Form **990**

Department of the Treasury
Internal Revenue Service

# Return of Organization Exempt From Income Tax

**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.

▶ Information about Form 990 and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

**2013**

**Open to Public Inspection**

A For the 2013 calendar year, or tax year beginning 05/01 , 2013, and ending 04/30 , 20 14

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization MOUNT DESERT ISLAND HOSPITAL

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) PO Box 8 10 Wayman Lane — Room/suite

City or town, state or province, country, and ZIP or foreign postal code Bar Harbor, ME, 04609-0008

D Employer identification number 01-0211797

E Telephone number 207-288-5081

G Gross receipts $ 56,372,674

F Name and address of principal officer: ARTHUR BLANK
10 WAYMAN LANE, PO BOX 8, BAR HARBOR, ME 04609-0008

H(a) Is this a group return for subordinates? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

I Tax-exempt status: ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ www.mdihospital.org

H(c) Group exemption number ▶

K Form of organization: ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1897

M State of legal domicile: ME

## Part I Summary

**Activities & Governance**

1 Briefly describe the organization's mission or most significant activities: Mount Desert Island Hospitals mission is to provide compassionate care and strengthen the health of our community by embracing tomorrow's methods and respecting time honored values.

2 Check this box ▶☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

| | | Line | Value |
|---|---|---|---|
| 3 | Number of voting members of the governing body (Part VI, line 1a) | 3 | 18 |
| 4 | Number of independent voting members of the governing body (Part VI, line 1b) | 4 | 14 |
| 5 | Total number of individuals employed in calendar year 2013 (Part V, line 2a) | 5 | 529 |
| 6 | Total number of volunteers (estimate if necessary) | 6 | 244 |
| 7a | Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 0 |
| b | Net unrelated business taxable income from Form 990-T, line 34 | 7b | 0 |

| Section | Line | Description | Prior Year | Current Year |
|---|---|---|---|---|
| Revenue | 8 | Contributions and grants (Part VIII, line 1h) | 2,254,053 | 1,735,208 |
| | 9 | Program service revenue (Part VIII, line 2g) | 47,520,943 | 45,127,799 |
| | 10 | Investment income (Part VIII, column (A), lines 3, 4, and 7d) | 424,924 | 72,733 |
| | 11 | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 2,333,173 | 3,058,207 |
| | 12 | Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 52,533,093 | 49,993,947 |
| Expenses | 13 | Grants and similar amounts paid (Part IX, column (A), lines 1–3) | 0 | 0 |
| | 14 | Benefits paid to or for members (Part IX, column (A), line 4) | 0 | 0 |
| | 15 | Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) | 32,850,936 | 31,466,270 |
| | 16a | Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| | b | Total fundraising expenses (Part IX, column (D), line 25) ▶ 155,569 | | |
| | 17 | Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | 22,267,919 | 21,346,329 |
| | 18 | Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25) | 55,118,855 | 52,812,599 |
| | 19 | Revenue less expenses. Subtract line 18 from line 12 | -2,585,762 | -2,818,652 |

| Section | Line | Description | Beginning of Current Year | End of Year |
|---|---|---|---|---|
| Net Assets or Fund Balances | 20 | Total assets (Part X, line 16) | 52,443,534 | 49,537,121 |
| | 21 | Total liabilities (Part X, line 26) | 31,102,021 | 28,955,798 |
| | 22 | Net assets or fund balances. Subtract line 21 from line 20 | 21,341,513 | 20,581,323 |

## Part II Signature Block

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

**Sign Here**

Signature of officer — Date

Christina Harding, CFO
Type or print name and title

**Paid Preparer Use Only**

| Print/Type preparer's name | Preparer's signature | Date | Check ☐ if self-employed | PTIN |
|---|---|---|---|---|
| | | | | |

Firm's name ▶ — Firm's EIN ▶

Firm's address ▶ — Phone no.

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:

Mount Desert Island Hospitals mission is to provide compassionate care and strengthen the health of our community by embracing tomorrows methods and respecting time honored values.

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

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? . . . . . . . . . ☐ Yes ☑ No

If "Yes," describe these changes on Schedule O.

4 Describe the 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 $ 39,585,686 including grants of $ 0 ) (Revenue $ 48,156,006 )

Mount Desert Island hospitals mission statement is described in Part II, Line 1 above. In Fiscal year 2014, MDI Hospital provided 3, 326,742 in services for which no compensation was expected or received. Policies exist to provide relief for those who cannot pay for medical care. MDI Hospital provides care to persons covered by governmental programs including Medicare, Medicaid and champus. The unreimbursed value for providing care to these patients approximates 1,244,181. The Hospital provides a number of health services and preventative health programs to the community. Available programs include cardiac pulmonary rehabilitation, wellness programs, diabetes education, nutrition counseling, parenting, pregnancy and sibling classes and physical and occupational therapy programs, as well as speech therapy, as well as our newly adopted oral health program adopted in Fiscal year 2014. Thoughout the years, staff from the hospital make presentations to area school children regarding smoking cessation and health nutrition, and now oral health, including a Give Kids a Smile day in which free or reduced cost screenings are available. Additionally, community groups such as Alcoholics Anonymous use the hospitals conference rooms for their meetings. Many hospital staff members serve other nonprofits in capacities such as volunteer hours, and Board of Directors memberships, as well as memberships in service organization such as the local Rotary, and Lioness clubs.

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

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

4d Other program services (Describe in Schedule O.)
(Expenses $ 0 including grants of $ 0 ) (Revenue $ 0 )

4e Total program service expenses ▶ 39,585,686

**Part IV** **Checklist of Required Schedules**

| | | | Yes | No |
|---|---|---|---|---|
| 1 | Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A* | 1 | ✓ | |
| 2 | Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)? | 2 | ✓ | |
| 3 | Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I* | 3 | | ✓ |
| 4 | **Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II* | 4 | ✓ | |
| 5 | Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III* | 5 | | ✓ |
| 6 | 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? *If "Yes," complete Schedule D, Part I* | 6 | | ✓ |
| 7 | Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II* | 7 | | ✓ |
| 8 | Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III* | 8 | | ✓ |
| 9 | 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? *If "Yes," complete Schedule D, Part IV* | 9 | | ✓ |
| 10 | Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V* | 10 | ✓ | |
| 11 | If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable. | | | |
| a | Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI* | 11a | ✓ | |
| 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? *If "Yes," complete Schedule D, Part VII* | 11b | | ✓ |
| c | Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII* | 11c | | ✓ |
| d | Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX* | 11d | ✓ | |
| e | Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X* | 11e | ✓ | |
| f | Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X* | 11f | ✓ | |
| 12 a | Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII* | 12a | ✓ | |
| b | Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional* | 12b | ✓ | |
| 13 | Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E* | 13 | | ✓ |
| 14 a | Did the organization maintain an office, employees, or agents outside of the United States? | 14a | | ✓ |
| 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? *If "Yes," complete Schedule F, Parts I and IV.* | 14b | | ✓ |
| 15 | 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? *If "Yes," complete Schedule F, Parts II and IV* | 15 | | ✓ |
| 16 | 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? *If "Yes," complete Schedule F, Parts III and IV.* | 16 | | ✓ |
| 17 | Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)* | 17 | | ✓ |
| 18 | Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II* | 18 | | ✓ |
| 19 | Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III* | 19 | | ✓ |
| 20 a | Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H* | 20a | ✓ | |
| b | If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? | 20b | ✓ | |

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

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

**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 . . . ☐

| | | Amount | Line | Yes | No |
|---|---|---|---|---|---|
| 1a | Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable | 1a 56 | | | |
| b | Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable | 1b 0 | | | |
| c | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | | 1c | ✓ | |
| 2a | Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return | 2a 529 | | | |
| b | If at least one is reported on line 2a, did the organization file all required federal employment tax returns? | | 2b | ✓ | |
| | **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions) | | | | |
| 3a | Did the organization have unrelated business gross income of $1,000 or more during the year? | | 3a | | ✓ |
| b | If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* | | 3b | | |
| 4a | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? | | 4a | | ✓ |
| b | If "Yes," enter the name of the foreign country: ▶ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. | | | | |
| 5a | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? | | 5a | | ✓ |
| b | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | | 5b | | ✓ |
| c | If "Yes" to line 5a or 5b, did the organization file Form 8886-T? | | 5c | | |
| 6a | Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? | | 6a | | ✓ |
| b | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | | 6b | | |
| 7 | **Organizations that may receive deductible contributions under section 170(c).** | | | | |
| a | Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor? | | 7a | | |
| b | If "Yes," did the organization notify the donor of the value of the goods or services provided? | | 7b | | |
| c | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | | 7c | | |
| d | If "Yes," indicate the number of Forms 8282 filed during the year | 7d | | | |
| e | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | | 7e | | |
| f | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? | | 7f | | |
| g | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? | | 7g | | |
| h | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? | | 7h | | |
| 8 | **Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year? | | 8 | | |
| 9 | **Sponsoring organizations maintaining donor advised funds.** | | | | |
| a | Did the organization make any taxable distributions under section 4966? | | 9a | | |
| b | Did the organization make a distribution to a donor, donor advisor, or related person? | | 9b | | |
| 10 | **Section 501(c)(7) organizations.** Enter: | | | | |
| a | Initiation fees and capital contributions included on Part VIII, line 12 | 10a | | | |
| b | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities | 10b | | | |
| 11 | **Section 501(c)(12) organizations.** Enter: | | | | |
| a | Gross income from members or shareholders | 11a | | | |
| b | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) | 11b | | | |
| 12a | **Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041? | | 12a | | |
| b | If "Yes," enter the amount of tax-exempt interest received or accrued during the year | 12b | | | |
| 13 | **Section 501(c)(29) qualified nonprofit health insurance issuers.** | | | | |
| a | Is the organization licensed to issue qualified health plans in more than one state? | | 13a | | |
| | **Note.** See the instructions for additional information the organization must report on Schedule O. | | | | |
| b | Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans | 13b | | | |
| c | Enter the amount of reserves on hand | 13c | | | |
| 14a | Did the organization receive any payments for indoor tanning services during the tax year? | | 14a | | ✓ |
| b | If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* | | 14b | | |

**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 . . . ☑

## Section A. Governing Body and Management

| | | | Yes | No |
|---|---|---|---|---|
| **1a** | Enter the number of voting members of the governing body at the end of the tax year . . **1a** 18<br>If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O. | | | |
| **b** | Enter the number of voting members included in line 1a, above, who are independent . **1b** 14 | | | |
| **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? | 2 | | ✓ |
| **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? | 3 | | ✓ |
| **4** | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | 4 | | ✓ |
| **5** | Did the organization become aware during the year of a significant diversion of the organization's assets? | 5 | | ✓ |
| **6** | Did the organization have members or stockholders? | 6 | | ✓ |
| **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? | 7a | | ✓ |
| **b** | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | 7b | | ✓ |
| **8** | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: | | | |
| **a** | The governing body? | 8a | ✓ | |
| **b** | Each committee with authority to act on behalf of the governing body? | 8b | ✓ | |
| **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* | 9 | | ✓ |

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

| | | | Yes | No |
|---|---|---|---|---|
| **10a** | Did the organization have local chapters, branches, or affiliates? | 10a | | ✓ |
| **b** | 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? | 10b | | |
| **11a** | Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? | 11a | ✓ | |
| **b** | 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* | 12a | ✓ | |
| **b** | Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? | 12b | ✓ | |
| **c** | Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done* | 12c | ✓ | |
| **13** | Did the organization have a written whistleblower policy? | 13 | ✓ | |
| **14** | Did the organization have a written document retention and destruction policy? | 14 | ✓ | |
| **15** | Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? | | | |
| **a** | The organization's CEO, Executive Director, or top management official | 15a | ✓ | |
| **b** | Other officers or key employees of the organization<br>If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions). | 15b | ✓ | |
| **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? | 16a | | ✓ |
| **b** | 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? | 16b | | |

## Section C. Disclosure

**17** List the states with which a copy of this Form 990 is required to be filed ▶ ME

**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.

☑ Own website ☑ Another's website ☑ 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, physical address, and telephone number of the person who possesses the books and records of the organization: ▶ Arthur Blank, (207)288-5081

PO Box 8, 10 Wayman Lane, Bar Harbor, ME 04609-0008

## 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 dotted 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 | | | |
| **Arthur J Blank**<br>**President and CEO** | 40<br>0 | ✓ | ✓ | ✓ | ✓ | | | 314,555 | 0 | 34,783 |
| **John Benson MD**<br>**Boardmember** | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |
| **Michael Bonsey**<br>**Chairman** | 5<br>0 | ✓ | | ✓ | | | | 0 | 0 | 0 |
| **Stewart Brecher**<br>**Board Member** | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |
| **David Einhorn Esq**<br>**Board Member** | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |
| **Kathleen Field**<br>**Board Member** | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |
| **Julius Krevans MD**<br>**Board Member** | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |
| **Julian Kuffler MD**<br>**2nd Vice Chair & Family Physician** | 40.00<br>0 | ✓ | | | | | | 222,993 | 0 | 25,173 |
| **Dean Read**<br>**Board Member** | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |
| **Patricia Hand PhD**<br>**Board Member** | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |
| **Elsie Flemings**<br>**Board Member** | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |
| **Noelle Wolf**<br>**Board Member** | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |
| **Vince Messer**<br>**1st Vice Chair** | 3<br>0 | ✓ | | ✓ | | | | 0 | 0 | 0 |
| **James Bright**<br>**Board member** | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |

