be made public.**  
▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

**A** For the **2020** calendar year, or tax year beginning **OCT 1, 2020** and ending **SEP 30, 2021**

|                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>B</b> Check if applicable:<br><br><input type="checkbox"/> Address change<br><input type="checkbox"/> Name change<br><input type="checkbox"/> Initial return<br><input type="checkbox"/> Final return/terminated<br><input type="checkbox"/> Amended return<br><input type="checkbox"/> Application pending | <b>C</b> Name of organization<br>MARCO ISLAND HOSPITAL, INC.<br>Doing business as <b>MARCO HEALTHCARE CENTER</b><br>Number and street (or P.O. box if mail is not delivered to street address) Room/suite<br>40 S. HEATHWOOD DRIVE<br>City or town, state or province, country, and ZIP or foreign postal code<br>MARCO ISLAND, FL 34145<br><b>F</b> Name and address of principal officer: <b>PAUL HILTZ</b><br>SAME AS C ABOVE | <b>D</b> Employer identification number<br>59-2315435<br><br><b>E</b> Telephone number<br>239-624-6338<br><br><b>G</b> Gross receipts \$ <b>8,821,951.</b><br><b>H(a)</b> Is this a group return for subordinates? ..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>H(b)</b> Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If "No," attach a list. See instructions<br><b>H(c)</b> Group exemption number ▶ |
| <b>I</b> Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>J</b> Website: ▶ <b>WWW.NCHMD.ORG</b>                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>L</b> Year of formation: <b>1983</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>M</b> State of legal domicile: <b>FL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |

**Part I Summary**

|                             |         |                                                                                                                                                 |                                                                  |                           |
|-----------------------------|---------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------|
|                             | 1       | Briefly describe the organization's mission or most significant activities: <b>HELPING EVERYONE LIVE A LONGER, HAPPIER, AND HEALTHIER LIFE.</b> |                                                                  |                           |
|                             | 2       | Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.         |                                                                  |                           |
| Activities & Governance     | 3       | Number of voting members of the governing body (Part VI, line 1a)                                                                               | <b>3</b>                                                         | 9                         |
|                             | 4       | Number of independent voting members of the governing body (Part VI, line 1b)                                                                   | <b>4</b>                                                         | 8                         |
|                             | 5       | Total number of individuals employed in calendar year 2020 (Part V, line 2a)                                                                    | <b>5</b>                                                         | 38                        |
|                             | 6       | Total number of volunteers (estimate if necessary)                                                                                              | <b>6</b>                                                         | 8                         |
|                             | 7a      | Total unrelated business revenue from Part VIII, column (C), line 12                                                                            | <b>7a</b>                                                        | 0.                        |
|                             | 7b      | Net unrelated business taxable income from Form 990-T, Part I, line 11                                                                          | <b>7b</b>                                                        | 0.                        |
|                             | Revenue | 8                                                                                                                                               | Contributions and grants (Part VIII, line 1h)                    | 0.                        |
| 9                           |         | Program service revenue (Part VIII, line 2g)                                                                                                    | 3,487,267.                                                       | 3,765,524.                |
| 10                          |         | Investment income (Part VIII, column (A), lines 3, 4, and 7d)                                                                                   | 0.                                                               | 3,984,974.                |
| 11                          |         | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)                                                                        | 66,884.                                                          | 86,428.                   |
| 12                          |         | Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)                                                              | 3,554,151.                                                       | 7,836,926.                |
| Expenses                    |         | 13                                                                                                                                              | Grants and similar amounts paid (Part IX, column (A), lines 1-3) | 0.                        |
|                             | 14      | Benefits paid to or for members (Part IX, column (A), line 4)                                                                                   | 0.                                                               | 0.                        |
|                             | 15      | Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)                                                               | 1,996,973.                                                       | 2,129,749.                |
|                             | 16a     | Professional fundraising fees (Part IX, column (A), line 11e)                                                                                   | 0.                                                               | 0.                        |
|                             | 16b     | Total fundraising expenses (Part IX, column (D), line 25) ▶                                                                                     | 0.                                                               |                           |
|                             | 17      | Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)                                                                                    | 925,054.                                                         | 1,004,720.                |
|                             | 18      | Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)                                                                       | 2,922,027.                                                       | 3,134,469.                |
|                             | 19      | Revenue less expenses. Subtract line 18 from line 12                                                                                            | 632,124.                                                         | 4,702,457.                |
| Net Assets or Fund Balances | 20      | Total assets (Part X, line 16)                                                                                                                  | Beginning of Current Year<br>5,093,077.                          | End of Year<br>4,377,535. |
|                             | 21      | Total liabilities (Part X, line 26)                                                                                                             | 258,158.                                                         | 378,998.                  |
|                             | 22      | Net assets or fund balances. Subtract line 21 from line 20                                                                                      | 4,834,919.                                                       | 3,998,537.                |

**Part II Signature Block**

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

|                               |                                                                                                                                                                |                                                   |
|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| <b>Sign Here</b>              | Signature of officer<br>RICK WYLES, CHIEF FINANCIAL OFFICER<br>Type or print name and title                                                                    | Date                                              |
| <b>Paid Preparer Use Only</b> | Print/Type preparer's name<br>REBEKUH ELEY<br>Preparer's signature<br>Date<br>08/01/22<br>Check if self-employed <input type="checkbox"/><br>PTIN<br>P01247672 | Firm's EIN ▶ 42-0714325<br>Phone no. 312-634-3400 |
|                               | Firm's name ▶ RSM US LLP<br>Firm's address ▶ 30 SOUTH WACKER DR, SUITE 3300<br>CHICAGO, IL 60606-3392                                                          |                                                   |

May the IRS discuss this return with the preparer shown above? See instructions  Yes  No

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

HELPING EVERYONE LIVE A LONGER, HAPPIER, AND HEALTHIER LIFE.

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

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? [ ] Yes [X] No

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code: ) (Expenses \$ 2,744,315. including grants of \$ ) (Revenue \$ 3,777,530. )
MARCO ISLAND HOSPITAL OPERATES A 11 1/2 HOUR/ 7 DAYS A WEEK URGENT CARE FACILITY AND SERVICES PATIENTS WITHOUT REGARD TO THEIR ABILITY TO PAY. DURING FYE 9/30/21, 6,186 PATIENTS WERE TREATED. OF THESE PATIENTS, 7.45% ARE CLASSIFIED AS MEDICAID, CHARITY OR BAD DEBTS.

4b (Code: ) (Expenses \$ including grants of \$ ) (Revenue \$ )

4c (Code: ) (Expenses \$ including grants of \$ ) (Revenue \$ )

4d Other program services (Describe on Schedule O.) (Expenses \$ including grants of \$ ) (Revenue \$ )

4e Total program service expenses 2,744,315.

**Part IV Checklist of Required Schedules**

|                                                                                                                                                                                                                                                                                                                           | Yes | No |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| <b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)?<br><i>If "Yes," complete Schedule A</i>                                                                                                                                                                      | X   |    |
| <b>2</b> Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ?                                                                                                                                                                                                                           |     | X  |
| <b>3</b> Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>                                                                                                                      |     | X  |
| <b>4 Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>                                                                                                              |     | X  |
| <b>5</b> Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? <i>If "Yes," complete Schedule C, Part III</i>                                                                               |     | X  |
| <b>6</b> Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>                                                    |     | X  |
| <b>7</b> Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>                                                                                            |     | X  |
| <b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>                                                                                                                                                         |     | X  |
| <b>9</b> Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>            |     | X  |
| <b>10</b> Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi endowments? <i>If "Yes," complete Schedule D, Part V</i>                                                                                                                               |     | X  |
| <b>11</b> 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.                                                                                                                                                                 |     |    |
| <b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>                                                                                                                                                                       | X   |    |
| <b>b</b> Did the organization report an amount for investments - other securities in Part X, line 12, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>                                                                                                  |     | X  |
| <b>c</b> Did the organization report an amount for investments - program related in Part X, line 13, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i>                                                                                                  |     | X  |
| <b>d</b> Did the organization report an amount for other assets in Part X, line 15, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i>                                                                                                                     |     | X  |
| <b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>                                                                                                                                                                                     | X   |    |
| <b>f</b> Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>                                                            | X   |    |
| <b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>                                                                                                                                                        |     | X  |
| <b>b</b> Was the organization included in consolidated, independent audited financial statements for the tax year?<br><i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>                                                                        | X   |    |
| <b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>                                                                                                                                                                                                        |     | X  |
| <b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?                                                                                                                                                                                                                    |     | X  |
| <b>b</b> Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i> |     | X  |
| <b>15</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>                                                                                                           |     | X  |
| <b>16</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>                                                                                                     |     | X  |
| <b>17</b> Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I</i>                                                                                                               |     | X  |
| <b>18</b> Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>                                                                                                                           |     | X  |
| <b>19</b> Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>                                                                                                                                                     |     | X  |
| <b>20a</b> Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>                                                                                                                                                                                                             | X   |    |
| <b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?                                                                                                                                                                                                     | X   |    |
| <b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>                                                                                            |     | X  |

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, Yes, No. Rows 22-38 covering various organizational requirements.

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with 3 columns: Question ID, Question Text, Yes, No. Rows 1a-1c regarding Form 1096 and backup withholding rules.

Part V Statements Regarding Other IRS Filings and Tax Compliance (continued)

Table with columns for question number, question text, and Yes/No columns. Includes questions 2a through 16 regarding employee counts, tax returns, business income, foreign accounts, prohibited transactions, and charitable contributions.

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 on Schedule O. See instructions.

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

Section A. Governing Body and Management

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

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates?; 10b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?; 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990.; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13; 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?; 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done; 13 Did the organization have a written whistleblower policy?; 14 Did the organization have a written document retention and destruction policy?; 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?; 15a The organization's CEO, Executive Director, or top management official; 15b Other officers or key employees of the organization; 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?; 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take 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 FL
18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
[X] Own website [ ] Another's website [X] Upon request [ ] Other (explain on Schedule O)
19 Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records
RICK WYLES, CHIEF FINANCIAL OFFICER - (239) 624-4005
350 7TH STREET NORTH, NAPLES, FL 34102

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

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

**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. See instructions for the order in which to list the persons above.

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

| (A)<br>Name and title                                               | (B)<br>Average hours per week (list any hours for related organizations below line) | (C)<br>Position (do not check more than one box, unless person is both an officer and a director/trustee) |                       |         |              |                              |        | (D)<br>Reportable compensation from the organization (W-2/1099-MISC) | (E)<br>Reportable compensation from related organizations (W-2/1099-MISC) | (F)<br>Estimated amount of other compensation from the organization and related organizations |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------|---------|--------------|------------------------------|--------|----------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
|                                                                     |                                                                                     | Individual trustee or director                                                                            | Institutional trustee | Officer | Key employee | Highest compensated employee | Former |                                                                      |                                                                           |                                                                                               |
| (1) PAUL HILTZ<br>PRESIDENT/CEO/TRUSTEE                             | 1.00<br>44.00                                                                       | X                                                                                                         |                       | X       |              |                              |        | 0.                                                                   | 897,053.                                                                  | 33,680.                                                                                       |
| (2) ALLEN S. WEISS, M.D. TERM 01/19<br>FORMER PRESIDENT/CEO/TRUSTEE | 0.00<br>0.00                                                                        |                                                                                                           |                       |         |              |                              | X      | 0.                                                                   | 909,806.                                                                  | 17,158.                                                                                       |
| (3) PHILLIP DUTCHER TERM 07/21<br>CHIEF OPERATING OFFICER SYSTEM    | 1.00<br>44.00                                                                       |                                                                                                           |                       | X       |              |                              |        | 0.                                                                   | 707,824.                                                                  | 14,142.                                                                                       |
| (4) RICK WYLES<br>CFO/ASSISTANT TREASURER                           | 1.00<br>44.00                                                                       |                                                                                                           |                       | X       |              |                              |        | 0.                                                                   | 516,031.                                                                  | 34,675.                                                                                       |
| (5) KEVIN D. COOPER TERM 01/19<br>FORMER CHIEF OF STAFF             | 0.00<br>0.00                                                                        |                                                                                                           |                       |         |              |                              | X      | 0.                                                                   | 522,084.                                                                  | 16,889.                                                                                       |
| (6) FRANK ASTOR M.D. TERM 11/19<br>FORMER CHIEF MEDICAL OFFICER     | 0.00<br>0.00                                                                        |                                                                                                           |                       |         |              |                              | X      | 0.                                                                   | 487,788.                                                                  | 16,236.                                                                                       |
| (7) JONATHAN KLING START 07/21<br>CHIEF OPERATING OFFICER SYSTEM    | 1.00<br>44.00                                                                       |                                                                                                           |                       | X       |              |                              |        | 0.                                                                   | 446,398.                                                                  | 33,658.                                                                                       |
| (8) ZACHARY BOSTOCK TERM 03/20<br>FORMER CHIEF ADMIN. OFFICER       | 0.00<br>0.00                                                                        |                                                                                                           |                       |         |              |                              | X      | 0.                                                                   | 441,291.                                                                  | 29,611.                                                                                       |
| (9) KRISTIN MASCOTTI, M.D.<br>CHIEF MEDICAL OFFICER                 | 1.00<br>44.00                                                                       |                                                                                                           |                       | X       |              |                              |        | 0.                                                                   | 425,744.                                                                  | 9,008.                                                                                        |
| (10) LINDA ROEBACK TERM 05/20<br>FORMER CHIEF COUNSEL               | 0.00<br>0.00                                                                        |                                                                                                           |                       |         |              |                              | X      | 0.                                                                   | 397,178.                                                                  | 22,045.                                                                                       |
| (11) JIM MAHON<br>SENIOR VICE PRESIDENT                             | 1.00<br>44.00                                                                       |                                                                                                           |                       | X       |              |                              |        | 0.                                                                   | 399,133.                                                                  | 2,931.                                                                                        |
| (12) RENEE M. THIGPEN<br>CHIEF HR OFFICER                           | 1.00<br>44.00                                                                       |                                                                                                           |                       | X       |              |                              |        | 0.                                                                   | 356,246.                                                                  | 30,108.                                                                                       |
| (13) MICHAEL RILEY TERM 11/20<br>CHIEF STRATEGY OFFICER             | 1.00<br>44.00                                                                       |                                                                                                           |                       | X       |              |                              |        | 0.                                                                   | 339,701.                                                                  | 28,889.                                                                                       |
| (14) PAMELA ZIPPERER-DAVIS<br>CHIEF ADMIN. OFFICER TERM 03/21       | 1.00<br>44.00                                                                       |                                                                                                           |                       | X       |              |                              |        | 0.                                                                   | 322,328.                                                                  | 12,569.                                                                                       |
| (15) GARY TOMCIK, TERM 04/20<br>FORMER CHIEF EXPERIENCE OFFICER     | 0.00<br>0.00                                                                        |                                                                                                           |                       |         |              |                              | X      | 0.                                                                   | 282,293.                                                                  | 27,943.                                                                                       |
| (16) GINA TEEGARDEN R.N. ST 07/21<br>INTERIM CHIEF NURSING OFFICER  | 1.00<br>44.00                                                                       |                                                                                                           |                       | X       |              |                              |        | 0.                                                                   | 197,163.                                                                  | 14,989.                                                                                       |
| (17) HETTY TOMS<br>OP REHAB MANAGER                                 | 40.00<br>0.00                                                                       |                                                                                                           |                       |         |              | X                            |        | 100,441.                                                             | 0.                                                                        | 24,653.                                                                                       |



