

PUBLIC DISCLOSURE COPY

Form **990**

**Return of Organization Exempt From Income Tax**

OMB No. 1545-0047

Department of the Treasury  
Internal Revenue Service

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

- ▶ 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.

**2017**  
Open to Public Inspection

**A** For the **2017** calendar year, or tax year beginning **OCT 1, 2017** and ending **SEP 30, 2018**

<b>B</b> Check if applicable:  <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C</b> Name of organization MARCO ISLAND HOSPITAL, INC. Doing business as MARCO HEALTHCARE CENTER Number and street (or P.O. box if mail is not delivered to street address) Room/suite 40 S. HEATHWOOD DRIVE City or town, state or province, country, and ZIP or foreign postal code MARCO ISLAND, FL 34145 <b>F</b> Name and address of principal officer: RICK WYLES P.O. BOX 413029, NAPLES, FL 34101-3029	<b>D</b> Employer identification number 59-2315435  <b>E</b> Telephone number 239-624-6338  <b>G</b> Gross receipts \$ 4,827,601. <b>H(a)</b> Is this a group return for subordinates? ..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>H(b)</b> Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions) <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: ▶ WWW.NCHMD.ORG		
<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: 1983
		<b>M</b> State of legal domicile: FL

**Part I Summary**

	1	Briefly describe the organization's mission or most significant activities: <u>HELPING EVERYONE LIVE A LONGER, HAPPIER, AND HEALTHIER LIFE.</u>		
	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)	3	9
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	8
	5	Total number of individuals employed in calendar year 2017 (Part V, line 2a)	5	45
	6	Total number of volunteers (estimate if necessary)	6	54
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
	7b	Net unrelated business taxable income from Form 990-T, line 34	7b	0.
	Revenue	8	Contributions and grants (Part VIII, line 1h)	Prior Year
9		Program service revenue (Part VIII, line 2g)	0.	0.
10		Investment income (Part VIII, column (A), lines 3, 4, and 7d)	4,669,998.	4,486,368.
11		Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	0.	0.
12		Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	67,945.	296,082.
12			4,737,943.	4,782,450.
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	1,500.
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	1,874,357.	1,983,168.
	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)	1,597,707.	1,318,015.
	18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	3,472,064.	3,302,683.
	19	Revenue less expenses. Subtract line 18 from line 12	1,265,879.	1,479,767.
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21	Total liabilities (Part X, line 26)	5,552,410.	5,458,615.
	22	Net assets or fund balances. Subtract line 21 from line 20	194,979.	223,202.
	22		5,357,431.	5,235,413.

**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 NOBLE ARRINGTON, CONTROLLER Type or print name and title	Date			
<b>Paid Preparer Use Only</b>	Print/Type preparer's name REBEKUH ELEY	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN P01247672
	Firm's name ▶ RSM US LLP	Firm's EIN ▶ 42-0714325	Phone no. 312-634-3400		
	Firm's address ▶ ONE SOUTH WACKER, STE 800 CHICAGO, IL 60606				

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. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code: ) (Expenses \$ 2,873,731. including grants of \$ 1,500. ) (Revenue \$ 4,709,713. ) MARCO ISLAND HOSPITAL OPERATES AN 11 1/2-HOUR/7-DAYS A WEEK URGENT CARE FACILITY AND SERVICES PATIENTS WITHOUT REGARD TO THEIR ABILITY TO PAY. DURING FYE 9/30/18, 9,719 PATIENTS WERE TREATED. OF THESE PATIENTS, 10.24% WERE 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 in Schedule O.) (Expenses \$ including grants of \$ ) (Revenue \$ )

4e Total program service expenses 2,873,731.

**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)? <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 temporarily restricted endowments, permanent endowments, or 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? <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

**Part IV Checklist of Required Schedules** (continued)

		Yes	No
<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
<b>22</b>	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> .....		X
<b>23</b>	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> .....	X	
<b>24a</b>	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> .....		X
<b>b</b>	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? .....		
<b>c</b>	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? .....		
<b>d</b>	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? .....		
<b>25a</b>	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> .....		X
<b>b</b>	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> .....		X
<b>26</b>	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i> .....		X
<b>27</b>	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> .....		X
<b>28</b>	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
<b>a</b>	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> .....		X
<b>b</b>	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> .....		X
<b>c</b>	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> .....		X
<b>29</b>	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> .....		X
<b>30</b>	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> .....		X
<b>31</b>	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> .....		X
<b>32</b>	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> .....		X
<b>33</b>	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> .....		X
<b>34</b>	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> .....	X	
<b>35a</b>	Did the organization have a controlled entity within the meaning of section 512(b)(13)? .....	X	
<b>b</b>	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> .....	X	
<b>36</b>	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> .....		X
<b>37</b>	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i> .....		X
<b>38</b>	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O .....	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question numbers (1a-14b), descriptions, and Yes/No checkboxes. Includes sub-questions for Form 1096, Form W-2G, Form W-3, Form 990-T, Form 8886-T, Form 8282, Form 8899, Form 1098-C, Form 4947(a)(1), and Form 720.

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

Check if Schedule O contains a response 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 in line 1a, above, who are independent; 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?; 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?; 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?; 5 Did the organization become aware during the year of a significant diversion of the organization's assets?; 6 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 in Schedule O.

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

Table with 3 columns: Question, Yes, No. Rows include: 10a 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 (or 1024 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 in Schedule O)
19 Describe in 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.