**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 dotted line) | (C) Position: Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | (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 |
|---|---|---|---|---|---|---|---|---|---|---|
| Christina M Harding<br>CFO/VP of Finance | 40<br>0 | | | ✓ | ✓ | | | 164,345 | 0 | 12,970 |
| Terry Musson<br>Board Member | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |
| Stuart Davidson<br>Physician | 40<br>0 | | | | | ✓ | | 480,974 | 0 | 37,120 |
| Michael Heniser<br>Physician | 40<br>0 | | | | | ✓ | | 382,683 | 0 | 27,638 |
| Michelle Kinbrook<br>Physician | 40<br>0 | | | | | ✓ | | 282,577 | 0 | 27,876 |
| Kendra Blount<br>General Surgeon | 40<br>0 | | | | | ✓ | | 288,257 | 0 | 37,120 |
| Tanya Hanke<br>Physician | 40<br>0 | | | | | ✓ | | 251,959 | 0 | 16,774 |
| Bev Paigen<br>Board Member | 1<br>0 | ✓ | | | | | | 0 | 0 | 0 |
| David Painter<br>MD | 40<br>1 | ✓ | | | | | | 183,062 | 0 | 34,313 |
| Audrey Leavitt<br>Secretary | 40<br>0 | | | ✓ | | | | 45,568 | 0 | 18,721 |
| | | | | | | | | | | |
| **1b Sub-total** . . . ▶ | | | | | | | | 2,616,973 | 0 | 272,488 |
| **c Total from continuation sheets to Part VII, Section A** ▶ | | | | | | | | | | |
| **d Total (add lines 1b and 1c)** ▶ | | | | | | | | 2,616,973 | 0 | 272,488 |

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 ▶ 40

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

**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 |
|---|---|---|
| Bay View Physical Therapy, 125 Oak Street, Ellsworth, ME 04605 | Physical Therapy | 522,273 |
| Rao Surapememi P Ramanadha MD, 50 358 Broad st, suite 207, Bangor, ME 04401 | Urologist | 336,000 |
| Dahl Chase Diagnostic Services, 417 State Street, Suite 441, Bangor, ME 04401 | pathology services | 388,859 |
| | | |
| | | |

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 ▶ 3

## Part VIII Statement of Revenue

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

| | | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512-514 |
|---|---|---|---|---|---|---|---|
| **Contributions, Gifts, Grants and Other Similar Amounts** | 1a Federated campaigns | 1a | 0 | | | | |
| | b Membership dues | 1b | 0 | | | | |
| | c Fundraising events | 1c | 0 | | | | |
| | d Related organizations | 1d | 0 | | | | |
| | e Government grants (contributions) | 1e | 116,921 | | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | 1,618,287 | | | | |
| | g Noncash contributions included in lines 1a-1f: $ | | 655,264 | | | | |
| | h **Total.** Add lines 1a–1f ▶ | | | 1,735,208 | | | |
| **Program Service Revenue** | | | Business Code | | | | |
| | 2a Patient Service Revenue | | 900099 | 19,489,185 | 19,489,185 | 0 | 0 |
| | b Medicare/Medicaid payments | | 900099 | 25,638,614 | 25,638,614 | 0 | 0 |
| | c | | | | | | |
| | d | | | | | | |
| | e | | | | | | |
| | f All other program service revenue . | | | | | | |
| | g **Total.** Add lines 2a–2f ▶ | | | 45,127,799 | | | |
| **Other Revenue** | 3 Investment income (including dividends, interest, and other similar amounts) ▶ | | | -39,557 | -39,557 | 0 | 0 |
| | 4 Income from investment of tax-exempt bond proceeds ▶ | | | 57,742 | 57,742 | 0 | 0 |
| | 5 Royalties ▶ | | | 0 | 0 | 0 | 0 |
| | | (i) Real | (ii) Personal | | | | |
| | 6a Gross rents | 30,000 | 0 | | | | |
| | b Less: rental expenses | 0 | 0 | | | | |
| | c Rental income or (loss) | 30,000 | 0 | | | | |
| | d Net rental income or (loss) ▶ | | | 30,000 | 30,000 | 0 | 0 |
| | 7a Gross amount from sales of assets other than inventory | (i) Securities 6,433,275 | (ii) Other 0 | | | | |
| | b Less: cost or other basis and sales expenses | 6,378,727 | 0 | | | | |
| | c Gain or (loss) | 54,548 | 0 | | | | |
| | d Net gain or (loss) ▶ | | | 54,548 | 54,548 | 0 | 0 |
| | 8a Gross income from fundraising events (not including $ 0 of contributions reported on line 1c). See Part IV, line 18 | a | | | | | |
| | b Less: direct expenses | b | | | | | |
| | c Net income or (loss) from fundraising events ▶ | | | | | | |
| | 9a Gross income from gaming activities. See Part IV, line 19 | a | | | | | |
| | b Less: direct expenses | b | | | | | |
| | c Net income or (loss) from gaming activities ▶ | | | | | | |
| | 10a Gross sales of inventory, less returns and allowances | a | | | | | |
| | b Less: cost of goods sold | b | | | | | |
| | c Net income or (loss) from sales of inventory ▶ | | | | | | |
| | Miscellaneous Revenue | | Business Code | | | | |
| | 11a Cafeteria sales | | 900099 | 194,338 | 194,338 | 0 | 0 |
| | b Misc Income - Other | | 900099 | 2,643,850 | 2,643,850 | 0 | 0 |
| | c Misc Income - HC Admin | | 900099 | 190,019 | 190,019 | 0 | 0 |
| | d All other revenue | | | 0 | 0 | 0 | 0 |
| | e **Total.** Add lines 11a–11d ▶ | | | 3,028,207 | | | |
| | 12 **Total revenue.** See instructions. ▶ | | | 49,993,947 | 48,258,739 | 0 | 0 |

## 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 |
|---|---|---|---|---|
| 1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21 | 0 | 0 | | |
| 2 Grants and other assistance to individuals in the United States. See Part IV, line 22 | 0 | 0 | | |
| 3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16 | 0 | 0 | | |
| 4 Benefits paid to or for members | 0 | 0 | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 727,284 | 0 | 727,284 | 0 |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 0 | 0 | 0 | 0 |
| 7 Other salaries and wages | 22,990,330 | 16,945,459 | 5,942,572 | 102,299 |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 492,461 | 350,713 | 139,607 | 2,141 |
| 9 Other employee benefits | 5,669,829 | 4,051,452 | 1,594,681 | 23,696 |
| 10 Payroll taxes | 1,586,366 | 1,133,407 | 446,117 | 6,842 |
| 11 Fees for services (non-employees): | | | | |
| a Management | 0 | 0 | 0 | 0 |
| b Legal | 125,961 | 0 | 125,961 | 0 |
| c Accounting | 117,305 | 0 | 117,305 | 0 |
| d Lobbying | 0 | 0 | 0 | 0 |
| e Professional fundraising services. See Part IV, line 17 | 0 | | | 0 |
| f Investment management fees | -39,557 | 0 | -39,557 | 0 |
| g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.) | 0 | 0 | 0 | 0 |
| 12 Advertising and promotion | 79,239 | 0 | 79,239 | 0 |
| 13 Office expenses | 4,276,452 | 4,045,497 | 230,955 | 0 |
| 14 Information technology | 0 | 0 | 0 | 0 |
| 15 Royalties | 0 | 0 | 0 | 0 |
| 16 Occupancy | 744,747 | 569,346 | 175,401 | 0 |
| 17 Travel | 136,569 | 113,323 | 23,246 | 0 |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | 0 | 0 | 0 | 0 |
| 19 Conferences, conventions, and meetings | 210,982 | 99,791 | 111,191 | 0 |
| 20 Interest | 694,276 | 567,469 | 126,807 | 0 |
| 21 Payments to affiliates | 0 | 0 | 0 | 0 |
| 22 Depreciation, depletion, and amortization | 1,771,190 | 1,395,822 | 375,368 | 0 |
| 23 Insurance | 597,688 | 486,715 | 110,973 | 0 |
| 24 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.) | | | | |
| a Purchased Services | 6,564,728 | 4,686,566 | 1,878,162 | 0 |
| b Bad Debt expense | 2,592,434 | 2,592,434 | 0 | 0 |
| c Physician Fees | 833,184 | 828,184 | 5,000 | 0 |
| d Hospital taxes | 1,125,762 | 1,125,762 | 0 | 0 |
| e All other expenses | 1,515,369 | 593,746 | 901,032 | 20,591 |
| 25 **Total functional expenses.** Add lines 1 through 24e | 52,812,599 | 39,585,686 | 13,071,344 | 155,569 |
| 26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720) | | | | |

## Part X Balance Sheet

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

| Section | Line | Description | | | (A) Beginning of year | Line | (B) End of year |
|---|---|---|---|---|---|---|---|
| Assets | 1 | Cash—non-interest-bearing | | | 0 | 1 | 0 |
| | 2 | Savings and temporary cash investments | | | 41,553 | 2 | 76,474 |
| | 3 | Pledges and grants receivable, net | | | 2,379,184 | 3 | 1,786,054 |
| | 4 | Accounts receivable, net | | | 6,056,753 | 4 | 6,139,447 |
| | 5 | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L | | | 0 | 5 | 0 |
| | 6 | 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 instructions). Complete Part II of Schedule L | | | 0 | 6 | 0 |
| | 7 | Notes and loans receivable, net | | | 0 | 7 | 0 |
| | 8 | Inventories for sale or use | | | 523,227 | 8 | 590,932 |
| | 9 | Prepaid expenses and deferred charges | | | 214,932 | 9 | 271,435 |
| | 10a | Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a | 48,507,798 | | | |
| | b | Less: accumulated depreciation | 10b | 25,337,958 | 22,720,683 | 10c | 23,169,840 |
| | 11 | Investments—publicly traded securities | | | 13,366,094 | 11 | 12,401,361 |
| | 12 | Investments—other securities. See Part IV, line 11 | | | 0 | 12 | 0 |
| | 13 | Investments—program-related. See Part IV, line 11 | | | 0 | 13 | 0 |
| | 14 | Intangible assets | | | 0 | 14 | 0 |
| | 15 | Other assets. See Part IV, line 11 | | | 7,141,108 | 15 | 5,101,578 |
| | 16 | **Total assets.** Add lines 1 through 15 (must equal line 34) | | | 52,443,534 | 16 | 49,537,121 |
| Liabilities | 17 | Accounts payable and accrued expenses | | | 12,545,489 | 17 | 11,237,965 |
| | 18 | Grants payable | | | 0 | 18 | 0 |
| | 19 | Deferred revenue | | | 11,693 | 19 | 9,154 |
| | 20 | Tax-exempt bond liabilities | | | 4,175,016 | 20 | 3,640,969 |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D | | | 0 | 21 | 0 |
| | 22 | 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 | | | 0 | 22 | 0 |
| | 23 | Secured mortgages and notes payable to unrelated third parties | | | 9,199,906 | 23 | 7,980,576 |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | | 0 | 24 | 0 |
| | 25 | 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 | | | 5,169,917 | 25 | 6,087,134 |
| | 26 | **Total liabilities.** Add lines 17 through 25 | | | 31,102,021 | 26 | 28,955,798 |
| Net Assets or Fund Balances | | **Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.** | | | | | |
| | 27 | Unrestricted net assets | | | 14,265,803 | 27 | 14,865,588 |
| | 28 | Temporarily restricted net assets | | | 5,141,021 | 28 | 3,674,156 |
| | 29 | Permanently restricted net assets | | | 1,934,689 | 29 | 2,041,579 |
| | | **Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.** | | | | | |
| | 30 | Capital stock or trust principal, or current funds | | | | 30 | |
| | 31 | Paid-in or capital surplus, or land, building, or equipment fund | | | | 31 | |
| | 32 | Retained earnings, endowment, accumulated income, or other funds | | | | 32 | |
| | 33 | Total net assets or fund balances | | | 21,341,513 | 33 | 20,581,323 |
| | 34 | Total liabilities and net assets/fund balances | | | 52,443,534 | 34 | 49,537,121 |

**Part XI Reconciliation of Net Assets**

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

| | | Line | Amount |
|---|---|---|---|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 49,993,947 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 52,812,599 |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | -2,818,652 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 21,341,513 |
| 5 | Net unrealized gains (losses) on investments | 5 | 352,042 |
| 6 | Donated services and use of facilities | 6 | 0 |
| 7 | Investment expenses | 7 | 0 |
| 8 | Prior period adjustments | 8 | 0 |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | 1,706,420 |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 20,581,323 |

**Part XII Financial Statements and Reporting**

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

| | | Line | Yes | No |
|---|---|---|---|---|
| 1 | Accounting method used to prepare the Form 990: ☐ Cash ☑ Accrual ☐ Other ______<br>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? | 2a | ✓ | |
| | 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:<br>☐ Separate basis ☐ Consolidated basis ☑ Both consolidated and separate basis | | | |
| b | Were the organization's financial statements audited by an independent accountant? | 2b | ✓ | |
| | 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:<br>☐ 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? | 2c | ✓ | |
| | 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? | 3a | | ✓ |
| b | If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits. | 3b | | |

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

Department of the Treasury
Internal Revenue Service

# Public Charity Status and Public Support

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

▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

**2013**

**Open to Public Inspection**

Name of the organization: MOUNT DESERT ISLAND HOSPITAL

Employer identification number: 01-0211797

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

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

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 ☑ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: ____________

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An organization that normally receives: (1) more than 33⅓% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33⅓% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I  b ☐ Type II  c ☐ Type III–Functionally integrated  d ☐ Type III–Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box . . . . . . ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

| | | Yes | No |
|---|---|---|---|
| (i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization? | 11g(i) | | |
| (ii) A family member of a person described in (i) above? | 11g(ii) | | |
| (iii) A 35% controlled entity of a person described in (i) or (ii) above? | 11g(iii) | | |

h Provide the following information about the supported organization(s).

