

PUBLIC DISCLOSURE COPY

Form **990**
(Rev. January 2020)
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)

OMB No. 1545-0047

2019

Open to Public Inspection

Do not enter social security numbers on this form as it may be made public.
Go to www.irs.gov/Form990 for instructions and the latest information.

A For the **2019** calendar year, or tax year beginning **OCT 1, 2019** and ending **SEP 30, 2020**

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization NAPLES COMMUNITY HOSPITAL, INC.		D Employer identification number 59-0694358
	Doing business as		E Telephone number 239-624-6338
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	
	P.O. BOX 413029		G Gross receipts \$ 622,282,984.
City or town, state or province, country, and ZIP or foreign postal code NAPLES, FL 34101-3029		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
F Name and address of principal officer: RICK WYLES SAME AS C ABOVE		H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		If "No," attach a list. (see instructions)	
J Website: WWW.NCHMD.ORG		H(c) Group exemption number	
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other		L Year of formation: 1957	M State of legal domicile: FL

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: HELPING EVERYONE LIVE A LONGER, HAPPIER, AND HEALTHIER LIFE.		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	13
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	11
	5 Total number of individuals employed in calendar year 2019 (Part V, line 2a)	5	4266
	6 Total number of volunteers (estimate if necessary)	6	880
	7 a Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
b Net unrelated business taxable income from Form 990-T, line 39	7b	0.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	17,104,627.	35,373,583.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	516,992,282.	487,722,549.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	12,901,077.	12,898,641.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	14,980,420.	13,314,548.
		561,978,406.	549,309,321.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	6,000.	6,000.
	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)	242,818,295.	242,724,917.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b Total fundraising expenses (Part IX, column (D), line 25)	5,644.	
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	266,932,851.	283,188,416.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	509,757,146.	525,919,333.	
19 Revenue less expenses. Subtract line 18 from line 12	52,221,260.	23,389,988.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21 Total liabilities (Part X, line 26)	816,364,702.	941,706,179.
	22 Net assets or fund balances. Subtract line 21 from line 20	189,315,894.	290,021,107.
	627,048,808.	651,685,072.	

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		
	RICK WYLES, CHIEF FINANCIAL OFFICER Type or print name and title				
Paid Preparer Use Only	Print/Type preparer's name REBEKUH ELEY	Preparer's signature	Date 08/12/21	Check if self-employed <input type="checkbox"/>	PTIN P01247672
	Firm's name RSM US LLP	Firm's EIN 42-0714325	Phone no. 312-634-3400		
	Firm's address 30 S. WACKER DRIVE, STE 3300 CHICAGO, IL 60606				

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: HELPING EVERYONE LIVE A LONGER, HAPPIER, AND HEALTHIER LIFE.

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

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

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

4a (Code:) (Expenses \$ 456,451,417. including grants of \$ 6,000.) (Revenue \$ 499,328,424.) SEE SCHEDULE O

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

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

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

4e Total program service expenses 456,451,417.

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)? <i>If "Yes," complete Schedule A</i>	X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ?	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		X
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? <i>If "Yes," complete Schedule C, Part II</i>		X
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? <i>If "Yes," complete Schedule C, Part III</i>		X
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? <i>If "Yes," complete Schedule D, Part I</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		X
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? <i>If "Yes," complete Schedule D, Part IV</i>		X
10 Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi endowments? <i>If "Yes," complete Schedule D, Part V</i>	X	
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? <i>If "Yes," complete Schedule D, Part VI</i>	X	
b Did the organization report an amount for investments - other securities in Part X, line 12, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>		X
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? <i>If "Yes," complete Schedule D, Part VIII</i>		X
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? <i>If "Yes," complete Schedule D, Part IX</i>	X	
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>	X	
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14a Did the organization maintain an office, employees, or agents outside of the United States?		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>		X
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? <i>If "Yes," complete Schedule F, Parts II and IV</i>		X
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? <i>If "Yes," complete Schedule F, Parts III and IV</i>		X
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? <i>If "Yes," complete Schedule G, Part I</i>		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	X	
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>		X

Part IV Checklist of Required Schedules (continued)

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

Note: All Form 990 filers are required to complete Schedule O

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

	Yes	No
1a Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable		
b Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable		
c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	X	

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

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

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year (13); 1b Enter the number of voting members included on line 1a, above, who are independent (11); 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? (X); 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person? (X); 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? (X); 5 Did the organization become aware during the year of a significant diversion of the organization's assets? (X); 6 Did the organization have members or stockholders? (X); 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? (X); 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? (X); 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body? (X); b Each committee with authority to act on behalf of the governing body? (X); 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses on Schedule O (X).

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates? (X); 10b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? (X); 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990.; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13 (X); 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (X); 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done (X); 13 Did the organization have a written whistleblower policy? (X); 14 Did the organization have a written document retention and destruction policy? (X); 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? a The organization's CEO, Executive Director, or top management official (X); b Other officers or key employees of the organization (X); If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).; 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? (X); 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? (X).

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed FL
18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. [X] Own website [] Another's website [X] Upon request [] Other (explain on Schedule O)
19 Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records RICK WYLES, CHIEF FINANCIAL OFFICER - 239-624-4005 350 SEVENTH STREET NORTH, NAPLES, FL 34102-3029

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

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

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

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) ALLEN S. WEISS, M.D. TERM 01/19 FORMER PRESIDENT/CEO/TRUSTEE	0.00 0.00						X	1,036,752.	0.	26,002.
(2) PHILLIP DUTCHER CHIEF OPERATING OFFICER SYSTEM	40.00 5.00			X				794,620.	0.	13,684.
(3) KEVIN D. COOPER TERM 01/19 FORMER CHIEF OF STAFF	0.00 0.00						X	595,431.	0.	22,324.
(4) FRANK ASTOR, M.D. TERM 11/19 CHIEF MEDICAL OFFICER	40.00 5.00			X				567,013.	0.	28,107.
(5) RICK WYLES CFO/ASSISTANT TREASURER	40.00 5.00			X				474,496.	0.	33,122.
(6) JONATHAN KLING, R.N. CHIEF NURSING OFFICER	40.00 5.00			X				468,304.	0.	32,450.
(7) ZACHARY BOSTOCK TERM 03/20 CHIEF ADMINISTRATIVE OFFICER	40.00 5.00			X				463,099.	0.	33,703.
(8) LINDA ROEBACK TERM 05/20 CHIEF COUNSEL	40.00 5.00			X				383,672.	0.	25,908.
(9) CHARLES GRAEBER, M.D. PROGRAM DIRECTOR, INT. MED. RES.	40.00 0.00					X		387,403.	0.	12,463.
(10) RENEE M. THIGPEN CHIEF HR OFFICER	40.00 5.00			X				336,163.	0.	28,917.
(11) MICHAEL RILEY CHIEF STRATEGY OFFICER	40.00 5.00			X				333,178.	0.	28,007.
(12) GARY TOMCIK TERM 04/20 CHIEF EXPERIENCE OFFICER	40.00 5.00			X				294,837.	0.	33,712.
(13) PAUL HILTZ PRESIDENT/CEO/TRUSTEE	40.00 5.00	X		X				286,692.	0.	6,163.
(14) KIM THORP DIRECTOR OF PHARMACY NCH HEALTHCARE	40.00 0.00					X		206,757.	0.	31,823.
(15) NOBLE ARRINGTON CONTROLLER	40.00 0.00					X		198,528.	0.	30,935.
(16) ILIA ECHEVARRIA, R.N. ASSOCIATE CHIEF NURSE PROF. PRACTICE	40.00 0.00					X		203,495.	0.	21,279.
(17) GINA TEEGARDEN, R.N. ASSOCIATE CHIEF NURSE OPERATIONS	40.00 0.00					X		198,714.	0.	16,542.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) PATRICK MULCAHY TRUSTEE TERM 05/20	40.50 1.50	X						96,208.	0.	19,773.
(19) CHRISTINA CARRANZA, R.N. TRUSTEE TERM 05/20	40.50 1.50	X						67,515.	0.	23,400.
(20) JIM MAHON START 11/19 CHIEF PHILANTHROPY OFFICER	40.00 5.00			X				83,489.	0.	0.
(21) SCOTT LUTGERT CHAIRMAN	0.50 1.50	X		X				0.	0.	0.
(22) KEVIN BEEBE 1ST VICE CHAIRMAN/SECRETARY	0.50 1.50	X		X				0.	0.	0.
(23) JANICE TEAL TRUSTEE START 05/20	0.50 1.50	X						0.	0.	0.
(24) MICHAEL WYNN 2ND VICE CHAIRMAN	0.50 1.50	X		X				0.	0.	0.
(25) DAVEY SCOON TREASURER	0.50 1.50	X		X				0.	0.	0.
(26) MARIANN MACDONALD EMERITUS BOARD CHAIRWOMAN	0.50 1.50	X		X				0.	0.	0.
1b Subtotal								7,476,366.	0.	468,314.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								7,476,366.	0.	468,314.

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 255

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
CERNER CORPORATION P.O. BOX 412702, KANSAS CITY, MO 64141	IT SUPPORT	12,506,032.
NTHRIVE P.O. BOX 733492, DALLAS, TX 75373-3492	MEDICAL RECORDS SUPPORT	11,324,014.
SODEXO, INC AND AFFILIATES P.O. BOX 536922, ATLANTA, GA 30353-6922	DIETARY AND ENVIRONMENTAL SERVICES	11,075,108.
WALTBILLIG AND HOOD GENERAL CONTRACTORS 1004 COLLIER CTR WAY #100, NAPLES, FL 34110	GENERAL CONTRACTOR	7,116,671.
MERGE HEALTHCARE P.O. BOX 205824, DALLAS, TX 75320-5824	IT SUPPORT	4,853,460.

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 85

SEE PART VII, SECTION A CONTINUATION SHEETS

Part VIII Statement of Revenue

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

				(A)	(B)	(C)	(D)	
				Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a						
	b Membership dues	1b						
	c Fundraising events	1c	1,452,622.					
	d Related organizations	1d	10,000.					
	e Government grants (contributions)	1e	15,000,000.					
	f All other contributions, gifts, grants, and similar amounts not included above ...	1f	18,910,961.					
	g Noncash contributions included in lines 1a-1f	1g	\$ 889,326.					
	h Total. Add lines 1a-1f			35,373,583.				
Program Service Revenue	2 a NET PATIENT SERVICE REVENUE	Business Code	621990	487,722,549.	487,722,549.			
	b _____							
	c _____							
	d _____							
	e _____							
	f All other program service revenue							
	g Total. Add lines 2a-2f			487,722,549.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			8,254,068.			8,254,068.	
	4 Income from investment of tax-exempt bond proceeds			237.			237.	
	5 Royalties							
	6 a Gross rents	6a	(i) Real	1,602,860.				
			(ii) Personal					
	b Less: rental expenses ...	6b		51,091.				
	c Rental income or (loss)	6c		1,551,769.				
	d Net rental income or (loss)			1,551,769.			1,551,769.	
	7 a Gross amount from sales of assets other than inventory	7a	(i) Securities	77,354,746.				
			(ii) Other		8,415.			
	b Less: cost or other basis and sales expenses	7b		72,669,698.	49,127.			
	c Gain or (loss)	7c		4,685,048.	-40,712.			
d Net gain or (loss)			4,644,336.			4,644,336.		
8 a Gross income from fundraising events (not including \$ 1,452,622. of contributions reported on line 1c). See Part IV, line 18	8a			360,651.				
				203,747.				
b Less: direct expenses	8b							
c Net income or (loss) from fundraising events			156,904.			156,904.		
9 a Gross income from gaming activities. See Part IV, line 19	9a							
b Less: direct expenses	9b							
c Net income or (loss) from gaming activities								
10 a Gross sales of inventory, less returns and allowances	10a							
b Less: cost of goods sold	10b							
c Net income or (loss) from sales of inventory								
Miscellaneous Revenue	11 a WELLNESS CENTER	Business Code	713940	2,484,680.	2,484,680.			
	b SCHOOL NURSE		621990	2,212,128.	2,212,128.			
	c DIETARY		722514	2,169,504.	2,169,504.			
	d All other revenue		900099	4,739,563.	4,739,563.			
	e Total. Add lines 11a-11d			11,605,875.				
12 Total revenue. See instructions			549,309,321.	499,328,424.	0.	14,607,314.		