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

| (A)<br>Name and title                                          | (B)<br>Average hours per week (list any hours for related organizations below line) | (C)<br>Position (do not check more than one box, unless person is both an officer and a director/trustee) |                       |         |              |                              |        | (D)<br>Reportable compensation from the organization (W-2/1099-MISC) | (E)<br>Reportable compensation from related organizations (W-2/1099-MISC) | (F)<br>Estimated amount of other compensation from the organization and related organizations |
|----------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------|---------|--------------|------------------------------|--------|----------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
|                                                                |                                                                                     | Individual trustee or director                                                                            | Institutional trustee | Officer | Key employee | Highest compensated employee | Former |                                                                      |                                                                           |                                                                                               |
| (18) KEVIN M. FITZGERALD<br>CHAIRMAN                           | 2.00<br>0.00                                                                        | X                                                                                                         |                       | X       |              |                              |        | 0.                                                                   | 0.                                                                        | 0.                                                                                            |
| (19) JOHN L. (JACK) PATTERSON<br>1ST VICE CHAIRMAN             | 2.00<br>0.00                                                                        | X                                                                                                         |                       | X       |              |                              |        | 0.                                                                   | 0.                                                                        | 0.                                                                                            |
| (20) RICHARD ADAMS<br>2ND VICE CHAIRMAN/SECRETARY              | 2.00<br>0.00                                                                        | X                                                                                                         |                       | X       |              |                              |        | 0.                                                                   | 0.                                                                        | 0.                                                                                            |
| (21) LISA GANDY<br>TRUSTEE                                     | 2.00<br>0.00                                                                        | X                                                                                                         |                       |         |              |                              |        | 0.                                                                   | 0.                                                                        | 0.                                                                                            |
| (22) DAVID CARUSO<br>TRUSTEE                                   | 2.00<br>0.00                                                                        | X                                                                                                         |                       |         |              |                              |        | 0.                                                                   | 0.                                                                        | 0.                                                                                            |
| (23) DIANNA DOHM<br>TRUSTEE                                    | 2.00<br>0.00                                                                        | X                                                                                                         |                       |         |              |                              |        | 0.                                                                   | 0.                                                                        | 0.                                                                                            |
| (24) PATRICIA KAUFMAN<br>TRUSTEE                               | 2.00<br>0.00                                                                        | X                                                                                                         |                       |         |              |                              |        | 0.                                                                   | 0.                                                                        | 0.                                                                                            |
| (25) SANDRA MONSON<br>TRUSTEE                                  | 2.00<br>0.00                                                                        | X                                                                                                         |                       |         |              |                              |        | 0.                                                                   | 0.                                                                        | 0.                                                                                            |
| <b>1b Subtotal</b>                                             |                                                                                     |                                                                                                           |                       |         |              |                              |        | 100,441.                                                             | 7,648,061.                                                                | 369,184.                                                                                      |
| <b>c Total from continuation sheets to Part VII, Section A</b> |                                                                                     |                                                                                                           |                       |         |              |                              |        | 0.                                                                   | 0.                                                                        | 0.                                                                                            |
| <b>d Total (add lines 1b and 1c)</b>                           |                                                                                     |                                                                                                           |                       |         |              |                              |        | 100,441.                                                             | 7,648,061.                                                                | 369,184.                                                                                      |

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization 1

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

**Section B. Independent Contractors**

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

| (A)<br>Name and business address                                       | (B)<br>Description of services | (C)<br>Compensation |
|------------------------------------------------------------------------|--------------------------------|---------------------|
| SODEXO INC AND AFFILIATES<br>P.O BOX 360170, PITTSBURGH, PA 15251-6170 | FACILITIES MANAGEMENT          | 149,229.            |
|                                                                        |                                |                     |
|                                                                        |                                |                     |
|                                                                        |                                |                     |

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization 1

**Part VIII Statement of Revenue**

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

|                                                                                                                                           |                                                                                             |                         | (A)            | (B)                                | (C)                        | (D)                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------|----------------|------------------------------------|----------------------------|----------------------------------------------------|--|
|                                                                                                                                           |                                                                                             |                         | Total revenue  | Related or exempt function revenue | Unrelated business revenue | Revenue excluded from tax under sections 512 - 514 |  |
| Contributions, Gifts, Grants and Other Similar Amounts                                                                                    | <b>1 a</b> Federated campaigns .....                                                        | <b>1a</b>               |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>b</b> Membership dues .....                                                              | <b>1b</b>               |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>c</b> Fundraising events .....                                                           | <b>1c</b>               |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>d</b> Related organizations .....                                                        | <b>1d</b>               |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>e</b> Government grants (contributions) .....                                            | <b>1e</b>               |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>f</b> All other contributions, gifts, grants, and similar amounts not included above ... | <b>1f</b>               |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>g</b> Noncash contributions included in lines 1a-1f                                      | <b>1g</b> \$            |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>h Total.</b> Add lines 1a-1f .....                                                       |                         |                |                                    |                            |                                                    |  |
| Program Service Revenue                                                                                                                   | <b>2 a</b> NET PATIENT SVC REV                                                              | Business Code<br>621400 | 3,765,524.     | 3,765,524.                         |                            |                                                    |  |
|                                                                                                                                           | <b>b</b> _____                                                                              |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>c</b> _____                                                                              |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>d</b> _____                                                                              |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>e</b> _____                                                                              |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>f</b> All other program service revenue .....                                            |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>g Total.</b> Add lines 2a-2f .....                                                       |                         | 3,765,524.     |                                    |                            |                                                    |  |
| Other Revenue                                                                                                                             | <b>3</b> Investment income (including dividends, interest, and other similar amounts) ..... |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>4</b> Income from investment of tax-exempt bond proceeds .....                           |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>5</b> Royalties .....                                                                    |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>6 a</b> Gross rents .....                                                                | <b>6a</b>               | (i) Real       | 97,439.                            |                            |                                                    |  |
|                                                                                                                                           |                                                                                             |                         | (ii) Personal  |                                    |                            |                                                    |  |
|                                                                                                                                           |                                                                                             |                         |                | 23,017.                            |                            |                                                    |  |
|                                                                                                                                           | <b>b</b> Less: rental expenses ...                                                          | <b>6b</b>               |                | 74,422.                            |                            |                                                    |  |
|                                                                                                                                           | <b>c</b> Rental income or (loss)                                                            | <b>6c</b>               |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>d</b> Net rental income or (loss) .....                                                  |                         |                | 74,422.                            |                            | 74,422.                                            |  |
|                                                                                                                                           | <b>7 a</b> Gross amount from sales of assets other than inventory                           | <b>7a</b>               | (i) Securities |                                    | 4,946,982.                 |                                                    |  |
|                                                                                                                                           |                                                                                             |                         | (ii) Other     |                                    |                            |                                                    |  |
|                                                                                                                                           |                                                                                             |                         |                |                                    | 962,008.                   |                                                    |  |
|                                                                                                                                           |                                                                                             |                         |                |                                    | 3,984,974.                 |                                                    |  |
| <b>b</b> Less: cost or other basis and sales expenses .....                                                                               | <b>7b</b>                                                                                   |                         |                |                                    |                            |                                                    |  |
| <b>c</b> Gain or (loss) .....                                                                                                             | <b>7c</b>                                                                                   |                         |                |                                    |                            |                                                    |  |
| <b>d</b> Net gain or (loss) .....                                                                                                         |                                                                                             |                         | 3,984,974.     |                                    | 3,984,974.                 |                                                    |  |
| <b>8 a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 ..... | <b>8a</b>                                                                                   |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           |                                                                                             |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           |                                                                                             |                         |                |                                    |                            |                                                    |  |
| <b>b</b> Less: direct expenses .....                                                                                                      | <b>8b</b>                                                                                   |                         |                |                                    |                            |                                                    |  |
| <b>c</b> Net income or (loss) from fundraising events .....                                                                               |                                                                                             |                         |                |                                    |                            |                                                    |  |
| <b>9 a</b> Gross income from gaming activities. See Part IV, line 19 .....                                                                | <b>9a</b>                                                                                   |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           |                                                                                             |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           |                                                                                             |                         |                |                                    |                            |                                                    |  |
| <b>b</b> Less: direct expenses .....                                                                                                      | <b>9b</b>                                                                                   |                         |                |                                    |                            |                                                    |  |
| <b>c</b> Net income or (loss) from gaming activities .....                                                                                |                                                                                             |                         |                |                                    |                            |                                                    |  |
| <b>10 a</b> Gross sales of inventory, less returns and allowances .....                                                                   | <b>10a</b>                                                                                  |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           |                                                                                             |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           |                                                                                             |                         |                |                                    |                            |                                                    |  |
| <b>b</b> Less: cost of goods sold .....                                                                                                   | <b>10b</b>                                                                                  |                         |                |                                    |                            |                                                    |  |
| <b>c</b> Net income or (loss) from sales of inventory .....                                                                               |                                                                                             |                         |                |                                    |                            |                                                    |  |
| Miscellaneous Revenue                                                                                                                     | <b>11 a</b> MIH PULMONARY REHAB                                                             | Business Code<br>621990 | 11,848.        | 11,848.                            |                            |                                                    |  |
|                                                                                                                                           | <b>b</b> OTHER INCOME                                                                       | 522100                  | 158.           | 158.                               |                            |                                                    |  |
|                                                                                                                                           | <b>c</b> _____                                                                              |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>d</b> All other revenue .....                                                            |                         |                |                                    |                            |                                                    |  |
|                                                                                                                                           | <b>e Total.</b> Add lines 11a-11d .....                                                     |                         | 12,006.        |                                    |                            |                                                    |  |
| <b>12 Total revenue.</b> See instructions .....                                                                                           |                                                                                             | 7,836,926.              | 3,777,530.     | 0.                                 | 4,059,396.                 |                                                    |  |

**Part IX Statement of Functional Expenses**

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.                                                                                                                              | (A)<br>Total expenses | (B)<br>Program service expenses | (C)<br>Management and general expenses | (D)<br>Fundraising expenses |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---------------------------------|----------------------------------------|-----------------------------|
| <b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 ...                                                                                           |                       |                                 |                                        |                             |
| <b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 .....                                                                                                                    |                       |                                 |                                        |                             |
| <b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 .....                                                             |                       |                                 |                                        |                             |
| <b>4</b> Benefits paid to or for members .....                                                                                                                                                              |                       |                                 |                                        |                             |
| <b>5</b> Compensation of current officers, directors, trustees, and key employees .....                                                                                                                     |                       |                                 |                                        |                             |
| <b>6</b> Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) .....                                                 |                       |                                 |                                        |                             |
| <b>7</b> Other salaries and wages .....                                                                                                                                                                     | 1,778,255.            | 1,546,495.                      | 231,760.                               |                             |
| <b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)                                                                                                 | 58,110.               | 50,537.                         | 7,573.                                 |                             |
| <b>9</b> Other employee benefits .....                                                                                                                                                                      | 157,722.              | 137,166.                        | 20,556.                                |                             |
| <b>10</b> Payroll taxes .....                                                                                                                                                                               | 135,662.              | 117,981.                        | 17,681.                                |                             |
| <b>11</b> Fees for services (nonemployees):                                                                                                                                                                 |                       |                                 |                                        |                             |
| <b>a</b> Management .....                                                                                                                                                                                   |                       |                                 |                                        |                             |
| <b>b</b> Legal .....                                                                                                                                                                                        |                       |                                 |                                        |                             |
| <b>c</b> Accounting .....                                                                                                                                                                                   |                       |                                 |                                        |                             |
| <b>d</b> Lobbying .....                                                                                                                                                                                     |                       |                                 |                                        |                             |
| <b>e</b> Professional fundraising services. See Part IV, line 17                                                                                                                                            |                       |                                 |                                        |                             |
| <b>f</b> Investment management fees .....                                                                                                                                                                   |                       |                                 |                                        |                             |
| <b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)                                                                                            | 258,962.              | 225,211.                        | 33,751.                                |                             |
| <b>12</b> Advertising and promotion .....                                                                                                                                                                   |                       |                                 |                                        |                             |
| <b>13</b> Office expenses .....                                                                                                                                                                             | 223,474.              | 194,349.                        | 29,125.                                |                             |
| <b>14</b> Information technology .....                                                                                                                                                                      |                       |                                 |                                        |                             |
| <b>15</b> Royalties .....                                                                                                                                                                                   |                       |                                 |                                        |                             |
| <b>16</b> Occupancy .....                                                                                                                                                                                   | 96,075.               | 83,553.                         | 12,522.                                |                             |
| <b>17</b> Travel .....                                                                                                                                                                                      |                       |                                 |                                        |                             |
| <b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials ...                                                                                                |                       |                                 |                                        |                             |
| <b>19</b> Conferences, conventions, and meetings .....                                                                                                                                                      |                       |                                 |                                        |                             |
| <b>20</b> Interest .....                                                                                                                                                                                    |                       |                                 |                                        |                             |
| <b>21</b> Payments to affiliates .....                                                                                                                                                                      |                       |                                 |                                        |                             |
| <b>22</b> Depreciation, depletion, and amortization .....                                                                                                                                                   | 228,881.              | 199,051.                        | 29,830.                                |                             |
| <b>23</b> Insurance .....                                                                                                                                                                                   | 56,442.               | 49,086.                         | 7,356.                                 |                             |
| <b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.) |                       |                                 |                                        |                             |
| <b>a</b> MEDICAL SUPPLIES                                                                                                                                                                                   | 132,661.              | 132,661.                        |                                        |                             |
| <b>b</b> BAD DEBT EXPENSE                                                                                                                                                                                   | 8,225.                | 8,225.                          |                                        |                             |
| <b>c</b> _____                                                                                                                                                                                              |                       |                                 |                                        |                             |
| <b>d</b> _____                                                                                                                                                                                              |                       |                                 |                                        |                             |
| <b>e</b> All other expenses _____                                                                                                                                                                           |                       |                                 |                                        |                             |
| <b>25</b> Total functional expenses. Add lines 1 through 24e                                                                                                                                                | 3,134,469.            | 2,744,315.                      | 390,154.                               | 0.                          |
| <b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.                                    |                       |                                 |                                        |                             |

Check here  if following SOP 98-2 (ASC 958-720)

**Part X Balance Sheet**

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

|                                                                           |                                                                                                                                                                                                                                | (A)<br>Beginning of year |                      | (B)<br>End of year    |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------|-----------------------|
| <b>Assets</b>                                                             | <b>1</b> Cash - non-interest-bearing .....                                                                                                                                                                                     | 9,459.                   | <b>1</b>             | 3,030.                |
|                                                                           | <b>2</b> Savings and temporary cash investments .....                                                                                                                                                                          |                          | <b>2</b>             |                       |
|                                                                           | <b>3</b> Pledges and grants receivable, net .....                                                                                                                                                                              |                          | <b>3</b>             |                       |
|                                                                           | <b>4</b> Accounts receivable, net .....                                                                                                                                                                                        | 384,292.                 | <b>4</b>             | 557,367.              |
|                                                                           | <b>5</b> Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons ..... |                          | <b>5</b>             |                       |
|                                                                           | <b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) .....                                                               |                          | <b>6</b>             |                       |
|                                                                           | <b>7</b> Notes and loans receivable, net .....                                                                                                                                                                                 |                          | <b>7</b>             |                       |
|                                                                           | <b>8</b> Inventories for sale or use .....                                                                                                                                                                                     |                          | <b>8</b>             |                       |
|                                                                           | <b>9</b> Prepaid expenses and deferred charges .....                                                                                                                                                                           |                          | <b>9</b>             |                       |
|                                                                           | <b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....                                                                                                                           | <b>10a</b> 10,309,622.   |                      |                       |
|                                                                           | <b>b</b> Less: accumulated depreciation .....                                                                                                                                                                                  | <b>10b</b> 6,493,699.    | 4,698,111.           | <b>10c</b> 3,815,923. |
|                                                                           | <b>11</b> Investments - publicly traded securities .....                                                                                                                                                                       |                          | <b>11</b>            |                       |
|                                                                           | <b>12</b> Investments - other securities. See Part IV, line 11 .....                                                                                                                                                           |                          | <b>12</b>            |                       |
|                                                                           | <b>13</b> Investments - program-related. See Part IV, line 11 .....                                                                                                                                                            |                          | <b>13</b>            |                       |
|                                                                           | <b>14</b> Intangible assets .....                                                                                                                                                                                              |                          | <b>14</b>            |                       |
|                                                                           | <b>15</b> Other assets. See Part IV, line 11 .....                                                                                                                                                                             |                          | 1,215.               | 1,215.                |
| <b>16 Total assets.</b> Add lines 1 through 15 (must equal line 33) ..... |                                                                                                                                                                                                                                | 5,093,077.               | <b>16</b> 4,377,535. |                       |
| <b>Liabilities</b>                                                        | <b>17</b> Accounts payable and accrued expenses .....                                                                                                                                                                          | 219,902.                 | <b>17</b>            | 339,920.              |
|                                                                           | <b>18</b> Grants payable .....                                                                                                                                                                                                 |                          | <b>18</b>            |                       |
|                                                                           | <b>19</b> Deferred revenue .....                                                                                                                                                                                               |                          | <b>19</b>            |                       |
|                                                                           | <b>20</b> Tax-exempt bond liabilities .....                                                                                                                                                                                    |                          | <b>20</b>            |                       |
|                                                                           | <b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D .....                                                                                                                                          |                          | <b>21</b>            |                       |
|                                                                           | <b>22</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....     |                          | <b>22</b>            |                       |
|                                                                           | <b>23</b> Secured mortgages and notes payable to unrelated third parties .....                                                                                                                                                 |                          | <b>23</b>            |                       |
|                                                                           | <b>24</b> Unsecured notes and loans payable to unrelated third parties .....                                                                                                                                                   |                          | <b>24</b>            |                       |
|                                                                           | <b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D .....                                          |                          | 38,256.              | 39,078.               |
|                                                                           | <b>26 Total liabilities.</b> Add lines 17 through 25 .....                                                                                                                                                                     |                          | 258,158.             | <b>26</b> 378,998.    |
| <b>Net Assets or Fund Balances</b>                                        | <b>Organizations that follow FASB ASC 958, check here</b> <input checked="" type="checkbox"/> <b>and complete lines 27, 28, 32, and 33.</b>                                                                                    |                          |                      |                       |
|                                                                           | <b>27</b> Net assets without donor restrictions .....                                                                                                                                                                          | 4,834,919.               | <b>27</b>            | 3,998,537.            |
|                                                                           | <b>28</b> Net assets with donor restrictions .....                                                                                                                                                                             |                          | <b>28</b>            |                       |
|                                                                           | <b>Organizations that do not follow FASB ASC 958, check here</b> <input type="checkbox"/> <b>and complete lines 29 through 33.</b>                                                                                             |                          |                      |                       |
|                                                                           | <b>29</b> Capital stock or trust principal, or current funds .....                                                                                                                                                             |                          | <b>29</b>            |                       |
|                                                                           | <b>30</b> Paid-in or capital surplus, or land, building, or equipment fund .....                                                                                                                                               |                          | <b>30</b>            |                       |
|                                                                           | <b>31</b> Retained earnings, endowment, accumulated income, or other funds .....                                                                                                                                               |                          | <b>31</b>            |                       |
|                                                                           | <b>32</b> Total net assets or fund balances .....                                                                                                                                                                              | 4,834,919.               | <b>32</b>            | 3,998,537.            |
| <b>33</b> Total liabilities and net assets/fund balances .....            | 5,093,077.                                                                                                                                                                                                                     | <b>33</b>                | 4,377,535.           |                       |