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

**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) 2009 | (b) 2010 | (c) 2011 | (d) 2012 | (e) 2013 | (f) Total |
|---|---|---|---|---|---|---|
| 1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") | | | | | | |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 **Total.** Add lines 1 through 3 | | | | | | |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) | | | | | | |
| 6 **Public support.** Subtract line 5 from line 4. | | | | | | |

**Section B. Total Support**

| Calendar year (or fiscal year beginning in) ▶ | (a) 2009 | (b) 2010 | (c) 2011 | (d) 2012 | (e) 2013 | (f) Total |
|---|---|---|---|---|---|---|
| 7 Amounts from line 4 | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.) | | | | | | |
| 11 **Total support.** Add lines 7 through 10 | | | | | | |

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

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

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

14 Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f)) . . . 14 %

15 Public support percentage from 2012 Schedule A, Part II, line 14 . . . 15 %

16a **33 1/3% support test—2013.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . ▶ ☐

b **33 1/3% support test—2012.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . ▶ ☐

17a **10%-facts-and-circumstances test—2013.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . ▶ ☐

b **10%-facts-and-circumstances test—2012.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . ▶ ☐

**Part III** **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

## Section A. Public Support

| Calendar year (or fiscal year beginning in) ▶ | (a) 2009 | (b) 2010 | (c) 2011 | (d) 2012 | (e) 2013 | (f) Total |
|---|---|---|---|---|---|---|
| 1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") | | | | | | |
| 2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose | | | | | | |
| 3 Gross receipts from activities that are not an unrelated trade or business under section 513 | | | | | | |
| 4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 5 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 6 **Total.** Add lines 1 through 5 | | | | | | |
| 7a Amounts included on lines 1, 2, and 3 received from disqualified persons | | | | | | |
| b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year | | | | | | |
| c Add lines 7a and 7b | | | | | | |
| 8 **Public support** (Subtract line 7c from line 6.) | | | | | | |

## Section B. Total Support

| Calendar year (or fiscal year beginning in) ▶ | (a) 2009 | (b) 2010 | (c) 2011 | (d) 2012 | (e) 2013 | (f) Total |
|---|---|---|---|---|---|---|
| 9 Amounts from line 6 | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.) | | | | | | |
| 13 **Total support.** (Add lines 9, 10c, 11, and 12.) | | | | | | |

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

## Section C. Computation of Public Support Percentage

15 Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f)) | 15 | %

16 Public support percentage from 2012 Schedule A, Part III, line 15 | 16 | %

## Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2013** (line 10c, column (f) divided by line 13, column (f)) | 17 | %

18 Investment income percentage from **2012** Schedule A, Part III, line 17 | 18 | %

19a **33⅓% support tests—2013.** If the organization did not check the box on line 14, and line 15 is more than 33⅓%, and line 17 is not more than 33⅓%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33⅓% support tests—2012.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33⅓%, and line 18 is not more than 33⅓%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

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

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

Department of the Treasury
Internal Revenue Service

# Political Campaign and Lobbying Activities

**For Organizations Exempt From Income Tax Under section 501(c) and section 527**

▶ Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.
▶ See separate instructions. ▶ Information about Schedule C (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990*.

OMB No. 1545-0047

2013

**Open to Public Inspection**

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

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

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

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

**If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35c (Proxy Tax), then**

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

| Name of organization | Employer identification number |
|---|---|
| MOUNT DESERT ISLAND HOSPITAL | 01-0211797 |

## Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.

2 Political expenditures . . . . . ▶ $

3 Volunteer hours . . . . .

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 . . . ▶ $

2 Enter the amount of any excise tax incurred by organization managers under section 4955 . . ▶ $

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? . . . ☐ Yes ☐ No

4a Was a correction made? . . . . . ☐ Yes ☐ No

b If "Yes," describe in Part IV.

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities . . . . . ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities . . . . . ▶ $

3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b . . . . . ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? . . . . . ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

| | (a) Name | (b) Address | (c) EIN | (d) Amount paid from filing organization's funds. If none, enter -0-. | (e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-. |
|---|---|---|---|---|---|
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |

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

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

| | **Limits on Lobbying Expenditures** (The term "expenditures" means amounts paid or incurred.) | (a) Filing organization's totals | (b) Affiliated group totals |
|---|---|---|---|
| 1a | Total lobbying expenditures to influence public opinion (grass roots lobbying) | | |
| b | Total lobbying expenditures to influence a legislative body (direct lobbying) | | |
| c | Total lobbying expenditures (add lines 1a and 1b) | | |
| d | Other exempt purpose expenditures | | |
| e | Total exempt purpose expenditures (add lines 1c and 1d) | | |
| f | Lobbying nontaxable amount. Enter the amount from the following table in both columns. | | |

| If the amount on line 1e, column (a) or (b) is: | The lobbying nontaxable amount is: |
|---|---|
| Not over $500,000 | 20% of the amount on line 1e. |
| Over $500,000 but not over $1,000,000 | $100,000 plus 15% of the excess over $500,000. |
| Over $1,000,000 but not over $1,500,000 | $175,000 plus 10% of the excess over $1,000,000. |
| Over $1,500,000 but not over $17,000,000 | $225,000 plus 5% of the excess over $1,500,000. |
| Over $17,000,000 | $1,000,000. |

| | | (a) | (b) |
|---|---|---|---|
| g | Grassroots nontaxable amount (enter 25% of line 1f) | | |
| h | Subtract line 1g from line 1a. If zero or less, enter -0- | | |
| i | Subtract line 1f from line 1c. If zero or less, enter -0- | | |

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ Yes ☐ No

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

**Lobbying Expenditures During 4-Year Averaging Period**

| Calendar year (or fiscal year beginning in) | (a) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) Total |
|---|---|---|---|---|---|
| 2a Lobbying nontaxable amount | | | | | |
| b Lobbying ceiling amount (150% of line 2a, column (e)) | | | | | |
| c Total lobbying expenditures | | | | | |
| d Grassroots nontaxable amount | | | | | |
| e Grassroots ceiling amount (150% of line 2d, column (e)) | | | | | |
| f Grassroots lobbying expenditures | | | | | |

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

| *For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.* | (a) Yes | (a) No | (b) Amount |
|---|---|---|---|
| **1** During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of: | | | |
| **a** Volunteers? | | ✓ | |
| **b** Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? | | ✓ | |
| **c** Media advertisements? | | ✓ | |
| **d** Mailings to members, legislators, or the public? | | ✓ | |
| **e** Publications, or published or broadcast statements? | | ✓ | |
| **f** Grants to other organizations for lobbying purposes? | | ✓ | |
| **g** Direct contact with legislators, their staffs, government officials, or a legislative body? | ✓ | | 0 |
| **h** Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? | | ✓ | |
| **i** Other activities? | ✓ | | 6,704 |
| **j** Total. Add lines 1c through 1i | | | 6,704 |
| **2a** Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? | | ✓ | |
| **b** If "Yes," enter the amount of any tax incurred under section 4912 | | | |
| **c** If "Yes," enter the amount of any tax incurred by organization managers under section 4912 | | | |
| **d** If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year? | | | |

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

| | | Yes | No |
|---|---|---|---|
| **1** Were substantially all (90% or more) dues received nondeductible by members? | 1 | | |
| **2** Did the organization make only in-house lobbying expenditures of $2,000 or less? | 2 | | |
| **3** Did the organization agree to carry over lobbying and political expenditures from the prior year? | 3 | | |

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

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

**Part IV** **Supplemental Information**

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

Schedule C, Part II-B, Line 1 - The CEO, for part of the fiscal year, was an officer of the Maine Hospital Association. As such, he met directly with legislators and other government officials as part of his advocacy efforts within that organization. Some of these meetings were with the intent to influence public opinion on matters relevant to the organization.

**SCHEDULE D (Form 990)**

Department of the Treasury
Internal Revenue Service

# Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Information about Schedule D (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No. 1545-0047
**2013**
**Open to Public Inspection**

Name of the organization: MOUNT DESERT ISLAND HOSPITAL

Employer identification number: 01-0211797

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

| | | (a) Donor advised funds | (b) Funds and other accounts |
|---|---|---|---|
| 1 | Total number at end of year | | |
| 2 | Aggregate contributions to (during year) | | |
| 3 | Aggregate grants from (during year) | | |
| 4 | Aggregate value at end of year | | |

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).
- ☐ Preservation of land for public use (e.g., recreation or education)
- ☐ Preservation of an historically important land area
- ☐ Protection of natural habitat
- ☐ Preservation of a certified historic structure
- ☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

| | | | Held at the End of the Tax Year |
|---|---|---|---|
| a | Total number of conservation easements | 2a | |
| b | Total acreage restricted by conservation easements | 2b | |
| c | Number of conservation easements on a certified historic structure included in (a) | 2c | |
| d | Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register | 2d | |

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ ____

4 Number of states where property subject to conservation easement is located ▶ ____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ ____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ ____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ ____

(ii) Assets included in Form 990, Part X ▶ $ ____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1 ▶ $ ____

b Assets included in Form 990, Part X ▶ $ ____

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

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

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

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part 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" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part 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? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

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

| | | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|---|---|---|---|---|---|---|
| 1a | Beginning of year balance | 6,591,431 | 6,300,481 | 8,117,020 | 6,997,367 | 3,938,882 |
| b | Contributions | 25,000 | 0 | 0 | 17,162 | 1,801,964 |
| c | Net investment earnings, gains, and losses | 625,391 | 588,719 | -421,691 | 1,180,156 | 1,284,232 |
| d | Grants or scholarships | 0 | 0 | 0 | 0 | 0 |
| e | Other expenditures for facilities and programs | 225,000 | 270,000 | 1,366,000 | 46,000 | 7,570 |
| f | Administrative expenses | 29,284 | 27,769 | 28,848 | 31,665 | 20,141 |
| g | End of year balance | 6,987,538 | 6,591,431 | 6,300,481 | 8,117,020 | 6,997,367 |

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ 94.86 %
b Permanent endowment ▶ 5.14 %
c Temporarily restricted endowment ▶ 0 %

The percentages in lines 2a, 2b, and 2c should equal 100%.

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

| | | | Yes | No |
|---|---|---|---|---|
| | (i) unrelated organizations | 3a(i) | ✓ | |
| | (ii) related organizations | 3a(ii) | | ✓ |
| b | If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R? | 3b | | |

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

**Part VI Land, Buildings, and Equipment.**
Complete if the organization answered "Yes" to 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 | 0 | 3,829,845 | | 3,829,845 |
| b | Buildings | 0 | 24,979,203 | 12,702,261 | 12,276,942 |
| c | Leasehold improvements | 0 | 235,558 | 149,701 | 85,857 |
| d | Equipment | 0 | 15,039,507 | 12,225,897 | 2,813,610 |
| e | Other | 0 | 4,423,685 | 260,099 | 4,163,586 |
| **Total.** Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶ | | | | | 23,169,840 |

**Part VII Investments—Other Securities.**
Complete if the organization answered "Yes" to 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) | | |
| **Total.** *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶ | | |

**Part VIII Investments—Program Related.**
Complete if the organization answered "Yes" to 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) | | |
| **Total.** *(Column (b) must equal Form 990, Part X, col. (B) line 13.)* ▶ | | |

**Part IX Other Assets.**
Complete if the organization answered "Yes" to Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

| (a) Description | (b) Book value |
|---|---|
| (1) Due from affiliates | 4,681,817 |
| (2) Deferred financing costs | 66,193 |
| (3) Estimated third party payor settlements | 249,273 |
| (4) Aetna deposit | 98,000 |
| (5) Other receivables | 6,295 |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| **Total.** *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶ | 5,101,578 |

**Part X Other Liabilities.**
Complete if the organization answered "Yes" to 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 | 0 |
| (2) Deferred compensation | 2,154,482 |
| (3) Estimated third party payor settlements | 3,622,845 |
| (4) Due to affiliate | 309,807 |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| **Total.** *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶ | 6,087,134 |

**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" to Form 990, Part IV, line 12a.

| | | | | | |
|---|---|---|---|---|---|
| 1 | Total revenue, gains, and other support per audited financial statements | | | 1 | 49,197,901 |
| 2 | Amounts included on line 1 but not on Form 990, Part VIII, line 12: | | | | |
| a | Net unrealized gains on investments | 2a | 0 | | |
| b | Donated services and use of facilities | 2b | 0 | | |
| c | Recoveries of prior year grants | 2c | 0 | | |
| d | Other (Describe in Part XIII.) | 2d | 0 | | |
| e | Add lines **2a** through **2d** | | | 2e | 0 |
| 3 | Subtract line **2e** from line **1** | | | 3 | 49,197,901 |
| 4 | Amounts included on Form 990, Part VIII, line 12, but not on line 1: | | | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | 0 | | |
| b | Other (Describe in Part XIII.) | 4b | 796,046 | | |
| c | Add lines **4a** and **4b** | | | 4c | 796,046 |
| 5 | Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)* | | | 5 | 49,993,947 |

## Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

| | | | | | |
|---|---|---|---|---|---|
| 1 | Total expenses and losses per audited financial statements | | | 1 | 50,393,478 |
| 2 | Amounts included on line 1 but not on Form 990, Part IX, line 25: | | | | |
| a | Donated services and use of facilities | 2a | 0 | | |
| b | Prior year adjustments | 2b | 0 | | |
| c | Other losses | 2c | 0 | | |
| d | Other (Describe in Part XIII.) | 2d | -2,419,121 | | |
| e | Add lines **2a** through **2d** | | | 2e | -2,419,121 |
| 3 | Subtract line **2e** from line **1** | | | 3 | 52,812,599 |
| 4 | Amounts included on Form 990, Part IX, line 25, but not on line 1: | | | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | 0 | | |
| b | Other (Describe in Part XIII.) | 4b | 0 | | |
| c | Add lines **4a** and **4b** | | | 4c | 0 |
| 5 | Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)* | | | 5 | 52,812,599 |

## 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.

Schedule D, Part V, Line 4 - Endowment amounts restricted by the Board of Directors are released by the Board as needed for Special Projects supplying benefit to the community at large. These funds are intended solely for the use of expanding services, and not for sustaining current operations.

Schedule D, Part X, Line 2 - No note

Schedule D, Part XI, Line 4b - Gifts and bequests, temporarily restricted contributions, changes in pledges receivable, net assets released.

Schedule D, Part XII, Line 2d - Fundraising expenses, investment mgmt fees

Schedule D, Part XII, Line 4b - Fundraising expenses, investment management fees

Schedule D, Part XII, Line 5 - The IRS software has a formula error and it won't let you override it. The sum of 50,393,478 and 2,419,121 is 52,812,599, not 47,974,357 as the software states and returns an error on. It is necessary to put this number in as negative in order to calculate correctly.