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 X

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 domestic organizations and domestic governments. See Part IV, line 21 ...				
2 Grants and other assistance to domestic individuals. See Part IV, line 22	6,000.	6,000.		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	4,983,806.		4,983,806.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	67,870.	67,870.		
7 Other salaries and wages	202,213,934.	170,661,710.	31,547,226.	4,998.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	6,092,318.	5,180,298.	912,020.	
9 Other employee benefits	14,386,986.	12,233,254.	2,153,468.	264.
10 Payroll taxes	14,980,003.	12,737,497.	2,242,124.	382.
11 Fees for services (nonemployees):				
a Management				
b Legal	2,277,720.		2,277,720.	
c Accounting	274,718.		274,718.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch. O.)	63,425,614.	53,930,800.	9,494,814.	
12 Advertising and promotion	2,284,709.	1,942,688.	342,021.	
13 Office expenses	21,311,765.	18,121,395.	3,190,370.	
14 Information technology	18,028,618.	15,329,734.	2,698,884.	
15 Royalties				
16 Occupancy	9,658,332.	8,212,480.	1,445,852.	
17 Travel	354,124.	301,112.	53,012.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials ...				
19 Conferences, conventions, and meetings				
20 Interest	5,686,947.	4,835,611.	851,336.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	42,662,660.	36,276,060.	6,386,600.	
23 Insurance	3,978,731.	3,383,115.	595,616.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	112,062,975.	112,062,975.		
b BAD DEBT EXPENSE	1,096,766.	1,096,766.		
c _____				
d _____				
e All other expenses _____	84,737.	72,052.	12,685.	
25 Total functional expenses. Add lines 1 through 24e	525,919,333.	456,451,417.	69,462,272.	5,644.
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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	17,465,308.	1	138,138,248.
	2 Savings and temporary cash investments	6,118,450.	2	4,299,249.
	3 Pledges and grants receivable, net	21,306,009.	3	25,161,770.
	4 Accounts receivable, net	69,189,390.	4	58,454,797.
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	50,000.	5	40,000.
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		6	
	7 Notes and loans receivable, net	7,643.	7	12,633.
	8 Inventories for sale or use	11,120,787.	8	13,227,422.
	9 Prepaid expenses and deferred charges	4,583,082.	9	4,444,169.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 880,651,116.		
	b Less: accumulated depreciation	10b 542,993,830.		
	11 Investments - publicly traded securities	336,976,353.	10c	337,657,286.
	12 Investments - other securities. See Part IV, line 11	23,556,105.	11	24,878,041.
	13 Investments - program-related. See Part IV, line 11		12	
	14 Intangible assets	654,468.	13	
	15 Other assets. See Part IV, line 11	654,468.	14	457,800.
16 Total assets. Add lines 1 through 15 (must equal line 33)	325,337,107.	15	334,934,764.	
	816,364,702.	16	941,706,179.	
Liabilities	17 Accounts payable and accrued expenses	51,667,798.	17	58,877,724.
	18 Grants payable		18	
	19 Deferred revenue	247,421.	19	12,454,339.
	20 Tax-exempt bond liabilities	97,732,705.	20	112,711,658.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		22	
	23 Secured mortgages and notes payable to unrelated third parties		23	
	24 Unsecured notes and loans payable to unrelated third parties		24	
	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	39,667,970.	25	105,977,386.
	26 Total liabilities. Add lines 17 through 25	189,315,894.	26	290,021,107.
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.			
	27 Net assets without donor restrictions	574,987,502.	27	598,157,406.
	28 Net assets with donor restrictions	52,061,306.	28	53,527,666.
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building, or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
	32 Total net assets or fund balances	627,048,808.	32	651,685,072.
33 Total liabilities and net assets/fund balances	816,364,702.	33	941,706,179.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	549,309,321.
2	Total expenses (must equal Part IX, column (A), line 25)	2	525,919,333.
3	Revenue less expenses. Subtract line 2 from line 1	3	23,389,988.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	627,048,808.
5	Net unrealized gains (losses) on investments	5	10,505,641.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	-9,259,365.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	651,685,072.

Part XII Financial Statements and Reporting

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

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

	Yes	No
2a		X
2b	X	
2c	X	
3a		X
3b		

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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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 VI.)						
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						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2018 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2019. 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		<input type="checkbox"/>
b 33 1/3% support test - 2018. 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		<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2019. 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 VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2018. 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 VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization		<input type="checkbox"/>
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		<input type="checkbox"/>

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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 VI.)						
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 2019 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2018 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2019 (line 10c, column (f), divided by line 13, column (f))	17	%
18 Investment income percentage from 2018 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2019. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

b 33 1/3% support tests - 2018. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2 Activities Test. Answer (a) and (b) below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
3 Parent of Supported Organizations. Answer (a) and (b) below.		
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		

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

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

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

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt-use assets	2	
3	Subtract line 2 from line 1d.	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035.	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	

Section C - Distributable Amount		(A) Prior Year	Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1.	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3.	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

Schedule A (Form 990 or 990-EZ) 2019

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions.	
7 Total annual distributions. Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	
9 Distributable amount for 2019 from Section C, line 6	
10 Line 8 amount divided by line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2019	(iii) Distributable Amount for 2019
1 Distributable amount for 2019 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required- explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2019			
a From 2014			
b From 2015			
c From 2016			
d From 2017			
e From 2018			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2019 distributable amount			
i Carryover from 2014 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2019 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI . See instructions.			
6 Remaining underdistributions for 2019. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI . See instructions.			
7 Excess distributions carryover to 2020. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2015			
b Excess from 2016			
c Excess from 2017			
d Excess from 2018			
e Excess from 2019			

Schedule B

(Form 990, 990-EZ, or 990-PF)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2019

Name of the organization

NAPLES COMMUNITY HOSPITAL, INC.

Employer identification number

59-0694358

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

501(c)(3) (enter number) organization

4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

4947(a)(1) nonexempt charitable trust treated as a private foundation

501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** \$5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ▶ \$ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	<hr/> <hr/> <hr/>	\$ 8,744.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
5	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	<hr/> <hr/> <hr/>	\$ 78,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13	<hr/> <hr/> <hr/>	\$ 112,640.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
14	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18	<hr/> <hr/> <hr/>	\$ 6,254.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
20	<hr/> <hr/> <hr/>	\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
21	<hr/> <hr/> <hr/>	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
22	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
23	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
24	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
26		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
27		\$ 42,804.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
28		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
29		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
30		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
32	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
33	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
34	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
35	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
36	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
37	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
38	<hr/> <hr/> <hr/>	\$ 200,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
39	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
40	<hr/> <hr/> <hr/>	\$ 34,070.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
41	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
42	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
43	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
44	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
45	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
46	<hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
47	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
48	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
49	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
50	<hr/> <hr/> <hr/>	\$ 130,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
51	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
52	<hr/> <hr/> <hr/>	\$ 34,788.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
53	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
54	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
55		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
56		\$ 30,803.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
57		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
58		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
59		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
60		\$ 57,409.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
61	<hr/> <hr/> <hr/>	\$ 23,060.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
62	<hr/> <hr/> <hr/>	\$ 17,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
63	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
64	<hr/> <hr/> <hr/>	\$ 16,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
65	<hr/> <hr/> <hr/>	\$ 22,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
66	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
67	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
68	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
69	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
70	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
71	<hr/> <hr/> <hr/>	\$ 48,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
72	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
73		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
74		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
75		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
76		\$ 57,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
77		\$ 15,074.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
78		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
79	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
80	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
81	<hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
82	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
83	<hr/> <hr/> <hr/>	\$ 166,667.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
84	<hr/> <hr/> <hr/>	\$ 83,779.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
85	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
86	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
87	<hr/> <hr/> <hr/>	\$ 12,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
88	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
89	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
90	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
91	<hr/> <hr/> <hr/>	\$ 35,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
92	<hr/> <hr/> <hr/>	\$ 12,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
93	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
94	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
95	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
96	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
97	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
98	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
99	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
100	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
101	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
102	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
103	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
104	<hr/> <hr/> <hr/>	\$ 500,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
105	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
106	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
107	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
108	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
109	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
110	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
111	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
112	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
113	<hr/> <hr/> <hr/>	\$ 7,683.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
114	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
115	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
116	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
117	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
118	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
119	 <hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
120	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
121	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
122	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
123	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
124	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
125	<hr/> <hr/> <hr/>	\$ 22,421.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
126	<hr/> <hr/> <hr/>	\$ 22,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
127	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
128	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
129	<hr/> <hr/> <hr/>	\$ 5,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
130	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
131	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
132	<hr/> <hr/> <hr/>	\$ 1,000,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
133	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
134	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
135	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
136	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
137	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
138	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
139	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
140	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
141	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
142	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
143	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
144	 <hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
145	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
146	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
147	 <hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
148	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
149	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
150	 <hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
151	<hr/> <hr/> <hr/>	\$ 11,952.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
152	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
153	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
154	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
155	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
156	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
157	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
158	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
159	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
160	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
161	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
162	<hr/> <hr/> <hr/>	\$ 2,287,855.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
163	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
164	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
165	<hr/> <hr/> <hr/>	\$ 10,152.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
166	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
167	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
168	<hr/> <hr/> <hr/>	\$ 98,533.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
169	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
170	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
171	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
172	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
173	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
174	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
175	_____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
176	_____	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
177	_____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
178	_____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
179	_____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
180	_____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
181	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
182	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
183	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
184	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
185	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
186	_____ _____ _____	\$ 7,099.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
187	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
188	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
189	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
190	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
191	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
192	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
193	<hr/> <hr/> <hr/>	\$ 10,830.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
194	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
195	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
196	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
197	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
198	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
199	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
200	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
201	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
202	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
203	<hr/> <hr/> <hr/>	\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
204	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
205	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
206	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
207	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
208	 <hr/> <hr/> <hr/>	\$ 16,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
209	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
210	 <hr/> <hr/> <hr/>	\$ 256,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
211	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
212	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
213	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
214	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
215	<hr/> <hr/> <hr/>	\$ 22,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
216	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
217	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
218	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
219	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
220	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
221	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
222	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
223	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
224	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
225	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
226	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
227	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
228	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
229	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
230	 	\$ 15,106.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
231	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
232	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
233	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
234	 	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
235	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
236	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
237	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
238	_____ _____ _____	\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
239	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
240	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
241	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
242	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
243	<hr/> <hr/> <hr/>	\$ 16,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
244	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
245	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
246	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
247	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
248	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
249	_____ _____ _____	\$ _____ 17,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
250	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
251	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
252	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
253	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
254	 	\$ 7,462.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
255	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
256	 	\$ 203,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
257	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
258	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
259	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
260	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
261	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
262	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
263	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
264	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
265	 <hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
266	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
267	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
268	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
269	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
270	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
271	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
272	<hr/> <hr/> <hr/>	\$ 107,981.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
273	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
274	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
275	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
276	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
277	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
278	<hr/> <hr/> <hr/>	\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
279	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
280	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
281	<hr/> <hr/> <hr/>	\$ 68,909.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
282	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
283	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
284	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
285	<hr/> <hr/> <hr/>	\$ 15,185.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
286	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
287	<hr/> <hr/> <hr/>	\$ 27,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
288	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
289	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
290	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
291	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
292	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
293	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
294	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
295	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
296	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
297	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
298	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
299	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
300	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
301	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
302	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
303	 <hr/> <hr/> <hr/>	\$ 126,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
304	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
305	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
306	 <hr/> <hr/> <hr/>	\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
307	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
308	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
309	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
310	<hr/> <hr/> <hr/>	\$ 27,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
311	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
312	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
313	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
314	_____ _____ _____	\$ 63,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
315	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
316	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
317	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
318	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
319	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
320	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
321	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
322	 <hr/> <hr/> <hr/>	\$ <u>15,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
323	 <hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
324	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
325		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
326		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
327		\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
328		\$ 358,795.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
329		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
330		\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
331	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
332	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
333	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
334	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
335	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
336	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
337	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
338	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
339	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
340	_____ _____ _____	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
341	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
342	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
343	<hr/> <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
344	<hr/> <hr/> <hr/>	\$ 20,141.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
345	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
346	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
347	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
348	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
349	 	\$ 12,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
350	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
351	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
352	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
353	 	\$ 16,854.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
354	 	\$ 5,144.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
355	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
356	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
357	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
358	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
359	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
360	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
361	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
362	 <hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
363	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
364	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
365	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
366	 <hr/> <hr/> <hr/>	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
367	<hr/> <hr/> <hr/>	\$ 15,403.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
368	<hr/> <hr/> <hr/>	\$ 10,137.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
369	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
370	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
371	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
372	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
373	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
374	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
375	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
376	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
377	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
378	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
379	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
380	 	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
381	 	\$ 9,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
382	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
383	 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
384	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
385	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
386	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
387	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
388	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
389	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
390	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
391	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
392	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
393	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
394	 <hr/> <hr/> <hr/>	\$ 60,095.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
395	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
396	 <hr/> <hr/> <hr/>	\$ 12,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
397	<hr/> <hr/> <hr/>	\$ 25,151.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
398	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
399	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
400	<hr/> <hr/> <hr/>	\$ 5,539.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
401	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
402	<hr/> <hr/> <hr/>	\$ 17,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
403	<hr/> <hr/> <hr/>	\$ 13,345.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
404	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
405	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
406	<hr/> <hr/> <hr/>	\$ 5,094.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
407	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
408	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
409	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
410	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
411	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
412	 <hr/> <hr/> <hr/>	\$ 48,771.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
413	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
414	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
415	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
416	_____ _____ _____	\$ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
417	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
418	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
419	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
420	_____ _____ _____	\$ 4,826,799.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
421	<hr/> <hr/> <hr/>	\$ 17,053.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
422	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
423	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
424	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
425	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
426	<hr/> <hr/> <hr/>	\$ 400,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
427	_____ _____ _____	\$ _____ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
428	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
429	_____ _____ _____	\$ _____ 817,879.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
430	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
431	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
432	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
433	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
434	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
435	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
436	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
437	_____ _____ _____	\$ 22,762.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
438	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
439	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
440	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
441	<hr/> <hr/> <hr/>	\$ 12,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
442	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
443	<hr/> <hr/> <hr/>	\$ 10,449.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
444	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
445	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
446	<hr/> <hr/> <hr/>	\$ 101,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
447	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
448	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
449	<hr/> <hr/> <hr/>	\$ 7,374.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
450	<hr/> <hr/> <hr/>	\$ 10,108.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
451	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
452	<hr/> <hr/> <hr/>	\$ 40,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
453	<hr/> <hr/> <hr/>	\$ 37,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
454	<hr/> <hr/> <hr/>	\$ 7,759.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
455	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
456	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
457	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
458	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
459	_____ _____ _____	\$ _____ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
460	_____ _____ _____	\$ _____ 91,007.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
461	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
462	_____ _____ _____	\$ _____ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
463	 <hr/> <hr/> <hr/>	\$ <u>50,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
464	 <hr/> <hr/> <hr/>	\$ <u>11,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
465	 <hr/> <hr/> <hr/>	\$ <u>30,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
466	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
467	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
468	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
469	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
470	_____ _____ _____	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
471	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
472	_____ _____ _____	\$ 75,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
473	_____ _____ _____	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
474	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
475	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
476	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
477	<hr/> <hr/> <hr/>	\$ 110,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
478	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
479	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
480	<hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
481	_____ _____ _____	\$ _____ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
482	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
483	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
484	_____ _____ _____	\$ _____ 8,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
485	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
486	_____ _____ _____	\$ _____ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
487	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
488	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
489	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
490	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
491	 <hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
492	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
493		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
494		\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
495		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
496		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
497		\$ 57,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
498		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
499	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
500	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
501	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
502	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
503	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
504	 	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
505	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
506	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
507	 <hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
508	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
509	 <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
510	 <hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
511	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
512	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
513	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
514	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
515	_____ _____ _____	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
516	_____ _____ _____	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
517	<hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
518	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
519	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
520	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
521	<hr/> <hr/> <hr/>	\$ 375,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
522	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
523	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
524	<hr/> <hr/> <hr/>	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
525	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
526	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
527	<hr/> <hr/> <hr/>	\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
528	<hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
529		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
530		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
531		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
532		\$ 10,560.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
533		\$ 5,975.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
534		\$ 68,900.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
535		\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
536		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
537		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
538		\$ 7,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
539		\$ 8,000.	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
540		\$ 15,000,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
4	INCLUDED IN THE TOTAL IS \$8,744 IN 85 SHARES OF LOWES COS INC COM	\$ 8,744.	01/10/20
13	INCLUDED IN THE TOTAL IS \$7,640 IN 24 SHARES OF TMO-THERMO FISHER CORP COM	\$ 7,640.	12/05/19
113	INCLUDED IN THE TOTAL IS \$7,683 IN 59 SHARES OF DISNEY WALT CO	\$ 7,683.	08/24/20
165	INCLUDED IN THE TOTAL IS \$10,152 IN 58 SHARES OF IWF-ISHARES RUSSEL 1000 GROWTH	\$ 10,152.	12/19/19
230	INCLUDED IN THE TOTAL IS \$7,606 IN 70 SHARES OF APPLE	\$ 7,606.	09/23/20
254	INCLUDED IN THE TOTAL IS \$7,462 IN 675 SHARES OF UCFC-UNITED CMNTY FINL CORP	\$ 7,462.	11/25/19