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) KEVIN M. FITZGERALD CHAIRMAN	2.00 0.00	X		X				0.	0.	0.
(2) JOHN L. (JACK) PATTERSON 1ST VICE CHAIRMAN	2.00 0.00	X		X				0.	0.	0.
(3) RICHARD ADAMS 2ND VICE CHAIRMAN/SECRETARY	2.00 0.00	X		X				0.	0.	0.
(4) LISA GANDY TRUSTEE	2.00 0.00	X						0.	0.	0.
(5) DENNIS PIDHERNY TRUSTEE	2.00 0.00	X						0.	0.	0.
(6) DAVID CARUSO TRUSTEE	2.00 0.00	X						0.	0.	0.
(7) DIANNA DOHM TRUSTEE	2.00 0.00	X						0.	0.	0.
(8) PATRICIA KAUFMAN TRUSTEE	2.00 0.00	X						0.	0.	0.
(9) ALLEN S. WEISS, M.D. PRESIDENT/CEO/TRUSTEE	1.00 44.00	X		X				0.	892,228.	43,326.
(10) KEVIN D. COOPER CHIEF OF STAFF	1.00 44.00			X				0.	517,919.	50,024.
(11) PHILLIP DUTCHER COO, NCH HEALTHCARE SYSTEM	1.00 44.00			X				0.	524,439.	24,924.
(12) RICK WYLES CHIEF FINANCIAL OFFICER	1.00 44.00			X				0.	400,398.	41,962.
(13) FRANK ASTOR M.D. CHIEF MEDICAL OFFICER	1.00 44.00			X				0.	502,866.	44,008.
(14) MICHAEL RILEY CHIEF STRATEGY OFFICER	1.00 44.00			X				0.	296,655.	42,541.
(15) RENEE M. THIGPEN CHIEF HR OFFICER	1.00 44.00			X				0.	283,575.	43,180.
(16) ELIZABETH MARTIN ASSISTANT SECRETARY	1.00 44.00			X				0.	67,878.	25,002.
(17) GARY TOMCIK CHIEF EXPERIENCE OFFICER	1.00 44.00			X				0.	227,392.	36,177.



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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) ZACHARY BOSTOCK CHIEF ADMINISTRATIVE OFFICER	1.00 44.00			X				0.	392,277.	48,490.
(19) JONATHAN KLING, R.N. CHIEF NURSING OFFICER	1.00 44.00			X				0.	242,755.	42,713.
(20) JOHN D CAMPBELL OP REHAB MANAGER	40.00 0.00					X		111,263.	0.	21,831.
(21) JAMES K. MARTIN TERM 05/17 FORMER CHIEF DEVELOPMENT OFFICER	0.00 0.00						X	0.	323,854.	26,431.
<b>1b Sub-total</b>								111,263.	4,672,236.	490,609.
<b>c Total from continuation sheets to Part VII, Section A</b>								0.	0.	0.
<b>d Total (add lines 1b and 1c)</b>								111,263.	4,672,236.	490,609.

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, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	X	
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i>	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization 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) Name and business address	(B) Description of services	(C) Compensation
NONE		

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 0

**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	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<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>h Total.</b> Add lines 1a-1f .....						
<b>Program Service Revenue</b>	<b>2 a</b> NET PATIENT SVC REV	<b>Business Code</b> 621400	4,486,368.	4,486,368.			
	<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 .....			4,486,368.			
<b>Other Revenue</b>	<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 .....	(i) Real	117,888.				
		(ii) Personal					
		<b>b</b> Less: rental expenses .....	45,151.				
		<b>c</b> Rental income or (loss) .....	72,737.				
	<b>d</b> Net rental income or (loss) .....			72,737.		72,737.	
	<b>7 a</b> Gross amount from sales of assets other than inventory .....	(i) Securities					
		(ii) Other					
		<b>b</b> Less: cost or other basis and sales expenses .....					
		<b>c</b> Gain or (loss) .....					
	<b>d</b> Net gain or (loss) .....						
	<b>8 a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 .....	<b>a</b>					
		<b>b</b> Less: direct expenses .....	<b>b</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>a</b>						
	<b>b</b> Less: direct expenses .....	<b>b</b>					
	<b>c</b> Net income or (loss) from gaming activities .....						
<b>10 a</b> Gross sales of inventory, less returns and allowances .....	<b>a</b>						
	<b>b</b> Less: cost of goods sold .....	<b>b</b>					
	<b>c</b> Net income or (loss) from sales of inventory .....						
<b>Miscellaneous Revenue</b>		<b>Business Code</b>					
<b>11 a</b> ENGLE WATER DAMAGE SET		900002	203,031.	203,031.			
	<b>b</b> AUXILIARY SALES REVENUE	900099	12,873.	12,873.			
	<b>c</b> MARCO PULMONARY REHAB	900099	7,074.	7,074.			
	<b>d</b> All other revenue .....	900099	367.	367.			
	<b>e Total.</b> Add lines 11a-11d .....			223,345.			
<b>12 Total revenue.</b> See instructions. ....			4,782,450.	4,709,713.	0.	72,737.	