**Part XI Reconciliation of Net Assets**

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

|           |                                                                                                                |           |             |
|-----------|----------------------------------------------------------------------------------------------------------------|-----------|-------------|
| <b>1</b>  | Total revenue (must equal Part VIII, column (A), line 12)                                                      | <b>1</b>  | 7,836,926.  |
| <b>2</b>  | Total expenses (must equal Part IX, column (A), line 25)                                                       | <b>2</b>  | 3,134,469.  |
| <b>3</b>  | Revenue less expenses. Subtract line 2 from line 1                                                             | <b>3</b>  | 4,702,457.  |
| <b>4</b>  | Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))                      | <b>4</b>  | 4,834,919.  |
| <b>5</b>  | Net unrealized gains (losses) on investments                                                                   | <b>5</b>  |             |
| <b>6</b>  | Donated services and use of facilities                                                                         | <b>6</b>  |             |
| <b>7</b>  | Investment expenses                                                                                            | <b>7</b>  |             |
| <b>8</b>  | Prior period adjustments                                                                                       | <b>8</b>  |             |
| <b>9</b>  | Other changes in net assets or fund balances (explain on Schedule O)                                           | <b>9</b>  | -5,538,839. |
| <b>10</b> | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B)) | <b>10</b> | 3,998,537.  |

**Part XII Financial Statements and Reporting**

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

- 1** Accounting method used to prepare the Form 990:  Cash  Accrual  Other \_\_\_\_\_  
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant? .....  
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant? .....  
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:  
 Separate basis  Consolidated basis  Both consolidated and separate basis
- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? .....  
If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? .....
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits .....

|           | Yes | No |
|-----------|-----|----|
|           |     |    |
| <b>2a</b> |     | X  |
|           |     |    |
| <b>2b</b> | X   |    |
|           |     |    |
| <b>2c</b> | X   |    |
|           |     |    |
| <b>3a</b> |     | X  |
|           |     |    |
| <b>3b</b> |     |    |

**SCHEDULE A**  
**(Form 990 or 990-EZ)**

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

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

▶ Attach to Form 990 or Form 990-EZ.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2020**

Open to Public Inspection

|                                                                |                                                     |
|----------------------------------------------------------------|-----------------------------------------------------|
| <b>Name of the organization</b><br>MARCO ISLAND HOSPITAL, INC. | <b>Employer identification number</b><br>59-2315435 |
|----------------------------------------------------------------|-----------------------------------------------------|

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

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

- 1  A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2  A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)
- 3  A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4  A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: \_\_\_\_\_
- 5  An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6  A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7  An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8  A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9  An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: \_\_\_\_\_
- 10  An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions, subject to certain exceptions; and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11  An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12  An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
  - a  **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
  - b  **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
  - c  **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
  - d  **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
  - e  Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
  - f Enter the number of supported organizations .....
  - g Provide the following information about the supported organization(s).

| (i) Name of supported organization | (ii) EIN | (iii) Type of organization (described on lines 1-10 above (see instructions)) | (iv) Is the organization listed in your governing document? |    | (v) Amount of monetary support (see instructions) | (vi) Amount of other support (see instructions) |
|------------------------------------|----------|-------------------------------------------------------------------------------|-------------------------------------------------------------|----|---------------------------------------------------|-------------------------------------------------|
|                                    |          |                                                                               | Yes                                                         | No |                                                   |                                                 |
|                                    |          |                                                                               |                                                             |    |                                                   |                                                 |
|                                    |          |                                                                               |                                                             |    |                                                   |                                                 |
|                                    |          |                                                                               |                                                             |    |                                                   |                                                 |
|                                    |          |                                                                               |                                                             |    |                                                   |                                                 |
|                                    |          |                                                                               |                                                             |    |                                                   |                                                 |
|                                    |          |                                                                               |                                                             |    |                                                   |                                                 |
|                                    |          |                                                                               |                                                             |    |                                                   |                                                 |
|                                    |          |                                                                               |                                                             |    |                                                   |                                                 |
|                                    |          |                                                                               |                                                             |    |                                                   |                                                 |
|                                    |          |                                                                               |                                                             |    |                                                   |                                                 |
| <b>Total</b>                       |          |                                                                               |                                                             |    |                                                   |                                                 |

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

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

**Section A. Public Support**

| Calendar year (or fiscal year beginning in) ►                                                                                                                                                                      | (a) 2016 | (b) 2017 | (c) 2018 | (d) 2019 | (e) 2020 | (f) Total |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|----------|----------|----------|-----------|
| <b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....                                                                                                  |          |          |          |          |          |           |
| <b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....                                                                                                     |          |          |          |          |          |           |
| <b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....                                                                                             |          |          |          |          |          |           |
| <b>4 Total.</b> Add lines 1 through 3 .....                                                                                                                                                                        |          |          |          |          |          |           |
| <b>5</b> The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) ..... |          |          |          |          |          |           |
| <b>6 Public support.</b> Subtract line 5 from line 4.                                                                                                                                                              |          |          |          |          |          |           |

**Section B. Total Support**

| Calendar year (or fiscal year beginning in) ►                                                                                                                                                     | (a) 2016 | (b) 2017 | (c) 2018 | (d) 2019 | (e) 2020 | (f) Total                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|----------|----------|----------|--------------------------|
| <b>7</b> Amounts from line 4 .....                                                                                                                                                                |          |          |          |          |          |                          |
| <b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources .....                                                    |          |          |          |          |          |                          |
| <b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on .....                                                                                 |          |          |          |          |          |                          |
| <b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....                                                                                   |          |          |          |          |          |                          |
| <b>11 Total support.</b> Add lines 7 through 10                                                                                                                                                   |          |          |          |          |          |                          |
| <b>12</b> Gross receipts from related activities, etc. (see instructions) .....                                                                                                                   |          |          |          |          | 12       |                          |
| <b>13 First 5 years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> ..... |          |          |          |          |          | <input type="checkbox"/> |

**Section C. Computation of Public Support Percentage**

|                                                                                                                                                                                                                                                                                                                                                                                                                 |    |                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|--------------------------|
| <b>14</b> Public support percentage for 2020 (line 6, column (f), divided by line 11, column (f)) .....                                                                                                                                                                                                                                                                                                         | 14 | %                        |
| <b>15</b> Public support percentage from 2019 Schedule A, Part II, line 14 .....                                                                                                                                                                                                                                                                                                                                | 15 | %                        |
| <b>16a 33 1/3% support test - 2020.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....                                                                                                                                                                        |    | <input type="checkbox"/> |
| <b>b 33 1/3% support test - 2019.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....                                                                                                                                                                     |    | <input type="checkbox"/> |
| <b>17a 10% -facts-and-circumstances test - 2020.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization .....    |    | <input type="checkbox"/> |
| <b>b 10% -facts-and-circumstances test - 2019.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization ..... |    | <input type="checkbox"/> |
| <b>18 Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions .....                                                                                                                                                                                                                                                              |    | <input type="checkbox"/> |

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

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

**Section A. Public Support**

| Calendar year (or fiscal year beginning in) ►                                                                                                                                           | (a) 2016 | (b) 2017 | (c) 2018 | (d) 2019 | (e) 2020 | (f) Total |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|----------|----------|----------|-----------|
| <b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....                                                                       |          |          |          |          |          |           |
| <b>2</b> 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 ..... |          |          |          |          |          |           |
| <b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 .....                                                                             |          |          |          |          |          |           |
| <b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....                                                                          |          |          |          |          |          |           |
| <b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....                                                                  |          |          |          |          |          |           |
| <b>6 Total.</b> Add lines 1 through 5 .....                                                                                                                                             |          |          |          |          |          |           |
| <b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons .....                                                                                                |          |          |          |          |          |           |
| <b>b</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 .....           |          |          |          |          |          |           |
| <b>c</b> Add lines 7a and 7b .....                                                                                                                                                      |          |          |          |          |          |           |
| <b>8 Public support.</b> (Subtract line 7c from line 6.)                                                                                                                                |          |          |          |          |          |           |

**Section B. Total Support**

| Calendar year (or fiscal year beginning in) ►                                                                                                    | (a) 2016 | (b) 2017 | (c) 2018 | (d) 2019 | (e) 2020 | (f) Total |
|--------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|----------|----------|----------|-----------|
| <b>9</b> Amounts from line 6 .....                                                                                                               |          |          |          |          |          |           |
| <b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources ..... |          |          |          |          |          |           |
| <b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 .....                           |          |          |          |          |          |           |
| <b>c</b> Add lines 10a and 10b .....                                                                                                             |          |          |          |          |          |           |
| <b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on .....      |          |          |          |          |          |           |
| <b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....                                  |          |          |          |          |          |           |
| <b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.)                                                                                         |          |          |          |          |          |           |

**14 First 5 years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ..... ►

**Section C. Computation of Public Support Percentage**

|                                                                                                         |           |   |
|---------------------------------------------------------------------------------------------------------|-----------|---|
| <b>15</b> Public support percentage for 2020 (line 8, column (f), divided by line 13, column (f)) ..... | <b>15</b> | % |
| <b>16</b> Public support percentage from 2019 Schedule A, Part III, line 15 .....                       | <b>16</b> | % |

**Section D. Computation of Investment Income Percentage**

|                                                                                                              |           |   |
|--------------------------------------------------------------------------------------------------------------|-----------|---|
| <b>17</b> Investment income percentage for 2020 (line 10c, column (f), divided by line 13, column (f)) ..... | <b>17</b> | % |
| <b>18</b> Investment income percentage from 2019 Schedule A, Part III, line 17 .....                         | <b>18</b> | % |

**19a 33 1/3% support tests - 2020.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ..... ►

**b 33 1/3% support tests - 2019.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ..... ►

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



**Part IV Supporting Organizations**

(Complete only if you checked a box in line 12 on Part I. If you checked box 12a, Part I, complete Sections A and B. If you checked box 12b, Part I, complete Sections A and C. If you checked box 12c, Part I, complete Sections A, D, and E. If you checked box 12d, Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| <b>1</b> Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>                                                                                                                                                                                                                    |     |    |
| <b>2</b> Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>                                                                                                                                                                                                                                                 |     |    |
| <b>3a</b> Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer lines 3b and 3c below.</i>                                                                                                                                                                                                                                                                                                                                                                                       |     |    |
| <b>b</b> Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>                                                                                                                                                                                                                                                               |     |    |
| <b>c</b> Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>                                                                                                                                                                                                                                                                                                        |     |    |
| <b>4a</b> Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.</i>                                                                                                                                                                                                                                                                                                                                    |     |    |
| <b>b</b> Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>                                                                                                                                                                                                            |     |    |
| <b>c</b> Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>                                                                                                                                                                               |     |    |
| <b>5a</b> Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i> |     |    |
| <b>b Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?                                                                                                                                                                                                                                                                                                                                                                             |     |    |
| <b>c Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?                                                                                                                                                                                                                                                                                                                                                                                                                                    |     |    |
| <b>6</b> Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>                                                              |     |    |
| <b>7</b> Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>                                                                                                                                                                                        |     |    |
| <b>8</b> Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>                                                                                                                                                                                                                                                                                                                                                  |     |    |
| <b>9a</b> Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>                                                                                                                                                                                                                                         |     |    |
| <b>b</b> Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>                                                                                                                                                                                                                                                                                                                              |     |    |
| <b>c</b> Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>                                                                                                                                                                                                                                                                                                   |     |    |
| <b>10a</b> Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>                                                                                                                                                                                                                                                  |     |    |
| <b>b</b> Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>                                                                                                                                                                                                                                                                                                                                                       |     |    |

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

**Section D. All Type III Supporting Organizations**

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

**Section E. Type III Functionally Integrated Supporting Organizations**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| <b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).                                                                                                                                                                                                                                                                                                                                                                                              |  |  |
| <b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |
| <b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| <b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a governmental entity (see instructions).                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| <b>2</b> Activities Test. Answer lines 2a and 2b below.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |
| <b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i> |  |  |
| <b>b</b> Did the activities described in line 2a, above, constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>                                                                                                                  |  |  |
| <b>3</b> Parent of Supported Organizations. Answer lines 3a and 3b below.                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |
| <b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>If "Yes" or "No" provide details in Part VI.</i>                                                                                                                                                                                                                                                                                                               |  |  |
| <b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>                                                                                                                                                                                                                                                                                   |  |  |

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

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

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

| Section B - Minimum Asset Amount |                                                                                                                                 | (A) Prior Year | (B) Current Year (optional) |
|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------|
| 1                                | Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year): |                |                             |
| a                                | Average monthly value of securities                                                                                             | 1a             |                             |
| b                                | Average monthly cash balances                                                                                                   | 1b             |                             |
| c                                | Fair market value of other non-exempt-use assets                                                                                | 1c             |                             |
| d                                | <b>Total</b> (add lines 1a, 1b, and 1c)                                                                                         | 1d             |                             |
| e                                | <b>Discount</b> claimed for blockage or other factors ( <i>explain in detail in Part VI</i> ):                                  |                |                             |
| 2                                | Acquisition indebtedness applicable to non-exempt-use assets                                                                    | 2              |                             |
| 3                                | Subtract line 2 from line 1d.                                                                                                   | 3              |                             |
| 4                                | Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).                                  | 4              |                             |
| 5                                | Net value of non-exempt-use assets (subtract line 4 from line 3)                                                                | 5              |                             |
| 6                                | Multiply line 5 by 0.035.                                                                                                       | 6              |                             |
| 7                                | Recoveries of prior-year distributions                                                                                          | 7              |                             |
| 8                                | <b>Minimum Asset Amount</b> (add line 7 to line 6)                                                                              | 8              |                             |

| Section C - Distributable Amount |                                                                                                                                                                           |   | Current Year |
|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|--------------|
| 1                                | Adjusted net income for prior year (from Section A, line 8, column A)                                                                                                     | 1 |              |
| 2                                | Enter 0.85 of line 1.                                                                                                                                                     | 2 |              |
| 3                                | Minimum asset amount for prior year (from Section B, line 8, column A)                                                                                                    | 3 |              |
| 4                                | Enter greater of line 2 or line 3.                                                                                                                                        | 4 |              |
| 5                                | Income tax imposed in prior year                                                                                                                                          | 5 |              |
| 6                                | <b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).                                             | 6 |              |
| 7                                | <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions). |   |              |