**SCHEDULE H (Form 990)**

Department of the Treasury
Internal Revenue Service

# Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

**2013**

**Open to Public Inspection**

Name of the organization: MOUNT DESERT ISLAND HOSPITAL

Employer identification number: 01 0211797

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

| | | | Yes | No |
|---|---|---|---|---|
| 1a | Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | 1a | ✓ | |
| b | If "Yes," was it a written policy? | 1b | ✓ | |
| 2 | If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.<br>☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities<br>☐ Generally tailored to individual hospital facilities | | | |
| 3 | Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. | | | |
| a | Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:<br>☐ 100% ☑ 150% ☐ 200% ☐ Other ______ % | 3a | ✓ | |
| b | Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:<br>☐ 200% ☑ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other ______ % | 3b | ✓ | |
| c | If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. | | | |
| 4 | Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | 4 | ✓ | |
| 5a | Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a | ✓ | |
| b | If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | ✓ | |
| c | If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? | 5c | | ✓ |
| 6a | Did the organization prepare a community benefit report during the tax year? | 6a | ✓ | |
| b | If "Yes," did the organization make it available to the public? | 6b | ✓ | |

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**

| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|---|---|---|---|---|---|---|
| a Financial Assistance at cost (from Worksheet 1) | 0 | 0 | 498,854 | 0 | 498,854 | 1% |
| b Medicaid (from Worksheet 3, column a) | 0 | 0 | 4,684,774 | 3,939,447 | 745,327 | 1.41% |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | 0 | 0 | 0 | 0 | 0 | 0% |
| d **Total** Financial Assistance and Means-Tested Government Programs | 0 | 0 | 5,183,628 | 3,939,447 | 1,244,181 | 2.41% |
| **Other Benefits** | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | 0 | 0 | 0 | 0 | 0 | 0% |
| f Health professions education (from Worksheet 5) | 0 | 0 | 0 | 0 | 0 | 0% |
| g Subsidized health services (from Worksheet 6) | 0 | 0 | 10,726,657 | 7,399,915 | 3,326,742 | 6.4% |
| h Research (from Worksheet 7) | 0 | 0 | 0 | 0 | 0 | 0% |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | 0 | 0 | 0 | 0 | 0 | 0% |
| j **Total.** Other Benefits | 0 | 0 | 10,726,657 | 7,399,915 | 3,326,742 | 6.4% |
| k **Total.** Add lines 7d and 7j | 0 | 0 | 15,910,285 | 11,339,362 | 4,570,923 | 8.81% |

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

| | | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|---|---|---|---|---|---|---|---|
| 1 | Physical improvements and housing | | | | | | |
| 2 | Economic development | | | | | | |
| 3 | Community support | | | | | | |
| 4 | Environmental improvements | | | | | | |
| 5 | Leadership development and training for community members | | | | | | |
| 6 | Coalition building | | | | | | |
| 7 | Community health improvement advocacy | | | | | | |
| 8 | Workforce development | | | | | | |
| 9 | Other | | | | | | |
| 10 | Total | | | | | | |

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

| | | | | Yes | No |
|---|---|---|---|---|---|
| 1 | Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? | | 1 | ✓ | |
| 2 | Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount | 2 | 2,592,434 | | |
| 3 | Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit | 3 | 1,697,175 | | |
| 4 | Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements. | | | | |

**Section B. Medicare**

| | | | |
|---|---|---|---|
| 5 | Enter total revenue received from Medicare (including DSH and IME) | 5 | 14,407,909 |
| 6 | Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 19,137,103 |
| 7 | Subtract line 6 from line 5. This is the surplus (or shortfall) | 7 | -4,729,194 |
| 8 | Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: | | |

☑ Cost accounting system ☐ Cost to charge ratio ☐ Other

**Section C. Collection Practices**

| | | | Yes | No |
|---|---|---|---|---|
| 9a | Did the organization have a written debt collection policy during the tax year? | 9a | ✓ | |
| b | If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI | 9b | ✓ | |

**Part IV Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

**Part V Facility Information**

**Section A. Hospital Facilities**

(list in order of size, from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year? 13

| Name, address, primary website address, and state license number | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | Other (describe) | Facility reporting group |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 Mount Desert Island Hospital<br>10 Wayman Lane, PO Box 8<br>Bar Harbor, ME, 04609-0008<br>www.mdihospital.org | ✓ | ✓ | | | ✓ | | ✓ | | | |
| 2 Cadillac Family Practice and Behavioral Health Center<br>322 Main Street<br>Bar Harbor, ME, 04609 | | | | | | | | | Outpatient clinic | |
| 3 Cooper Gilmore Health Center<br>17 Hancock Road<br>Bar Harbor, ME, 04609 | | | | | | | | | Outpatient clinic | |
| 4 Trenton Health Center<br>394 Bar Harbor Road<br>Trenton, ME, 04605 | | | | | | | | | Outpatient clinic | |
| 5 Community Health Center<br>16 Community Lane<br>Southwest Harbor, ME, 04679 | | | | | | | | | Outpatient clinic | |
| 6 Family Health Center<br>9 Hancock Road<br>Bar Harbor, ME, 04609 | | | | | | | | | Outpatient Clinic | |
| 7 Women's Health Center<br>8 Wayman Lane<br>Bar Harbor, ME, 04609 | | | | | | | | | Outpatient clinic | |
| 8 Northeast Harbor Clinic<br>Kimball Road<br>Northeast Harbor, ME, 04679 | | | | | | | | | Outpatient clinic | |
| 9 MDI Orthopedic clinic<br>10 Wayman Lane<br>Bar Harbor, ME, 04609 | | | | | | | | | Outpatient Clinic | |
| 10 (Continued on Schedule H, Part VI, Statement 1) | | | | | | | | | | |

**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 facility reporting group** Mount Desert Island Hospital

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 1

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | | |
| 1 | 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 9. | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospital.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 1-Mount Desert Island Hospital**

**Financial Assistance Policy**

| | | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 | Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 | Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 | Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 | Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| | If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a | ☑ Income level | | | |
| b | ☑ Asset level | | | |
| c | ☑ Medical indigency | | | |
| d | ☑ Insurance status | | | |
| e | ☑ Uninsured discount | | | |
| f | ☑ Medicaid/Medicare | | | |
| g | ☑ State regulation | | | |
| h | ☐ Residency | | | |
| i | ☐ Other (describe in Section C) | | | |
| 13 | Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 | Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a | ☑ The policy was posted on the hospital facility's website | | | |
| b | ☐ The policy was attached to billing invoices | | | |
| c | ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d | ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e | ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f | ☑ The policy was available on request | | | |
| g | ☐ Other (describe in Section C) | | | |

**Billing and Collections**

| | | | Yes | No |
|---|---|---|---|---|
| 15 | 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 | 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 | ☑ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☑ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |
| 17 | Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| | If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a | ☐ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☐ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |

**Part V Facility Information** *(continued)* **Facility: 1-Mount Desert Island Hospital**

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | Yes | No |
|---|---|---|---|
| 19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? | 19 | ✓ | |

If "No," indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

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

20 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.

- a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

| | | Yes | No |
|---|---|---|---|
| 21 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? | 21 | | ✓ |
| If "Yes," explain in Section C. | | | |
| 22 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? | 22 | | ✓ |
| If "Yes," explain in Section C. | | | |

**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 facility reporting group** Cadillac Family Practice and Behavioral Health Center

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 2

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | | |
| 1 | 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 9 | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply):<br>a ☑ A definition of the community served by the hospital facility<br>b ☑ Demographics of the community<br>c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community<br>d ☑ How data was obtained<br>e ☑ The health needs of the community<br>f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups<br>g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs<br>h ☑ The process for consulting with persons representing the community's interests<br>i ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs<br>j ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply):<br>a ☑ Hospital facility's website (list url): www.mdihospital.org<br>b ☐ Other website (list url):<br>c ☑ Available upon request from the hospital facility<br>d ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year):<br>a ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA<br>b ☑ Execution of the implementation strategy<br>c ☑ Participation in the development of a community-wide plan<br>d ☑ Participation in the execution of a community-wide plan<br>e ☑ Inclusion of a community benefit section in operational plans<br>f ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA<br>g ☑ Prioritization of health needs in its community<br>h ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community<br>i ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8 a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 2-Cadillac Family Practice and Behavioral Health Cent**

**Financial Assistance Policy**

| | | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 | Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 | Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 | Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 | Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| | If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a | ☑ Income level | | | |
| b | ☑ Asset level | | | |
| c | ☑ Medical indigency | | | |
| d | ☑ Insurance status | | | |
| e | ☑ Uninsured discount | | | |
| f | ☑ Medicaid/Medicare | | | |
| g | ☑ State regulation | | | |
| h | ☐ Residency | | | |
| i | ☐ Other (describe in Section C) | | | |
| 13 | Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 | Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a | ☑ The policy was posted on the hospital facility's website | | | |
| b | ☐ The policy was attached to billing invoices | | | |
| c | ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d | ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e | ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f | ☑ The policy was available on request | | | |
| g | ☐ Other (describe in Section C) | | | |

**Billing and Collections**

| | | | Yes | No |
|---|---|---|---|---|
| 15 | 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 | 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 | ☑ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☑ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |
| 17 | Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| | If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a | ☐ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☐ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |

**Part V Facility Information** *(continued)* **Facility: 2-Cadillac Family Practice and Behavioral Health Cent**

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | Yes | No |
|---|---|---|---|
| 19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . | 19 | ✓ | |
| If "No," indicate why:<br>a ☐ The hospital facility did not provide care for any emergency medical conditions<br>b ☐ The hospital facility's policy was not in writing<br>c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)<br>d ☐ Other (describe in Section C) | | | |

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

| | | Yes | No |
|---|---|---|---|
| 20 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.<br>a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged<br>b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged<br>c ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged<br>d ☐ Other (describe in Section C) | | | |
| 21 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? . . . . . . . . . . . . . . . . . . . . | 21 | | ✓ |
| If "Yes," explain in Section C. | | | |
| 22 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? . . . . . . . . . . . . . . . . . . . . . | 22 | | ✓ |
| If "Yes," explain in Section C. | | | |

**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 facility reporting group** Cooper Gilmore Health Center

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 3

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | | |
| 1 | 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 9 | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospita.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 3-Cooper Gilmore Health Center**

| | **Financial Assistance Policy** | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 | Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 | Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 | Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 | Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| | If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a | ☑ Income level | | | |
| b | ☑ Asset level | | | |
| c | ☑ Medical indigency | | | |
| d | ☑ Insurance status | | | |
| e | ☑ Uninsured discount | | | |
| f | ☑ Medicaid/Medicare | | | |
| g | ☑ State regulation | | | |
| h | ☐ Residency | | | |
| i | ☐ Other (describe in Section C) | | | |
| 13 | Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 | Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a | ☑ The policy was posted on the hospital facility's website | | | |
| b | ☐ The policy was attached to billing invoices | | | |
| c | ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d | ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e | ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f | ☑ The policy was available on request | | | |
| g | ☐ Other (describe in Section C) | | | |
| | **Billing and Collections** | | | |
| 15 | 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 | 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 | ☑ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☑ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |
| 17 | Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| | If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a | ☐ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☐ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |

**Part V Facility Information** *(continued)* **Facility: 3-Cooper Gilmore Health Center**

**18** Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- **a** ☐ Notified individuals of the financial assistance policy on admission
- **b** ☐ Notified individuals of the financial assistance policy prior to discharge
- **c** ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- **d** ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | Yes | No |
|---|---|---|---|
| **19** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? | 19 | ✓ | |

If "No," indicate why:

- **a** ☐ The hospital facility did not provide care for any emergency medical conditions
- **b** ☐ The hospital facility's policy was not in writing
- **c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- **d** ☐ Other (describe in Section C)

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

**20** 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.

- **a** ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** ☐ Other (describe in Section C)

| | | Yes | No |
|---|---|---|---|
| **21** 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? | 21 | | ✓ |
| If "Yes," explain in Section C. | | | |
| **22** 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? | 22 | | ✓ |
| If "Yes," explain in Section C. | | | |

**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 facility reporting group** Trenton Health Center

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 4

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | | |
| 1 | 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 9 | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospital.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 4-Trenton Health Center**

| Financial Assistance Policy | | Yes | No |
|---|---|---|---|
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % | | | |
| If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 % | | | |
| If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a ☑ Income level | | | |
| b ☑ Asset level | | | |
| c ☑ Medical indigency | | | |
| d ☑ Insurance status | | | |
| e ☑ Uninsured discount | | | |
| f ☑ Medicaid/Medicare | | | |
| g ☑ State regulation | | | |
| h ☐ Residency | | | |
| i ☐ Other (describe in Section C) | | | |
| 13 Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a ☑ The policy was posted on the hospital facility's website | | | |
| b ☐ The policy was attached to billing invoices | | | |
| c ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f ☑ The policy was available on request | | | |
| g ☐ Other (describe in Section C) | | | |
| **Billing and Collections** | | | |
| 15 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 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 ☑ Reporting to credit agency | | | |
| b ☐ Lawsuits | | | |
| c ☑ Liens on residences | | | |
| d ☐ Body attachments | | | |
| e ☐ Other similar actions (describe in Section C) | | | |
| 17 Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a ☐ Reporting to credit agency | | | |
| b ☐ Lawsuits | | | |
| c ☐ Liens on residences | | | |
| d ☐ Body attachments | | | |
| e ☐ Other similar actions (describe in Section C) | | | |

**Part V Facility Information** *(continued)* **Facility: 4-Trenton Health Center**

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | Yes | No |
|---|---|---|---|
| 19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . | 19 | ✓ | |

If "No," indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

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

20 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.