**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) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) 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 .....	1,500.	1,500.		
<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 .....	1,706,468.	1,440,600.	265,868.	
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	48,163.	40,659.	7,504.	
<b>9</b> Other employee benefits .....	104,549.	88,260.	16,289.	
<b>10</b> Payroll taxes .....	123,988.	104,671.	19,317.	
<b>11</b> Fees for services (non-employees):				
<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.)	187,365.	159,342.	28,023.	
<b>12</b> Advertising and promotion .....	2,042.	1,724.	318.	
<b>13</b> Office expenses .....	204,517.	172,653.	31,864.	
<b>14</b> Information technology .....				
<b>15</b> Royalties .....				
<b>16</b> Occupancy .....	86,700.	73,192.	13,508.	
<b>17</b> Travel .....	3,054.	2,578.	476.	
<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 .....	262,163.	221,318.	40,845.	
<b>23</b> Insurance .....	31,707.	26,767.	4,940.	
<b>24</b> Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> <b>BAD DEBT EXPENSE</b>	408,217.	408,217.		
<b>b</b> <b>MEDICAL SUPPLIES</b>	131,715.	131,715.		
<b>c</b> _____				
<b>d</b> _____				
<b>e</b> All other expenses _____	535.	535.		
<b>25</b> <b>Total functional expenses.</b> Add lines 1 through 24e	3,302,683.	2,873,731.	428,952.	0.
<b>26</b> <b>Joint costs.</b> 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) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing .....	10,096.	<b>1</b>	6,024.
	<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 .....	544,815.	<b>4</b>	483,264.
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L .....		<b>5</b>	
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L .....		<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> 10,552,034.		
	<b>b</b> Less: accumulated depreciation .....	<b>10b</b> 5,582,707.	4,966,858.	<b>10c</b> 4,969,327.
	<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 .....	30,641.	<b>15</b>	0.
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) .....	5,552,410.	<b>16</b>	5,458,615.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses .....	154,003.	<b>17</b>	190,696.
	<b>18</b> Grants payable .....		<b>18</b>	
	<b>19</b> Deferred revenue .....	2,613.	<b>19</b>	0.
	<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 current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L .....		<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 .....	38,363.	<b>25</b>	32,506.
	<b>26 Total liabilities.</b> Add lines 17 through 25 .....	194,979.	<b>26</b>	223,202.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets .....	5,357,431.	<b>27</b>	5,235,413.
	<b>28</b> Temporarily restricted net assets .....		<b>28</b>	
	<b>29</b> Permanently restricted net assets .....		<b>29</b>	
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds .....		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building, or equipment fund .....		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds .....		<b>32</b>	
<b>33</b> Total net assets or fund balances .....	5,357,431.	<b>33</b>	5,235,413.	
<b>34</b> Total liabilities and net assets/fund balances .....	5,552,410.	<b>34</b>	5,458,615.	

**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>	4,782,450.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	3,302,683.
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	1,479,767.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	5,357,431.
<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 in Schedule O)	<b>9</b>	-1,601,785.
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	5,235,413.

**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 in 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 in 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>		



**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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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 five 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 2017 (line 6, column (f) divided by line 11, column (f)) .....	14	%
<b>15</b> Public support percentage from 2016 Schedule A, Part II, line 14 .....	15	%
<b>16a 33 1/3% support test - 2017.</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 - 2016.</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 - 2017.</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 - 2016.</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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(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 five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ..... ►

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

<b>15</b> Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f)) .....	<b>15</b>	%
<b>16</b> Public support percentage from 2016 Schedule A, Part III, line 15 .....	<b>16</b>	%

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

<b>17</b> Investment income percentage for 2017 (line 10c, column (f) divided by line 13, column (f)) .....	<b>17</b>	%
<b>18</b> Investment income percentage from 2016 Schedule A, Part III, line 17 .....	<b>18</b>	%

**19a 33 1/3% support tests - 2017.** 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 - 2016.** 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 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of 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 (b) and (c) 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 12a or 12b in Part I, answer (b) and (c) 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 (b) and (c) 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 (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 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 (b) and (c) below, the governing body of a supported organization?		
<b>b</b> A family member of a person described in (a) above?		
<b>c</b> A 35% controlled entity of a person described in (a) or (b) above? <i>If "Yes" to a, b, or c, provide detail in Part VI.</i>		

**Section B. Type I Supporting Organizations**

	Yes	No
<b>1</b> Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's 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 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 (2), 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 government entity (see instructions).		
<b>2</b> Activities Test. Answer (a) and (b) 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 (a) 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 (a) and (b) 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>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 (explain in detail in <b>Part VI</b> ):		
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 1-1/2% 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 .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		(A) Prior Year	Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 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) 2017

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

Section D - Distributions	Current Year
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	
<b>4</b> Amounts paid to acquire exempt-use assets	
<b>5</b> Qualified set-aside amounts (prior IRS approval required)	
<b>6</b> Other distributions (describe in <b>Part VI</b> ). See instructions.	
<b>7 Total annual distributions.</b> Add lines 1 through 6.	
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive (provide details in <b>Part VI</b> ). See instructions.	
<b>9</b> Distributable amount for 2017 from Section C, line 6	
<b>10</b> Line 8 amount divided by line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2017	(iii) Distributable Amount for 2017
<b>1</b> Distributable amount for 2017 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2017 (reasonable cause required- explain in <b>Part VI</b> ). See instructions.			
<b>3</b> Excess distributions carryover, if any, to 2017			
<b>a</b>			
<b>b</b> From 2013			
<b>c</b> From 2014			
<b>d</b> From 2015			
<b>e</b> From 2016			
<b>f Total</b> of lines 3a through e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2017 distributable amount			
<b>i</b> Carryover from 2012 not applied (see instructions)			
<b>j</b> Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
<b>4</b> Distributions for 2017 from Section D, line 7: \$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2017 distributable amount			
<b>c</b> Remainder. Subtract lines 4a and 4b from 4.			
<b>5</b> Remaining underdistributions for years prior to 2017, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in <b>Part VI</b> . See instructions.			
<b>6</b> Remaining underdistributions for 2017. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in <b>Part VI</b> . See instructions.			
<b>7 Excess distributions carryover to 2018.</b> Add lines 3j and 4c.			
<b>8</b> Breakdown of line 7:			
<b>a</b> Excess from 2013			
<b>b</b> Excess from 2014			
<b>c</b> Excess from 2015			
<b>d</b> Excess from 2016			
<b>e</b> Excess from 2017			

Schedule A (Form 990 or 990-EZ) 2017



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

2017

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 about 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 questions (1-9) regarding conservation easements, including checkboxes for various purposes, a table for tracking easements (2a-2d), and yes/no questions about monitoring and reporting.