Schedule A (Form 990 or 990-EZ) 2020

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

| <b>Section D - Distributions</b> |                                                                                                                                                     | <b>Current Year</b> |
|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| <b>1</b>                         | Amounts paid to supported organizations to accomplish exempt purposes                                                                               | <b>1</b>            |
| <b>2</b>                         | Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity               | <b>2</b>            |
| <b>3</b>                         | Administrative expenses paid to accomplish exempt purposes of supported organizations                                                               | <b>3</b>            |
| <b>4</b>                         | Amounts paid to acquire exempt-use assets                                                                                                           | <b>4</b>            |
| <b>5</b>                         | Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i> )                                                      | <b>5</b>            |
| <b>6</b>                         | Other distributions ( <i>describe in Part VI</i> ). See instructions.                                                                               | <b>6</b>            |
| <b>7</b>                         | <b>Total annual distributions.</b> Add lines 1 through 6.                                                                                           | <b>7</b>            |
| <b>8</b>                         | Distributions to attentive supported organizations to which the organization is responsive ( <i>provide details in Part VI</i> ). See instructions. | <b>8</b>            |
| <b>9</b>                         | Distributable amount for 2020 from Section C, line 6                                                                                                | <b>9</b>            |
| <b>10</b>                        | Line 8 amount divided by line 9 amount                                                                                                              | <b>10</b>           |

| <b>Section E - Distribution Allocations</b> (see instructions)                                                                                                                           | <b>(i)<br/>Excess Distributions</b> | <b>(ii)<br/>Underdistributions<br/>Pre-2020</b> | <b>(iii)<br/>Distributable<br/>Amount for 2020</b> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------|----------------------------------------------------|
| <b>1</b> Distributable amount for 2020 from Section C, line 6                                                                                                                            |                                     |                                                 |                                                    |
| <b>2</b> Underdistributions, if any, for years prior to 2020 (reasonable cause required - <i>explain in Part VI</i> ). See instructions.                                                 |                                     |                                                 |                                                    |
| <b>3</b> Excess distributions carryover, if any, to 2020                                                                                                                                 |                                     |                                                 |                                                    |
| <b>a</b> From 2015                                                                                                                                                                       |                                     |                                                 |                                                    |
| <b>b</b> From 2016                                                                                                                                                                       |                                     |                                                 |                                                    |
| <b>c</b> From 2017                                                                                                                                                                       |                                     |                                                 |                                                    |
| <b>d</b> From 2018                                                                                                                                                                       |                                     |                                                 |                                                    |
| <b>e</b> From 2019                                                                                                                                                                       |                                     |                                                 |                                                    |
| <b>f</b> <b>Total</b> of lines 3a through 3e                                                                                                                                             |                                     |                                                 |                                                    |
| <b>g</b> Applied to underdistributions of prior years                                                                                                                                    |                                     |                                                 |                                                    |
| <b>h</b> Applied to 2020 distributable amount                                                                                                                                            |                                     |                                                 |                                                    |
| <b>i</b> Carryover from 2015 not applied (see instructions)                                                                                                                              |                                     |                                                 |                                                    |
| <b>j</b> Remainder. Subtract lines 3g, 3h, and 3i from line 3f.                                                                                                                          |                                     |                                                 |                                                    |
| <b>4</b> Distributions for 2020 from Section D, line 7: \$                                                                                                                               |                                     |                                                 |                                                    |
| <b>a</b> Applied to underdistributions of prior years                                                                                                                                    |                                     |                                                 |                                                    |
| <b>b</b> Applied to 2020 distributable amount                                                                                                                                            |                                     |                                                 |                                                    |
| <b>c</b> Remainder. Subtract lines 4a and 4b from line 4.                                                                                                                                |                                     |                                                 |                                                    |
| <b>5</b> Remaining underdistributions for years prior to 2020, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions. |                                     |                                                 |                                                    |
| <b>6</b> Remaining underdistributions for 2020. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions.                        |                                     |                                                 |                                                    |
| <b>7</b> <b>Excess distributions carryover to 2021.</b> Add lines 3j and 4c.                                                                                                             |                                     |                                                 |                                                    |
| <b>8</b> Breakdown of line 7:                                                                                                                                                            |                                     |                                                 |                                                    |
| <b>a</b> Excess from 2016                                                                                                                                                                |                                     |                                                 |                                                    |
| <b>b</b> Excess from 2017                                                                                                                                                                |                                     |                                                 |                                                    |
| <b>c</b> Excess from 2018                                                                                                                                                                |                                     |                                                 |                                                    |
| <b>d</b> Excess from 2019                                                                                                                                                                |                                     |                                                 |                                                    |
| <b>e</b> Excess from 2020                                                                                                                                                                |                                     |                                                 |                                                    |



SCHEDULE D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

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

Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2020

Open to Public Inspection

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

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

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include total number at end of year, aggregate value of contributions, grants, and end of year, and two Yes/No questions regarding donor property and grant fund usage.

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

Form with multiple sections: 1. Purpose(s) of conservation easements (checkboxes for land, habitat, open space, historic area, structure). 2. Conservation contribution details (2a-2d table). 3-7. Monitoring and enforcement details. 8-9. Reporting requirements.

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

Form with sections 1a-1b and 2. 1a-1b: Reporting requirements for art collections. 2: Reporting requirements for art held for financial gain. Includes dollar amounts for revenue and assets.

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

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

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

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

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

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

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment  \_\_\_\_\_ %
  - b Permanent endowment  \_\_\_\_\_ %
  - c Term endowment  \_\_\_\_\_ %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- |                                                                                            | Yes    | No |
|--------------------------------------------------------------------------------------------|--------|----|
| (i) Unrelated organizations                                                                | 3a(i)  |    |
| (ii) Related organizations                                                                 | 3a(ii) |    |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? | 3b     |    |
- 4 Describe in Part XIII the intended uses of the organization's endowment funds.

**Part VI Land, Buildings, and Equipment.**

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

| Description of property                                                                                | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|--------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land                                                                                                |                                      | 997,275.                        |                              | 997,275.       |
| b Buildings                                                                                            |                                      | 6,718,242.                      | 4,252,454.                   | 2,465,788.     |
| c Leasehold improvements                                                                               |                                      |                                 |                              |                |
| d Equipment                                                                                            |                                      | 2,180,096.                      | 1,827,236.                   | 352,860.       |
| e Other                                                                                                |                                      | 414,009.                        | 414,009.                     | 0.             |
| <b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) |                                      |                                 |                              | 3,815,923.     |

**Part VII Investments - Other Securities.**

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

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

**Part VIII Investments - Program Related.**

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

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

**Part IX Other Assets.**

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

| (a) Description                                                             | (b) Book value |
|-----------------------------------------------------------------------------|----------------|
| (1)                                                                         |                |
| (2)                                                                         |                |
| (3)                                                                         |                |
| (4)                                                                         |                |
| (5)                                                                         |                |
| (6)                                                                         |                |
| (7)                                                                         |                |
| (8)                                                                         |                |
| (9)                                                                         |                |
| <b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶ |                |

**Part X Other Liabilities.**

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

| 1. (a) Description of liability                                             | (b) Book value |
|-----------------------------------------------------------------------------|----------------|
| (1) Federal income taxes                                                    |                |
| (2) ACCRUED EXP - PROF/GEN LIAB INSURANCE                                   | 31,748.        |
| (3) ACCRUED EXP - WORKER ' S COMP                                           | 7,330.         |
| (4)                                                                         |                |
| (5)                                                                         |                |
| (6)                                                                         |                |
| (7)                                                                         |                |
| (8)                                                                         |                |
| (9)                                                                         |                |
| <b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶ | 39,078.        |

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



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

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

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

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

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

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

**Part XIII Supplemental Information.**

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

PART X, LINE 2:

THE SYSTEM AND ALL OF ITS NOT-FOR-PROFIT SUBSIDIARIES ARE EXEMPT FROM

FEDERAL INCOME TAXES ON RELATED INCOME UNDER SECTION 501(A) OF THE

INTERNAL REVENUE CODE (THE CODE). THE SYSTEM AND ALL OF ITS NOT-FOR-PROFIT

SUBSIDIARIES DO NOT HAVE SIGNIFICANT UNRELATED BUSINESS INCOME; HOWEVER,

SUCH STATUS IS SUBJECT TO FINAL DETERMINATION UPON EXAMINATION OF THE

RELATED INCOME TAX RETURNS BY THE APPROPRIATE TAXING AUTHORITIES. THE

SYSTEM IS GENERALLY NO LONGER SUBJECT TO TAX EXAMINATIONS IN THE MAJOR

U.S. TAXING JURISDICTIONS IN WHICH THEY OPERATE FOR TAX YEARS PRIOR TO

2017.



**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2020**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

- ▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
- ▶ **Attach to Form 990.**
- ▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

|                                                                |                                                     |
|----------------------------------------------------------------|-----------------------------------------------------|
| <b>Name of the organization</b><br>MARCO ISLAND HOSPITAL, INC. | <b>Employer identification number</b><br>59-2315435 |
|----------------------------------------------------------------|-----------------------------------------------------|

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |           | Yes | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|----|
| <b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a .....                                                                                                                                                                                                                                                                                                                                                            | <b>1a</b> | X   |    |
| <b>b</b> If "Yes," was it a written policy? .....                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>1b</b> | X   |    |
| <p><b>2</b> 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.</p> <p><input checked="" type="checkbox"/> Applied uniformly to all hospital facilities      <input type="checkbox"/> Applied uniformly to most hospital facilities</p> <p><input type="checkbox"/> Generally tailored to individual hospital facilities</p> |           |     |    |
| <b>3</b> 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.                                                                                                                                                                                                                                                                                                          |           |     |    |
| <b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? .....                                                                                                                                                                                                                                                                                                                                      | <b>3a</b> | X   |    |
| <p>If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: .....</p> <p><input type="checkbox"/> 100%    <input type="checkbox"/> 150%    <input checked="" type="checkbox"/> 200%    <input type="checkbox"/> Other _____ %</p>                                                                                                                                                                                                    |           |     |    |
| <b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: .....                                                                                                                                                                                                                                                  | <b>3b</b> | X   |    |
| <p>If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: .....</p> <p><input type="checkbox"/> 200%    <input type="checkbox"/> 250%    <input type="checkbox"/> 300%    <input type="checkbox"/> 350%    <input checked="" type="checkbox"/> 400%    <input type="checkbox"/> Other _____ %</p>                                                                                                                                |           |     |    |
| <b>c</b> If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. ....                                                                                                        |           |     |    |
| <b>4</b> 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"? .....                                                                                                                                                                                                                                                                            | <b>4</b>  | X   |    |
| <b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? .....                                                                                                                                                                                                                                                                                                                                  | <b>5a</b> | X   |    |
| <b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? .....                                                                                                                                                                                                                                                                                                                                                                            | <b>5b</b> |     | X  |
| <b>c</b> 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? .....                                                                                                                                                                                                                                                                                  | <b>5c</b> |     |    |
| <b>6a</b> Did the organization prepare a community benefit report during the tax year? .....                                                                                                                                                                                                                                                                                                                                                                                         | <b>6a</b> | X   |    |
| <b>b</b> If "Yes," did the organization make it available to the public? .....                                                                                                                                                                                                                                                                                                                                                                                                       | <b>6b</b> | X   |    |

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

**7 Financial Assistance and Certain Other Community Benefits at Cost**

|                                                                                                          | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|----------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| <b>Financial Assistance and Means-Tested Government Programs</b>                                         |                                                 |                               |                                     |                               |                                   |                              |
| <b>a</b> Financial Assistance at cost (from Worksheet 1) .....                                           |                                                 | 6,186                         | 6,197.                              |                               | 6,197.                            | .20%                         |
| <b>b</b> Medicaid (from Worksheet 3, column a) .....                                                     |                                                 |                               | 50,854.                             | 18,492.                       | 32,362.                           | 1.03%                        |
| <b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) .....              |                                                 |                               |                                     |                               |                                   |                              |
| <b>d Total.</b> Financial Assistance and Means-Tested Government Programs .....                          |                                                 | 6,186                         | 57,051.                             | 18,492.                       | 38,559.                           | 1.23%                        |
| <b>Other Benefits</b>                                                                                    |                                                 |                               |                                     |                               |                                   |                              |
| <b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) ..... | 2                                               | 44                            | 841.                                |                               | 841.                              | .03%                         |
| <b>f</b> Health professions education (from Worksheet 5) .....                                           |                                                 |                               |                                     |                               |                                   |                              |
| <b>g</b> Subsidized health services (from Worksheet 6) .....                                             |                                                 |                               |                                     |                               |                                   |                              |
| <b>h</b> Research (from Worksheet 7) .....                                                               |                                                 |                               |                                     |                               |                                   |                              |
| <b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) .....                   |                                                 |                               |                                     |                               |                                   |                              |
| <b>j Total.</b> Other Benefits .....                                                                     | 2                                               | 44                            | 841.                                |                               | 841.                              | .03%                         |
| <b>k Total.</b> Add lines 7d and 7j .....                                                                | 2                                               | 6,230                         | 57,892.                             | 18,492.                       | 39,400.                           | 1.26%                        |





**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

Name of hospital facility or letter of facility reporting group MARCO ISLAND HOSPITAL, INC.

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Yes | No |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| <b>Community Health Needs Assessment</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |     |    |
| <b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? .....                                                                                                                                                                                                                                                                       |     | X  |
| <b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C .....                                                                                                                                                                                                                                          |     | X  |
| <b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 .....                                                                                                                                                                                                                                                                     | X   |    |
| If "Yes," indicate what the CHNA report describes (check all that apply):                                                                                                                                                                                                                                                                                                                                                                                           |     |    |
| <b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility                                                                                                                                                                                                                                                                                                                                                          |     |    |
| <b>b</b> <input checked="" type="checkbox"/> Demographics of the community                                                                                                                                                                                                                                                                                                                                                                                          |     |    |
| <b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community                                                                                                                                                                                                                                                                                  |     |    |
| <b>d</b> <input checked="" type="checkbox"/> How data was obtained                                                                                                                                                                                                                                                                                                                                                                                                  |     |    |
| <b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community                                                                                                                                                                                                                                                                                                                                                                          |     |    |
| <b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups                                                                                                                                                                                                                                                                                                |     |    |
| <b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs                                                                                                                                                                                                                                                                                                    |     |    |
| <b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests                                                                                                                                                                                                                                                                                                                                         |     |    |
| <b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)                                                                                                                                                                                                                                                                                            |     |    |
| <b>j</b> <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                                                                                                                                     |     |    |
| <b>4</b> Indicate the tax year the hospital facility last conducted a CHNA: <u>20 18</u>                                                                                                                                                                                                                                                                                                                                                                            |     |    |
| <b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted ..... | X   |    |
| <b>6a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C .....                                                                                                                                                                                                                                                                                                    | X   |    |
| <b>6b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C .....                                                                                                                                                                                                                                                                                       |     | X  |
| <b>7</b> Did the hospital facility make its CHNA report widely available to the public? .....                                                                                                                                                                                                                                                                                                                                                                       | X   |    |
| If "Yes," indicate how the CHNA report was made widely available (check all that apply):                                                                                                                                                                                                                                                                                                                                                                            |     |    |
| <b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>HTTP://WWW.NCHMD.ORG/ABOUT-US/ANNUAL-REPORTS</u>                                                                                                                                                                                                                                                                                                                            |     |    |
| <b>b</b> <input type="checkbox"/> Other website (list url): .....                                                                                                                                                                                                                                                                                                                                                                                                   |     |    |
| <b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility                                                                                                                                                                                                                                                                                                                              |     |    |
| <b>d</b> <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                                                                                                                                     |     |    |
| <b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 .....                                                                                                                                                                                                                                                              | X   |    |
| <b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy: <u>20 18</u>                                                                                                                                                                                                                                                                                                                                                          |     |    |
| <b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? .....                                                                                                                                                                                                                                                                                                                                                       | X   |    |
| <b>a</b> If "Yes," (list url): <u>HTTP://WWW.NCHMD.ORG/ABOUT-US/ANNUAL-REPORTS</u>                                                                                                                                                                                                                                                                                                                                                                                  |     |    |
| <b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....                                                                                                                                                                                                                                                                                                                                           |     |    |
| <b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.                                                                                                                                                                                                      |     |    |
| <b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? .....                                                                                                                                                                                                                                                                                                |     | X  |
| <b>b</b> If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....                                                                                                                                                                                                                                                                                                                                                     |     |    |
| <b>c</b> If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$                                                                                                                                                                                                                                                                                                    |     |    |

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

Name of hospital facility or letter of facility reporting group MARCO ISLAND HOSPITAL, INC.