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
272	INCLUDED IN THE TOTAL IS \$100,481 IN 518 SHARES OF WD40 CO COM	\$ 100,481.	12/06/19
285	INCLUDED IN THE TOTAL IS \$15,185 IN 90 SHARES OF VANGUARD	\$ 15,185.	02/10/20
328	INCLUDED IN THE TOTAL IS \$53,415 IN STOCK/PROPERTY	\$ 53,415.	06/04/20
344	INCLUDED IN THE TOTAL IS \$20,141 IN 402 SHARES OF CARDINAL HEALTH INC	\$ 20,141.	04/16/20
354	INCLUDED IN THE TOTAL IS \$5,144 IN 34 SHARES OF MSFT-MICROSOFT CORP COM	\$ 5,144.	12/04/19
368	INCLUDED IN THE TOTAL IS \$10,137 IN 71 SHARES OF JNJ-JOHNSON & JOHNSON COM	\$ 10,137.	12/11/19

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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
394	INCLUDED IN THE TOTAL IS \$55,095 IN 1600 SHARES OF JABIL INC	\$ 55,095.	08/24/20
400	INCLUDED IN THE TOTAL IS \$539 IN 300 SHARES OF NFRA FLEXXSHARE TR STOXX GLOBAL BROAD INFRASTRUCTURE	\$ 539.	10/21/19
406	INCLUDED IN THE TOTAL IS \$5,094 IN 39 SHARES OF JOHNSON & JOHNSON	\$ 5,094.	11/05/19
429	INCLUDED IN THE TOTAL IS \$7,879 IN 56 SHARES OF JNJ-JOHNSON & JOHNSON COM	\$ 7,879.	12/11/19
437	INCLUDED IN THE TOTAL IS \$22,762 IN 91 SHARES OF SHERWIN WILLIAMS, NIKE INC AND COSTAR GROUP COMPANIES	\$ 22,762.	08/11/20
443	INCLUDED IN THE TOTAL IS \$9,449 IN 61 SHARES OF MICROSOFT CORP COM	\$ 9,449.	01/22/20

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Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
449	INCLUDED IN THE TOTAL IS \$7,374 IN 42 SHARES OF MICROSOFT, BLACKROCK, AND DANAHER COMPANIES <hr/> <hr/>	\$ 7,374.	11/19/19
454	INCLUDED IN THE TOTAL IS \$7,759 IN 65 SHARES OF LOWES COS INC COM <hr/> <hr/>	\$ 7,759.	12/13/19
539	INCLUDED IN THE TOTAL IS \$8,000 PEARL SET JEWELRY <hr/> <hr/>	\$ 8,000.	11/01/19
	<hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/>	\$ _____	_____

Name of organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this info. once.) ▶ \$ _____
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	

SCHEDULE D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

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

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

OMB No. 1545-0047

2019 Open to Public Inspection

Name of the organization: NAPLES COMMUNITY HOSPITAL, INC. Employer identification number: 59-0694358

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

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

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

Form with multiple sections: 1. Purpose(s) of conservation easements (check all that apply). 2. Complete lines 2a through 2d if the organization held a qualified conservation contribution... 3. Number of conservation easements modified... 4. Number of states where property subject to conservation easement is located... 5. Does the organization have a written policy regarding the periodic monitoring... 6. Staff and volunteer hours devoted to monitoring... 7. Amount of expenses incurred in monitoring... 8. Does each conservation easement reported on line 2(d) above satisfy the requirements... 9. In Part XIII, describe how the organization reports conservation easements...

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

Form with multiple sections: 1a. If the organization elected, as permitted under FASB 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... 1b. If the organization elected, as permitted under FASB ASC 958, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition... 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 FASB ASC 958 relating to these items:

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

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

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

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	15,631,211.	15,584,397.	14,783,076.	14,561,078.	14,426,617.
b Contributions	117,661.	3,907.	601,291.	6,000.	7,000.
c Net investment earnings, gains, and losses	319,735.	42,907.	200,030.	215,998.	127,461.
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	16,068,607.	15,631,211.	15,584,397.	14,783,076.	14,561,078.

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment _____ %
 - b Permanent endowment 100.00 %
 - c Term endowment _____ %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|-----|----|
| (i) Unrelated organizations | | X |
| (ii) Related organizations | | X |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? <input type="checkbox"/> | 3b | |
- 4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		26,835,317.		26,835,317.
b Buildings		435,632,188.	235,493,647.	200,138,541.
c Leasehold improvements		6,798,411.	6,525,578.	272,833.
d Equipment		378,280,401.	294,633,332.	83,647,069.
e Other		33,104,799.	6,341,273.	26,763,526.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				337,657,286.

Part VII Investments - Other Securities.

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

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

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) ASSETS LIMITED AS TO USE	332,693,275.
(2) OTHER ASSETS	1,581,594.
(3) DEPOSITS	207,368.
(4) THIRD-PARTY RECEIVABLE	452,527.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	334,934,764.

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO RELATED ORGANIZATIONS	13,108,039.
(3) SELF-INSURANCE LIABILITIES	9,211,306.
(4) PUBLIC MEDICAL FUND PAYABLE	3,304,149.
(5) ACCRUED INTEREST	2,795,332.
(6) OTHER LIABILITIES	3,470,918.
(7) MEDICARE ACCELERATED PAYMENTS	74,087,642.
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	105,977,386.

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

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

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

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

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

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

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

Part XIII Supplemental Information.

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

PART V, LINE 4:

INTENDED USE OF THE ORGANIZATION'S ENDOWMENT FUNDS

ALL ENDOWMENT FUNDS MAINTAINED BY NAPLES COMMUNITY HOSPITAL, INC. ARE USED

IN FURTHERANCE OF THE ORGANIZATION'S TAX-EXEMPT PURPOSES.

PART X, LINE 2:

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

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

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

SUBSIDIARIES DO NOT HAVE SIGNIFICANT UNRELATED BUSINESS INCOME; HOWEVER,

SUCH STATUS IS SUBJECT TO FINAL DETERMINATION UPON EXAMINATION OF THE

Part XIII Supplemental Information *(continued)*

RELATED INCOME TAX RETURNS BY THE APPROPRIATE TAXING AUTHORITIES. THE

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

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

2016.

Part II Fundraising Events. Complete if the organization answered "Yes" on Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

		(a) Event #1	(b) Event #2	(c) Other events NONE	(d) Total events (add col. (a) through col. (c))
		HOSPITAL BALL (event type)	(event type)	(total number)	
Revenue	1 Gross receipts	1,813,273.			1,813,273.
	2 Less: Contributions	1,452,622.			1,452,622.
	3 Gross income (line 1 minus line 2)	360,651.			360,651.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs	34,258.			34,258.
	7 Food and beverages	110,111.			110,111.
	8 Entertainment	30,118.			30,118.
	9 Other direct expenses	29,260.			29,260.
	10 Direct expense summary. Add lines 4 through 9 in column (d)				203,747.
11 Net income summary. Subtract line 10 from line 3, column (d)				156,904.	