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 questions (1a-1b) regarding reporting of art and historical treasures, including checkboxes and dollar amount fields 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 are a significant use of its collection items (check all that apply):
- a  Public exhibition
  - b  Scholarly research
  - c  Preservation for future generations
  - d  Loan or exchange programs
  - e  Other \_\_\_\_\_
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part 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 Temporarily restricted 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:

- (i) unrelated organizations
- (ii) related organizations

	Yes	No
3a(i)		
3a(ii)		
3b		

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

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		1,959,284.		1,959,284.
b Buildings		6,430,040.	3,715,764.	2,714,276.
c Leasehold improvements				
d Equipment		1,748,701.	1,464,081.	284,620.
e Other		414,009.	402,862.	11,147.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				4,969,327.

**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	22,408.
(3) ACCRUED EXP - WORKER ' S COMP	10,098.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	32,506.

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 FIN 48 (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

2014.



**SCHEDULE H  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Hospitals**

- ▶ 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.

OMB No. 1545-0047

**2017**

Open to Public Inspection

<b>Name of the organization</b> MARCO ISLAND HOSPITAL, INC.	<b>Employer identification number</b> 59-2315435
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**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	
<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.			
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities			
<input type="checkbox"/> Applied uniformly to most hospital facilities			
<input type="checkbox"/> Generally tailored to individual hospital facilities			
<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? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: .....	<b>3a</b>	X	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %			
<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	
<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 _____ %			
<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) .....		9,719	4,373.		4,373.	.13%
<b>b</b> Medicaid (from Worksheet 3, column a) .....			66,834.	82,616.	0.	.00%
<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 .....		9,719	71,207.	82,616.	4,373.	.13%
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) .....	2	957	8,391.		8,391.	.25%
<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	957	8,391.		8,391.	.25%
<b>k Total.</b> Add lines 7d and 7j .....	2	10,676	79,598.	82,616.	12,764.	.38%





**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>		
1 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
2 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
3 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):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <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		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <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)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: <u>20 15</u>		
5 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	
6a 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 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
7 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):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>HTTP://WWW.NCHMD.ORG/ABOUT-US/ANNUAL-REPORTS</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 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	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: <u>20 15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? .....	X	
a If "Yes," (list url): <u>HTTP://WWW.NCHMD.ORG/ABOUT-US/ANNUAL-REPORTS</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....		
11 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.		
12a 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 If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....		
c 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 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? ..... If "Yes," check all actions in which the hospital facility or a third party engaged:		X
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 b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations 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? ..... If "No," indicate why:	X	
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? ..... 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? ..... 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, 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, THE IMMOKALEE FOUNDATION, CHILDREN'S MEDICAL SERVICES, 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. THE CURRENT COMMUNITY HEALTH IMPROVEMENT PLAN

BEGAN IN 2016 AND A NEW COMMUNITY HEALTH ASSESSMENT WAS COMPLETED IN 2016.

SINCE 2013, LOCAL PUBLIC HEALTH SYSTEM PARTNERS HAVE CONVENED THE

LEADERSHIP FOR COMMUNITY HEALTH IMPROVEMENT PLANNING (LCHIP) COMMITTEE

MEETINGS TO GUIDE THE DEVELOPMENT OF THE COMMUNITY HEALTH IMPROVEMENT PLAN

(CHIP) FOR COLLIER COUNTY.

USING THE MOBILIZING FOR ACTION THROUGH THE PLANNING AND PARTNERSHIP

(MAPP) FRAMEWORK, THE LCHIP COMMITTEE REVIEWED THE 2016 COMMUNITY HEALTH

ASSESSMENT (CHA) AND HELD DISCUSSIONS REGARDING GROUP PRIORITIES AND

**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, 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.

OBJECTIVES GOING FORWARD. FOR THE PAST FEW YEARS, THE COLLECTIVE FOCUS WAS

REDUCING OBESITY. THE COMMITTEE AGREED TO CONTINUE THE FOCUS ON REDUCING

OBESITY. IN ADDITION, THE LCHIP COMMITTEE SAW THE NEED TO CONCENTRATE

EFFORTS ON BEHAVIORAL HEALTH.

THE LCHIP COMMITTEE DEVELOPED THE HEALTHIEST COLLIER OBESITY AND

BEHAVIORAL HEALTH OBJECTIVES TO PROMOTE AWARENESS AND PROVIDE

OPPORTUNITIES FOR CHILDREN AND ADULTS TO MAKE CONSISTENT, INFORMED CHOICES

ABOUT HEALTHY EATING, ACTIVE LIVING AND SOCIAL WELL-BEING.

THE LCHIP ESTABLISHED THE FOLLOWING GOALS FOR OBESITY AND BEHAVIORAL

HEALTH:

OBESITY

1. INCREASE THE INITIATION, DURATION AND EXCLUSIVITY

OF BREASTFEEDING

2. TO MAKE HEALTHIER CHOICES EASIER FOR STUDENTS

3. TO PROMOTE HEALTHY BEHAVIORS AND EXPAND OPPORTUNITIES TO IMPROVE HEALTH

4. INCREASE AWARENESS AND PARTICIPATION IN HEALTH AND WELLNESS INITIATIVES

5. RAISE WELL-BEING IN SOUTHWEST FLORIDA THROUGH A COMPREHENSIVE APPROACH

TO HEALTH IMPROVEMENT

6. SHARE EFFECTIVE STRATEGIES AND MESSAGES THAT SUPPORT HEALTHY BEHAVIORS

7. PROMOTING ALL ASPECTS OF HEALTH AND WELLNESS IN SENIORS

BEHAVIORAL HEALTH

1. TO PROMOTE EMOTIONAL, PSYCHOLOGICAL AND SOCIAL WELL-BEING PROGRAMS

IN 2018, THE NAME OF THE CHIP STEERING COMMITTEE WAS CHANGED FROM LCHIP TO

**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, 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 EXECUTIVE COMMITTEE FOR COMMUNITY HEALTH PLANNING (CHIP EC). THE CHIP

EC MET TO REVIEW THE GOALS, STRATEGIES, OBJECTIVES, INDICATORS, OUTCOMES

AND STATUS OF THE 7 HEALTHIEST COLLIER OBESITY OBJECTIVES AND THE 1

HEALTHIEST COLLIER BEHAVIORAL HEALTH OBJECTIVE.