|                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                     | Yes | No |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that:                                                                                             |                                                                                                                                                                                                                                                                                                                                                     |     |    |
| <b>13</b>                                                                                                                                                                                           | Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....                                                                                                                                                                                                                        | X   |    |
| If "Yes," indicate the eligibility criteria explained in the FAP:                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                     |     |    |
| <b>a</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %                                                                                                                    |     |    |
| <b>b</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)                                                                                                                                                                                                                                                             |     |    |
| <b>c</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Asset level                                                                                                                                                                                                                                                                                                     |     |    |
| <b>d</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Medical indigency                                                                                                                                                                                                                                                                                               |     |    |
| <b>e</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Insurance status                                                                                                                                                                                                                                                                                                |     |    |
| <b>f</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Underinsurance status                                                                                                                                                                                                                                                                                           |     |    |
| <b>g</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Residency                                                                                                                                                                                                                                                                                                       |     |    |
| <b>h</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                   |     |    |
| <b>14</b>                                                                                                                                                                                           | Explained the basis for calculating amounts charged to patients? .....                                                                                                                                                                                                                                                                              | X   |    |
| <b>15</b>                                                                                                                                                                                           | Explained the method for applying for financial assistance? .....                                                                                                                                                                                                                                                                                   | X   |    |
| If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply): |                                                                                                                                                                                                                                                                                                                                                     |     |    |
| <b>a</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application                                                                                                                                                                                          |     |    |
| <b>b</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application                                                                                                                                                                              |     |    |
| <b>c</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process                                                                                                                                                            |     |    |
| <b>d</b>                                                                                                                                                                                            | <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications                                                                                                                                                                                 |     |    |
| <b>e</b>                                                                                                                                                                                            | <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                              |     |    |
| <b>16</b>                                                                                                                                                                                           | Was widely publicized within the community served by the hospital facility? .....                                                                                                                                                                                                                                                                   | X   |    |
| If "Yes," indicate how the hospital facility publicized the policy (check all that apply):                                                                                                          |                                                                                                                                                                                                                                                                                                                                                     |     |    |
| <b>a</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>                                                                                                                                                                                                                                 |     |    |
| <b>b</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>                                                                                                                                                                                                                |     |    |
| <b>c</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>                                                                                                                                                                                                     |     |    |
| <b>d</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)                                                                                                                                                                                                |     |    |
| <b>e</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)                                                                                                                                                                               |     |    |
| <b>f</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)                                                                                                                                                                    |     |    |
| <b>g</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention |     |    |
| <b>h</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP                                                                                                                                                                                             |     |    |
| <b>i</b>                                                                                                                                                                                            | <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations                                                                                                                                       |     |    |
| <b>j</b>                                                                                                                                                                                            | <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                                                                                              |     |    |

**Part V Facility Information** (continued)

**Billing and Collections**

Name of hospital facility or letter of facility reporting group MARCO ISLAND HOSPITAL, INC.

|                                                                                                                                                                                                                                                                                   | Yes | No |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| <b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? ..... | X   |    |
| <b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:                            |     |    |
| a <input type="checkbox"/> Reporting to credit agency(ies)                                                                                                                                                                                                                        |     |    |
| b <input type="checkbox"/> Selling an individual's debt to another party                                                                                                                                                                                                          |     |    |
| c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP                                                                           |     |    |
| d <input type="checkbox"/> Actions that require a legal or judicial process                                                                                                                                                                                                       |     |    |
| e <input type="checkbox"/> Other similar actions (describe in Section C)                                                                                                                                                                                                          |     |    |
| f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted                                                                                                                                                                               |     |    |
| <b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? .....                                                 |     | X  |
| If "Yes," check all actions in which the hospital facility or a third party engaged:                                                                                                                                                                                              |     |    |
| a <input type="checkbox"/> Reporting to credit agency(ies)                                                                                                                                                                                                                        |     |    |
| b <input type="checkbox"/> Selling an individual's debt to another party                                                                                                                                                                                                          |     |    |
| c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP                                                                           |     |    |
| d <input type="checkbox"/> Actions that require a legal or judicial process                                                                                                                                                                                                       |     |    |
| e <input type="checkbox"/> Other similar actions (describe in Section C)                                                                                                                                                                                                          |     |    |
| <b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):                                                                                     |     |    |
| a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)                                       |     |    |
| b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)                                                                                                             |     |    |
| c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)                                                                                                                                                          |     |    |
| d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)                                                                                                                                                                 |     |    |
| e <input type="checkbox"/> Other (describe in Section C)                                                                                                                                                                                                                          |     |    |
| f <input type="checkbox"/> None of these efforts were made                                                                                                                                                                                                                        |     |    |

**Policy Relating to Emergency Medical Care**

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



**Part V Facility Information** *(continued)*

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

Name of hospital facility or letter of facility reporting group MARCO ISLAND HOSPITAL, INC.

|           |                                                                                                                                                                                                                                                                                                               | Yes | No |
|-----------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| <b>22</b> | Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.                                                                                                                      |     |    |
| <b>a</b>  | <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period                                                                                                                                                     |     |    |
| <b>b</b>  | <input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period                                                                 |     |    |
| <b>c</b>  | <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period                              |     |    |
| <b>d</b>  | <input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method                                                                                                                                                                                                                 |     |    |
| <b>23</b> | During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? .....<br>If "Yes," explain in Section C. | 23  | X  |
| <b>24</b> | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? .....<br>If "Yes," explain in Section C.                                                                                                   | 24  | X  |

**Part V Facility Information** (continued)

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

MARCO ISLAND HOSPITAL, INC.:

PART V, SECTION B, LINE 5: CHNA TAKING INTO ACCOUNT INPUT FROM THE

COMMUNITY

THE NCH LEADERSHIP TEAM IS ACTIVELY INVOLVED AND PARTICIPATES IN MANY

COMMUNITY RELATED ORGANIZATIONS AND GROUPS THAT ARE CONTINUALLY ASSESSING

UNMET NEEDS WITHIN COLLIER COUNTY. NCH HAS HISTORICALLY WORKED WITH OUR

BOARD OF TRUSTEES, COLLIER COUNTY CHILDREN'S ALLIANCE, COLLIER COUNTY

PUBLIC SCHOOLS, BLUE ZONES PROJECT OF SWFL AND OTHER AGENCIES THROUGHOUT

THE COMMUNITY IN ASSESSING AND COLLABORATING IN EFFORTS TO IMPROVE THE

HEALTH OF OUR COMMUNITY.

NCH WORKS COLLABORATIVELY WITH THE FLORIDA DEPARTMENT OF HEALTH IN COLLIER

COUNTY, THE COUNTY AND CITY GOVERNMENT, THE NAPLES AREA CHAMBER OF

COMMERCE AND SEVERAL OTHER COMMUNITY GROUPS TO FORM THE COMMUNITY

ASSESSMENT DESIGN GROUP. THE PURPOSE IS TO ASSESS THE COMMUNITY'S

STRENGTHS AND OPPORTUNITIES. A NEW COMMUNITY HEALTH ASSESSMENT WAS

COMPLETED IN 2019. THE 2020-2023 COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

PRIORITIES WERE ESTABLISHED IN 2020 BY THE HEALTHY COLLIER EXECUTIVE

COMMITTEE BASED ON THE RESULTS FROM THE CHA. DOH-COLLIER FACILITATED THE

CHIP PROCESS BY USING THE NATIONAL ASSOCIATION OF CITY AND COUNTY HEALTH

OFFICIALS MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIP (MAPP)

STRATEGIC PLANNING MODEL.

USING THE MOBILIZING FOR ACTION THROUGH THE PLANNING AND PARTNERSHIP

(MAPP) FRAMEWORK, THE LEADERSHIP FOR COMMUNITY HEALTH IMPROVEMENT PLANNING

**Part V Facility Information** *(continued)*

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

(LCHIP) COMMITTEE REVIEWED THE 2019 COMMUNITY HEALTH ASSESSMENT (CHA) AND

HELD DISCUSSIONS REGARDING GROUP PRIORITIES AND OBJECTIVES GOING FORWARD.

THE COMMITTEE AGREED THAT THE RESULTS STRONGLY CORROBORATED THE RESULTS OF

OTHER RECENT COMMUNITY ASSESSMENTS AND ACCURATELY REFLECT THE NEEDS OF

COLLIER COUNTY.

THE 2020-2023 CHIP WAS THEN SHAPED USING THE FIVE HIGHEST RANKED HEALTH

PRIORITY AREAS FROM THE CHA RESULTS. THEY INCLUDE MENTAL HEALTH, CHRONIC

DISEASES, ACCESS TO CARE, ALCOHOL AND DRUG USE, AND HEALTH OF OLDER

ADULTS. MENTAL HEALTH AND ALCOHOL & DRUG USE WERE COMBINED INTO THE

MENTAL HEALTH & SUBSTANCE ABUSE WORKGROUP.

IN FEBRUARY AND MARCH OF 2020, THE DOH-COLLIER FACILITATORS CONVENED THE

HEALTH PRIORITY WOKGROUPS TO FINALIZE THE GOALS, STRATEGIES, AND

OBJECTIVES THAT EACH GROUP WILL WORK ON FOR THE NEXT THREE YEARS.

HEALTH PRIORITY: MENTAL HEALTH AND SUBSTANCE ABUSE

GOAL: IMPROVE IDENTIFICATION AND TREATMENT OF MENTAL HEALTH AND SUBSTANCE

USE DISORDERS.

OBJECTIVES:

1. INCREASE THE NUMBER OF PRIMARY CARE PROVIDER OFFICES AND URGENT CARE

FACILITIES IN COLLIER COUNTY THAT ARE USING THE COLLABORATION/INTEGRATION

CARE MODEL FROM 12 IN 2019 TO 25 BY THE END OF 2022. PROGRESS: AT THE

END OF 2021, THE NUMBER OF PRIMARY CARE PROVIDER OFFICES AND URGENT CARE

FACILITIES USING THE MODEL INCREASED TO 20.

2. INCREASE THE NUMBER OF INDIVIDUALS TRAINED PER YEAR IN YOUTH AND ADULT

MENTAL HEALTH FIRST AID FROM 1060 IN 2019 TO 3000 BY THE END OF 2021.

**Part V Facility Information** (continued)

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

PROGRESS: COVID-19 AFFECTED PROGRESS IN 2020 AND GREATLY REDUCED THE

NUMBER OF OPPORTUNITIES TO OFFER THE MHFA CLASS. AS A RESULT, THE NUMBER

OF INDIVIDUALS TRAINED IN 2021 WERE 1,256.

HEALTH PRIORITY: CHRONIC DISEASES

GOAL: DELIVER CULTURALLY RELEVANT HEALTH EDUCATION TO COLLIER COUNTY

RESIDENTS IN POPULATIONS WITH DISPARITIES IN HEALTH OUTCOMES.

OBJECTIVES:

1. INCREASE THE NUMBER OF BLUE ZONES APPROVED WORKSITES FROM 49 IN 2019 TO

65 BY THE END OF 2022. PROGRESS: THIRTEEN NEWLY APPROVED WORKSITES WERE

ADDED IN 2021 WHICH RESULTED IN A TOTAL OF 66 APPROVED WORKSITES.

2. INCREASE THE NUMBER OF WORKSITES IN COLLIER COUNTY USING THE CDC

WORKSITE WELLNESS SCORECARD FROM ONE IN 2019 TO FOUR BY THE END OF 2022.

PROGRESS: THERE WERE NO NEW CDC WORKSITE WELLNESS SCORECARD SITES ADDED

IN 2021. DOH-COLLIER'S RESPONSE TO THE COVID-19 PANDEMIC SLOWED PROGRAM

DEVELOPMENT AND ONBOARDING.

3. REACH A MINIMUM OF 1000 UNDUPLICATED SNAP-ELIGIBLE YOUTH THROUGH

NUTRITION EDUCATION IN 2021. PROGRESS: THIS PROGRAM EXCEEDED ITS 2021

TARGET WITH 2,711 SNAP-ELIGIBLE YOUTH. AS A RESULT, THE TARGET FOR 2022

WAS INCREASED TO 2,000.

4. REACH A MINIMUM OF 100 UNDUPLICATED SNAP-ELIGIBLE ADULTS THROUGH

NUTRITION EDUCATION IN 2021. PROGRESS: IN 2021, 225 SNAP-ELIGIBLE ADULTS

PARTICIPATED IN THE PROGRAM. AS A RESULT, THE TARGET FOR 2022 WAS

INCREASED TO 250.

5. ENSURE THE ANNUAL FUNDED ALLOWABLE MAXIMUM NUMBER OF PARTICIPANTS

COMPLETE THE HEALTHY FOR GOOD™ PROGRAM EACH YEAR THROUGH DECEMBER 31,

2022. PROGRESS: FOR 2021, THERE WERE 100 PARTICIPANTS IN THIS PROGRAM.

**Part V Facility Information** (continued)

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

HEALTH PRIORITY: ACCESS TO CARE

GOAL: INCREASE ACCESS TO BLOOD PRESSURE SCREENING SERVICES FOR UNINSURED

COLLIER COUNTY RESIDENTS.

OBJECTIVE:

1. INCREASE THE NUMBER OF UNINSURED RESIDENTS PER YEAR IN COLLIER COUNTY

WHO RECEIVED A BLOOD PRESSURE SCREENING FROM 12,404 IN 2019 TO 14,000 IN

2022, AN INCREASE OF ABOUT 5% PER YEAR. PROGRESS: WHILE COVID-19 TESTING

DROVE PATIENTS TO THE CLINICS IN 2020, WORKGROUP MEMBERS CONCLUDED THAT

MASK AND VACCINE REQUIREMENTS KEPT SOME AWAY IN 2021. THIS RESULTED IN

12,311 UNINSURED RESIDENTS RECEIVING BLOOD PRESSURE SCREENINGS.

HEALTH PRIORITY: HEALTH OF OLDER ADULTS

GOAL: INCREASE CAPACITY FOR OLDER ADULTS (AGE 60+) TO COMFORTABLY AND

SAFELY AGE IN PLACE WITH APPROPRIATE RESOURCES IN A LIVABLE COMMUNITY.

OBJECTIVES:

1. COMPLETE 100% OF THE STEPS REQUIRED TO SUBMIT PRODUCE THE COLLIER

COUNTY AGE-FRIENDLY ACTION PLAN BY DECEMBER 2022. PROGRESS: THIS

WORKGROUP HAS BROKEN UP INTO THREE CLUSTER GROUPS THAT COVER THE 8 DOMAINS

OF A LIVABLE COMMUNITY. AS A RESULT, 60% OF THE PROJECT HAS BEEN

COMPLETED BY THE END OF 2021.

2. REACH A MINIMUM OF 50 COMMUNITY TOUCHPOINTS REGARDING DEMENTIA

PRESENTATIONS, OUTREACH, TRAININGS, AND EVENTS BY DECEMBER 2022.

PROGRESS: AT THE END OF 2021, 83 COMMUNITY TOUCHPOINTS WERE MADE. AS A

RESULT THE TARGET FOR 2022 HAS BEEN INCREASED TO 100.

THE CHIP SERVES AS A ROADMAP FOR CONTINUOUS IMPROVEMENT. THE CHIP WILL

**Part V Facility Information** (continued)

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

CONTINUE TO EVALUATE THE NEEDS OF THE COMMUNITY AND BY WORKING TOGETHER,

WE CAN HAVE A SIGNIFICANT IMPACT ON COLLIER COUNTY'S HEALTH AND WELL-BEING

AWARENESS.

MARCO ISLAND HOSPITAL, INC.:

PART V, SECTION B, LINE 6A: CHNA CONDUCTED WITH ONE OR MORE HOSPITAL

FACILITIES

AS PART OF AN INTEGRATED HEALTHCARE SYSTEM, THE CHNA FOR NAPLES COMMUNITY

HOSPITAL AND MARCO ISLAND HOSPITAL WAS PREPARED JOINTLY.

MARCO ISLAND HOSPITAL, INC.:

PART V, SECTION B, LINE 11: ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA

THE CHNA IDENTIFIED PROBLEM AREAS THAT NEEDED TO BE ADDRESSED. THESE

INCLUDE SUFFICIENT JOB EMPLOYMENT, ECONOMIC OPPORTUNITIES, ACCESS TO

AFFORDABLE HOUSING, DRUG AND ALCOHOL ABUSE, SAFE ROADWAYS FOR BICYCLIST

AND PEDESTRIANS, PRIMARY CARE RESOURCES, ACCESS TO AFFORDABLE HEALTHY

FOOD, ACCESS TO LONG TERM CARE NEEDS, COMMUNICABLE DISEASE, OBESITY,

CHRONIC DISEASE, MENTAL HEALTH, DENTAL HEALTH, ACCESS TO CARE,

DISABILITIES AND UNINTENTIONAL INJURIES.

UPON REVIEW OF THE FINDINGS OF THE CHNA, THE NCH LEADERSHIP TEAM CAME UP

WITH FIVE KEY AREAS TO FOCUS ON WHICH INCLUDED MENTAL HEALTH, CHRONIC

DISEASE (ONCOLOGY), MATERNAL AND INFANT HEALTH, HEALTH OF THE OLDER

**Part V Facility Information** (continued)

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

POPULATION AND HEALTH BEHAVIORS AND OUTCOMES. BELOW IS A SUMMARY OF

ACTIVITIES AND INITIATIVES NCH ACHIEVED IN THE PAST THREE YEARS IN THESE

SPECIFIC KEY AREAS.

MENTAL HEALTH

IN AN EFFORT TO EXPAND ACCESS OF OUTPATIENT BEHAVIORAL HEALTH SERVICE NCH

CO-LOCATED PHYSICIAN PRACTICES AND NCH HAS BEEN PARTICIPATING IN THE

COLLIER COUNTY COMMISSIONERS AD HOC TASK FORCE ON MENTAL HEALTH AND

ADDICTION NEEDS IN COLLIER COUNTY. THE COMMITTEE SPONSORED A ONE-CENT

SALES TAX, WHICH WAS APPROVED FOR \$25 MILLION FOR IMPROVING MENTAL HEALTH

IN COLLIER.