Part III Gaming. Complete if the organization answered "Yes" on Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	
	7 Direct expense summary. Add lines 2 through 5 in column (d)				
	8 Net gaming income summary. Subtract line 7 from line 1, column (d)				

9 Enter the state(s) in which the organization conducts gaming activities: _____

a Is the organization licensed to conduct gaming activities in each of these states? Yes No

b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended, or terminated during the tax year? Yes No

b If "Yes," explain: _____

**SCHEDULE H
(Form 990)**

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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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	X	
b If "Yes," was it a written policy?	1b	X	
<p>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.</p> <p><input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities</p> <p><input type="checkbox"/> Generally tailored to individual hospital facilities</p>			
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 <i>free</i> care?	3a	X	
<p>If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:</p> <p><input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %</p>			
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	3b	X	
<p>If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:</p> <p><input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %</p>			
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
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	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		X
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a Did the organization prepare a community benefit report during the tax year?	6a	X	
b If "Yes," did the organization make it available to the public?	6b	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			19,345,263.		19,345,263.	3.69%
b Medicaid (from Worksheet 3, column a)			55,276,708.	25,070,212.	30,206,496.	5.76%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			74,621,971.	25,070,212.	49,551,759.	9.45%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			3,780,879.		3,780,879.	.72%
f Health professions education (from Worksheet 5)			38,344.		38,344.	.01%
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits			3,819,223.		3,819,223.	.73%
k Total. Add lines 7d and 7j			78,441,194.	25,070,212.	53,370,982.	10.18%

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group NAPLES COMMUNITY HOSPITAL, INC.

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

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

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group NAPLES COMMUNITY HOSPITAL, INC.

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

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group NAPLES COMMUNITY HOSPITAL, INC.

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group NAPLES COMMUNITY HOSPITAL, INC.

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

Part V Facility Information (continued)

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

NAPLES COMMUNITY HOSPITAL, INC.:

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

COMMUNITY

THE NCH LEADERSHIP TEAM IS ACTIVELY INVOLVED AND PARTICIPATES IN MANY

COMMUNITY RELATED ORGANIZATIONS AND GROUPS THAT ARE CONTINUALLY ASSESSING

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

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

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

THE COMMUNITY IN ASSESSING AND COLLABORATING IN EFFORTS TO IMPROVE THE

HEALTH OF OUR COMMUNITY.

NCH WORKS COLLABORATIVELY WITH THE FLORIDA DEPARTMENT OF HEALTH IN COLLIER

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

COMMERCE AND SEVERAL OTHER COMMUNITY GROUPS TO FORM THE COMMUNITY

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

STRENGTHS AND OPPORTUNITIES. A NEW COMMUNITY HEALTH ASSESSMENT WAS

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

PRIORITIES WERE ESTABLISHED IN 2020 BY THE HEALTHY COLLIER EXECUTIVE

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

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

OFFICIALS MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIP (MAPP)

STRATEGIC PLANNING MODEL.

USING THE MOBILIZING FOR ACTION THROUGH THE PLANNING AND PARTNERSHIP

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

Part V Facility Information (continued)

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

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

HELD DISCUSSIONS REGARDING GROUP PRIORITIES AND OBJECTIVES GOING FORWARD.

THE COMMITTEE AGREED THAT THE RESULTS STRONGLY CORROBORATED THE RESULTS OF

OTHER RECENT COMMUNITY ASSESSMENTS AND ACCURATELY REFLECT THE NEEDS OF

COLLIER COUNTY.

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

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

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

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

MENTAL HEALTH & SUBSTANCE ABUSE WORKGROUP.

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

HEALTH PRIORITY WOKGROUPS TO FINALIZE THE GOALS, STRATEGIES, AND

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

HEALTH PRIORITY: MENTAL HEALTH AND SUBSTANCE ABUSE

GOAL: IMPROVE IDENTIFICATION AND TREATMENT OF MENTAL HEALTH AND SUBSTANCE

USE DISORDERS.

OBJECTIVES:

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

FACILITIES IN COLLIER COUNTY THAT ARE USING THE COLLABORATION/INTEGRATION

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

END OF 2020, THE NUMBER OF PRIMARY CARE PROVIDER OFFICES AND URGENT CARE

FACILITIES USING THE MODEL INCREASED TO 14.

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

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

Part V Facility Information (continued)

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

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

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

OF INDIVIDUALS TRAINED IN 2020 WERE 524.

HEALTH PRIORITY: CHRONIC DISEASES

GOAL: DELIVER CULTURALLY RELEVANT HEALTH EDUCATION TO COLLIER COUNTY

RESIDENTS IN POPULATIONS WITH DISPARITIES IN HEALTH OUTCOMES.

OBJECTIVES:

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

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

IN 2020 WHICH RESULTED IN A TOTAL OF 53 APPROVED WORKSITES.

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

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

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

IN 2020. DOH-COLLIER'S RESPONSE TO THE COVID-19 PANDEMIC SLOWED PROGRAM

DEVELOPMENT AND ONBOARDING.

3. INCREASE THE NUMBER OF TOBACCO FREE WORKPLACE POLICIES IN COLLIER

COUNTY WITH CESSATION SERVICES NEW OR ADDED FROM ONE IN FISCAL YEAR 2019

TO THREE IN FISCAL YEAR 2020. PROGRESS: TWO NEW WORKSITES WITH CESSATION

POLICIES WERE ADDED IN FISCAL YEAR 2019-2020. THE EXECUTIVE COMMITTEE

AGREED TO REMOVING THIS OBJECTIVE BECAUSE THE NEW PROGRAM GRANT CYCLE

BEGINNING IN JUNE 2021 DOES NOT HAVE A WORKSITES FOCUS AND THE NEW PROGRAM

OBJECTIVE WILL NOT BE FINALIZED UNTIL JUNE.

HEALTH PRIORITY: ACCESS TO CARE

GOAL: INCREASE ACCESS TO BLOOD PRESSURE SCREENING SERVICES FOR UNINSURED

COLLIER COUNTY RESIDENTS.

Part V Facility Information *(continued)*

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

OBJECTIVE:

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

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

2022, AN INCREASE OF ABOUT 5% PER YEAR. PROGRESS: THE DEMAND FOR

COVID-19 TESTING BROUGHT MORE UNINSURED PEOPLE TO THE CLINICS IN 2020

CREATING MORE OPPORTUNITIES TO OFFER HEALTH SCREENINGS INCLUDING BLOOD

PRESSURE. THIS DEMAND RESULTED IN 13,403 UNINSURED RESIDENTS RECEIVING

BLOOD PRESSURE SCREENINGS.

HEALTH PRIORITY: HEALTH OF OLDER ADULTS

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

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

OBJECTIVES:

1. COMPLETE 100% OF THE STEPS REQUIRED TO SUBMIT A SUCCESSFUL APPLICATION

IN DECEMBER OF 2020 TO JOIN THE AARP NETWORK OF AGE-FRIENDLY COMMUNITIES.

PROGRESS: THE APPLICATION PACKAGE WAS SUBMITTED TO AARP AND COLLIER

COUNTY OFFICIALLY RECEIVED DESIGNATION AS AN AARP AGE-FRIENDLY COMMUNITY

IN DECEMBER 2020.

2. COMPLETE 100% OF THE STEPS REQUIRED TO ESTABLISH A DEMENTIA CARE AND

CURE TASKFORCE IN COLLIER COUNTY BY DECEMBER 2020. PROGRESS: COLLIER

COUNTY DCCI TASKFORCE WAS ESTABLISHED AND DEVELOPED THE MISSION AND

VISION. THE STATUS OF THIS OBJECTIVE IS COMPLETED.

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

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

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

AWARENESS.

Part V Facility Information (continued)

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

NAPLES COMMUNITY HOSPITAL, INC.:

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

FACILITIES

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

HOSPITAL AND MARCO ISLAND HOSPITAL WAS PREPARED JOINTLY.

NAPLES COMMUNITY HOSPITAL, INC.:

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

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

INCLUDE SUFFICIENT JOB EMPLOYMENT, ECONOMIC OPPORTUNITIES, ACCESS TO

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

AND PEDESTRIANS, PRIMARY CARE RESOURCES, ACCESS TO AFFORDABLE HEALTHY

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

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

DISABILITIES AND UNINTENTIONAL INJURIES.

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

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

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

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

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

SPECIFIC KEY AREAS.

Part V Facility Information *(continued)*

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

MENTAL HEALTH

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

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

COLLIER COUNTY COMMISSIONERS AD HOC TASK FORCE ON MENTAL HEALTH AND

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

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

IN COLLIER.

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

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

ED AND INPATIENT SERVICES.

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

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

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

WHEN APPROVED BY THE FDA.

CHRONIC DISEASE (ONCOLOGY)

MAMMOGRAM SCREENINGS ARE OFFERED AND PROVIDED TO UNINSURED AND

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

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

STUDY HAS ALSO BEEN COMPLETED.

NCH HIRED CARDIO THORACIC SURGEONS WHO DEVELOPED A COMPREHENSIVE LUNG

Part V Facility Information *(continued)*

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

CANCER PROGRAM FOCUSING ON SCREENING, NAVIGATION, SURVIVORSHIP AND

SURGICAL INTERVENTION.

NCH EXPANDED ITS NURSE NAVIGATION PROGRAM WITH FOCUS ON FOLLOWING ONCOLOGY

PATIENTS THROUGHOUT THE CONTINUUM OF CARE WITH SPECIAL EMPHASIS ON BREAST

AND LUNG PATIENTS AS WELL AS SCREENING ACTIVITIES.

MATERNAL AND INFANT HEALTH

NCH'S INITIAL LATCH MEASUREMENT IS 82%. NCH IS IMPLEMENTING SKIN TO SKIN

IN THE DELIVERY ROOM. THE SKIN TO SKIN RATE IS 87%. ALL REGISTERED NURSES

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

PEDIATRICS AND PEDIATRICS ED ARE EDUCATED IN BREASTFEEDING.

NCH MAINTAINS A BREASTFEEDING RATE OF 46%. NCH EMPLOYS 1 FULL-TIME AND 1

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

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

COALITION WITH AN OVERALL GOAL TO INCREASE BREASTFEEDING RATES IN COLLIER

COUNTY.

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

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

SUPPORTS NURSE EDUCATIONAL PROGRAMS FOR PARENTS ON THE DETRIMENTAL EFFECTS

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

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

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

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

Part V Facility Information (continued)

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

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

HEALTH OF THE OLDER POPULATION

NCH HAS EXPANDED GERIATRIC MEDICINE TO MULTIPLE NCH PHYSICIAN PRACTICES.

TWO NCH PHYSICIANS ARE MEDICAL DIRECTORS OF TWO SKILLED NURSING FACILITIES

IN COLLIER COUNTY.

DIABETES MANAGEMENT

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

AMERICAN DIABETES PROGRAMS THAT MAINTAIN DATA COLLECTION AND REPORTING

REQUIREMENTS. DIABETES SUPPORT GROUPS ARE PROVIDED TO THE COMMUNITY.

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

THROUGHOUT THE YEAR.

PHILANTHROPIC FUNDS HAVE BEEN ALLOCATED FOR PEDIATRICS TO ASSURE THEY HAVE

APPOINTMENTS SCHEDULED WITH REGISTERED DIETICIANS OR NURSES FOR

UNDERINSURED OR UNINSURED CHILDREN. PHILANTHROPIC FUNDS ARE ALSO USED FOR

GESTATIONAL PATIENTS PROVIDING EDUCATIONAL CLASSES, AND SUPPLIES.