THE FOLLOWING ACCOMPLISHMENTS WERE MADE IN COLLIER COUNTY IN 2018 IN

REGARDS TO THE GOALS ESTABLISHED BY THE CHIP EC COMMITTEE.

OBESITY GOAL 1. INCREASE THE INITIATION, DURATION, AND EXCLUSIVITY OF

BREASTFEEDING

OBJECTIVE: DOUBLE NUMBER OF BREASTFEEDING FRIENDLY (BFF) CHILD CARES BY

DECEMBER 2018.

ACCOMPLISHMENT: INCREASED BFF CHILDCARES FROM A TARGET OF 6 TO A CURRENT

LEVEL OF 7. TARGET EXCEEDED. INCREASING TARGET TO 12.

COMMUNITY BENEFIT: BREASTFEEDING SAVES LIVES. RESEARCH SHOWS THAT IF 90%

OF FAMILIES BREASTFED EXCLUSIVELY FOR 6 MONTHS, NEARLY 1,000 DEATHS AMONG

INFANTS COULD BE SAVED.

OBESITY GOAL 2. TO MAKE HEALTHIER CHOICES EASIER FOR STUDENTS

OBJECTIVE: INCREASE THE NUMBER OF BLUE ZONE APPROVED SCHOOLS BY THREE PER

YEAR.

ACCOMPLISHMENT: THERE ARE 19 BLUE ZONE APPROVED SCHOOLS AND THE 10

REMAINING PUBLIC SCHOOLS ARE IN PROCESS. IN ADDITION, WE ARE ADDING

PRIVATE SCHOOLS.

COMMUNITY BENEFIT: SCHOOLS THAT OBTAIN BLUE ZONE APPROVAL DEMONSTRATE A

**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, 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.

COMMITMENT TO PROVIDING A LEARNING ENVIRONMENT THAT SUPPORTS WELLNESS,

NUTRITION, AND AN ACTIVE LIFESTYLE THROUGH A VARIETY OF INITIATIVES

INVOLVING STUDENTS, STAFF AND FAMILIES.

OBESITY GOAL 3. TO PROMOTE HEALTHY BEHAVIORS AND EXPAND OPPORTUNITIES TO

IMPROVE HEALTH.

OBJECTIVE: DECREASE THE PERCENTAGE OF OVERWEIGHT/OBESE CHILDREN 24 TO 60

MONTHS OLD CERTIFIED IN THE COLLIER WOMEN, INFANTS, AND CHILDREN (WIC)

PROGRAM FROM 34.8% TO 32.8%.

ACCOMPLISHMENT: THE CURRENT LEVEL IS 36.4% WITH A TARGET OF 32.8%.

EXTENDED TIMEFRAME TO DECEMBER 2020. CONTINUE NUTRITION EDUCATION.

COMMUNITY BENEFIT: CHANGING HEALTH RELATED BEHAVIORS CAN PRODUCE LONG-TERM

HEALTH BENEFITS.

OBESITY GOAL 4.: INCREASE AWARENESS AND PARTICIPATION IN HEALTH AND

WELLNESS INITIATIVES.

OBJECTIVE: BLUE ZONE WILL ENGAGE 10 FAITH BASED ORGANIZATIONS TO BECOME

BLUE ZONE APPROVED BY IMPLEMENTING BEST PRACTICES TO RAISE WELL-BEING OF

THEIR CONGREGANTS.

ACCOMPLISHMENT: THE CURRENT LEVEL OF 11 FAITH BASED ORGANIZATIONS EXCEEDED

THE TARGET OF 10. INCREASE TARGET TO 15.

COMMUNITY BENEFIT: REGULAR PHYSICAL ACTIVITY AND HEALTHY EATING CAN

PRODUCE LONG-TERM HEALTH BENEFITS.

OBESITY GOAL 5. RAISE WELL-BEING IN SOUTHWEST FLORIDA THROUGH A

**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, 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.

COMPREHENSIVE APPROACH TO HEALTH IMPROVEMENT.

OBJECTIVE: IMPROVE 8 OR MORE INDICATORS OVER AN 8-YEAR PERIOD (BY SEPT 2022).

ACCOMPLISHMENT: GALLUP-HEALTHWAYS WELL-BEING INDEX. 8 INDICATORS INCREASED FROM 2015-2017. MAINTAIN EFFORTS TO EXCEED TARGET.

COMMUNITY BENEFIT: CHANGING HEALTH RELATED BEHAVIORS CAN PRODUCE LONG-TERM HEALTH BENEFITS.

OBEISITY GOAL 6. SHARE EFFECTIVE STRATEGIES AND MESSAGES THAT SUPPORT HEALTHY BEHAVIORS.

OBJECTIVE: PASSIVE NUTRITION EDUCATION IS VISIBLE NEAR VENDING MACHINES AT COLLIER COUNTY PARKS AND RECREATION SITES.

ACCOMPLISHMENT: CURRENT LEVEL IS 0 WITH A TARGET OF 4. EDUCATION MATERIALS ARE GOING THROUGH AN APPROVAL PROCESS.