IN RESPONSE TO MANAGING HIGH-RISK PSYCHIATRIC PATIENTS, NCH HAS PLACED

CASE MANAGERS IN NCH EMERGENCY DEPARTMENTS TO WORK WITH FREQUENT USERS OF

ED AND INPATIENT SERVICES.

IN ORDER TO TARGET SEVERE DEPRESSION NCH WILL SOON BE IMPLEMENTING AN

ELECTRO CONVULSIVE THERAPY PROGRAM (ECT) AND A TRANS MAGNETIC SIMULATION

PROGRAM (TMS), AS WELL AS IV KETAMINE AND INTRA NASAL KETAMINE PROGRAMS

WHEN APPROVED BY THE FDA.

CHRONIC DISEASE (ONCOLOGY)

MAMMOGRAM SCREENINGS ARE OFFERED AND PROVIDED TO UNINSURED AND

UNDERINSURED PATIENTS. IN ADDITION, A COMMUNITY FAIR IS SCHEDULED EACH

YEAR AT LOCAL CHURCHES, CP-3 SCREENINGS AND AN AMERICAN CANCER ASSOCIATION

**Part V Facility Information** *(continued)*

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

STUDY HAS ALSO BEEN COMPLETED.

NCH HIRED CARDIO THORACIC SURGEONS WHO DEVELOPED A COMPREHENSIVE LUNG

CANCER PROGRAM FOCUSING ON SCREENING, NAVIGATION, SURVIVORSHIP AND

SURGICAL INTERVENTION.

NCH EXPANDED ITS NURSE NAVIGATION PROGRAM WITH FOCUS ON FOLLOWING ONCOLOGY

PATIENTS THROUGHOUT THE CONTINUUM OF CARE WITH SPECIAL EMPHASIS ON BREAST

AND LUNG PATIENTS AS WELL AS SCREENING ACTIVITIES.

MATERNAL AND INFANT HEALTH

NCH'S INITIAL LATCH MEASUREMENT IS 86%. NCH IS IMPLEMENTING SKIN TO SKIN

IN THE DELIVERY ROOM. THE SKIN TO SKIN RATE IS 94%. ALL REGISTERED NURSES

IN LABOR AND DELIVERY, MOTHER/BABY, NEONATAL INTENSIVE CARE UNIT,

PEDIATRICS AND PEDIATRICS ED ARE EDUCATED IN BREASTFEEDING.

NCH MAINTAINS A BREASTFEEDING RATE OF 56%. NCH EMPLOYS 1 FULL-TIME AND 1

PART-TIME EQUIVALENT LACTATION CONSULTANTS WHICH ARE AVAILABLE 7 DAYS A

WEEK 16 HOURS PER DAY. NCH ALSO HOSTS THE COLLIER COUNTY BREASTFEEDING

COALITION WITH AN OVERALL GOAL TO INCREASE BREASTFEEDING RATES IN COLLIER

COUNTY.

NCH IS A HOST MEMBER OF A SUBSTANCE ABUSE COALITION AND SPONSORS REGULAR

MEETINGS HELD AT NCH. THE COALITION REPORTS DATA TO THE STATE AND ALSO

SUPPORTS NURSE EDUCATIONAL PROGRAMS FOR PARENTS ON THE DETRIMENTAL EFFECTS

OF SUBSTANCE ABUSE FOR NEWBORNS. ALL PATIENTS AND PARENTS ARE OFFERED TDAP



**Part V Facility Information** (continued)

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

IMMUNIZATION AND CURRENTLY ON WOMEN AND CHILDREN'S AND PEDIATRIC NURSING

UNITS A STANDING ORDER FOR TDAP ADMINISTRATION IF STATUS IS UNKNOWN. IN

ADDITION, IN WOMEN AND CHILDREN'S AND PEDIATRIC NURSING UNITS ALL NCH

STAFF HAVE RECEIVED THE TDAP VACCINE AS WELL AS ANY NEW STAFF.

HEALTH OF THE OLDER POPULATION

NCH HAS EXPANDED GERIATRIC MEDICINE TO MULTIPLE NCH PHYSICIAN PRACTICES.

TWO NCH PHYSICIANS ARE MEDICAL DIRECTORS OF TWO SKILLED NURSING FACILITIES

IN COLLIER COUNTY.

DIABETES MANAGEMENT

NCH HEALTHCARE SYSTEM'S VON ARX DIABETES CENTER HAS TWO RECOGNIZED

AMERICAN DIABETES PROGRAMS THAT MAINTAIN DATA COLLECTION AND REPORTING

REQUIREMENTS. DIABETES SUPPORT GROUPS ARE PROVIDED TO THE COMMUNITY.

ALSO, FREE PRE-DIABETES SEMINARS AND COMMUNITY LECTURES ARE OFFERED

THROUGHOUT THE YEAR.

PHILANTHROPIC FUNDS HAVE BEEN ALLOCATED FOR PEDIATRICS TO ASSURE THEY HAVE

APPOINTMENTS SCHEDULED WITH REGISTERED DIETICIANS OR NURSES FOR

UNDERINSURED OR UNINSURED CHILDREN. PHILANTHROPIC FUNDS ARE ALSO USED FOR

GESTATIONAL PATIENTS PROVIDING EDUCATIONAL CLASSES, AND SUPPLIES.

OUR RESULTS INCLUDE 80% OF WOMEN ACHIEVED TARGET RANGES FOR BLOOD GLUCOSE

LEVELS AND 85% OF BABIES BORN MET BIRTH WEIGHT GOALS (<9 LBS.).

**Part V Facility Information** *(continued)*

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

ACCOMPLISHMENTS FOR 2021 INCLUDE, BUT ARE NOT LIMITED TO:

I. THE VON ARX DIABETES CENTER SERVED 5,644 OUTPATIENT VISITS;

II. SERVICES WERE EXPANDED TO MARCO ISLAND AND BONITA SPRINGS;

III. EXPANDED GROCERY STORE TOURS;

IV. MAINTAINED ACCREDITATION WITH THE AMERICAN DIABETES ASSOCIATION

NCH WORKING WITH THE FLORIDA DEPARTMENT OF HEALTH - COLLIER COUNTY

PARTICIPATED AGAIN IN THE COLLIER COUNTY COMMUNITY ASSESSMENT DESIGN

GROUP. THE SCOPE OF THE GROUP IS TO DESIGN A COMMUNITY

STRENGTHS/OPPORTUNITIES SURVEY. A SURVEY WAS PREPARED AND SENT OUT TO THE

HEALTH CARE LEADERS, COMMUNITY FOCUS GROUPS AND HEALTH CARE STAFF.

IDENTIFIED PROBLEM AREAS INCLUDED THE FOLLOWING:

CHRONIC DISEASE AND MORTALITY

INFECTIOUS DISEASE

MATERNAL AND INFANT HEALTH

INJURIES

ACCESS TO HEALTHCARE

HEALTH BEHAVIORS AND HEALTH STATUS

MENTAL HEALTH

ORAL HEALTH

THE HEALTH OF THE OLDER POPULATION

SUBSEQUENTLY, THE LEADERSHIP FOCUS GROUP MET TO DISCUSS BOTH THE POSITIVE

AND NEGATIVE FACTORS THAT INFLUENCED THESE AREAS.

**Part V Facility Information** (continued)

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

THE NEXT STEP IN THE PROCESS WAS TO CONDUCT GEOGRAPHICAL AREA COMMUNITY

FOCUS GROUPS. THESE GROUPS WERE CHOSEN TO REFLECT AND INCLUDE THE

DIVERSITY OF COMMUNITY LOCATIONS, ETHNICITY, AND SOCIO-ECONOMIC FACTORS.

THE DISTINCT AREAS OF THE COUNTY REPRESENTED UNIQUE DEMOGRAPHIC AND

SOCIOECONOMIC CHARACTERISTICS. THE DIFFERENCES WERE VALUABLE AND USEFUL

FOR ASSESSING AND PRIORITIZING HEALTHCARE NEEDS WITHIN OUR COMMUNITY.

IN ADDITION, WE PROVIDED INPUT INTO THE ANALYSIS ON VARIOUS HEALTH

INDICATORS WHICH INCLUDED THE FOLLOWING:

POPULATION

SOCIOECONOMIC CHARACTERISTICS

INFECTIOUS DISEASE

HEALTH BEHAVIORS AND HEALTH STATUS

MORTALITY INDICATORS

MATERNAL AND INFANT HEALTH

HEALTH OF THE OLDER POPULATION

UPON REVIEW OF THE FINDINGS OF THE (CHNA) THE NCH LEADERSHIP TEAM REVIEWED

THE FINDINGS. A PRIORITIZATION SESSION WAS COMPLETED WHICH WAS BASED ON

THE MISSION, VISION AND CORE VALUES OF THE NCH HEALTHCARE SYSTEM WITH A

PRIMARY FOCUS ON THE GOAL OF COLLIER COUNTY BECOMING THE HEALTHIEST COUNTY

IN THE UNITED STATES. UPON MUCH DISCUSSION THE TEAM CAME UP WITH FOUR KEY

AREAS OF FOCUS WHICH INCLUDE:

MENTAL HEALTH

**Part V Facility Information** *(continued)*

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

ACCESS TO CARE

CHRONIC DISEASE

HEALTH OF OLDER ADULTS

UNADDRESSED IDENTIFIED NEEDS

ALTHOUGH SEVERAL COMMUNITY NEEDS WERE IDENTIFIED, NCH MUST FOCUS OUR EXISTING CLINICAL STRENGTHS AND INFRASTRUCTURE WHERE WE CAN MAXIMIZE OUR RESOURCES TO BENEFIT THE GREATEST NUMBER OF PEOPLE IN THE COMMUNITY. NCH WILL CONTINUE TO RE-EVALUATE THE UNADDRESSED IDENTIFIED NEEDS AND PURSUE ACTION WHEN AND WHERE RESOURCES ALLOW.

MARCO ISLAND HOSPITAL, INC.:

PART V, SECTION B, LINE 13B: NCH HEALTHCARE SYSTEM, INC., WHICH INCLUDES MIH, HAS A POLICY THAT ALLOWS A DISCOUNT FOR SELF-PAY UNINSURED OR UNDERINSURED PATIENTS WITH INCOME AND ASSETS GREATER THAN 200% OF FPG WHEN THE FAP APPPLICATION AND SUPPORTING DOCUMENTATION IS PROVIDED.

MIH RETAINS DISCRETION TO PROVIDE FINANCIAL ASSISTANCE TO PATIENTS WHO FALL OUTSIDE THE FPG INCOME GUIDELINES. OTHER CONSIDERATIONS TO INCOME LEVEL ARE PERCENTAGE OF TOTAL AMOUNT CHARGED BASED ON SERVICES PROVIDED TO THE PATIENT COMPARED TO PATIENTS INCOME.

MARCO ISLAND HOSPITAL, INC.:

PART V, SECTION B, LINE 13H: MIH

**Part V Facility Information** *(continued)*

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

BASIS FOR CALCULATING AMOUNTS CHARGED TO PATIENTS.

OTHER CRITERIA USED TO DETERMINE ELIGIBILITY ARE PATIENTS WHO ARE ELIGIBLE

TO RECEIVE BENEFITS FROM A GOVERNMENTAL AGENCY AS THE VICTIM OF A VIOLENT

CRIME OR SEXUAL ASSAULT AND THE TREATMENT IS RELATED TO THE VIOLENT CRIME

OR SEXUAL ASSAULT.

MARCO ISLAND HOSPITAL, INC.

PART V, LINE 16A, FAP WEBSITE:

[HTTP://WWW.NCHMD.ORG/PATIENTS-AND-VISITORS/BILLING-INFO](http://WWW.NCHMD.ORG/PATIENTS-AND-VISITORS/BILLING-INFO)

MARCO ISLAND HOSPITAL, INC.

PART V, LINE 16B, FAP APPLICATION WEBSITE:

[HTTP://WWW.NCHMD.ORG/PATIENTS-AND-VISITORS/BILLING-INFO](http://WWW.NCHMD.ORG/PATIENTS-AND-VISITORS/BILLING-INFO)

MARCO ISLAND HOSPITAL, INC.

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

[HTTP://WWW.NCHMD.ORG/PATIENTS-AND-VISITORS/BILLING-INFO](http://WWW.NCHMD.ORG/PATIENTS-AND-VISITORS/BILLING-INFO)



**Part VI Supplemental Information**

Provide the following information.

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

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PART I, LINE 3C:

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FORM 990 SCHEDULE H

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MIH USES OTHER FACTORS OTHER THAN FPG TO DETERMINE ELIGIBILITY FOR  
PROVIDING FREE OR DISCOUNTED CARE AS DESCRIBED BELOW.

---

PRESUMPTIVE ELIGIBILITY

---

PATIENTS MAY BE ELIGIBLE FOR A DISCOUNT OF THE FULL UNPAID BALANCE IN THE  
ABSENCE OF A COMPLETED FINANCIAL ASSISTANCE APPLICATION FORM IF THE  
PATIENT MEETS ONE OF THE FOLLOWING:

---

1. IS HOMELESS

---

2. IS DECEASED AND HAS NO KNOWN ESTATE AVAILABLE TO PAY MEDICAL BILLS

---

3. IS CURRENTLY ELIGIBLE FOR MEDICAID (AS PRIMARY INSURANCE) BUT WAS NOT  
AT DATE OF SERVICE OR MEDICAID BENEFITS ARE EXHAUSTED.

---

4. IS ELIGIBLE TO RECEIVE BENEFITS FROM A GOVERNMENTAL AGENCY AS THE

---

VICTIM OF A VIOLENT CRIME OR SEXUAL ASSAULT AND THE TREATMENT IS RELATED

**Part VI** Supplemental Information (Continuation)

TO THE VIOLENT CRIME OR SEXUAL ASSAULT.

5. A DEMONSTRATED INABILITY TO PAY FOR SERVICES BASED ON ALL AVAILABLE

ASSETS. PATIENTS RECEIVING CARE IN OR FROM THE EMERGENCY DEPARTMENT WHO

ARE WITHOUT FINANCIAL RESOURCES MAY BE ELIGIBLE FOR THE FAP IF THEY ARE

UNEMPLOYED OR SELF-EMPLOYED AND CANNOT PROVIDE INCOME AN INCOME TAX

STATEMENT, ARE INDIGENT WITHOUT ACCESS TO THE REQUIRED APPLICATION

DOCUMENTATION MAY STILL BE ELIGIBLE FOR FINANCIAL ASSISTANCE.

PART I, LINE 6A:

RELATED PARTY DISCLOSURES

MARCO ISLAND HOSPITAL, INC. ("MIH") IS AN AFFILIATE OF NCH HEALTHCARE

SYSTEM, INC. ("NCHS"). NCHS PREPARES A COMMUNITY BENEFIT REPORT ANNUALLY

AND INCLUDES THIS REPORT WITH ITS FORM 990 TAX RETURN FILING.

THE COMMUNITY BENEFIT REPORT PREPARED INCLUDES ALL ORGANIZATIONS OF THE

SYSTEM, INCLUDING MARCO ISLAND HOSPITAL, INC.

PART I, LINE 7:

COSTING METHOD USED

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 FORM 990, SCH. H, WORKSHEET 2.

PART I, LN 7 COL(F):

BAD DEBT EXPENSE INCLUDED FORM 990, PART IX, LINE 25



**Part VI** Supplemental Information (Continuation)

THE BAD DEBT EXPENSE AMOUNT INCLUDED ON FORM 990, PART IX, LINE 25 WAS \$

8,225 FOR THE YEAR ENDED SEPTEMBER 30, 2021. THIS AMOUNT HAS BEEN

SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGES REPORTED ON THE

SCHEDULE H, PART I, LINE 7 TABLE.

PART III, LINE 2:

BAD DEBT EXPENSE, COSTING METHODOLOGY USED

BAD DEBT EXPENSE IN THE FINANCIAL STATEMENTS IS DETERMINED BY PATIENTS

THAT HAVE FILED FOR BANKRUPTCY AND/OR HAVE LOSS OF EMPLOYMENT AFTER THE

DATE OF SERVICE.

PART III, LINE 3:

BAD DEBT EXPENSE

THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNT REPORTED ON LINE 2

IS BASED ON A COST TO CHARGE RATIO. THE COST TO CHARGE RATIO WAS DERIVED

FROM FORM 990, SCH. H, WORKSHEET 2.