- a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

| | | Yes | No |
|---|---|---|---|
| 21 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? . . . . . . . . . . . . . . . . . . . . . . . . | 21 | | ✓ |
| If "Yes," explain in Section C. | | | |
| 22 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? . . . . . . . . . . . . . . . . . . . . . . . | 22 | | ✓ |

If "Yes," explain in Section C.

**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 facility reporting group** Community Health Center

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 5

| | | Line | Yes | No |
|---|---|---|---|---|
| | **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | |
| 1 | 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 9. | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospital.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 5-Community Health Center**

| | | | Yes | No |
|---|---|---|---|---|
| **Financial Assistance Policy** | | | | |
| | Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 | Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 | Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 | Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 | Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| | If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a | ☑ Income level | | | |
| b | ☑ Asset level | | | |
| c | ☑ Medical indigency | | | |
| d | ☑ Insurance status | | | |
| e | ☑ Uninsured discount | | | |
| f | ☑ Medicaid/Medicare | | | |
| g | ☑ State regulation | | | |
| h | ☐ Residency | | | |
| i | ☐ Other (describe in Section C) | | | |
| 13 | Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 | Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a | ☑ The policy was posted on the hospital facility's website | | | |
| b | ☐ The policy was attached to billing invoices | | | |
| c | ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d | ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e | ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f | ☑ The policy was available on request | | | |
| g | ☐ Other (describe in Section C) | | | |
| **Billing and Collections** | | | | |
| 15 | 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 | 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 | ☑ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☑ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |
| 17 | Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| | If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a | ☐ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☐ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |

**Part V** **Facility Information** *(continued)* **Facility: 5-Community Health Center**

**18** Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- **a** ☐ Notified individuals of the financial assistance policy on admission
- **b** ☐ Notified individuals of the financial assistance policy prior to discharge
- **c** ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- **d** ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | Yes | No |
|---|---|---|---|
| **19** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? | 19 | ✓ | |

If "No," indicate why:

- **a** ☐ The hospital facility did not provide care for any emergency medical conditions
- **b** ☐ The hospital facility's policy was not in writing
- **c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- **d** ☐ Other (describe in Section C)

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

**20** 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.

- **a** ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** ☐ Other (describe in Section C)

| | | Yes | No |
|---|---|---|---|
| **21** 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. | 21 | | ✓ |
| **22** 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. | 22 | | ✓ |

**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 facility reporting group** Family Health Center

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 6

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | | |
| 1 | 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 9. | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospital.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* Facility: 6-Family Health Center

### Financial Assistance Policy

| | | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 | Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 | Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 | Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 | Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| | If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a | ☑ Income level | | | |
| b | ☑ Asset level | | | |
| c | ☑ Medical indigency | | | |
| d | ☑ Insurance status | | | |
| e | ☑ Uninsured discount | | | |
| f | ☑ Medicaid/Medicare | | | |
| g | ☑ State regulation | | | |
| h | ☐ Residency | | | |
| i | ☐ Other (describe in Section C) | | | |
| 13 | Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 | Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a | ☑ The policy was posted on the hospital facility's website | | | |
| b | ☐ The policy was attached to billing invoices | | | |
| c | ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d | ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e | ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f | ☑ The policy was available on request | | | |
| g | ☐ Other (describe in Section C) | | | |

### Billing and Collections

| | | | Yes | No |
|---|---|---|---|---|
| 15 | 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 | 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 | ☑ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☑ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |
| 17 | Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| | If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a | ☐ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☐ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |

**Part V** **Facility Information** *(continued)* **Facility: 6-Family Health Center**

**18** Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- **a** ☐ Notified individuals of the financial assistance policy on admission
- **b** ☐ Notified individuals of the financial assistance policy prior to discharge
- **c** ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- **d** ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | Yes | No |
|---|---|---|---|
| **19** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? | 19 | ✓ | |

If "No," indicate why:

- **a** ☐ The hospital facility did not provide care for any emergency medical conditions
- **b** ☐ The hospital facility's policy was not in writing
- **c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- **d** ☐ Other (describe in Section C)

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

**20** 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.

- **a** ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** ☐ Other (describe in Section C)

| | | Yes | No |
|---|---|---|---|
| **21** 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? | 21 | | ✓ |
| If "Yes," explain in Section C. | | | |
| **22** 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? | 22 | | ✓ |
| If "Yes," explain in Section C. | | | |

**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 facility reporting group** Women's Health Center

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 7

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | | |
| 1 | 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 9. . . . . . . . . . . . . . . | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . . . . . . . . . . . . . . . . . . . . . . . . | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? . . . . . . . . . . . . | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospital.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8 a | 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)? . . . . . . . . . . . . . . . . . . . . . . | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . . . | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 7-Women's Health Center**

**Financial Assistance Policy**

| | | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 | Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 | Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 | Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 | Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| | If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a | ☑ Income level | | | |
| b | ☑ Asset level | | | |
| c | ☑ Medical indigency | | | |
| d | ☑ Insurance status | | | |
| e | ☑ Uninsured discount | | | |
| f | ☑ Medicaid/Medicare | | | |
| g | ☑ State regulation | | | |
| h | ☐ Residency | | | |
| i | ☐ Other (describe in Section C) | | | |
| 13 | Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 | Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a | ☑ The policy was posted on the hospital facility's website | | | |
| b | ☐ The policy was attached to billing invoices | | | |
| c | ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d | ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e | ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f | ☑ The policy was available on request | | | |
| g | ☐ Other (describe in Section C) | | | |

**Billing and Collections**

| | | | Yes | No |
|---|---|---|---|---|
| 15 | 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 | 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 | ☑ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☑ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |
| 17 | Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| | If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a | ☐ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☐ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |

**Part V Facility Information** *(continued)* **Facility: 7-Women's Health Center**

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | Yes | No |
|---|---|---|---|
| 19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . | 19 | ✓ | |

If "No," indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

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

20 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.

- a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

| | | Yes | No |
|---|---|---|---|
| 21 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? . . . . . . . . . . . . . . . . . . . . . . . . . . | 21 | | ✓ |
| If "Yes," explain in Section C. | | | |
| 22 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? . . . . . . . . . . . . . . . . . . . . . . | 22 | | ✓ |

If "Yes," explain in Section C.

**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 facility reporting group** Northeast Harbor Clinic

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 8

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | | |
| 1 | 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 9. | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospital.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8 a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 8-Northeast Harbor Clinic**

| **Financial Assistance Policy** | | Yes | No |
|---|---|---|---|
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % | | | |
| If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 % | | | |
| If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a ☑ Income level | | | |
| b ☑ Asset level | | | |
| c ☑ Medical indigency | | | |
| d ☑ Insurance status | | | |
| e ☑ Uninsured discount | | | |
| f ☑ Medicaid/Medicare | | | |
| g ☑ State regulation | | | |
| h ☐ Residency | | | |
| i ☐ Other (describe in Section C) | | | |
| 13 Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a ☑ The policy was posted on the hospital facility's website | | | |
| b ☐ The policy was attached to billing invoices | | | |
| c ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f ☑ The policy was available on request | | | |
| g ☐ Other (describe in Section C) | | | |
| **Billing and Collections** | | | |
| 15 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 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 ☑ Reporting to credit agency | | | |
| b ☐ Lawsuits | | | |
| c ☑ Liens on residences | | | |
| d ☐ Body attachments | | | |
| e ☐ Other similar actions (describe in Section C) | | | |
| 17 Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a ☐ Reporting to credit agency | | | |
| b ☐ Lawsuits | | | |
| c ☐ Liens on residences | | | |
| d ☐ Body attachments | | | |
| e ☐ Other similar actions (describe in Section C) | | | |

**Part V Facility Information** *(continued)* **Facility: 8-Northeast Harbor Clinic**

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | Yes | No |
|---|---|---|---|
| 19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . . | 19 | ✓ | |

If "No," indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

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

20 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.

- a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

| | | Yes | No |
|---|---|---|---|
| 21 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? . . . . . | 21 | | ✓ |
| If "Yes," explain in Section C. | | | |
| 22 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? . . . . . | 22 | | ✓ |
| If "Yes," explain in Section C. | | | |

**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 facility reporting group** MDI Orthopedic clinic

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 9

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | | |
| 1 | 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 9 | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospital.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8 a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 9-MDI Orthopedic clinic**

| **Financial Assistance Policy** | | Yes | No |
|---|---|---|---|
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % | | | |
| If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 % | | | |
| If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a ☑ Income level | | | |
| b ☑ Asset level | | | |
| c ☑ Medical indigency | | | |
| d ☑ Insurance status | | | |
| e ☑ Uninsured discount | | | |
| f ☑ Medicaid/Medicare | | | |
| g ☑ State regulation | | | |
| h ☐ Residency | | | |
| i ☐ Other (describe in Section C) | | | |
| 13 Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a ☑ The policy was posted on the hospital facility's website | | | |
| b ☐ The policy was attached to billing invoices | | | |
| c ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f ☑ The policy was available on request | | | |
| g ☐ Other (describe in Section C) | | | |
| **Billing and Collections** | | | |
| 15 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 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 ☑ Reporting to credit agency | | | |
| b ☐ Lawsuits | | | |
| c ☑ Liens on residences | | | |
| d ☐ Body attachments | | | |
| e ☐ Other similar actions (describe in Section C) | | | |
| 17 Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a ☐ Reporting to credit agency | | | |
| b ☐ Lawsuits | | | |
| c ☐ Liens on residences | | | |
| d ☐ Body attachments | | | |
| e ☐ Other similar actions (describe in Section C) | | | |

**Part V** **Facility Information** *(continued)* **Facility: 9-MDI Orthopedic clinic**

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | | Yes | No |
|---|---|---|---|---|
| 19 | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? | 19 | ✓ | |

If "No," indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

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

20 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.

- a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

| | | | Yes | No |
|---|---|---|---|---|
| 21 | 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. | 21 | | ✓ |
| 22 | 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. | 22 | | ✓ |

**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 facility reporting group** MDI Dermatology Clinic

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 10

| | | Line | Yes | No |
|---|---|---|---|---|
| | **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | |
| 1 | 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 9 | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospital.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8 a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 10-MDI Dermatology Clinic**

| | **Financial Assistance Policy** | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 | Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 | Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % If "No," explain in Section C the criteria the hospital facility used. | 10 | ✓ | |
| 11 | Used FPG to determine eligibility for providing *discounted* care? If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 % If "No," explain in Section C the criteria the hospital facility used. | 11 | ✓ | |
| 12 | Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| | If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a | ☑ Income level | | | |
| b | ☑ Asset level | | | |
| c | ☑ Medical indigency | | | |
| d | ☑ Insurance status | | | |
| e | ☑ Uninsured discount | | | |
| f | ☑ Medicaid/Medicare | | | |
| g | ☑ State regulation | | | |
| h | ☐ Residency | | | |
| i | ☐ Other (describe in Section C) | | | |
| 13 | Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 | Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a | ☑ The policy was posted on the hospital facility's website | | | |
| b | ☐ The policy was attached to billing invoices | | | |
| c | ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d | ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e | ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f | ☑ The policy was available on request | | | |
| g | ☐ Other (describe in Section C) | | | |
| | **Billing and Collections** | | | |
| 15 | 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 | 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 | ☑ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☑ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |
| 17 | Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| | If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a | ☐ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☐ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |

**Part V Facility Information** *(continued)* **Facility: 10-MDI Dermatology Clinic**

**18** Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | Yes | No |
|---|---|---|---|
| **19** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . | 19 | ✓ | |

If "No," indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

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

**20** 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.

- a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

| | | Yes | No |
|---|---|---|---|
| **21** 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? . . . . . . . . . . . . . . . . . . . . . . | 21 | | ✓ |
| If "Yes," explain in Section C. | | | |
| **22** 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? . . . . . . . . . . . . . . . . . . . . . . . | 22 | | ✓ |
| If "Yes," explain in Section C. | | | |

## 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 facility reporting group** MDI Urology Clinic

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 11

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | | |
| 1 | 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 9 | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospital.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 11-MDI Urology Clinic**

| | **Financial Assistance Policy** | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 | Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 | Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 | Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 % | | | |
| | If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 | Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| | If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a | ☑ Income level | | | |
| b | ☑ Asset level | | | |
| c | ☑ Medical indigency | | | |
| d | ☑ Insurance status | | | |
| e | ☑ Uninsured discount | | | |
| f | ☑ Medicaid/Medicare | | | |
| g | ☑ State regulation | | | |
| h | ☐ Residency | | | |
| i | ☐ Other (describe in Section C) | | | |
| 13 | Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 | Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a | ☑ The policy was posted on the hospital facility's website | | | |
| b | ☐ The policy was attached to billing invoices | | | |
| c | ☑ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d | ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e | ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f | ☑ The policy was available on request | | | |
| g | ☐ Other (describe in Section C) | | | |
| | **Billing and Collections** | | | |
| 15 | 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 | 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 | ☑ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☑ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |
| 17 | Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| | If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a | ☐ Reporting to credit agency | | | |
| b | ☐ Lawsuits | | | |
| c | ☐ Liens on residences | | | |
| d | ☐ Body attachments | | | |
| e | ☐ Other similar actions (describe in Section C) | | | |

**Part V** **Facility Information** *(continued)* **Facility: 11-MDI Urology Clinic**

**18** Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | | Yes | No |
|---|---|---|---|---|
| **19** | Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . | 19 | ✓ | |

If "No," indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

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

**20** 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.

- a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

| | | | Yes | No |
|---|---|---|---|---|
| **21** | 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? . . . . . . . . . . . . . . . . . . . . | 21 | | ✓ |
| | If "Yes," explain in Section C. | | | |
| **22** | 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? . . . . . . . . . . . . . . . . . . . . . . | 22 | | ✓ |
| | If "Yes," explain in Section C. | | | |

**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 facility reporting group** MDI General Surgery Clinic

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 12

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | | |
| 1 | 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 9. | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospital.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☐ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8 a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 12-MDI General Surgery Clinic**

**Financial Assistance Policy**

| | | | Yes | No |
|---|---|---|---|---|
| | Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 | Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 | Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for free care: 150 %<br>If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 | Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| | If "Yes," indicate the FPG family income limit for eligibility for discounted care: 250 %<br>If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 | Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| | If "Yes," indicate the factors used in determining such amounts (check all that apply):<br>a ☑ Income level<br>b ☑ Asset level<br>c ☑ Medical indigency<br>d ☑ Insurance status<br>e ☑ Uninsured discount<br>f ☑ Medicaid/Medicare<br>g ☑ State regulation<br>h ☐ Residency<br>i ☐ Other (describe in Section C) | | | |
| 13 | Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 | Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply):<br>a ☑ The policy was posted on the hospital facility's website<br>b ☐ The policy was attached to billing invoices<br>c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms<br>d ☑ The policy was posted in the hospital facility's admissions offices<br>e ☑ The policy was provided, in writing, to patients on admission to the hospital facility<br>f ☑ The policy was available on request<br>g ☐ Other (describe in Section C) | | | |

**Billing and Collections**

| | | | Yes | No |
|---|---|---|---|---|
| 15 | 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 | 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:<br>a ☑ Reporting to credit agency<br>b ☐ Lawsuits<br>c ☑ Liens on residences<br>d ☐ Body attachments<br>e ☐ Other similar actions (describe in Section C) | | | |
| 17 | Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| | If "Yes," check all actions in which the hospital facility or a third party engaged:<br>a ☐ Reporting to credit agency<br>b ☐ Lawsuits<br>c ☐ Liens on residences<br>d ☐ Body attachments<br>e ☐ Other similar actions (describe in Section C) | | | |

**Part V Facility Information** *(continued)* **Facility: 12-MDI General Surgery Clinic**

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a ☐ Notified individuals of the financial assistance policy on admission
- b ☐ Notified individuals of the financial assistance policy prior to discharge
- c ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | Yes | No |
|---|---|---|---|
| 19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . | 19 | ✓ | |

If "No," indicate why:

- a ☐ The hospital facility did not provide care for any emergency medical conditions
- b ☐ The hospital facility's policy was not in writing
- c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d ☐ Other (describe in Section C)

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

20 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.