COMMUNITY BENEFIT: A NUMBER OF FACTORS DETERMINE WHAT PEOPLE EAT, BUT ACCESS TO HEALTHY FOOD AND BEVERAGES HAS A MAJOR INFLUENCE. HEALTHIER VENDOR OPTIONS PROVIDES ACCESS TO HIGHER QUALITY OF FOOD CHOICES.

OBEISITY GOAL 7. PROMOTING ALL ASPECTS OF HEALTH AND WELLNESS IN SENIORS

OBJECTIVE: BY DECEMBER 2018, HAVE PROGRAMS IN EACH SENIOR CENTER TO PROMOTE GOOD NUTRITION AND EXERCISE FOR SENIORS.

ACCOMPLISHMENT: CURRENTLY THERE ARE OVER 90 PROGRAMS ON NUTRITION, EXERCISE AND GENERAL HEALTH AND WELLNESS. TARGET WAS INCREASED TO 100.

COMMUNITY BENEFIT: REGULAR PHYSICAL ACTIVITY CAN PRODUCE LONG-TERM 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, 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.

BENEFITS.

BEHAVIORAL HEALTH GOAL 1. TO PROMOTE EMOTIONAL, PSYCHOLOGICAL AND SOCIAL

WELL-BEING PROGRAMS

OBJECTIVE: CREATE AN OUTREACH PROTOCOL THAT REACHES ALL HEALTH CARE

PROVIDERS IN COLLIER COUNTY AND PROVIDES EDUCATION ABOUT HOW TO RECOGNIZE

AND REFER PATIENTS WITH BEHAVIORAL HEALTH NEEDS.

ACCOMPLISHMENT: PROTOCOL APPROVED BY CHIP EC COMMITTEE. REPLACED THIS

OBJECTIVE WITH FOUR NEW OBJECTIVES AND QUANTITATIVE INDICATORS.

COMMUNITY BENEFIT: THERE IS EMERGING EVIDENCE THAT POSITIVE BEHAVIORAL

HEALTH IS ASSOCIATED WITH IMPROVED HEALTH OUTCOMES. POSITIVE BEHAVIORAL

HEALTH IS DIRECTLY RELATED TO EMOTIONAL, PSYCHOLOGICAL AND SOCIAL

WELL-BEING, WHICH IS CRUCIAL TO LIVING A LONG AND HEALTHY LIFE.

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

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.

**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, 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 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 CARDIOVASCULAR HEALTH,

CANCERS, DIABETES, MATERNAL AND INFANT HEALTH AND OBESITY. BELOW IS A

SUMMARY OF ACTIVITIES AND INITIATIVES NCH ACHIEVED IN THE PAST THREE YEARS

IN THESE SPECIFIC KEY AREAS.

CARDIOVASCULAR HEALTH

1. ALIGNED WITH POPULATION HEALTH, NCH IS SPONSORING THE SOUTHWEST FLORIDA

BLUE ZONE INITIATIVE WHICH WAS LAUNCHED IN THE SUMMER OF 2015. THE

WELL-BEING INDEX, AN IMPORTANT METRIC IN THE BLUE ZONE ASSESSMENT IS AN

AVERAGE OF SIX SUB-INDICES INCLUDING PHYSICAL HEALTH SCREENINGS, A KEY

COMPONENT IN ASSESSING BASELINE PHYSICAL HEALTH INCLUDING CARDIAC ISSUES

WHICH ARE ALSO USED FOR MEASURING IMPROVEMENT.



**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, 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.

2. A DOZEN COMMUNITY LECTURES RELATED TO CARDIOVASCULAR HEALTH AND PREVENTION WERE PRESENTED TO THE COMMUNITY AT VARIOUS LOCATIONS THROUGHOUT SOUTHWEST FLORIDA. TOPICS INCLUDE "KEEPING YOUR HEART HEALTHY", "PREVENTING CORONARY HEART DISEASE" AND "HEALTHY LIFESTYLE" ARE PROVIDED BY CARDIOLOGISTS, PRIMARY CARE PHYSICIANS, REGISTERED DIETICIANS AND OTHERS.

3. CARDIOVASCULAR SCREENING PROGRAMS AT DISCOUNTED RATES HAVE BEEN IMPLEMENTED AT DESIGNATED TIMES THROUGHOUT THE YEAR. MEDICAL SPECIALISTS PROVIDED SAME-DAY, ONE-ON-ONE CONSULTATIONS BASED ON SCREENING RESULTS WITH EVERY PARTICIPANT. FUTURE PLANS INCLUDE THE POSSIBILITY OF ESTABLISHING OR PARTNERING WITH A MOBILE UNIT TO PROVIDE ADDITIONAL SCREENING AND OUTREACH TO THE COMMUNITY.

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 STUDY HAS ALSO BEEN COMPLETED.

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.

**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, 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.

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.).

ACCOMPLISHMENTS FOR 2018 INCLUDE, BUT ARE NOT LIMITED TO:

- I. THE VON ARX DIABETES CENTER SERVED 1,263 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

MATERNAL AND INFANT HEALTH

NCH'S INITIAL LATCH MEASUREMENT IS 87%. NCH IS IMPLEMENTING SKIN TO SKIN

IN THE DELIVERY ROOM. THE SKIN TO SKIN RATE IS 80%. NCH RECEIVED IN 2018 A

GRANT FROM THE FLORIDA DEPARTMENT OF HEALTH TO ATTAIN "BABY USA" HOSPITAL

DESIGNATION. 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 46%. NCH EMPLOYS 3 FULL-TIME

**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, 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.

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

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.