PART III, LINE 4:

BAD DEBT EXPENSE FOOTNOTE

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 SYSTEM'S DECISION

TO CEASE FURTHER COLLECTION EFFORTS. BAD DEBT EXPENSE IN THE FINANCIAL

STATEMENTS IS DETERMINED BY PATIENTS THAT HAVE FILED FOR BANKRUPTCY AND/OR

**Part VI** Supplemental Information (Continuation)

HAVE LOSS OF EMPLOYMENT AFTER THE DATE OF SERVICE.

THE BAD DEBT EXPENSE FOOTNOTE DISCLOSURE CAN BE FOUND ON PAGES 17 AND 18

OF THE ATTACHED CONSOLIDATED FINANCIAL STATEMENTS FOR THE NCH HEALTHCARE

SYSTEM, INC. AND SUBSIDIARIES.

PART III, LINE 8:

COSTING METHODOLOGY, MEDICARE SHORTFALL

THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNT REPORTED ON LINE 6

IS BASED ON A COST TO CHARGE RATIO. THE COST TO CHARGE RATIO WAS DERIVED

FROM FORM 990, SCHEDULE H, WORKSHEET 2.

CONSISTENT WITH THE CHARITABLE HEALTHCARE MISSION OF MARCO ISLAND

HOSPITAL, INC. AND THE COMMUNITY BENEFIT STANDARD SET FORTH IN IRS 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.

PART III, LINE 9B:

COLLECTION PRACTICES

MARCO ISLAND HOSPITAL, INC. PROVIDES CARE WITHOUT CHARGE OR AT AMOUNTS

**Part VI** Supplemental Information (Continuation)

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 QUALIFY AS

CHARITY CARE, THESE AMOUNTS ARE NOT REPORTED AS REVENUE.

PART VI, LINE 2:

NEEDS ASSESSMENT

THE ORGANIZATION ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITIES IT

SERVES IN VARIOUS WAYS. OUR LEADERSHIP TEAM IS ACTIVELY INVOLVED AND

PARTICIPATES IN MANY COMMUNITY RELATED ORGANIZATIONS AND GROUPS THAT ARE

CONTINUALLY ASSESSING UNMET NEEDS WITHIN COLLIER COUNTY. WE HAVE

HISTORICALLY WORKED WITH OUR BOARD OF TRUSTEES, COLLIER COUNTY CHILDREN'S

ALLIANCE, COLLIER COUNTY PUBLIC SCHOOLS, THE IMMOKALEE FOUNDATION,

CHILDREN'S MEDICAL SERVICES, AND OTHER AGENCIES THROUGHOUT OUR COMMUNITY

IN ASSESSING AND COLLABORATING IN EFFORTS TO IMPROVE THE HEALTH OF OUR

COMMUNITY.

NCH PROVIDES MANY HEALTH-ENHANCING EDUCATIONAL PROGRAMS AND RESOURCES IN

PROMOTING HEALTH TO THE COMMUNITY. THE CURRENT PROGRAMS AND RESOURCES

PROVIDED TO THE COMMUNITY INCLUDE THE FOLLOWING: HEALTH SEMINARS,

COMMUNITY HEALTH FAIRS, FREE DIAGNOSTIC AND SCREENING/TESTING, THE

NEIGHBORHOOD HEALTH CLINIC, HEART PROGRAMS, CANCER SURVIVAL AWARENESS,

PATIENT SUPPORT GROUPS, TWO WELLNESS CENTERS, VON ARX DIABETES CENTER,

PASTORAL CARE SERVICES, AND SPONSOR AND SUPPORT CLINICAL NURSING SCHOOLS.

IN ADDITION TO THE PROGRAMS LISTED, WE ARE ALSO WORKING WITH THE SAFE AND

HEALTHY CHILDREN'S COALITION OF COLLIER COUNTY TO DEVELOP PROGRAMS FOR

**Part VI** Supplemental Information (Continuation)

DROWNING PREVENTION, CHILDHOOD OBESITY, SAFE SLEEP EFFORTS, AND

BREASTFEEDING PROGRAMS.

DURING 2019, WE COMPLETED A COMMUNITY NEEDS ASSESSMENT REPORT AND HAVE

POSTED THIS REPORT ON OUR WEBSITE

([HTTP://WWW.NCHMD.ORG/ABOUT-US/ANNUAL-REPORTS](http://www.nchmd.org/about-us/annual-reports)). WE ARE COMMITTED TO

PROMOTING EXISTING AND POTENTIAL NEW PROGRAMS TO THE COMMUNITY IN RESPONSE

TO THE COMMUNITY HEALTH NEEDS ASSESSMENT. PLEASE REFER TO THIS REPORT AND

DETAILED PLAN WHICH WAS REVIEWED BY THE NCH HEALTHCARE SYSTEM BOARD OF

TRUSTEES AND APPROVED AT THE SEPTEMBER 25, 2019 BOARD OF TRUSTEES MEETING.

INCLUDED IN THE 2019 REPORT IS THE BLUE ZONE PROJECT WHICH BEGAN IN 2015

AND IS SPONSORED BY NCH. THE BLUE ZONE PROJECT IS A COMPREHENSIVE

WELL-BEING IMPROVEMENT INITIATIVE DESIGNED TO HELP PEOPLE LIVE LONGER AND

BETTER BY BUILDING STRONG SOCIAL NETWORKS AND ENCOURAGING SUSTAINABLE

CHANGES THROUGHOUT THE COMMUNITY THAT LEADS TO HEALTHIER CHOICES.

PART VI, LINE 3:

INFORMATION REGARDING PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

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

**Part VI** Supplemental Information (Continuation)

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 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.

PART VI, LINE 4:

COMMUNITY INFORMATION

MARCO ISLAND HOSPITAL, INC. SERVES AN OLDER COMMUNITY. THE MEDIAN AGE IS

58.2. THE ESTIMATED MEDIAN HOUSEHOLD INCOME IS \$138,171. THE UNEMPLOYMENT

RATE IS APPROXIMATELY 6.6%. THE PERCENTAGE OF RESIDENTS IN THE POVERTY

LEVEL IS APPROXIMATELY 6.03%.

PART VI, LINE 5:

INFORMATION REGARDING PROMOTION OF COMMUNITY HEALTH

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 THROUGH FRIDAY FROM 9:00 AM TO 4:00 PM (9:00 AM TO NOON

IN THE SUMMER MONTHS). FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2021, 44

COMPLIMENTARY BLOOD PRESSURE CHECKS WERE GIVEN TO THE PUBLIC. FREE BLOOD

PRESSURE READINGS HALTED DUE TO COVID-19.

**Part VI** Supplemental Information (Continuation)

PART VI, LINE 6:

AFFILIATED HEALTHCARE SYSTEM INFORMATION

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, REGISTERED NURSES EDUCATING FUTURE PATIENTS, SUPPORTING THE NEIGHBORHOOD HEALTH CLINIC, PHYSICIAN LED ACCESS NETWORK OF COLLIER COUNTY, HEART PROGRAMS, CANCER SURVIVAL AWARENESS, SUPPORT OF PATIENT FAMILIES, DR. JOHN BRIGGS WELLNESS CENTER, AND 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 ORGANIZATION'S CIVIC INVOLVEMENT INCLUDES MEMBERS OF NCH MANAGEMENT WHO SERVE ON COMMUNITY BOARDS IN VARIOUS CAPACITIES. THE HOSPITALS HAVE ALWAYS PROVIDED EXEMPLARY PASTORAL CARE SERVICES. 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 IS LOCATED IN COLLIER COUNTY, FLORIDA. THE HOSPITAL CONSISTS OF NAPLES COMMUNITY HOSPITAL, A 391-BED ACUTE CARE FACILITY, AND NORTH NAPLES HOSPITAL, A 322-BED ACUTE CARE FACILITY. THE HOSPITAL ALSO HAS A BLOOD CENTER AND MAINTAINS VARIOUS OTHER OUTPATIENT CENTERS LOCATED THROUGHOUT THE COUNTY.

**Part VI** Supplemental Information (Continuation)

>COLLIER HEALTH CARE, INC. OWNS AND LEASES HEALTHCARE FACILITIES IN NAPLES

AND IMMOKALEE, FLORIDA.

>NCHMD, INC. OWNS AND OPERATES PHYSICIAN MEDICAL PRACTICES AND OUTPATIENT

RADIOLOGY SERVICES IN COLLIER AND LEE COUNTY, FLORIDA.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

FL

**SCHEDULE J  
(Form 990)**

**Compensation Information**

OMB No. 1545-0047

**2020**

Open to Public Inspection

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

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

▶ Attach to Form 990.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

Department of the Treasury  
Internal Revenue Service

Name of the organization  
**MARCO ISLAND HOSPITAL, INC.**

Employer identification number  
**59-2315435**

**Part I Questions Regarding Compensation**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

|           | Yes | No |
|-----------|-----|----|
| <b>1a</b> |     |    |
| <b>1b</b> |     |    |
| <b>2</b>  |     |    |
| <b>3</b>  |     |    |
| <b>4a</b> | X   |    |
| <b>4b</b> | X   |    |
| <b>4c</b> |     | X  |
| <b>5a</b> |     | X  |
| <b>5b</b> |     | X  |
| <b>6a</b> |     | X  |
| <b>6b</b> |     | X  |
| <b>7</b>  | X   |    |
| <b>8</b>  |     | X  |
| <b>9</b>  |     |    |

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

Schedule J (Form 990) 2020



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

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

**Note:** The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

| (A) Name and Title                                                  |      | (B) Breakdown of W-2 and/or 1099-MISC compensation |                                     |                                     | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|---------------------------------------------------------------------|------|----------------------------------------------------|-------------------------------------|-------------------------------------|------------------------------------------------|-------------------------|---------------------------------|-----------------------------------------------------------------------|
|                                                                     |      | (i) Base compensation                              | (ii) Bonus & incentive compensation | (iii) Other reportable compensation |                                                |                         |                                 |                                                                       |
| (1) PAUL HILTZ<br>PRESIDENT/CEO/TRUSTEE                             | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 855,115.                                           | 21,250.                             | 20,688.                             | 11,400.                                        | 22,280.                 | 930,733.                        | 0.                                                                    |
| (2) ALLEN S. WEISS, M.D. TERM 01/19<br>FORMER PRESIDENT/CEO/TRUSTEE | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 0.                                                 | 0.                                  | 909,806.                            | 0.                                             | 17,158.                 | 926,964.                        | 0.                                                                    |
| (3) PHILLIP DUTCHER TERM 07/21<br>CHIEF OPERATING OFFICER SYSTEM    | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 607,258.                                           | 77,358.                             | 23,208.                             | 11,400.                                        | 2,742.                  | 721,966.                        | 0.                                                                    |
| (4) RICK WYLES<br>CFO/ASSISTANT TREASURER                           | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 452,476.                                           | 42,867.                             | 20,688.                             | 11,400.                                        | 23,275.                 | 550,706.                        | 0.                                                                    |
| (5) KEVIN D. COOPER TERM 01/19<br>FORMER CHIEF OF STAFF             | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 0.                                                 | 0.                                  | 522,084.                            | 0.                                             | 16,889.                 | 538,973.                        | 0.                                                                    |
| (6) FRANK ASTOR M.D. TERM 11/19<br>FORMER CHIEF MEDICAL OFFICER     | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 0.                                                 | 0.                                  | 487,788.                            | 0.                                             | 16,236.                 | 504,024.                        | 0.                                                                    |
| (7) JONATHAN KLING START 07/21<br>CHIEF OPERATING OFFICER SYSTEM    | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 384,005.                                           | 42,623.                             | 19,770.                             | 11,400.                                        | 22,258.                 | 480,056.                        | 0.                                                                    |
| (8) ZACHARY BOSTOCK TERM 03/20<br>FORMER CHIEF ADMIN. OFFICER       | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 98,702.                                            | 41,802.                             | 300,787.                            | 5,559.                                         | 24,052.                 | 470,902.                        | 0.                                                                    |
| (9) KRISTIN MASCOTTI, M.D.<br>CHIEF MEDICAL OFFICER                 | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 316,117.                                           | 90,000.                             | 19,627.                             | 0.                                             | 9,008.                  | 434,752.                        | 0.                                                                    |
| (10) LINDA ROEBACK TERM 05/20<br>FORMER CHIEF COUNSEL               | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 119,967.                                           | 29,754.                             | 247,457.                            | 6,514.                                         | 15,531.                 | 419,223.                        | 0.                                                                    |
| (11) JIM MAHON<br>SENIOR VICE PRESIDENT                             | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 374,692.                                           | 3,095.                              | 21,346.                             | 2,338.                                         | 593.                    | 402,064.                        | 0.                                                                    |
| (12) RENEE M. THIGPEN<br>CHIEF HR OFFICER                           | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 305,567.                                           | 29,991.                             | 20,688.                             | 11,400.                                        | 18,708.                 | 386,354.                        | 0.                                                                    |
| (13) MICHAEL RILEY TERM 11/20<br>CHIEF STRATEGY OFFICER             | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 264,261.                                           | 29,630.                             | 45,810.                             | 11,400.                                        | 17,489.                 | 368,590.                        | 0.                                                                    |
| (14) PAMELA ZIPPERER-DAVIS<br>CHIEF ADMIN. OFFICER TERM 03/21       | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 252,554.                                           | 50,000.                             | 19,774.                             | 0.                                             | 12,569.                 | 334,897.                        | 0.                                                                    |
| (15) GARY TOMCIK, TERM 04/20<br>FORMER CHIEF EXPERIENCE OFFICER     | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 82,909.                                            | 26,378.                             | 173,006.                            | 4,422.                                         | 23,521.                 | 310,236.                        | 0.                                                                    |
| (16) GINA TEEGARDEN R.N. ST 07/21<br>INTERIM CHIEF NURSING OFFICER  | (i)  | 0.                                                 | 0.                                  | 0.                                  | 0.                                             | 0.                      | 0.                              | 0.                                                                    |
|                                                                     | (ii) | 190,216.                                           | 6,533.                              | 414.                                | 6,010.                                         | 8,979.                  | 212,152.                        | 0.                                                                    |

**Part III Supplemental Information**

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

PART I, LINES 4A-B:

PART I, LINE 4A:

PRESIDENT AND CEO RESIGNED 01/2019 AND RECEIVED A SEVERANCE PAYMENT OF

\$909,806 FOR CALENDAR YEAR 2020.

CHIEF OF STAFF RESIGNED 01/2019 AND RECEIVED A SEVERANCE PAYMENT OF

\$522,084 FOR CALENDAR YEAR 2020.

CHIEF MEDICAL OFFICER RESIGNED 11/19 AND RECEIVED A SEVERANCE PAYMENT OF

\$487,788 FOR CALENDAR YEAR 2020.

CHIEF ADMINISTRATIVE OFFICER RESIGNED 03/20 AND RECEIVED A SEVERANCE

PAYMENT OF \$296,107 FOR CALENDAR YEAR 2020.

GENERAL COUNSEL RESIGNED 05/20 AND RECEIVED A SEVERANCE PAYMENT OF \$239,933

FOR CALENDAR YEAR 2020.

CHIEF EXPERIENCE OFFICER RESIGNED 04/20 AND RECEIVED A SEVERANCE PAYMENT OF

**Part III Supplemental Information**

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

\$165,818 FOR CALENDAR YEAR 2020.

PART I, LINE 4B:

THE FOLLOWING EXECUTIVES PARTICIPATED IN A 457 (F) SUPPLEMENTAL

NON-QUALIFIED RETIREMENT PLAN.

NO DISTRIBUTIONS WERE PAID IN CALENDAR YEAR 2020.

PAUL HILTZ, PRESIDENT AND CEO

PHILLIP DUTCHER, CHIEF OPERATING OFFICER

RICK WYLES, CHIEF FINANCIAL OFFICER

JONATHAN KLING, CHIEF OPERATIONS OFFICER

KRISTIN MASCOTTI, M.D., CHIEF MEDICAL OFFICER

JIM MAHON, SENIOR VICE PRESIDENT

RENEE THIGPEN, CHIEF HUMAN RESOURCES OFFICER

PAMELA ZIPPERER-DAVIS, CHIEF ADMINISTRATIVE OFFICER

PART I, LINE 7:

PROVISION OF NON-FIXED PAYMENTS

**Part III Supplemental Information**

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

THIS ORGANIZATION IS AN AFFILIATE OF NCH HEALTHCARE SYSTEM, INC. ("THE SYSTEM"). THE SYSTEM MAY PROVIDE DISCRETIONARY BONUS AND/OR INCENTIVE COMPENSATION PAYMENTS TO ELIGIBLE EMPLOYEES. COMPENSATION PAYMENTS FOR ALL EMPLOYEES EXCLUDING THE CEO AND SENIOR LEADERSHIP TEAM IS DETERMINED BY THE SYSTEM BOARD OF TRUSTEES HUMAN RESOURCES COMMITTEE AND/OR CEO. COMPENSATION PAYMENTS MADE TO ANY DISQUALIFIED PERSON IS APPROVED BY THE SYSTEM THROUGH THE PROCESS DESCRIBED IN FORM 990, PART VI, SECTION B, LINE 15.