- a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d ☐ Other (describe in Section C)

| | | Yes | No |
|---|---|---|---|
| 21 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? . . . . . . . . . . . . . . . . . . . . . . . . . | 21 | | ✓ |
| If "Yes," explain in Section C. | | | |
| 22 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? . . . . . . . . . . . . . . . . . . . . . . . . | 22 | | ✓ |

If "Yes," explain in Section C.

**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 facility reporting group** Community Dental Clinic

**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** 13

| | | | Yes | No |
|---|---|---|---|---|
| **Community Health Needs Assessment** (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012) | | | | |
| 1 | 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 9. | 1 | ✓ | |
| | If "Yes," indicate what the CHNA report describes (check all that apply): | | | |
| a | ☑ A definition of the community served by the hospital facility | | | |
| b | ☑ Demographics of the community | | | |
| c | ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | | |
| d | ☑ How data was obtained | | | |
| e | ☑ The health needs of the community | | | |
| f | ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | | |
| g | ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs | | | |
| h | ☑ The process for consulting with persons representing the community's interests | | | |
| i | ☐ Information gaps that limit the hospital facility's ability to assess the community's health needs | | | |
| j | ☐ Other (describe in Section C) | | | |
| 2 | Indicate the tax year the hospital facility last conducted a CHNA: 20 11 | | | |
| 3 | 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 | 3 | ✓ | |
| 4 | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 4 | | ✓ |
| 5 | Did the hospital facility make its CHNA report widely available to the public? | 5 | ✓ | |
| | If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | | |
| a | ☑ Hospital facility's website (list url): www.mdihospital.org | | | |
| b | ☐ Other website (list url): | | | |
| c | ☑ Available upon request from the hospital facility | | | |
| d | ☑ Other (describe in Section C) | | | |
| 6 | If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year): | | | |
| a | ☑ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA | | | |
| b | ☑ Execution of the implementation strategy | | | |
| c | ☑ Participation in the development of a community-wide plan | | | |
| d | ☑ Participation in the execution of a community-wide plan | | | |
| e | ☑ Inclusion of a community benefit section in operational plans | | | |
| f | ☐ Adoption of a budget for provision of services that address the needs identified in the CHNA | | | |
| g | ☑ Prioritization of health needs in its community | | | |
| h | ☑ Prioritization of services that the hospital facility will undertake to meet health needs in its community | | | |
| i | ☐ Other (describe in Section C) | | | |
| 7 | Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs | 7 | ✓ | |
| 8a | 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)? | 8a | | ✓ |
| b | If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? | 8b | | |
| c | If "Yes" to line 8b, 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)* **Facility: 13-Community Dental Clinic**

| **Financial Assistance Policy** | | Yes | No |
|---|---|---|---|
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | | |
| 9 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? | 9 | ✓ | |
| 10 Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care? | 10 | ✓ | |
| If "Yes," indicate the FPG family income limit for eligibility for free care: 150 % | | | |
| If "No," explain in Section C the criteria the hospital facility used. | | | |
| 11 Used FPG to determine eligibility for providing *discounted* care? | 11 | ✓ | |
| If "Yes," indicate the FPG family income limit for eligibility for discounted care: 175 % | | | |
| If "No," explain in Section C the criteria the hospital facility used. | | | |
| 12 Explained the basis for calculating amounts charged to patients? | 12 | ✓ | |
| If "Yes," indicate the factors used in determining such amounts (check all that apply): | | | |
| a ☑ Income level | | | |
| b ☑ Asset level | | | |
| c ☑ Medical indigency | | | |
| d ☑ Insurance status | | | |
| e ☑ Uninsured discount | | | |
| f ☑ Medicaid/Medicare | | | |
| g ☑ State regulation | | | |
| h ☐ Residency | | | |
| i ☐ Other (describe in Section C) | | | |
| 13 Explained the method for applying for financial assistance? | 13 | ✓ | |
| 14 Included measures to publicize the policy within the community served by the hospital facility? | 14 | ✓ | |
| If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | | |
| a ☑ The policy was posted on the hospital facility's website | | | |
| b ☐ The policy was attached to billing invoices | | | |
| c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms | | | |
| d ☑ The policy was posted in the hospital facility's admissions offices | | | |
| e ☑ The policy was provided, in writing, to patients on admission to the hospital facility | | | |
| f ☑ The policy was available on request | | | |
| g ☐ Other (describe in Section C) | | | |
| **Billing and Collections** | | | |
| 15 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 actions the hospital facility may take upon non-payment? | 15 | ✓ | |
| 16 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 ☑ Reporting to credit agency | | | |
| b ☐ Lawsuits | | | |
| c ☑ Liens on residences | | | |
| d ☐ Body attachments | | | |
| e ☐ Other similar actions (describe in Section C) | | | |
| 17 Did the hospital facility or an authorized third 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? | 17 | | ✓ |
| If "Yes," check all actions in which the hospital facility or a third party engaged: | | | |
| a ☐ Reporting to credit agency | | | |
| b ☐ Lawsuits | | | |
| c ☐ Liens on residences | | | |
| d ☐ Body attachments | | | |
| e ☐ Other similar actions (describe in Section C) | | | |

**Part V Facility Information** *(continued)* **Facility: 13-Community Dental Clinic**

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

a ☐ Notified individuals of the financial assistance policy on admission
b ☐ Notified individuals of the financial assistance policy prior to discharge
c ☑ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
d ☑ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
e ☐ Other (describe in Section C)

**Policy Relating to Emergency Medical Care**

| | | Yes | No |
|---|---|---|---|
| 19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . | 19 | ✓ | |

If "No," indicate why:
a ☐ The hospital facility did not provide care for any emergency medical conditions
b ☐ The hospital facility's policy was not in writing
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
d ☐ Other (describe in Section C)

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

20 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.
a ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
c ☑ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
d ☐ Other (describe in Section C)

| | | Yes | No |
|---|---|---|---|
| 21 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. | 21 | | ✓ |
| 22 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. | 22 | | ✓ |

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

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Schedule H, Part V, Section B, Line 3-Mount Desert Island Hospital - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-Cadillac Family Practice and Behavioral Health Center - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-Cooper Gilmore Health Center - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-Trenton Health Center - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-Community Health Center - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-Family Health Center - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-Women's Health Center - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant

## Part V- Section C - Supplemental Information For Part V Secton B (Continued)

communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-Northeast Harbor Clinic - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-MDI Orthopedic clinic - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-MDI Dermatology Clinic - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-MDI Urology Clinic - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-MDI General Surgery Clinic - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 3-Community Dental Clinic - The Hospital Partnered with Healthy Acadia to perform a comprehensive community needs assessment, focused on the overall health of the community. The participants were a multifaceted representation of the community, including business, public health, community health and healthcare providers. Healthy Acadia is dedicated to building vibrant communities and making it easier for people to make healthy choices for themselves and their families. They create lasting improvements to the health of our communities by connecting individuals with health supports, building partnerships, coordinating education and prevention services, and improving policies and environments. Healthy Acadia is a 501c3 non profit with more than 100 partners. They address critical locally defined health priorities across Hancock County. They serve as the Healthy Maine Partnership for Hancock County.

Schedule H, Part V, Section B, Line 5-Mount Desert Island Hospital - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board

## Part V- Section C - Supplemental Information For Part V Secton B (Continued)

Committees.

Schedule H, Part V, Section B, Line 5-Cadillac Family Practice and Behavioral Health Center - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board Committees.

Schedule H, Part V, Section B, Line 5-Cooper Gilmore Health Center - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board Committees.

Schedule H, Part V, Section B, Line 5-Trenton Health Center - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board Committees.

Schedule H, Part V, Section B, Line 5-Community Health Center - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board Committees.

Schedule H, Part V, Section B, Line 5-Family Health Center - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board Committees.

Schedule H, Part V, Section B, Line 5-Women's Health Center - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board Committees.

Schedule H, Part V, Section B, Line 5-Northeast Harbor Clinic - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board Committees.

Schedule H, Part V, Section B, Line 5-MDI Orthopedic clinic - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board Committees.

Schedule H, Part V, Section B, Line 5-MDI Dermatology Clinic - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board Committees.

Schedule H, Part V, Section B, Line 5-MDI Urology Clinic - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board Committees.

Schedule H, Part V, Section B, Line 5-Community Dental Clinic - The Community Health Needs Assessment is available to our community members through our public website and the ongoing implementation and workplan is documented by our Planning and Board Committees.

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

## Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? ______

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

## Part VI Supplemental Information

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.

Schedule H, Part I, Line 7 - The costing methodology utilized for this table were derived from Worksheet 2, Ratio of patient care cost to charges with data from filed cost reports for the filing fiscal year.

Schedule H, Part I, Line 7, Column f - The bad debt expense included on Form 990, Part IX, line 25, Column A, but subtracted for puposes of caculating the percentage in this column is 2,952,434

Schedule H, Part I, Line 7g - The Hospital provides to the community several provider based physician and specialty practices to serve this rural island population. These practices are listed on Part V of this schedule. The facility subsidizes their operating costs to maintain access and coordination of care to our population.

Schedule H, Part III, Section A, Line 4 - Patient accounts receivable are stated at the amount that management expects to collect from outstanding balances. Management provides for probable uncollectible amounts through a charge to operations and a credit to a valuation allowance based on its assessment to individual accounts and historical adjustments. Balances that are still outstanding, after management has used reasonable collection efforts are written off through a charge to the valuation allowance and a credit to the patient accounts receivable. The Hospital follows the Medicare guidelines for allowable bad debts. It uses the following criteria. A. Establishing that reasonable collection efforts were made B. Establishing that the accounts were uncollectible C. Establishing that there is no likelihood of recovery at anytime in the future.

Schedule H, Part III, Section B, Line 8 - The IRS 990H instructions and guidance provide a template in worksheet 2 template as a way to determine the overall cost to charge ratio that could be applied throughout the IRS 990H form in order to convert charges to cost. Where applicable, we have utilized the worksheet 2 template calculation. The only area where we did not utilize this template calculation was in form 990H worksheet B, Line 2 and 6 Medicare allowable costs and payments related to the subsidized health services we utilized the Medicare cost report estimated cost and payment for these services. The Hospital believes that provider based clinics listed in 1C above should be and are considered a community benefit due to the fact that without the Hospital subsidizing and offering the services that these clinics offer, the community at large would have to travel at least 45 to 65 minutes to the nearest like hospital and that hospital's service offerings. As such, Mount Desert Island Hospital believes that by offering and subsidizing these clinics within its community and thus enabling community members to have easy access and an easier commute for these services, that this benefits the whole community at large.