OBESITY

NCH IS A MEMBER OF THE SCHOOL HEALTH ADVISORY COUNCIL AND MEETS ON A

REGULAR BASIS TO ADDRESS SCHOOL NUTRITION, DIET AND EXERCISE FOR HEALTH

LIVING STUDENTS. NCH ALSO SPONSORS A YOUTH OBESITY SUPPORT GROUP WHERE

PEDIATRIC PATIENTS ARE TREATED AT THE VON ARX DIABETES AND NUTRITION

CENTER ON A MONTHLY BASIS. THE KEY INITIATIVES THAT WILL ADDRESS THE

COMMUNITY TO REDUCE OBESITY IS THE BLUE ZONE PROJECT WHICH WAS MENTIONED

IN MUCH DETAIL EARLIER IN THIS REPORT.

NCH WORKING WITH THE FLORIDA DEPARTMENT OF HEALTH - COLLIER COUNTY

PARTICIPATED AGAIN IN THE COLLIER COUNTY COMMUNITY ASSESSMENT DESIGN

GROUP. SIMILAR TO THE 2012 PROJECT THE SCOPE OF THE GROUP WAS TO DESIGN A

COMMUNITY STRENGTHS/OPPORTUNITIES SURVEY. A SURVEY WAS PREPARED AND SENT

**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, 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.

OUT TO THE HEALTH CARE LEADERS, COMMUNITY FOCUS GROUPS AND HEALTH CARE

STAFF. IDENTIFIED PROBLEM AREAS INCLUDED THE FOLLOWING:

SUFFICIENT JOB EMPLOYMENT

ECONOMIC OPPORTUNITIES

ACCESS TO AFFORDABLE HOUSING

DRUG AND ALCOHOL ABUSE

SAFE ROADWAYS FOR BICYCLISTS AND PEDESTRIANS

PRIMARY CARE RESOURCES

ACCESS TO AFFORDABLE HEALTH FOOD

ACCESS TO LONG-TERM CARE BEDS

COMMUNICABLE DISEASE

OBESITY

CHRONIC DISEASE

MENTAL HEALTH

DENTAL HEALTH

HEALTH OF THE ELDERLY

ACCESS TO CARE

DISABILITIES

UNINTENTIONAL INJURIES

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

AND NEGATIVE FACTORS THAT INFLUENCED THESE AREAS.

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.

**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, 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 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

ACCESS TO HEALTH CARE

MENTAL HEALTH

CHRONIC DISEASES

INJURIES

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 FIVE KEY AREAS OF FOCUS WHICH INCLUDE:

CHRONIC DISEASE

**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, 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.

CANCER

MENTAL HEALTH

HEALTH OF THE OLDER POPULATION

OBESITY

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.

MARCO ISLAND HOSPITAL, INC.:

PART V, SECTION B, LINE 13H: MIH BASIS FOR CALCULATING AMOUNTS CHARGED TO PATIENTS.

ANOTHER FACTOR MIH USES IN DETERMINING AMOUNTS CHARGED TO PATIENTS IS

FAMILY SIZE.

**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, 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, LINE 16A, FAP WEBSITE:

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

MARCO ISLAND HOSPITAL, INC.

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

HTTP://WWW.NCHMD.ORG/PATIENTS-AND-VISITORS/BILLING-INFO

SCHEDULE H, PART V, SECTION B, LINE 4

THE TAX YEAR IS 2015 FOR YEAR END 2016. THE COMMUNITY HEALTH NEEDS

ASSESSMENT REPORT ON OUR WEBSITE REFERS TO FYE 2016.





**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.

---

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 WORKSHEET 2.

---

PART I, LN 7 COL(F):

**Part VI** Supplemental Information (Continuation)

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

THE BAD DEBT EXPENSE AMOUNT INCLUDED ON FORM 990, PART IX, LINE 25(A) WAS

\$408,217 FOR THE YEAR ENDED SEPTEMBER 30, 2018. 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

THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNTS REPORTED ON LINES

2 AND 3 ARE BASED ON THE COST TO CHARGE RATIO.

PART III, LINE 3:

BAD DEBT EXPENSE

MIH PROVIDES CARE WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED

RATES TO PATIENTS WHO MEET SPECIFIC CRITERIA UNDER ITS CHARITY CARE

GUIDELINES BECAUSE MIH DOES NOT PURSUE COLLECTION OF ACCOUNTS DETERMINED

TO QUALIFY AS CHARITY CARE. THESE AMOUNTS ARE NOT REPORTED AS REVENUE BUT

DEEMED AN ITEM OF COMMUNITY BENEFIT.

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

**Part VI** Supplemental Information (Continuation)

PATIENT'S REFUSAL TO PAY FOR SERVICES PROVIDED AND THE SYSTEM'S DECISION

TO CEASE FURTHER COLLECTION EFFORTS.

THE BAD DEBT EXPENSE FOOTNOTE DISCLOSURE CAN BE FOUND ON PAGE 15-16 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 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

**Part VI** Supplemental Information (Continuation)

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

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

**Part VI** Supplemental Information (Continuation)

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

DROWNING PREVENTION, CHILDHOOD OBESITY, SAFE SLEEP EFFORTS, AND

BREASTFEEDING PROGRAMS.

DURING 2016, 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 28, 2016 BOARD OF TRUSTEES MEETING.

INCLUDED IN THE 2016 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

**Part VI** Supplemental Information (Continuation)

INCLUDES OBTAINING THE PATIENT'S CURRENT FINANCIAL INFORMATION, OBTAINING

A CREDIT REPORT, AND REVIEWING THE PATIENT'S PAYMENT HISTORY WITH MARCO

ISLAND HOSPITAL, INC. PERSONS REQUIRING ASSISTANCE WITH THE UNFUNDED

PORTION OF THEIR BILLS ARE ENCOURAGED TO 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

66.2. THE ESTIMATED MEDIAN HOUSEHOLD INCOME IS \$81,368. THE UNEMPLOYMENT

RATE IS APPROXIMATELY 1.3%. THE PERCENTAGE OF RESIDENTS IN THE POVERTY

LEVEL IS APPROXIMATELY 5.4%.