**SCHEDULE O**  
**(Form 990 or 990-EZ)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Information to Form 990 or 990-EZ**

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

▶ Attach to Form 990 or 990-EZ.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2020**

Open to Public  
Inspection

Name of the organization

MARCO ISLAND HOSPITAL, INC.

Employer identification number

59-2315435

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

OUR VISION IS TO BE A WORLD-CLASS LEADER OF EXCELLENCE IN

HEALTHCARE AND TO PROVIDE EXCELLENCE IN EVERY PATIENT EXPERIENCE.

MARCO ISLAND HOSPITAL, INC. OPERATES AN URGENT CARE CENTER AND

MEDICAL OFFICE BUILDING TO SERVE THE NEEDS OF THE

COMMUNITY.

FORM 990, PART VI, SECTION A, LINE 6:

GOVERNING BODY AND MANAGEMENT

NCH HEALTHCARE SYSTEM, INC. IS THE SOLE CORPORATE MEMBER OF THE

ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7A:

GOVERNING BODY AND MANAGEMENT

NCH HEALTHCARE SYSTEM, INC. SOLE MEMBER OF THIS ORGANIZATION, ELECTS THIS

ORGANIZATION'S DIRECTORS.

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

GOVERNING BODY AND MANAGEMENT

ALL OF THE GOVERNANCE DECISIONS FOR MARCO ISLAND HOSPITAL, INC. ARE

RESERVED TO THE GOVERNING BODY OF NCH HEALTHCARE SYSTEM, INC.

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

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

Schedule O (Form 990 or 990-EZ) 2020

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

## REVIEW PROCESS

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

FILING IS GATHERED BY FINANCE STAFF AND PROVIDED TO RSM US LLP FOR REVIEW.

AFTER THE REVIEW BY RSM US LLP, THE FORM 990 IS REVIEWED BY THE NCH

HEALTHCARE SYSTEM CHIEF FINANCIAL OFFICER. THE FORM 990 IS THEN REVIEWED BY

OUTSIDE COUNSEL FOR THE BOARD. PRIOR TO BOARD APPROVAL, THE FORM 990 IS

PROVIDED TO ALL OF THE FINANCE COMMITTEE BOARD OF TRUSTEES FOR THEIR REVIEW

VIA THE BOARD PORTAL. AT THE CONCLUSION OF THIS REVIEW PROCESS THE FORM 990

IS APPROVED BY THE BOARD OF TRUSTEES PRIOR TO FILING WITH THE IRS.

FORM 990, PART VI, SECTION B, LINE 12C:

CONFLICT OF INTEREST POLICY

ANNUALLY, ALL NCH HEALTHCARE SYSTEM, INC. OFFICERS, DIRECTORS, TRUSTEES AND

KEY EMPLOYEES ARE REQUIRED TO DISCLOSE INTERESTS THAT COULD POTENTIALLY

GIVE RISE TO CONFLICTS. AFTER DISCLOSURE OF THE FINANCIAL INTEREST AND ALL

MATERIAL FACTS, AND AFTER ANY DISCUSSION WITH THE INTERESTED PERSON, HE/SHE

SHALL LEAVE THE BOARD OR COMMITTEE MEETING WHILE THE DETERMINATION OF A

CONFLICT OF INTEREST IS DISCUSSED AND VOTED UPON. THE REMAINING BOARD OR

COMMITTEE MEMBERS SHALL DECIDE IF A CONFLICT OF INTEREST EXISTS. MANAGEMENT

SHALL DISCLOSE OTHER POTENTIAL CONFLICTS WITH THE COMPLIANCE OFFICER.

AFTER EXERCISING DUE DILIGENCE, THE BOARD OR COMMITTEE SHALL DETERMINE

WHETHER THE CORPORATION CAN OBTAIN A MORE ADVANTAGEOUS TRANSACTION OR

ARRANGEMENT WITH REASONABLE EFFORTS FROM A PERSON OR ENTITY THAT WOULD NOT

GIVE RISE TO A CONFLICT OF INTEREST, IF A MORE ADVANTAGEOUS TRANSACTION OR

ARRANGEMENT IS NOT REASONABLY ATTAINED UNDER CIRCUMSTANCES THAT WOULD NOT

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

GIVE RISE TO A CONFLICT OF INTEREST, THE BOARD OR COMMITTEE SHALL DETERMINE BY A GREATER THAN TWO-THIRDS VOTE OF THE DISINTERESTED TRUSTEES WHETHER THE TRANSACTION OR ARRANGEMENT IS IN THE CORPORATION'S BEST INTEREST AND FOR ITS OWN BENEFIT AND WHETHER THE TRANSACTION IS FAIR AND REASONABLE TO THE CORPORATION AND SHALL MAKE ITS DECISION AS TO WHETHER TO ENTER INTO THE TRANSACTION OR ARRANGEMENT IN CONFORMITY WITH SUCH DETERMINATION.

THE COMPLIANCE OFFICER WILL DETERMINE IF A MANAGEMENT TEAM MEMBER OR EMPLOYEE SHOULD BE EXCUSED FROM A DISCUSSION OR PARTICIPATE IN A DECISION IN WHICH THERE MAY BE A CONFLICT OF INTEREST.

FORM 990, PART VI, SECTION B, LINE 15:

COMPENSATION PROCESS

THIS ORGANIZATION IS AN AFFILIATE OF THE NCH HEALTHCARE SYSTEM, INC. ("THE SYSTEM"). COMPENSATION ARRANGEMENTS INVOLVING OUR CEO AND SENIOR LEADERSHIP TEAM ARE ESTABLISHED BY THE SYSTEM BOARD OF TRUSTEES COMPENSATION COMMITTEE 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 DETERMINATION BY DISINTERESTED PERSONS, USE OF APPROPRIATE COMPARABILITY DATA, AND CONTEMPORANEOUS DOCUMENTATION OF THE PROCESS).

FORM 990, PART VI, SECTION C, LINE 19:

DOCUMENTS AVAILABLE TO THE PUBLIC

THE FORMS 1023 AND 990, GOVERNING DOCUMENTS, AUDITED FINANCIAL STATEMENTS, AND CONFLICT OF INTEREST POLICY OF NHSI ARE AVAILABLE TO THE PUBLIC UPON

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

REQUEST. FINANCIAL STATEMENTS ARE ALSO AVAILABLE VIA OUR WEBSITE:

HTTP://WWW.NCHMD.ORG/ABOUT-US/ANNUAL-REPORTS. DOCUMENTS AVAILABLE FOR

REQUEST ARE AVAILABLE PURSUANT TO THE PERIOD OF DISCLOSURE PROVIDED IN

SECTION 6104(D).

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

|                                    |             |
|------------------------------------|-------------|
| TRANSFERS TO RELATED ORGANIZATIONS | -5,538,839. |
|------------------------------------|-------------|



**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Related Organizations and Unrelated Partnerships**

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

▶ Attach to Form 990.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2020**

Open to Public Inspection

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

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

| (a)<br>Name, address, and EIN (if applicable)<br>of disregarded entity | (b)<br>Primary activity | (c)<br>Legal domicile (state or<br>foreign country) | (d)<br>Total income | (e)<br>End-of-year assets | (f)<br>Direct controlling<br>entity |
|------------------------------------------------------------------------|-------------------------|-----------------------------------------------------|---------------------|---------------------------|-------------------------------------|
|                                                                        |                         |                                                     |                     |                           |                                     |
|                                                                        |                         |                                                     |                     |                           |                                     |
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|                                                                        |                         |                                                     |                     |                           |                                     |
|                                                                        |                         |                                                     |                     |                           |                                     |

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

| (a)<br>Name, address, and EIN<br>of related organization                            | (b)<br>Primary activity | (c)<br>Legal domicile (state or<br>foreign country) | (d)<br>Exempt Code<br>section | (e)<br>Public charity<br>status (if section<br>501(c)(3)) | (f)<br>Direct controlling<br>entity | (g)<br>Section 512(b)(13)<br>controlled<br>entity? |    |
|-------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------|-------------------------------|-----------------------------------------------------------|-------------------------------------|----------------------------------------------------|----|
|                                                                                     |                         |                                                     |                               |                                                           |                                     | Yes                                                | No |
| NCH HEALTHCARE SYSTEM, INC. - 59-2314655<br>P.O. BOX 413029<br>NAPLES, FL 34101     | HOLDING CO              | FLORIDA                                             | 501 (C) (3)                   | LINE 12B, II                                              | N/A                                 |                                                    | X  |
| NAPLES COMMUNITY HOSPITAL, INC. - 59-0694358<br>P.O. BOX 413029<br>NAPLES, FL 34101 | HEALTHCARE              | FLORIDA                                             | 501 (C) (3)                   | LINE 3                                                    | NCH SYSTEM                          | X                                                  |    |
| NCHMD, INC. - 33-1075317<br>P.O. BOX 413029<br>NAPLES, FL 34101                     | HEALTHCARE              | FLORIDA                                             | 501 (C) (3)                   | LINE 10                                                   | NCH SYSTEM                          | X                                                  |    |
| COMMUNITY HOME SERVICES, INC. - 59-2440516<br>P.O. BOX 413029<br>NAPLES, FL 34101   | SUPPORT ORG             | FLORIDA                                             | 501 (C) (3)                   | LINE 12B, II                                              | NCH SYSTEM                          | X                                                  |    |

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

Schedule R (Form 990) 2020



**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)<br>Name, address, and EIN<br>of related organization                            | (b)<br>Primary activity | (c)<br>Legal domicile<br>(state or<br>foreign<br>country) | (d)<br>Direct controlling<br>entity | (e)<br>Predominant income<br>(related, unrelated,<br>excluded from tax under<br>sections 512-514) | (f)<br>Share of total<br>income | (g)<br>Share of<br>end-of-year<br>assets | (h)<br>Disproportionate<br>allocations? |    | (i)<br>Code V-UBI<br>amount in box<br>20 of Schedule<br>K-1 (Form 1065) | (j)<br>General or<br>managing<br>partner? |    | (k)<br>Percentage<br>ownership |
|-------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------|-----------------------------------------|----|-------------------------------------------------------------------------|-------------------------------------------|----|--------------------------------|
|                                                                                     |                         |                                                           |                                     |                                                                                                   |                                 |                                          | Yes                                     | No |                                                                         | Yes                                       | No |                                |
| PROSCAN NCH IMAGING, LLC -<br>86-1212843, 350 7TH STREET<br>NORTH, NAPLES, FL 34102 | RADIOLOGY<br>SERVICES   | DE                                                        | N/A                                 | N/A                                                                                               | N/A                             | N/A                                      |                                         | X  | N/A                                                                     |                                           | X  | N/A                            |
|                                                                                     |                         |                                                           |                                     |                                                                                                   |                                 |                                          |                                         |    |                                                                         |                                           |    |                                |
|                                                                                     |                         |                                                           |                                     |                                                                                                   |                                 |                                          |                                         |    |                                                                         |                                           |    |                                |
|                                                                                     |                         |                                                           |                                     |                                                                                                   |                                 |                                          |                                         |    |                                                                         |                                           |    |                                |
|                                                                                     |                         |                                                           |                                     |                                                                                                   |                                 |                                          |                                         |    |                                                                         |                                           |    |                                |
|                                                                                     |                         |                                                           |                                     |                                                                                                   |                                 |                                          |                                         |    |                                                                         |                                           |    |                                |
|                                                                                     |                         |                                                           |                                     |                                                                                                   |                                 |                                          |                                         |    |                                                                         |                                           |    |                                |
|                                                                                     |                         |                                                           |                                     |                                                                                                   |                                 |                                          |                                         |    |                                                                         |                                           |    |                                |
|                                                                                     |                         |                                                           |                                     |                                                                                                   |                                 |                                          |                                         |    |                                                                         |                                           |    |                                |
|                                                                                     |                         |                                                           |                                     |                                                                                                   |                                 |                                          |                                         |    |                                                                         |                                           |    |                                |

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

| (a)<br>Name, address, and EIN<br>of related organization                                         | (b)<br>Primary activity | (c)<br>Legal domicile<br>(state or<br>foreign<br>country) | (d)<br>Direct controlling<br>entity | (e)<br>Type of entity<br>(C corp, S corp,<br>or trust) | (f)<br>Share of total<br>income | (g)<br>Share of<br>end-of-year<br>assets | (h)<br>Percentage<br>ownership | (i)<br>Section<br>512(b)(13)<br>controlled<br>entity? |    |
|--------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------|-------------------------------------|--------------------------------------------------------|---------------------------------|------------------------------------------|--------------------------------|-------------------------------------------------------|----|
|                                                                                                  |                         |                                                           |                                     |                                                        |                                 |                                          |                                | Yes                                                   | No |
| HEALTH RESOURCES CORPORATION - 59-2568003<br>350 7TH STREET NORTH<br>NAPLES, FL 34102            | HOLDING COMPANY         | FL                                                        | NCH SYSTEM                          | C CORP                                                 |                                 |                                          |                                |                                                       | X  |
| AMBULATORY SURGICAL CARE CENTER, INC. -<br>59-2568029, 350 7TH STREET NORTH, NAPLES, FL<br>34102 | OUTPATIENT SURGERY      | FL                                                        | HRC                                 | C CORP                                                 |                                 |                                          |                                |                                                       | X  |
| COMMUNITY HOME CARE, INC. - 59-2372966<br>350 7TH STREET NORTH<br>NAPLES, FL 34102               | HOME HEALTH             | FL                                                        | HRC                                 | C CORP                                                 |                                 |                                          |                                |                                                       | X  |
| COMMUNITY IMAGING, INC. - 59-2446336<br>350 7TH STREET NORTH<br>NAPLES, FL 34102                 | RADIOLOGY LAB           | FL                                                        | HRC                                 | C CORP                                                 |                                 |                                          |                                |                                                       | X  |
|                                                                                                  |                         |                                                           |                                     |                                                        |                                 |                                          |                                |                                                       |    |
|                                                                                                  |                         |                                                           |                                     |                                                        |                                 |                                          |                                |                                                       |    |
|                                                                                                  |                         |                                                           |                                     |                                                        |                                 |                                          |                                |                                                       |    |
|                                                                                                  |                         |                                                           |                                     |                                                        |                                 |                                          |                                |                                                       |    |

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

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

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

|                                                                                                                | Yes | No |
|----------------------------------------------------------------------------------------------------------------|-----|----|
| <b>a</b> Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity ..... | X   |    |
| <b>b</b> Gift, grant, or capital contribution to related organization(s) .....                                 | X   |    |
| <b>c</b> Gift, grant, or capital contribution from related organization(s) .....                               | X   |    |
| <b>d</b> Loans or loan guarantees to or for related organization(s) .....                                      |     | X  |
| <b>e</b> Loans or loan guarantees by related organization(s) .....                                             |     | X  |
| <b>f</b> Dividends from related organization(s) .....                                                          |     | X  |
| <b>g</b> Sale of assets to related organization(s) .....                                                       |     | X  |
| <b>h</b> Purchase of assets from related organization(s) .....                                                 |     | X  |
| <b>i</b> Exchange of assets with related organization(s) .....                                                 | X   |    |
| <b>j</b> Lease of facilities, equipment, or other assets to related organization(s) .....                      | X   |    |
| <b>k</b> Lease of facilities, equipment, or other assets from related organization(s) .....                    | X   |    |
| <b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) .....  | X   |    |
| <b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) .....   | X   |    |
| <b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) .....   | X   |    |
| <b>o</b> Sharing of paid employees with related organization(s) .....                                          | X   |    |
| <b>p</b> Reimbursement paid to related organization(s) for expenses .....                                      | X   |    |
| <b>q</b> Reimbursement paid by related organization(s) for expenses .....                                      | X   |    |
| <b>r</b> Other transfer of cash or property to related organization(s) .....                                   | X   |    |
| <b>s</b> Other transfer of cash or property from related organization(s) .....                                 | X   |    |

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

| (a)<br>Name of related organization | (b)<br>Transaction type (a-s) | (c)<br>Amount involved | (d)<br>Method of determining amount involved |
|-------------------------------------|-------------------------------|------------------------|----------------------------------------------|
| (1) NAPLES COMMUNITY HOSPITAL, INC. | P                             | 5,557,851. FMV         |                                              |
| (2)                                 |                               |                        |                                              |
| (3)                                 |                               |                        |                                              |
| (4)                                 |                               |                        |                                              |
| (5)                                 |                               |                        |                                              |
| (6)                                 |                               |                        |                                              |