Schedule H, Part III, Section C, Line 9b - The Hospital would not initiate collection efforts against a patient that qualified for a sliding fee scale unless that patient failed to meet their obligation under a mutually agreed upon payment arrangement. After it was determined that the patient did not qualify for a readjustment to their payment terms, the Hospital would follow normal notification practices dictated by our collection policy which may result in the account sent to collections. When a patient is referred out to collections but then applies for free or discounted care, we pull the account back from collections when it is determined they qualify for one of the programs. If the collection agency suspects that someone may need to apply for one of the programs, they send out an application and notify us. We make every effort to screen as many people as possible before we send them to collections. Information about our free and sliding scale programs are

## Part VI- Supplemental Information (Continued)

on our website, on our account statements, posted in public areas and at our provider clinics. We also make available a Patient Financial Counselor to help navigate the process

Schedule H, Part VI, Line 2 - Mount Desert Island Hospital assesses the health needs of the community through the use of a collaborative Community Health Needs Assessment. As a key participant in the CHNA process our institution is able to further address and identify those areas of most concern and need in our community. A community needs assessment is a point in time effort to measure the health and well being of the community. It serves as a constructive tool to and basis for Mount Desert Island Hospital's strategic and subsequent action planning to develop Health Policy Advocacy, allocate resources, improve or expand existing services, implement new programs and collaborate with other community health care providers. A community health needs assessment also serves as a benchmark for future assessment of measured progress toward established community health objectives. The Mount Desert Island Hospital's Community Health Needs Assessment provides an opportunity to gain insight into the needs and assets that are served, it also provides a measure to identify and address the needs of the vulnerable populations with our community. The Mount Desert Island Hospital process was a partnership with Healthy Acadia, a comprehensive community health coalition that was formed in 2001 with the public health funding provided by the Maine Center for Disease Control and Prevention. The Community Health Improvement Plan and Health Needs Assessment were performed using the Mobilizing for Action through Planning and Partnerships process utilizing a broad cross section of our demographic and service area. This process delivered the basis for the assessment which demonstrated the strengths and opportunities for our plan. This process involved gather of two types of data, quantitative demographics, health indicators, local statistics, etc. and qualitative Public Surveys, Focus Groups and Community Stakeholders. The data helps support short-term and long-term decisions about allocation of community human and capital resources. Participants included members of the Hospitals medical staff, nursing staff, board of trustees and administration. Focus groups were used to gain feedback from diverse and remote populations, as an institution that serves the rural and coastal community of Mount Desert Island and the other islands off the Coast of Hancock County, this feedback was essential to continue to develop strategies to meet the needs of our residents. This collaborative effort developed the eight themes for strategic initiatives and goals. The organization reviewed the overarching needs and validated those to the health needs of the community. This process was reviewed and prioritized through the Board Designated Planning Committee of the organization, which developed and maintains oversight of the Hospitals official Community Health Needs Assessment and Implementation Plan. The implementation plan is reviewed periodically. Those items that were not achievable are reviewed and documented as to the barrier for successful implementation and or alternatives.

Schedule H, Part VI, Line 3 - The Financial Assistance Policy application is sent with all account statements, it is printed on the back of the statement. A notice of the FAP is also available on our Hospital website, posted in public areas and available within the departments and clinics of our organization. The hospital provides a Patient Financial Representative to help navigate the process to ensure that our patients have access to care and services they need. MDIH is committed to Providing access to quality healthcare services with compassion, dignity and respect for those we serve, particularly the poor, indigent, and underserved in our communities. Caring for all members of our communities or persons needed care, regardless of their ability to pay for services. Assisting our patients who cannot afford to pay for part or all of the services received by working with our community to address those in need and aid in finding the financial resources available. MDIH has adopted guiding principles when handling the billing, collections and financial support functions for our patients. Provide effective communications with patients regarding hospital bills Make affirmative efforts to help patients apply for public and private financial support programs. We implement policies and procedures for assisting low income patients in a consistent manner. We implement fair and consistent billing and collection practices for all patients with patient payment obligations. We communicate effectively and timely with our patients regarding patient payment obligation. Noting that a patient financial representative is available to assist with triaging patient needs and working with our patients to align resources. This representative is available to explain and review patient payment obligations as well we have a patient advocate to facilitate issues that arise in the course of this process. Information about hospital based financial support polices and external support programs that provide coverage for services are made available to patients during the pre registration and registration processes and or through communications with patients seeking financial assistance. Support is available to uninsured and underinsured patients who do not qualify for public programs or other means of assistance. Notification about financial assistance programs at MDIH, including contact information, is available through messaging included on patient bills, physician offices, public areas, care management staff, registration areas, billing support staff and reception in the hospital, and clinics. Patient brochures describing the financial counseling and assistance services are available in these areas as well as on our public website, mdihospital.org.

Schedule H, Part VI, Line 4 - Mount Desert Island Hospital is a 25 Critical Access Hospital located in Bar Harbor, Maine providing acute, swing, obstetrics and nursery services. It is a not-for profit hospital located in Bar Harbor, Maine Hancock County. The Hospital is licensed by the State of Maine. The mission is to provide compassionate care and strengthen the health of our community by embracing tomorrow's methods and respecting time honored values. Its services include acute inpatient, 24 hours emergency center, and diagnostic and surgical services. Along with hospital services, the Hospital employs the majority of primary and specialty care physicians in the area. The Hospital provides the only Behavioral Health Clinic services in Hancock County. Hancock and Washington county is considered rural by the state of Maine and the United States Census Bureau, under guidelines set forth by the office of Management and Budget OMB. The Hospital

## Part VI- Supplemental Information (Continued)

service area HSA as defined by the Maine Health Data Organization MHDO uses the statistical method where the greatest proportion of residents received their inpatient care.

Schedule H, Part VI, Line 5 - The volunteer Board of Trustees sets the strategic direction for the Hospital and is comprised of community members from the Hospital service area. Mount Desert Island Hospital non-profit status allows the Hospital to reinvest any excess of revenues over expense back into the Hospital to continuously improve the medical care it delivers. The Hospital provides staff and space to the community for Health Forums, Medical Certification Courses, Physician Education, Nutrition Education, Advocacy, Community Health Forums, Vaccination Clinics, Public Kiosks to access Healthcare.gov, and a Public Website with links to Healthy Choices. The Hospital works with the local YMCA to promote healthy choices and early education about exercise benefits to the youth of the area. The Hospital engages with the school systems to provide Nurses and Health Coaches to promote the health of the community and sponsors and annual Health Fair for the community to educate and engage the members of the community about choosing wisely and healthy options within their lifestyles. Mount Desert Island Hospital Organization was able to maintain and expand its ongoing Affordable Care Act outreach, enrollment and education efforts during the 2015 open enrollment period on the Health Insurance Marketplace. This was achieved through broadening our base of Certified Application Counselors, which now includes public affairs and care management professionals in addition to patient advocacy representatives and finance specialists. MDI Hospital Organization certified 9 CACs in advance of 2015 open enrollment, which allowed for a robust outreach and education schedule. During the 2015 open enrollment period, MDI Hospital Organization CACs provided enrollment counseling through public enrollment sessions, private appointments, telephone, social media and one-on-one support. MDI Hospital Organization application counselors also provided and will continue to offer counseling to those with questions about how best to utilize their new health insurance coverage through one-on-one, telephone, email and social media support. By expanding our public outreach to local eateries, we connected with a demographic that we had not previously reached, such as area retail and restaurant employees as well as local small business owners. By meeting our community in an environment that was comfortable to them, we removed their hesitancy to explore their options. Additionally, we found that the people we met during this outreach were more apt to share their experience with friends, coworkers and family, so our outreach began to spread much more organically through word of mouth. By expanding our social media outreach, we removed another barrier to access for many people, allowing them to connect with us through text and social media messaging. Our Facebook outreach was not only done through our organization's Facebook page, but through specifically targeted Facebook groups formed around sharing public events and employment options. As a result, we received many email, social media and text inquiries and referrals. By certifying application counselors across a wide variety of disciplines, we were able to more fully integrate our outreach efforts and offer support to a broader community base.

**Description of Facility Information**

| Name, Address, Website and License No. | C1 | C2 | C3 | C4 | C5 | C6 | C7 | C8 | Other | FRG |
|---|---|---|---|---|---|---|---|---|---|---|
| MDI Dermatology Clinic<br>322 Main Street<br>Bar Harbor, ME, 04609 | | | | | | | | | Outpatient Clinic | |
| MDI Urology Clinic<br>322 Main Street<br>Bar Harbor, ME, 04609 | | | | | | | | | Outpatient Clinic | |
| MDI General Surgery Clinic<br>17 Hancock Road<br>Bar Harbor, ME, 04609 | | | | | | | | | Outpatient clinic | |
| Community Dental Clinic<br>16 Community Lane<br>Southwest Harbor, ME, 04679<br>www.mdihospital.org | | | | | | | | Yes | Outpatient Clinic | |

C1 = Licensed hospital
C2 = General medical and surgical
C3 = Children's hospital
C4 = Teaching hospital
C5 = Critical Access hospital
C6 = Research facility
C7 = ER - 24 hours
C8 = ER - other
FRG = Facility reporting group

**SCHEDULE J** (Form 990)

Department of the Treasury
Internal Revenue Service

# Compensation Information

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

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule J (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

**2013**

**Open to Public Inspection**

Name of the organization: MOUNT DESERT ISLAND HOSPITAL

Employer identification number: 01-0211797

## Part I Questions Regarding Compensation

| | | | Yes | No |
|---|---|---|---|---|
| **1a** | Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.<br>☐ First-class or charter travel ☐ Housing allowance or residence for personal use<br>☐ Travel for companions ☐ Payments for business use of personal residence<br>☐ Tax indemnification and gross-up payments ☑ Health or social club dues or initiation fees<br>☐ Discretionary spending account ☐ Personal services (e.g., maid, chauffeur, chef) | | | |
| **b** | If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain | 1b | ✓ | |
| **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 in line 1a? | 2 | ✓ | |
| **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.<br>☐ Compensation committee ☑ Written employment contract<br>☐ Independent compensation consultant ☑ Compensation survey or study<br>☐ Form 990 of other organizations ☑ Approval by the board or compensation committee | | | |
| **4** | During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization: | | | |
| **a** | Receive a severance payment or change-of-control payment? | 4a | | ✓ |
| **b** | Participate in, or receive payment from, a supplemental nonqualified retirement plan? | 4b | | ✓ |
| **c** | Participate in, or receive payment from, an equity-based compensation arrangement?<br>If "Yes" to any of lines 4a–c, list the persons and provide the applicable amounts for each item in Part III. | 4c | | ✓ |
| | **Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5–9.** | | | |
| **5** | For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: | | | |
| **a** | The organization? | 5a | | ✓ |
| **b** | Any related organization?<br>If "Yes" to line 5a or 5b, describe in Part III. | 5b | | ✓ |
| **6** | For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: | | | |
| **a** | The organization? | 6a | | ✓ |
| **b** | Any related organization?<br>If "Yes" to line 6a or 6b, describe in Part III. | 6b | | ✓ |
| **7** | For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III | 7 | | ✓ |
| **8** | Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III | 8 | | ✓ |
| **9** | If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? | 9 | | |

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

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

**Note.** The sum of columns (B)(i)–(iii) 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 reported as deferred in prior Form 990 |
|---|---|---|---|---|---|---|---|---|
| | | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| 1 Arthur J Blank, President and CEO | (i) | 314,555 | 0 | 0 | 17,500 | 34,783 | 366,838 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2 Christina M Harding, CFO/VP of Finance | (i) | 164,345 | 0 | 0 | 0 | 12,970 | 177,315 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 3 Stuart Davidson, Physician | (i) | 480,974 | 0 | 0 | 17,500 | 37,120 | 535,594 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4 Michael Heniser, Physician | (i) | 382,683 | 0 | 0 | 17,500 | 27,638 | 427,821 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 5 Michelle Kinbrook, Physician | (i) | 282,577 | 0 | 0 | 17,500 | 27,876 | 327,953 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 6 Kendra Blount, General Surgeon | (i) | 288,257 | 0 | 0 | 17,500 | 37,120 | 342,877 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7 Tanya Hanke, Physician | (i) | 251,959 | 0 | 0 | 0 | 16,774 | 268,733 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 8 David Painter, MD | (i) | 183,062 | 0 | 0 | 17,500 | 34,313 | 234,875 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 9 | (i) | | | | | | | |
| | (ii) | | | | | | | |
| 10 | (i) | | | | | | | |
| | (ii) | | | | | | | |
| 11 | (i) | | | | | | | |
| | (ii) | | | | | | | |
| 12 | (i) | | | | | | | |
| | (ii) | | | | | | | |
| 13 | (i) | | | | | | | |
| | (ii) | | | | | | | |
| 14 | (i) | | | | | | | |
| | (ii) | | | | | | | |
| 15 | (i) | | | | | | | |
| | (ii) | | | | | | | |
| 16 | (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.

Schedule J, Part I, Line 1a - The Hospital provides the CEO's fitness membership, which is approximately $399 per year. MDI Hospital reimburses all other benefited employees up to $100 per year toward the YMCA or other health club membership with appropriate supporting documentation.

Schedule J, Part I, Line 7 - Fitness memberships

SCHEDULE K
(Form 990)

Department of the Treasury
Internal Revenue Service

# Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule K (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047
2013
**Open to Public Inspection**

Name of the organization: MOUNT DESERT ISLAND HOSPITAL

Employer identification number: 01-0211797

## Part I Bond Issues

| | (a) Issuer name | (b) Issuer EIN | (c) CUSIP # | (d) Date issued | (e) Issue price | (f) Description of purpose | (g) Defeased Yes | (g) Defeased No | (h) On behalf of issuer Yes | (h) On behalf of issuer No | (i) Pooled financing Yes | (i) Pooled financing No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A | MHHEFA 2006F Bond | | | 07/03/2005 | 707,200 | Replacement of central chiller | | ✓ | | ✓ | | ✓ |
| B | MHHEFA 2007B Bond | | | 07/03/2007 | 4,427,988 | Clinic construction, office and clinic space | | ✓ | | ✓ | | ✓ |
| C | MHEFFA 2010 Bond | | | 07/01/2010 | 1,200,000 | Refinancing of 98A Bond for renovation of outpatient service area | | ✓ | | ✓ | | ✓ |
| D | | | | | | | | | | | | |

## Part II Proceeds

| | | A | B | C | D |
|---|---|---|---|---|---|
| 1 | Amount of bonds retired | 0 | 0 | 0 | |
| 2 | Amount of bonds legally defeased | 0 | 0 | 0 | |
| 3 | Total proceeds of issue | 707,200 | 4,427,988 | 1,200,000 | |
| 4 | Gross proceeds in reserve funds | 0 | 0 | 0 | |
| 5 | Capitalized interest from proceeds | 0 | 0 | 0 | |
| 6 | Proceeds in refunding escrows | 0 | 0 | 0 | |
| 7 | Issuance costs from proceeds | 0 | 0 | 0 | |
| 8 | Credit enhancement from proceeds | 0 | 0 | 0 | |
| 9 | Working capital expenditures from proceeds | 0 | 0 | 0 | |
| 10 | Capital expenditures from proceeds | 707,200 | 4,427,988 | 0 | |
| 11 | Other spent proceeds | 0 | 0 | 1,200,000 | |
| 12 | Other unspent proceeds | 0 | 0 | 0 | |
| 13 | Year of substantial completion | 2008 | 2009 | 1999 | |

| | | A Yes | A No | B Yes | B No | C Yes | C No | D Yes | D No |
|---|---|---|---|---|---|---|---|---|---|
| 14 | Were the bonds issued as part of a current refunding issue? | | ✓ | | ✓ | ✓ | | | |
| 15 | Were the bonds issued as part of an advance refunding issue? | | ✓ | | ✓ | | ✓ | | |
| 16 | Has the final allocation of proceeds been made? | ✓ | | ✓ | | ✓ | | | |
| 17 | Does the organization maintain adequate books and records to support the final allocation of proceeds? | ✓ | | ✓ | | ✓ | | | |