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

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

ACCOMPLISHMENTS FOR 2020 INCLUDE, BUT ARE NOT LIMITED TO:

I. THE VON ARX DIABETES CENTER SERVED 4,634 OUTPATIENT VISITS;

Part V Facility Information *(continued)*

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

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

III. EXPANDED GROCERY STORE TOURS;

IV. MAINTAINED ACCREDITATION WITH THE AMERICAN DIABETES ASSOCIATION

NCH WORKING WITH THE FLORIDA DEPARTMENT OF HEALTH - COLLIER COUNTY

PARTICIPATED AGAIN IN THE COLLIER COUNTY COMMUNITY ASSESSMENT DESIGN

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

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

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

IDENTIFIED PROBLEM AREAS INCLUDED THE FOLLOWING:

CHRONIC DISEASE AND MORTALITY

INFECTIOUS DISEASE

MATERNAL AND INFANT HEALTH

INJURIES

ACCESS TO HEALTHCARE

HEALTH BEHAVIORS AND HEALTH STATUS

MENTAL HEALTH

ORAL HEALTH

THE HEALTH OF THE OLDER POPULATION

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

AND NEGATIVE FACTORS THAT INFLUENCED THESE AREAS.

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

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

Part V Facility Information *(continued)*

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

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

THE DISTINCT AREAS OF THE COUNTY REPRESENTED UNIQUE DEMOGRAPHIC AND

SOCIOECONOMIC CHARACTERISTICS. THE DIFFERENCES WERE VALUABLE AND USEFUL

FOR ASSESSING AND PRIORITIZING HEALTHCARE NEEDS WITHIN OUR COMMUNITY.

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

INDICATORS WHICH INCLUDED THE FOLLOWING:

POPULATION

SOCIOECONOMIC CHARACTERISTICS

INFECTIOUS DISEASE

HEALTH BEHAVIORS AND HEALTH STATUS

MORTALITY INDICATORS

MATERNAL AND INFANT HEALTH

HEALTH OF THE OLDER POPULATION

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

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

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

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

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

AREAS OF FOCUS WHICH INCLUDE:

MENTAL HEALTH

ACCESS TO CARE

CHRONIC DISEASE

HEALTH OF OLDER ADULTS

Part V Facility Information *(continued)*

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

UNADDRESSED IDENTIFIED NEEDS

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

NAPLES COMMUNITY HOSPITAL, INC.:

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

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

NAPLES COMMUNITY HOSPITAL, INC.:

PART V, SECTION B, LINE 13H: NAPLES COMMUNITY HOSPITAL, INC.: BASIS FOR CALCULATING AMOUNTS CHARGED TO PATIENTS.

OTHER CRITERIA USED TO DETERMINE ELIGIBILITY ARE PATIENTS WHO ARE ELIGIBLE

Part V Facility Information *(continued)*

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

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

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

OR SEXUAL ASSAULT.

NAPLES COMMUNITY HOSPITAL, INC.

PART V, LINE 16A, FAP WEBSITE:

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

NAPLES COMMUNITY HOSPITAL, INC.

PART V, LINE 16B, FAP APPLICATION WEBSITE:

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

NAPLES COMMUNITY HOSPITAL, INC.

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

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

Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 3C:

NCH USES OTHER FACTORS OTHER THAN FPG TO DETERMINE ELIGIBILITY FOR

PROVIDING FREE OR DISCOUNTED CARE AS DESCRIBED BELOW.

PRESUMPTIVE ELIGIBILITY

PATIENTS MAY BE ELIGIBLE FOR A DISCOUNT OF THE FULL UNPAID BALANCE IN THE

ABSENCE OF A COMPLETED FINANCIAL ASSISTANCE APPLICATION FORM IF THE

PATIENT MEETS ONE OF THE FOLLOWING:

1. IS HOMELESS

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

3. IS CURRENTLY ELIGIBLE FOR MEDICAID (AS PRIMARY INSURANCE) BUT WAS NOT

AT DATE OF SERVICE OR MEDICAID BENEFITS ARE EXHAUSTED.

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

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

TO THE VIOLENT CRIME OR SEXUAL ASSAULT.

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

Part VI Supplemental Information (Continuation)

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

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

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

STATEMENT, ARE INDIGENT WITHOUT ACCESS TO THE REQUIRED APPLICATION

DOCUMENTATION MAY STILL BE ELIGIBLE FOR FINANCIAL ASSISTANCE.

PART I, LINE 6A:

RELATED PARTY DISCLOSURE

NAPLES COMMUNITY HOSPITAL, INC. ("NCH") IS AN AFFILIATE OF NCH HEALTHCARE

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

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

THE COMMUNITY BENEFIT REPORT PREPARED INCLUDES ALL ORGANIZATIONS OF THE

SYSTEM, INCLUDING NAPLES COMMUNITY HOSPITAL, INC.

PART I, LINE 7:

COSTING METHOD USED

THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNTS REPORTED ON LINE 7

ARE BASED ON THE COST TO CHARGE RATIO. THE COST TO CHARGE RATIO WAS

DERIVED FROM FORM 990, SCH. H, WORKSHEET 2.

PART I, LN 7 COL(F):

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

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

WAS \$1,096,766 FOR THE YEAR ENDED SEPTEMBER 30, 2020. THIS AMOUNT HAS BEEN

Part VI Supplemental Information (Continuation)

SUBTRACTED FOR THE PURPOSE OF CALCULATING THE PERCENTAGE REPORTED ON THE SCHEDULE H, PART I, LINE 7 TABLE.

PART II, COMMUNITY BUILDING ACTIVITIES:

COMMUNITY BUILDING ACTIVITIES

SHARING OUR SPACE

WHEN SPACE IS AVAILABLE, NCH PROVIDES SPACE AT NO COST TO NEEDY, NOT-FOR-PROFIT ORGANIZATIONS. THE TELFORD EDUCATION CENTER IS AVAILABLE TO NOT-FOR-PROFIT HEALTHCARE RELATED GROUPS SUCH AS MENDED HEARTS AND THOSE THAT PROVIDE SUPPORT FOR STROKE AND KIDNEY PATIENTS. RESIDENTS OF MARCO BENEFITED WITH THE USE OF OUR FACILITY FOR COMMUNITY EDUCATION AND THE HOSPICE SUPPORT GROUP.

CLINICAL NURSING SCHOOL

THE CLINICAL NURSING SCHOOL OF FLORIDA SOUTHWESTERN STATE COLLEGE IS PROVIDED HERE AT NCH. FOR YEARS, NCH HAS ALWAYS WELCOMED STUDENTS OF FLORIDA SOUTHWESTERN STATE COLLEGE AND LORENZO WALKER INSTITUTE OF TECHNOLOGY TO OUR FACILITIES. NCH PROVIDES ON-SITE CLASSROOMS FOR CLINICAL EDUCATION.

NURSING AND RADIOLOGY SCHOLARSHIPS ARE GENEROUSLY FUNDED AT BOTH FLORIDA SOUTHWESTERN STATE COLLEGE AND FGCU.

SHARING OUR EXPERTISE

MEMBERS OF NCH MANAGEMENT SERVE ON COMMUNITY BOARDS IN VARIOUS CAPACITIES. WE ALSO PROVIDE EXPERTISE TO OTHER COMMUNITY ISSUES SUCH AS WORKFORCE HOUSING AND WORKFORCE DEVELOPMENT.

Part VI Supplemental Information (Continuation)

EMPLOYING THE COMMUNITY

NCH IS GROWING OUR OWN HEALTHCARE PROFESSIONALS, AND HELPING OTHERS

SEEKING WORK, TO FIND IT. CAREER DAYS, JOB SHADOWING, AND LECTURES AT

LOCAL MIDDLE AND HIGH SCHOOLS ENLIGHTEN STUDENTS ABOUT THE MANY

OPPORTUNITIES IN THE HEALTHCARE WORLD.

PART III, LINE 2:

BAD DEBT EXPENSE, COSTING METHODOLOGY USED

BAD DEBT EXPENSE IN THE FINANCIAL STATEMENTS IS DETERMINED BY PATIENTS

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

DATE OF SERVICE.

PART III, LINE 3:

BAD DEBT EXPENSE

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

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

FROM FORM 990, SCH. H, WORKSHEET 2.

PART III, LINE 4:

BAD DEBT FOOTNOTE

BAD DEBTS REPRESENT CHARGES DEEMED UNCOLLECTIBLE DUE TO EITHER: (A) A

PATIENT'S INABILITY TO QUALIFY AS CHARITY, WELFARE, OR MEDICAID, YET CLEAR

FINANCIAL INDICATIONS EXIST THAT DEMONSTRATE AN INABILITY TO PAY, OR (B) A

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

Part VI Supplemental Information (Continuation)

TO CEASE FURTHER COLLECTION EFFORTS. BAD DEBT EXPENSE IN THE FINANCIAL STATEMENTS IS DETERMINED BY PATIENTS THAT HAVE FILED FOR BANKRUPTCY AND/OR HAVE LOSS OF EMPLOYMENT AFTER THE DATE OF SERVICE.

THE BAD DEBT EXPENSE FOOTNOTE DISCLOSURES CAN BE FOUND ON PAGES 17 AND 18 OF THE ATTACHED CONSOLIDATED FINANCIAL STATEMENTS FOR THE NCH HEALTHCARE SYSTEM, INC. AND SUBSIDIARIES.

PART III, LINE 8:

COSTING METHODOLOGY, MEDICARE

THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNT REPORTED ON LINE 6 IS BASED ON A COST TO CHARGE RATIO. THE COST TO CHARGE RATIO WAS DERIVED FROM FORM 990, SCH. H, WORKSHEET 2.

CONSISTENT WITH THE CHARITABLE HEALTHCARE MISSION OF NCH AND THE COMMUNITY BENEFIT STANDARD SET FORTH IN IRS REVENUE RULING 69-545, THE HOSPITAL PROVIDES CARE FOR ALL PATIENTS COVERED BY MEDICARE SEEKING MEDICAL CARE. SUCH CARE IS PROVIDED FOR SUCH SERVICES MEETS OR EXCEEDS THE COSTS INCURRED BY THE HOSPITAL TO PROVIDE SUCH SERVICES.

AS A RESULT, NAPLES COMMUNITY HOSPITAL, INC. VIEWS ANY SHORTFALL REPORTED IN LINE 7 AS AN ADDITIONAL ITEM OF COMMUNITY BENEFIT PROVIDED BY THE ORGANIZATION.

PART III, LINE 9B:

COLLECTION PRACTICES

Part VI Supplemental Information (Continuation)

NAPLES COMMUNITY HOSPITAL, INC. PROVIDES URGENT/EMERGENT MEDICAL SERVICES

WITHOUT REGARD TO ABILITY TO PAY. NAPLES COMMUNITY HOSPITAL, INC. ALSO

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

TO PATIENTS WHO MEET SPECIFIC CRITERIA UNDER THE STATE'S CHARITY CARE

GUIDELINES. BECAUSE NAPLES COMMUNITY HOSPITAL, INC. DOES NOT PURSUE

COLLECTION OF ACCOUNTS DETERMINED TO QUALIFY AS CHARITY CARE, THESE

AMOUNTS ARE NOT REPORTED AS REVENUE.

PART VI, LINE 2:

NEEDS ASSESSMENT

THE ORGANIZATION ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITIES IT

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

PARTICIPATES IN MANY COMMUNITY RELATED ORGANIZATIONS AND GROUPS THAT ARE

CONTINUALLY ASSESSING UNMET NEEDS WITHIN COLLIER COUNTY. WE HAVE

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

ALLIANCE, COLLIER COUNTY PUBLIC SCHOOLS, THE IMMOKALEE FOUNDATION,

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

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

COMMUNITY.

NCH PROVIDES MANY HEALTH-ENHANCING EDUCATIONAL PROGRAMS AND RESOURCES IN

PROMOTING HEALTH TO THE COMMUNITY. THE CURRENT PROGRAMS AND RESOURCES

PROVIDED TO THE COMMUNITY INCLUDE THE FOLLOWING: HEALTH SEMINARS,

COMMUNITY HEALTH FAIRS, FREE DIAGNOSTIC AND SCREENING TESTING, THE

NEIGHBORHOOD HEALTH CLINIC, HEART PROGRAMS, CANCER SURVIVAL AWARENESS,

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

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

Part VI Supplemental Information (Continuation)

IN ADDITION TO THE PROGRAMS LISTED, WE ARE ALSO WORKING WITH THE SAFE AND HEALTHY CHILDREN'S COALITION OF COLLIER COUNTY TO DEVELOP PROGRAMS FOR DROWNING PREVENTION, CHILDHOOD OBESITY, SAFE SLEEP EFFORTS, AND BREASTFEEDING PROGRAMS.