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, 2018,

957 COMPLIMENTARY BLOOD PRESSURE CHECKS WERE GIVEN TO THE PUBLIC. MARCO

ISLAND HOSPITAL, INC. ALSO PARTICIPATED IN THE CITY OF MARCO HEALTH FAIR

**Part VI** Supplemental Information (Continuation)

AND MARCO COMMUNITY HEALTH FAIR.

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

**Part VI** Supplemental Information (Continuation)

CENTERS LOCATED THROUGHOUT THE COUNTY.

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

AND IMMOKALEE, FLORIDA. THIS ORGANIZATION ALSO OPERATES CHILDREN'S MEDICAL

SERVICES, A PROGRAM SERVING CHRONICALLY ILL AND SPECIAL NEEDS CHILDREN

UNDER TITLE V AND THE FLORIDA KIDCARE PROGRAM THROUGH TITLE XXI.

>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

**2017**

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 filing 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>1b</b>		
<b>2</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) 2017

**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) ALLEN S. WEISS, M.D. PRESIDENT/CEO/TRUSTEE	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	779,423.	91,097.	21,708.	21,400.	21,926.	935,554.	0.
(2) KEVIN D. COOPER CHIEF OF STAFF	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	446,875.	52,630.	18,414.	21,400.	28,624.	567,943.	0.
(3) PHILLIP DUTCHER COO, NCH HEALTHCARE SYSTEM	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	451,523.	52,630.	20,286.	21,400.	3,524.	549,363.	0.
(4) RICK WYLES CHIEF FINANCIAL OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	344,311.	37,313.	18,774.	13,439.	28,523.	442,360.	0.
(5) FRANK ASTOR M.D. CHIEF MEDICAL OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	433,386.	49,194.	20,286.	21,400.	22,608.	546,874.	0.
(6) MICHAEL RILEY CHIEF STRATEGY OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	247,951.	29,516.	19,188.	21,400.	21,141.	339,196.	0.
(7) RENEE M. THIGPEN CHIEF HR OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	237,697.	27,104.	18,774.	21,400.	21,780.	326,755.	0.
(8) GARY TOMCIK CHIEF EXPERIENCE OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	189,606.	19,012.	18,774.	8,940.	27,237.	263,569.	0.
(9) ZACHARY BOSTOCK CHIEF ADMINISTRATIVE OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	334,619.	39,478.	18,180.	21,400.	27,090.	440,767.	0.
(10) JONATHAN KLING, R.N. CHIEF NURSING OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	227,679.	0.	15,076.	16,971.	25,742.	285,468.	0.
(11) JAMES K. MARTIN TERM 05/17 FORMER CHIEF DEVELOPMENT OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	118,672.	33,033.	172,149.	15,152.	11,279.	350,285.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

**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, LINE 4A:

JAMES MARTIN, FORMER OFFICER RESIGNED 5/27/2017 AND RECEIVED A SEVERANCE

PAYMENT OF \$164,388 FOR CALENDAR YEAR 2017.

PART I, LINE 7:

PROVISION OF NON-FIXED PAYMENTS

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

**2017**

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.

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:

REVIEW PROCESS

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

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

Schedule O (Form 990 or 990-EZ) (2017)

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

THE CHAIRMAN OF THE NCH FINANCE COMMITTEE AND OUTSIDE COUNSEL FOR THE

BOARD. PRIOR TO BOARD APPROVAL, THE FORM 990 IS PROVIDED TO ALL OF THE

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

(EXECUTIVE COMMITTEE) 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

GIVE RISE TO A CONFLICT OF INTEREST, THE BOARD OR COMMITTEE SHALL DETERMINE

BY A MAJORITY VOTE OF THE DISINTERESTED TRUSTEES WHETHER THE TRANSACTION OR

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

ARRANGEMENT IS IN THE CORPORATION'S BEST INTEREST AND FOR ITS OWN BENEFIT.  
 IF THE TRANSACTION IS FAIR AND REASONABLE TO THE CORPORATION THE BOARD OR  
 COMMITTEE 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 NCHS ARE AVAILABLE TO THE PUBLIC UPON  
 REQUEST. FINANCIAL STATEMENTS ARE ALSO AVAILABLE VIA OUR WEBSITE:

[HTTP://WWW.NCHMD.ORG/ABOUT-US/ANNUAL-REPORTS](http://www.nchmd.org/about-us/annual-reports). DOCUMENTS AVAILABLE FOR

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

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	-1,601,785.
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**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Related Organizations and Unrelated Partnerships**

▶ Complete if the organization answered "Yes" 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

**2017**

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
NCH HEALTHCARE SYSTEM, INC. - 59-2314655 P.O. BOX 413029 NAPLES, FL 34101	HOLDING CO	FLORIDA	501 (C) (3)	LINE 12B, II	N/A		X
NAPLES COMMUNITY HOSPITAL, INC. - 59-0694358 P.O. BOX 413029 NAPLES, FL 34101	HEALTHCARE	FLORIDA	501 (C) (3)	3	NCH SYSTEM		X
NCHMD, INC. - 33-1075317 P.O. BOX 413029 NAPLES, FL 34101	HEALTHCARE	FLORIDA	501 (C) (3)	LINE 10	NCH SYSTEM		X
COMMUNITY HOME SERVICES, INC. - 59-2440516 P.O. BOX 413029 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) 2017







**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) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) NAPLES COMMUNITY HOSPITAL, INC.	Q	1,610,021.	FMV
(2)			
(3)			
(4)			
(5)			
(6)			