## Part III Private Business Use

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

## Part III Private Business Use *(Continued)*

| | | A Yes | A No | B Yes | B No | C Yes | C No | D Yes | D No |
|---|---|---|---|---|---|---|---|---|---|
| 3a | Are there any management or service contracts that may result in private business use of bond-financed property? | | ✓ | | ✓ | | ✓ | | |
| b | If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property? | | | | | | | | |
| c | Are there any research agreements that may result in private business use of bond-financed property? | | ✓ | | ✓ | | ✓ | | |
| d | If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property? | | | | | | | | |
| 4 | Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶ | 0 % | | 0 % | | 0 % | | % | |
| 5 | Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶ | 0 % | | 0 % | | 0 % | | % | |
| 6 | Total of lines 4 and 5 | 0 % | | 0 % | | 0 % | | % | |
| 7 | Does the bond issue meet the private security or payment test? | ✓ | | ✓ | | ✓ | | | |
| 8a | Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? | | ✓ | | ✓ | | ✓ | | |
| b | If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of | % | | % | | % | | % | |
| c | If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? | | | | | | | | |
| 9 | Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? | ✓ | | ✓ | | ✓ | | | |

## Part IV Arbitrage

| | | A Yes | A No | B Yes | B No | C Yes | C No | D Yes | D No |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? | | ✓ | | ✓ | | ✓ | | |
| 2 | If "No" to line 1, did the following apply? | | | | | | | | |
| a | Rebate not due yet? | | ✓ | | ✓ | | ✓ | | |
| b | Exception to rebate? | | ✓ | | ✓ | | ✓ | | |
| c | No rebate due? | | ✓ | | ✓ | | ✓ | | |
| | If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed | | | | | | | | |
| 3 | Is the bond issue a variable rate issue? | | ✓ | | ✓ | | ✓ | | |
| 4a | Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? | | ✓ | | ✓ | | ✓ | | |
| b | Name of provider | | | | | | | | |
| c | Term of hedge | | | | | | | | |
| d | Was the hedge superintegrated? | | | | | | | | |
| e | Was the hedge terminated? | | | | | | | | |

## Part IV Arbitrage *(Continued)*

| | A | | B | | C | | D | |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 5a Were gross proceeds invested in a guaranteed investment contract (GIC)? | | ✓ | | ✓ | | ✓ | | |
| b Name of provider | | | | | | | | |
| c Term of GIC | | | | | | | | |
| d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied? | | | | | | | | |
| 6 Were any gross proceeds invested beyond an available temporary period? | | ✓ | | ✓ | | ✓ | | |
| 7 Has the organization established written procedures to monitor the requirements of section 148? | ✓ | | ✓ | | ✓ | | | |

## Part V Procedures To Undertake Corrective Action

| | A | | B | | C | | D | |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations? | | | | | | | | |

## Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K (see instructions).

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

Department of the Treasury
Internal Revenue Service

# Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.
▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047
**2013**
**Open To Public Inspection**

Name of the organization: MOUNT DESERT ISLAND HOSPITAL
Employer identification number: 01-0211797

**Part I** **Excess Benefit Transactions** (section 501(c)(3) and section 501(c)(4) organizations only).
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

| 1 (a) Name of disqualified person | (b) Relationship between disqualified person and organization | (c) Description of transaction | (d) Corrected? Yes | No |
|---|---|---|---|---|
| (1) | | | | |
| (2) | | | | |
| (3) | | | | |
| (4) | | | | |
| (5) | | | | |
| (6) | | | | |

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 . . . ▶ $

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

**Part II** **Loans to and/or From Interested Persons.**
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

| (a) Name of interested person | (b) Relationship with organization | (c) Purpose of loan | (d) Loan to or from the organization? | | (e) Original principal amount | (f) Balance due | (g) In default? | | (h) Approved by board or committee? | | (i) Written agreement? | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | To | From | | | Yes | No | Yes | No | Yes | No |
| (1) | | | | | | | | | | | | |
| (2) | | | | | | | | | | | | |
| (3) | | | | | | | | | | | | |
| (4) | | | | | | | | | | | | |
| (5) | | | | | | | | | | | | |
| (6) | | | | | | | | | | | | |
| (7) | | | | | | | | | | | | |
| (8) | | | | | | | | | | | | |
| (9) | | | | | | | | | | | | |
| (10) | | | | | | | | | | | | |
| Total . . . ▶ $ | | | | | | | | | | | | |

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

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of assistance | (d) Type of assistance | (e) Purpose of assistance |
|---|---|---|---|---|
| (1) | | | | |
| (2) | | | | |
| (3) | | | | |
| (4) | | | | |
| (5) | | | | |
| (6) | | | | |
| (7) | | | | |
| (8) | | | | |
| (9) | | | | |
| (10) | | | | |

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

| | (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? Yes | No |
|---|---|---|---|---|---|---|
| (1) | J and D Imaging John Benson MD | Board member | 379,708 | Equipment leasing and radiology se | | ✓ |
| (2) | | | | | | |
| (3) | | | | | | |
| (4) | | | | | | |
| (5) | | | | | | |
| (6) | | | | | | |
| (7) | | | | | | |
| (8) | | | | | | |
| (9) | | | | | | |
| (10) | | | | | | |

**Part V Supplemental Information**
Provide additional information for responses to questions on Schedule L (see instructions).

Schedule L, Part I, Line 1 - John Benson, MD is the propiretor of J&D Imaging Co. J&D Imaging does consulting for MDI Hospital in the form of radiology services performed by Dr. John Benson. MDI Hospital also leases radiology equipment from J&D Imaging. Although Dr. Benson is a member of the Board of Directors of MDI Hospital, he abstains from any situation which may be deemed a conflict of interest, and duly reports and compeltes required disclosures.

**SCHEDULE M (Form 990)**

Department of the Treasury
Internal Revenue Service

# Noncash Contributions

▶ Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
▶ Attach to Form 990.
▶ Information about Schedule M (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

**2013**

**Open To Public Inspection**

Name of the organization: MOUNT DESERT ISLAND HOSPITAL

Employer identification number: 01-0211797

## Part I Types of Property

| | | (a) Check if applicable | (b) Number of contributions or items contributed | (c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g | (d) Method of determining noncash contribution amounts |
|---|---|---|---|---|---|
| 1 | Art—Works of art | | | | |
| 2 | Art—Historical treasures | | | | |
| 3 | Art—Fractional interests | | | | |
| 4 | Books and publications | | | | |
| 5 | Clothing and household goods | | | | |
| 6 | Cars and other vehicles | | | | |
| 7 | Boats and planes | | | | |
| 8 | Intellectual property | | | | |
| 9 | Securities—Publicly traded | ✓ | 7 | 515,927 | Fair Market Value |
| 10 | Securities—Closely held stock | | | | |
| 11 | Securities—Partnership, LLC, or trust interests | | | | |
| 12 | Securities—Miscellaneous | | | | |
| 13 | Qualified conservation contribution—Historic structures | | | | |
| 14 | Qualified conservation contribution—Other | | | | |
| 15 | Real estate—Residential | | | | |
| 16 | Real estate—Commercial | | | | |
| 17 | Real estate—Other | | | | |
| 18 | Collectibles | | | | |
| 19 | Food inventory | | | | |
| 20 | Drugs and medical supplies | | | | |
| 21 | Taxidermy | | | | |
| 22 | Historical artifacts | | | | |
| 23 | Scientific specimens | | | | |
| 24 | Archeological artifacts | | | | |
| 25 | Other ▶ ( ) | | | | |
| 26 | Other ▶ ( ) | | | | |
| 27 | Other ▶ ( ) | | | | |
| 28 | Other ▶ ( ) | | | | |

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement . . . . . 29 | 0

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

**Part II** **Supplemental Information.** Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

Schedule M, Part I, Line 32b - The hospital policy requires that sotck donations are immediately sold by the Advisors Account to which they are received.

**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.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

**2013**

**Open to Public Inspection**

| Name of the organization | Employer identification number |
|---|---|
| MOUNT DESERT ISLAND HOSPITAL | 01-0211797 |

Form 990, Part III, Line 2 - Oral Health Services Reference Part III, Line 4a of 990

Form 990, Part VI, Section B, Line 11b - The initial review of the Form 990 is performed by the Finance Sub Committee of the Board of Directors of the Hospital. The members are provided with an electronic copy of the Form 990 and all supporting schedules (printed versions are also available upon request). Once reviewed by the Finance Sub-Committee, all Board of Trustees members are provided with a copy of the Form 990 and supporting schedules for review. Board Members are given the opportunity to comment and review. Both the CEO, President and CFO, Vice President are available to answer any inquiries. Board Members are also given the opportunity to receive the final copy via an electronic format or a printed copy.

Form 990, Part VI, Section B, Line 12c - Per the conflict of interest policy, the organization monitors and enforces disclosure compliance of interests that could give rise to conflicts by officers, directors, or trustees and key employees. disclosures are completed and submitted to the CEO. Board members will abstain from discussions or approval if there is even an appearance of possible conflict of interest during meetings.

Form 990, Part VI, Section B, Line 15 - The compensation for the President and CEO of MDI Hospital is reviewed and approved by the governing body of the organization. The governing body uses market data from an independent source to compare compensation models of similar size organizations within like demographiscs and geographical similarities to align compensation packages. Other officers and key employees' compensation is reviewed by the Human Resource Department of the organization using the same market data guidelines to compare compensation for these positions relative to like organizations with like demographic and geographic similarities.

Form 990, Part VI, Section C, Line 19 - The annual report and Form 990, including financial information is available to the public through our website at mdihospital.org. Additional financial information is available on federal and state governmental websites for required reporting. Governing documents and conflict of interest policy are available upon request, as are audited financial statements.

Form 990, Part XI, Line 9 - Changes in pledges rec, value of beneficial interest in perpetual trust

**Reasonable Cause Explanations**

| Explanation |
|---|
| no late filing |

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. ▶ See separate instructions.
▶ Information about Schedule R (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047
2013
**Open to Public Inspection**

Name of the organization: MOUNT DESERT ISLAND HOSPITAL
Employer identification number: 01-0211797

**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 |
|---|---|---|---|---|---|
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |
| (6) | | | | | |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? Yes | No |
|---|---|---|---|---|---|---|---|
| (1) Birch Bay Village Retirement Community (01-0481696) 10 Wayman Lane, Bar Harbor, ME 04609 | Retirement Community | ME | 501(c)(3) | 170(b)(1)(A)(iii) | Mount Desert Island Hospital | | ✓ |
| (2) | | | | | | | |
| (3) | | | | | | | |
| (4) | | | | | | | |
| (5) | | | | | | | |
| (6) | | | | | | | |
| (7) | | | | | | | |

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

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

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512(b)(13) controlled entity? | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Yes | No |
| (1) Mount Desert Management Company (01-053877( PO Box 8 10 Wayman Lane, Bar Harbor, ME 04609 | Real Estate Development | ME | Birch Bay Village | C | | | 100% | | ✓ |
| (2) Hancock County Community Health LLC (46-427! 4 Community Lane PO Box 731, Southwest Harbor, N | Lease dental provider services | ME | | C | 50 | 50 | 50% | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| (5) | | | | | | | | | |
| (6) | | | | | | | | | |
| (7) | | | | | | | | | |

## 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.

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

**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 |
|---|---|---|---|
| See Schedule R, Part VII, Statement 1 | | | |
| (1) | | | |
| (2) | | | |
| (3) | | | |
| (4) | | | |
| (5) | | | |
| (6) | | | |

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

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

| (a) Name, address, and EIN of entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (e) Are all partners section 501(c)(3) organizations? | | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? | | (i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Yes | No | | | Yes | No | | Yes | No | |
| (1) | | | | | | | | | | | | | |
| (2) | | | | | | | | | | | | | |
| (3) | | | | | | | | | | | | | |
| (4) | | | | | | | | | | | | | |
| (5) | | | | | | | | | | | | | |
| (6) | | | | | | | | | | | | | |
| (7) | | | | | | | | | | | | | |
| (8) | | | | | | | | | | | | | |
| (9) | | | | | | | | | | | | | |
| (10) | | | | | | | | | | | | | |
| (11) | | | | | | | | | | | | | |
| (12) | | | | | | | | | | | | | |
| (13) | | | | | | | | | | | | | |
| (14) | | | | | | | | | | | | | |
| (15) | | | | | | | | | | | | | |
| (16) | | | | | | | | | | | | | |

**Part VII** **Supplemental Information**

Provide additional information for responses to questions on Schedule R (see instructions).

**Description of Covered Relationships and Transaction Thresholds**

| | | Amt. Involved |
|---|---|---|
| **Name** | Birch Bay Village Retirement Community | 32,400 |
| **Transaction type** | a-iv | |
| **Method of determining amt. involved** | building costs allocated by square footage equal to amount of rent charged | |
| **Name** | Birch Bay Village Retirement Community | 119,970 |
| **Transaction type** | q | |
| **Method of determining amt. involved** | Receivable account - a receivable account is maintained on the general ledger of MDI Hospital, as well as an accounts payable account on the general ledger of Birch Bay Village Retirement Community. Transfers to the Birch Bay Village Retirement Community are recorded as receivables at the time of transfer. A detail of this account in maintained in order to provide this information. | |