DURING 2019, WE COMPLETED A COMMUNITY HEALTH NEEDS ASSESSMENT REPORT AND HAVE POSTED THIS REPORT ON OUR WEBSITE ([HTTP://WWW.NCHMD.ORG/ABOUT-US/ANNUAL-REPORTS](http://www.nchmd.org/about-us/annual-reports)). WE ARE COMMITTED TO PROMOTING EXISTING AND POTENTIAL NEW PROGRAMS TO THE COMMUNITY IN RESPONSE TO THE COMMUNITY HEALTH NEEDS ASSESSMENT. PLEASE REFER TO THIS REPORT AND DETAILED PLAN WHICH WAS REVIEWED BY THE NCH HEALTHCARE SYSTEM BOARD OF TRUSTEES AND APPROVED AT THE SEPTEMBER 25, 2019 BOARD OF TRUSTEE MEETING. INCLUDED IN THE 2019 REPORT IS THE BLUE ZONE PROJECT WHICH BEGAN IN 2015 AND IS SPONSORED BY NCH. THE BLUE ZONE PROJECT IS A COMPREHENSIVE WELL-BEING IMPROVEMENT INITIATIVE DESIGNED TO HELP PEOPLE LIVE LONGER AND BETTER BY BUILDING STRONG SOCIAL NETWORKS AND ENCOURAGING SUSTAINABLE CHANGES THROUGHOUT THE COMMUNITY THAT LEADS TO HEALTHIER CHOICES.

PART VI, LINE 3:

INFORMATION REGARDING PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

NAPLES COMMUNITY HOSPITAL, INC. RECOGNIZES ITS RESPONSIBILITY TO COMMUNICATE ITS FINANCIAL POLICIES AND EXPECTATIONS TO PATIENTS. THE HOSPITAL INFORMS AND EDUCATES PATIENTS BY PROVIDING PATIENTS WITH THE NCH HEALTHCARE SYSTEM PATIENT RIGHTS AND RESPONSIBILITIES. INCLUDED IN THESE RIGHTS IS THE RIGHT TO BE GIVEN, UPON REQUEST, FULL MEDICAL INFORMATION AND FINANCIAL COUNSELING. IN ADDITION, A PATIENT REPRESENTATIVE WILL

Part VI Supplemental Information (Continuation)

CONTACT PATIENTS PRIOR TO SERVICES TO EVALUATE THE PATIENT'S ABILITY TO
PAY. THIS PROCESS INCLUDES OBTAINING THE PATIENT'S CURRENT FINANCIAL
INFORMATION, OBTAINING A CREDIT REPORT AND REVIEWING THE PATIENT'S PAYMENT
HISTORY WITH NAPLES COMMUNITY HOSPITAL, INC. PERSONS REQUIRING ASSISTANCE
WITH THE UNFUNDED PORTION OF THEIR BILLS ARE ENCOURAGED TO REQUEST A
CHARITY EVALUATION. NCH ALSO PROVIDES ASSISTANCE FOR PATIENTS TO APPLY FOR
MEDICAID COVERAGE OR OTHER STATE OR LOCAL ASSISTANCE PROGRAMS WHICH MAY
ASSIST WITH PAYMENT FOR MEDICAL SERVICES.

PART VI, LINE 4:

COMMUNITY INFORMATION

NAPLES COMMUNITY HOSPITAL, INC. SERVES A DIVERSE AND SEASONAL COMMUNITY.
THE POPULATION IS APPROXIMATELY 363,267. THE MEDIAN AGE OF RESIDENTS IS
50. THE ESTIMATED MEDIAN HOUSEHOLD INCOME IS \$70,702. THE UNEMPLOYMENT
RATE IS APPROXIMATELY 3.5%. THE PERCENTAGE OF RESIDENTS BELOW THE POVERTY
LEVEL IS APPROXIMATELY 7.9%.

PART VI, LINE 5:

INFORMATION REGARDING PROMOTION OF COMMUNITY HEALTH

NAPLES COMMUNITY HOSPITAL, INC. PROVIDES HEALTH-ENHANCING EDUCATIONAL
PROGRAMS AND RESOURCES IN PROMOTING THE HEALTH OF OUR COMMUNITY. THE TYPE
OF PROGRAMS/RESOURCES PROVIDED INCLUDE: HEALTH SEMINARS, COMMUNITY HEALTH
FAIRS AND TESTING, REGISTERED NURSES EDUCATING FUTURE PATIENTS, SUPPORTING
THE NEIGHBORHOOD HEALTH CLINIC, PHYSICIAN LED ACCESS NETWORK OF COLLIER
COUNTY, HEART PROGRAMS, CANCER SURVIVAL AWARENESS, SUPPORT OF PATIENT
FAMILIES, DR. JOHN BRIGGS WELLNESS CENTER, AS WELL AS THE SHARING OF SPACE

Part VI Supplemental Information (Continuation)

AT NO COST TO NEEDY, NOT-FOR-PROFIT ORGANIZATIONS. THE ORGANIZATION ALSO

SPONSORS AND SUPPORTS THE CLINICAL NURSING SCHOOLS IN THE COMMUNITY.

THE ORGANIZATION'S CIVIC INVOLVEMENT INCLUDES MEMBERS OF NCH MANAGEMENT

SERVING ON COMMUNITY BOARDS IN VARIOUS CAPACITIES. THE HOSPITALS HAVE

ALWAYS PROVIDED EXEMPLARY PASTORAL CARE SERVICES. NCH IS ENCOURAGING THEIR

OWN HEALTHCARE PROFESSIONAL BY SPONSORING CAREER DAYS, JOB SHADOWING, AND

LECTURES AT LOCAL MIDDLE AND HIGH SCHOOLS ON THE MANY OPPORTUNITIES IN THE

HEALTHCARE FIELD. FOR ADDITIONAL COMMUNITY ACTIVITIES THAT NAPLES

COMMUNITY HOSPITAL, INC. SUPPORTS, PLEASE REFER TO FORM 990, SCHEDULE O,

PART III, PROGRAM SERVICES.

PART VI, LINE 6:

AFFILIATED HEALTHCARE SYSTEM INFORMATION

NAPLES COMMUNITY HOSPITAL, INC. IS AN AFFILIATE OF THE NCH HEALTHCARE

SYSTEM, INC. NCH HEALTHCARE SYSTEM, INC. PROVIDES HEALTH-ENHANCING

EDUCATIONAL PROGRAMS AND RESOURCES IN PROMOTING THE HEALTH OF OUR

COMMUNITY. IN ADDITION TO NAPLES COMMUNITY HOSPITAL, INC., THE NCH

HEALTHCARE SYSTEM ALSO INCLUDES THE FOLLOWING NON-PROFIT ORGANIZATIONS:

> MARCO ISLAND HOSPITAL, INC., OPERATES AN 11 1/2-HOUR/7-DAYS A WEEK

URGENT CARE FACILITY AND SERVICES PATIENTS WITHOUT REGARD TO THEIR ABILITY

TO PAY. DURING FYE 09/30/2020, 7,033 PATIENTS WERE TREATED. OF THESE

PATIENTS, 8.22 % WERE CLASSIFIED AS MEDICAID, CHARITY, OR BAD DEBTS.

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

NAPLES AND IMMOKALEE, FLORIDA.

Part VI Supplemental Information (Continuation)

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

RADIOLOGY SERVICES IN COLLIER AND LEE COUNTY, FLORIDA.

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

FL

Part III Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" on Form 990, Part IV, line 22.
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
EDUCATIONAL SCHOLARSHIPS	3	6,000.	0.		

Part IV Supplemental Information. Provide the information required in Part I, line 2; Part III, column (b); and any other additional information.

PART I, LINE 2:

PROCEDURES FOR MONITORING THE USE OF GRANT FUNDS

NAPLES COMMUNITY HOSPITAL AUXILIARIES ARE PROUD TO MAKE SCHOLARSHIPS

AVAILABLE TO STUDENTS VIA THE AUXILIARY SCHOLARSHIP PROGRAM. THE PURPOSE OF

THIS SCHOLARSHIP IS TO HELP ENCOURAGE STUDENTS TO ENTER THE HEALTHCARE

FIELD. THE PROGRAM IS OPEN TO STUDENTS STUDYING IN APPROVED AREAS OF

HEALTHCARE. AS DETAILED BELOW, APPLICANTS WISHING CONSIDERATION FOR THE

SCHOLARSHIP PROGRAM MUST BE AN ACTIVE NCH AUXILIARY VOLUNTEER OR A

Part IV Supplemental Information

DEPENDENT CHILD OF AN NCH EMPLOYEE AND MUST SUBMIT A COMPLETED SCHOLARSHIP

APPLICATION AND ATTACH THE FOLLOWING INFORMATION:

1. SHOW PROOF THAT YOU ARE AN ACTIVE NCH AUXILIARY VOLUNTEER AND IN GOOD

STANDING (VOLUNTEER A MINIMUM OF 50 HOURS PRIOR TO THE TIME

APPLICATION) OR HAVE A PARENT THAT IS A CURRENT NCH EMPLOYEE WITH AT

LEAST ONE YEAR OF SERVICE.

2. SEEK A CAREER IN THE HEALTHCARE FIELD.

3. HAVE A MINIMUM OF 3.0 GPA, UNWEIGHTED.

4. COMPLETE AND ATTACH A 500 WORD ESSAY ON WHY THE APPLICANT HAS CHOSEN

HEALTHCARE AS A CAREER PATH AND WHY YOU FEEL YOU ARE A TOP CANDIDATE TO

BE CHOSEN FOR THIS SCHOLARSHIP. IN LIEU OF AN ESSAY, VOLUNTEERS CAN

SERVE AN ADDITIONAL 50 HOURS AS AN NCH AUXILIARY VOLUNTEER.

5. PROOF OF PAID RECENT ENROLLMENT.

6. OFFICIAL SCHOOL TRANSCRIPT (NO MORE THAN 30 DAYS OLD).

7. TWO PROFESSIONAL LETTERS OF REFERENCE (NO MORE THAN 30 DAYS OLD).

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
 ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
 ▶ Attach to Form 990.
 ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
NAPLES COMMUNITY HOSPITAL, INC.

Employer identification number
59-0694358

Part I Questions Regarding Compensation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	Yes	No
1b		
2		
4a	X	
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7	X	
8		X
9		

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

Schedule J (Form 990) 2019

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) ALLEN S. WEISS, M.D. TERM 01/19 FORMER PRESIDENT/CEO/TRUSTEE	(i)	81,226.	0.	955,526.	9,417.	16,585.	1,062,754.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) PHILLIP DUTCHER CHIEF OPERATING OFFICER SYSTEM	(i)	683,212.	90,122.	21,286.	11,200.	2,484.	808,304.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) KEVIN D. COOPER TERM 01/19 FORMER CHIEF OF STAFF	(i)	47,383.	0.	548,048.	5,468.	16,856.	617,755.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) FRANK ASTOR, M.D. TERM 11/19 CHIEF MEDICAL OFFICER	(i)	463,456.	83,002.	20,555.	11,200.	16,907.	595,120.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) RICK WYLES CFO/ASSISTANT TREASURER	(i)	384,824.	69,484.	20,188.	11,200.	21,922.	507,618.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) JONATHAN KLING, R.N. CHIEF NURSING OFFICER	(i)	399,287.	49,747.	19,270.	11,200.	21,250.	500,754.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) ZACHARY BOSTOCK TERM 03/20 CHIEF ADMINISTRATIVE OFFICER	(i)	376,328.	67,591.	19,180.	11,200.	22,503.	496,802.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) LINDA ROEBACK TERM 05/20 CHIEF COUNSEL	(i)	345,179.	18,719.	19,774.	11,200.	14,708.	409,580.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) CHARLES GRAEBER, M.D. PROGRAM DIRECTOR, INT. MED. RES.	(i)	357,131.	26,564.	3,708.	11,200.	1,263.	399,866.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) RENEE M. THIGPEN CHIEF HR OFFICER	(i)	267,354.	48,621.	20,188.	11,200.	17,717.	365,080.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) MICHAEL RILEY CHIEF STRATEGY OFFICER	(i)	264,955.	48,035.	20,188.	11,200.	16,807.	361,185.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) GARY TOMCIK TERM 04/20 CHIEF EXPERIENCE OFFICER	(i)	235,942.	38,707.	20,188.	11,200.	22,512.	328,549.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) PAUL HILTZ PRESIDENT/CEO/TRUSTEE	(i)	247,601.	20,000.	19,091.	0.	6,163.	292,855.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) KIM THORP DIRECTOR OF PHARMACY NCH HEALTHCARE	(i)	190,740.	15,243.	774.	8,514.	23,309.	238,580.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) NOBLE ARRINGTON CONTROLLER	(i)	183,277.	14,837.	414.	8,176.	22,759.	229,463.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) ILIA ECHEVARRIA, R.N. ASSOCIATE CHIEF NURSE PROF. PRACTICE	(i)	188,498.	14,727.	270.	8,254.	13,025.	224,774.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(17) GINA TEEGARDEN, R.N. ASSOCIATE CHIEF NURSE OPERATIONS	(i)	184,016.	14,284.	414.	7,296.	9,246.	215,256.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

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

PART I, LINES 4A-B:

PART I, LINE 4A:

PRESIDENT AND CEO RESIGNED 01/2019 AND RECEIVED A SEVERANCE PAYMENT OF \$950,356 FOR CALENDAR YEAR 2019.

CHIEF OF STAFF RESIGNED 01/2019 AND RECEIVED A SEVERANCE PAYMENT OF \$545,812 FOR CALENDAR YEAR 2019.

PART I, LINE 4B:

CHIEF MEDICAL OFFICER PARTICIPATED IN A 457(F) SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN BUT DID NOT RECEIEVE A PAYMENT FOR CALENDAR YEAR 2019.

CHIEF ADMINISTRATIVE OFFICER PARTICIPATED IN A 457(F) SUPPLEMENTAL NON-QUALIFIED PLAN BUT DID NOT RECEIVE A PAYMENT FOR CALENDAR YEAR 2019.

PART I, LINE 7:

PROVISIONS OF NON-FIXED PAYMENTS

Part III Supplemental Information

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

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

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

Name of the organization **NAPLES COMMUNITY HOSPITAL, INC.** Employer identification number **59-0694358**

Part I Bond Issues											
SEE PART VI FOR COLUMNS (A) AND (F) CONTINUATIONS											
(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A COLLIER CTY INDSTL DEVLMT AUTHORITY	59-1695679	NONE	12/30/10	30,000,000.	NEW CAPITAL EQUIPMENT		X		X		X
B COLLIER CTY INDSTL DEVLMT AUTHORITY	59-1695679	194641AK2	04/14/11	100,955,824.	REFINANCE 93/96 BONDS & NEW CAPITAL EQUIPMENT		X		X		X
C COLLIER CTY INDSTL DEVLMT AUTHORITY	59-1695679	NONE	03/31/20	50,000,000.	NEW CAPITAL FOR FACILITIES AND EQUIPMENT		X		X		X
D											

Part II Proceeds										
	A		B		C		D			
1 Amount of bonds retired	26,260,184.		12,260,000.							
2 Amount of bonds legally defeased										
3 Total proceeds of issue	30,050,966.		101,013,628.		20,500,000.					
4 Gross proceeds in reserve funds										
5 Capitalized interest from proceeds										
6 Proceeds in refunding escrows			49,222,562.							
7 Issuance costs from proceeds	159,198.		1,414,549.		250,525.					
8 Credit enhancement from proceeds										
9 Working capital expenditures from proceeds										
10 Capital expenditures from proceeds	29,891,768.		50,376,517.		20,249,475.					
11 Other spent proceeds										
12 Other unspent proceeds										
13 Year of substantial completion	2013		2014		2022					
	Yes	No	Yes	No	Yes	No	Yes	No		
14 Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?		X	X			X				
15 Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X		X		X				
16 Has the final allocation of proceeds been made?	X		X			X				
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X					

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

Part III Private Business Use								
	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X		
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		
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?		X		X		X		
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								
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government								
6 Total of lines 4 and 5								
7 Does the bond issue meet the private security or payment test?		X		X		X		
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		
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?	X		X		X			

Part IV Arbitrage								
	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X		X		
b Exception to rebate?	X		X		X			
c No rebate due?		X		X		X		
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X		X		X		

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X		
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X		X		
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		X			

	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 isn't available under applicable regulations?	X		X		X			

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. See instructions

SCHEDULE K, PART I, BOND ISSUES:

(A) ISSUER NAME: COLLIER CTY INDSTL DEVLMT AUTHORITY

(F) DESCRIPTION OF PURPOSE: NEW CAPITAL EQUIPMENT

(A) ISSUER NAME: COLLIER CTY INDSTL DEVLMT AUTHORITY

(F) DESCRIPTION OF PURPOSE: REFINANCE 93/96 BONDS & NEW CAPITAL EQUIPMENT

(A) ISSUER NAME: COLLIER CTY INDSTL DEVLMT AUTHORITY

(F) DESCRIPTION OF PURPOSE: NEW CAPITAL FOR FACILITIES AND EQUIPMENT

FORM 990, SCHEDULE K, PART II, LINE 3

FOR COLLIER COUNTY INDUSTRIAL DEVELOPMENT AUTHORITY-SERIES 2010, THE

TOTAL PROCEEDS OF ISSUE REPORTED INCLUDES \$50,996 IN INVESTMENT

EARNINGS.

FOR COLLIER COUNTY INDUSTRIAL DEVELOPMENT AUTHORITY-SERIES 2011 PUBLIC,

THE TOTAL PROCEEDS OF ISSUE REPORTED INCLUDES \$1,159,176 IN NET

ORIGINAL ISSUE DISCOUNTS AND \$57,804 IN INVESTMENT EARNINGS.

FOR COLLIER COUNTY INDUSTRIAL DEVELOPMENT AUTHORITY-SERIES 2020, AS OF

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. See instructions *(continued)*

SEPTEMBER 30, 2020, ADVANCES TOTALED \$20,500,000 OF THE TOTAL AVAILABLE
OF \$50,000,000. INTEREST IS PAID ONLY ON THE AMOUNT OF THE ADVANCES
THAT HAVE BEEN MADE.

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
SHARIE TOMCIK	FMLY MEMBER/OFFICER	23,385.	PYMT COMP		X
WYNN PROPERTIES	OWNER/TRUSTEE	102,128.	RENTAL PAYM		X
SUNSHINE ACE HARDWARE	OWNER/TRUSTEE	128,113.	PURCHASES		X
MEGAN RILEY	FMLY MEMBER/OFFICER	44,485.	PYMT COMP		X

Part V Supplemental Information.

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

SCHEDULE L, PART II, LOANS TO AND FROM INTERESTED PERSONS:

(A) NAME OF PERSON: PAUL HILTZ

(B) RELATIONSHIP WITH ORGANIZATION: CEO/PRESIDENT

(C) PURPOSE OF LOAN: RETAIN - RETENTION INCENTIVE

(D) LOAN TO OR FROM ORGANIZATION? = FROM

(E) ORIGINAL PRINCIPAL AMOUNT \$ 50,000. (F) BALANCE DUE \$ 40,000.

(G) LOAN IN DEFAULT? = NO

(H) APPROVED BY BOARD OR COMMITTEE? = YES

(I) WRITTEN AGREEMENT? = YES

FORM 990, SCHEDULE L, PART IV

MEGAN RILEY IS THE DAUGHTER OF MICHAEL RILEY, CHIEF STRATEGY OFFICER.

SHARIE TOMCIK, R.N., IS THE SPOUSE OF GARY TOMCIK, CHIEF EXPERIENCE OFFICER.

MICHAEL WYNN IS A TRUSTEE AND AN OWNER OF WYNN PROPERTIES WHICH NCH PAYS FOR RENTAL SPACE.

MICHAEL WYNN IS A TRUSTEE AND AN OWNER OF SUNSHINE ACE HARDWARE WHERE

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No. 1545-0047

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

- ▶ Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

Name of the organization **NAPLES COMMUNITY HOSPITAL, INC.** Employer identification number **59-0694358**

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	X		388,723.	FMV
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities - Publicly traded	X	27	481,489.	FMV
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	X	6	275.	
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other (JEWELRY)	X	3	9,000.	FMV
26 Other (ENTERTAINMENT)	X	11	7,510.	FMV
27 Other (SPORT EVENTS)	X	4	1,429.	FMV
28 Other (LEASE BENTLEY)	X	1	900.	FMV

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

- 30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period? **30a** X
- b If "Yes," describe the arrangement in Part II.
- 31 Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions? **31** X
- 32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions? **32a** X
- b If "Yes," describe in Part II.
- 33 If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.

	Yes	No
30a		X
31	X	
32a		X

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

Schedule M (Form 990) 2019

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, COLUMN (B):

NAPLES COMMUNITY HOSPITAL, INC. IS REPORTING IN PART I, COLUMN (B) THE
NUMBER OF CONTRIBUTIONS.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2019

Open to Public
Inspection

Name of the organization

NAPLES COMMUNITY HOSPITAL, INC.

Employer identification number

59-0694358

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

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

HEALTHCARE AND TO PROVIDE EXCELLENCE IN EVERY PATIENT EXPERIENCE.

NAPLES COMMUNITY HOSPITAL, INC. LOCATED IN COLLIER COUNTY, FLORIDA,

CONSISTS OF TWO HOSPITALS WITH 713 BEDS. THE DOWNTOWN HOSPITAL

CAMPUS IS A 391-BED ACUTE CARE FACILITY AND NORTH NAPLES HOSPITAL

CAMPUS IS A 322-BED ACUTE CARE FACILITY. THE HOSPITAL ALSO HAS A BLOOD

CENTER AND VARIOUS OTHER OUTPATIENT CENTERS LOCATED THROUGHOUT

THE COMMUNITY.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

NAPLES COMMUNITY HOSPITAL, INC. (NCH) PROVIDES INPATIENT AND OUTPATIENT

HEALTHCARE SERVICES WITHOUT REGARD TO A PATIENT'S ABILITY TO PAY. FROM

ITS TWO HOSPITALS, CANCER TREATMENT CENTERS, WOUND CARE CENTERS AND

OUTPATIENT REHABILITATION CENTERS, NCH PROVIDED \$93,716,891 OF CHARITY

CARE TO PATIENTS WHO WERE UNABLE TO PAY AND NOT COVERED BY ANY

GOVERNMENTAL OR PRIVATE INSURANCE PROGRAM. ADDITIONALLY, NCH WROTE OFF

\$1,096,766 CLASSIFIED AS BAD DEBTS, MUCH OF WHICH REPRESENTED SERVICES

DELIVERED TO INDIGENT PATIENTS, WHO DID NOT RECEIVE A CHARITY CARE

DETERMINATION IN ACCORDANCE WITH THE STATE'S CRITERIA.

THE SERVICES OFFERED AT NCH ARE EXTENSIVE AND INCLUDE MEDICAL,

SURGICAL, OBSTETRIC, PEDIATRIC, REHABILITATIVE, PSYCHIATRIC,

DIAGNOSTIC, AND EMERGENCY TREATMENT. A TOTAL OF 554 ACTIVE AND

ASSOCIATE PHYSICIANS, 2,853 FULL-TIME EQUIVALENT EMPLOYEES, AND 880

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

Schedule O (Form 990 or 990-EZ) (2019)

Name of the organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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VOLUNTEERS COMPRISE THE OUTSTANDING MEDICAL TEAM WORKING TOGETHER TO
PROVIDE THESE SERVICES.

THE TWO HOSPITALS ARE COMPRISED OF 617 ACUTE CARE BEDS, A 54 BED

REHABILITATIVE UNIT, 19 NICU BEDS, AND A 23 BED PSYCHIATRIC UNIT.

ADDITIONAL SPECIALTY SERVICES FOR THE CARE OF CERTAIN CRITICAL AND LIFE

THREATENING MEDICAL CONDITIONS INCLUDE THE MEDICAL INTENSIVE CARE UNIT,

SURGICAL INTENSIVE CARE UNIT, CARDIAC CARE UNIT, CARDIAC

CATHETERIZATION UNIT AND INTERMEDIATE CARE UNIT. OTHER SPECIALTIES

INCLUDE ONCOLOGY, DIAGNOSTIC SERVICES (CARDIO-DIAGNOSTICS, MAMMOGRAPHY,

COMPUTERIZED TOPOGRAPHIC SCANNING (CT), AND MAGNETIC RESONANCE IMAGING

(MRI), AND SPECIAL PROCEDURES SUCH AS BIOPSY, ANGIOGRAPHY, AND

ANGIOPLASTY).

DURING THE 2020 FISCAL YEAR, NCH HAD 28,207 INPATIENT ADMISSIONS

RESULTING IN 132,407 DAYS OF CARE. ADDITIONALLY, 102,572 PATIENTS WERE

TREATED IN OUR EMERGENCY CARE CENTERS.

NAPLES COMMUNITY HOSPITAL, INC. RECEIVES VOLUNTEER ASSISTANCE FOR

OPERATING ITS HOSPITALITY, GIFT, AND RETAIL SHOPS.

NAPLES COMMUNITY HOSPITAL, INC. ALSO PROVIDES HEALTH ENHANCING

EDUCATIONAL PROGRAMS IN ADDITION TO MEDICAL CARE. THESE PROGRAMS

INCLUDE: WHITAKER WELLNESS CENTER; BETTER BREATHERS CLUB; MENDED

HEARTS; DIABETES EDUCATION PROGRAM; CHILDBIRTH CLASSES; HEALTH FAIRS;

AND CAREER DAYS. IN ADDITION, NCH SUPPORTS THE FOLLOWING: NURSES IN THE

COLLIER COUNTY PUBLIC SCHOOL SYSTEM AND ATHLETIC TRAINERS AT THE LOCAL

HIGH-SCHOOLS AND SPORTING EVENTS.

Name of the organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
---	--

FORM 990, PART VI, SECTION A, LINE 4:

BYLAWS AMENDED AND RESTATED

NCH HEALTHCARE SYSTEM, INC. AMENDED AND RESTATED ITS BYLAWS IN FISCAL YEAR

2020. ALTHOUGH THIS CHANGE WAS MADE ONLY TO THE NCH HEALTHCARE SYSTEM, INC.

BYLAWS THEY DECIDE AND INFLUENCE THE GOVERNANCE OF ALL ENTITIES OF THE

SYSTEM.

ARTICLE II BOARD OF TRUSTEES

2.2.1 NUMBER AND TENURE WERE REVISED TO INCLUDE "NOT MORE THAN 15" MEMBERS

AND "AN INITIAL TERM OF THREE YEARS, AND ELIGIBLE TO SERVE UP TO ONE

ADDITIONAL TERM OF THREE YEARS." DELETED THE REQUIREMENT OF TWO ELECTED

EMPLOYEE TRUSTEES.

2.8 AFFIRMATIVE VOTE REQUIREMENTS CHANGED FROM MAJORITY TO TWO-THIRDS OR

GREATER.

ARTICLE III OFFICERS

3.3 AFFIRMATIVE VOTE REQUIREMENTS CHANGED FROM MAJORITY TO TWO-THIRDS OR

GREATER.

ARTICLE V AMENDMENTS TO BYLAWS

AMENDMENTS TO BYLAWS REQUIREMENT CHANGED FROM MAJORITY TO TWO THIRDS OR

GREATER VOTE.

Name of the organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
---	--

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

GOVERNING BODY AND MANAGEMENT

NCH HEALTHCARE SYSTEM, INC. IS THE SOLE MEMBER OF THIS ORGANIZATION.

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

GOVERNING BODY AND MANAGEMENT

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

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

GOVERNING BODY AND MANAGEMENT

ALL OF THE GOVERNANCE DECISIONS FOR NAPLES COMMUNITY HOSPITAL, INC. ARE RESERVED TO THE GOVERNING BODY OF NCH HEALTHCARE SYSTEM, INC.

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

REVIEW PROCESS

INFORMATION RELATED TO NAPLES COMMUNITY HOSPITAL, INC.'S ("NCH") FORM 990 FILING IS GATHERED BY FINANCE STAFF AND PROVIDED TO RSM US LLP, FOR REVIEW. AFTER THE REVIEW BY RSM US LLP, THE FORM 990 IS REVIEWED BY THE NCH HEALTHCARE SYSTEM CHIEF FINANCIAL OFFICER. THE FORM 990 IS THEN REVIEWED BY OUTSIDE COUNSEL FOR THE BOARD. PRIOR TO BOARD APPROVAL, THE FORM 990 IS PROVIDED TO ALL OF THE FINANCE COMMITTEE BOARD OF TRUSTEES FOR THEIR REVIEW VIA THE BOARD PORTAL. AT THE CONCLUSION OF THIS REVIEW PROCESS THE FORM 990

Name of the organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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IS APPROVED BY THE BOARD OF TRUSTEES PRIOR TO FILING WITH THE IRS.

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

CONFLICT OF INTEREST POLICY

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

KEY EMPLOYEES ARE REQUIRED TO DISCLOSE INTERESTS THAT COULD POTENTIALLY

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

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

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

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

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

SHALL DISCLOSE OTHER POTENTIAL CONFLICTS WITH THE COMPLIANCE OFFICER.

AFTER EXERCISING DUE DILIGENCE, THE BOARD OR COMMITTEE SHALL DETERMINE

WHETHER THE CORPORATION CAN OBTAIN A MORE ADVANTAGEOUS TRANSACTION OR

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

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

ARRANGEMENT IS NOT REASONABLY ATTAINED UNDER CIRCUMSTANCES THAT WOULD NOT

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

BY A GREATER THAN TWO-THIRDS VOTE OF THE DISINTERESTED TRUSTEES WHETHER THE

TRANSACTION OR ARRANGEMENT IS IN THE CORPORATION'S BEST INTEREST AND FOR

ITS OWN BENEFIT AND WHETHER THE TRANSACTION IS FAIR AND REASONABLE TO THE

CORPORATION AND SHALL MAKE ITS DECISION AS TO WHETHER TO ENTER INTO THE

TRANSACTION OR ARRANGEMENT IN CONFORMITY WITH SUCH DETERMINATION.

THE COMPLIANCE OFFICER WILL DETERMINE IF A MANAGEMENT TEAM MEMBER OR

EMPLOYEE SHOULD BE EXCUSED FROM A DISCUSSION OR PARTICIPATE IN A DECISION

Name of the organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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IN WHICH THERE MAY BE A CONFLICT OF INTEREST.

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

COMPENSATION PROCESS

THIS ORGANIZATION IS AN AFFILIATE OF THE NCH HEALTHCARE SYSTEM, INC. ("THE SYSTEM"). COMPENSATION ARRANGEMENTS INVOLVING OUR CEO AND SENIOR LEADERSHIP TEAM ARE ESTABLISHED BY THE SYSTEM BOARD OF TRUSTEES COMPENSATION COMMITTEE PURSUANT TO A PROCESS THAT SATISFIES THE REBUTTABLE PRESUMPTION PROCEDURE AVAILABLE FOR SECTION 4958 EXCESS BENEFIT TRANSACTION TAX PURPOSES (WHICH REQUIRES A REVIEW OF COMPENSATION DETERMINATION BY DISINTERESTED PERSONS, USE OF APPROPRIATE COMPARABILITY DATA, AND CONTEMPORANEOUS DOCUMENTATION OF THE PROCESS).

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

DOCUMENTS AVAILABLE TO THE PUBLIC

THE FORMS 1023 AND 990, GOVERNING DOCUMENTS, AUDITED FINANCIAL STATEMENTS, AND CONFLICT OF INTEREST POLICY OF NAPLES COMMUNITY HOSPITAL, INC. ARE AVAILABLE TO THE PUBLIC UPON REQUEST. FINANCIAL STATEMENTS ARE ALSO AVAILABLE VIA OUR WEBSITE: [HTTP://WWW.NCHMD.ORG/ABOUT-US/ANNUAL-REPORTS](http://www.nchmd.org/about-us/annual-reports). DOCUMENTS AVAILABLE FOR REQUEST ARE AVAILABLE PURSUANT TO THE PERIOD OF DISCLOSURE PROVIDED IN SECTION 6104(D).

FORM 990, PART VIII, LINE 11A

PHSSEF FUNDS

OF THE PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND (THE PHSSEF)

Name of the organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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PAYMENTS, \$15,000,000 QUALIFIED AS REIMBURSEMENT FOR LOST OPERATING

MARGIN AND INCREMENTAL EXPENSES AND WAS RECOGNIZED AS OTHER REVENUE IN

THE CONSOLIDATED STATEMENTS OF OPERATIONS.

FORM 990, PART IX, LINE 11G, OTHER FEES:

PHYSICIAN FEES:

PROGRAM SERVICE EXPENSES	2,078,027.
MANAGEMENT AND GENERAL EXPENSES	365,848.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	2,443,875.

RECRUITING:

PROGRAM SERVICE EXPENSES	555,928.
MANAGEMENT AND GENERAL EXPENSES	97,874.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	653,802.

OUTSIDE SERVICES:

PROGRAM SERVICE EXPENSES	39,245,890.
MANAGEMENT AND GENERAL EXPENSES	6,909,455.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	46,155,345.

COLLECTION FEES:

PROGRAM SERVICE EXPENSES	3,381,190.
MANAGEMENT AND GENERAL EXPENSES	595,277.
FUNDRAISING EXPENSES	0.

Name of the organization NAPLES COMMUNITY HOSPITAL, INC.	Employer identification number 59-0694358
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TOTAL EXPENSES 3,976,467.

CONSULTING FEES:

PROGRAM SERVICE EXPENSES 2,557,434.

MANAGEMENT AND GENERAL EXPENSES 450,250.

FUNDRAISING EXPENSES 0.

TOTAL EXPENSES 3,007,684.

MEMBERSHIP FEES:

PROGRAM SERVICE EXPENSES 537,410.

MANAGEMENT AND GENERAL EXPENSES 94,614.

FUNDRAISING EXPENSES 0.

TOTAL EXPENSES 632,024.

PUBLIC MEDICAL ASSISTANCE TRUST FUND (FL) FEES:

PROGRAM SERVICE EXPENSES 5,574,921.

MANAGEMENT AND GENERAL EXPENSES 981,496.

FUNDRAISING EXPENSES 0.

TOTAL EXPENSES 6,556,417.

TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A 63,425,614.

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

TRANSFERS TO RELATED ORGANIZATIONS -9,259,365.

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization **NAPLES COMMUNITY HOSPITAL, INC.** Employer identification number **59-0694358**

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
NCH HEALTHCARE SYSTEM, INC. - 59-2314655 P.O. BOX 413029 NAPLES, FL 34101-3029	NOT-FOR-PROFIT HOLDING COMPANY	FLORIDA	501(C)(3)	LINE 12B, II	N/A		X
MARCO ISLAND HOSPITAL, INC. - 59-2315435 40 HEATHWOOD DRIVE MARCO ISLAND, FL 34145	HEALTHCARE	FLORIDA	501(C)(3)	LINE 3	NCH SYSTEM	X	
COLLIER HEALTH CARE, INC. - 65-0244276 P.O. BOX 413029 NAPLES, FL 34101-3029	HEALTHCARE	FLORIDA	501(C)(3)	LINE 3	NCH SYSTEM	X	
COMMUNITY HOME SERVICES, INC. - 59-2440516 P.O. BOX 413029 NAPLES, FL 34101-3029	SUPPORT ORGANIZATION	FLORIDA	501(C)(3)	LINE 12B, II	NCH SYSTEM	X	

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

Schedule R (Form 990) 2019

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

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) COLLIER HEALTH CARE, INC.	K	-64,500.	FMV
(2) NCHMD, INC.	P	-1,068,429.	FMV
(3) NCHMD, INC.	P	-1,733,918.	FMV
(4) NCHMD, INC.	P	-816,740.	FMV
(5) COLLIER HEALTH CARE, INC.	Q	-186,000.	FMV
(6) MARCO ISLAND HOSPITAL, INC.	Q	-834,013.	FMV

Part V Continuation of Transactions With Related Organizations (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(7) NCHMD, INC.	Q	25,716,225.	FMV
(8)			
(9)			
(10)			
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			

