Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

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

OMB No. 1545-0047

2010

A For the 2010 calendar year, or tax year beginning **10/01/10** , and ending **09/30/11**

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

C Name of organization
Northeast Hospital Corporation

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) **85 Herrick St** | Room/suite

City or town, state or country, and ZIP + 4 **Beverly MA 01915**

D Employer identification number **04-2121317**

E Telephone number **978-922-3000**

G Gross receipts$ **324,805,721**

F Name and address of principal officer:
Denis Conroy
85 Herrick St
Beverly MA 01915

H(a) Is this a group return for affiliates? ☐ Yes ☒ No

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

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

J Website: ▶ **www.beverlyhospital.org**

H(c) Group exemption number ▶

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

L Year of formation: **1893**

M State of legal domicile: **MA**

Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: **See Schedule O**

2 Check this box ▶ ☐ 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	26
4 Number of independent voting members of the governing body (Part VI, line 1b)	4	19
5 Total number of individuals employed in calendar year 2010 (Part V, line 2a)	5	2904
6 Total number of volunteers (estimate if necessary)	6	350
7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	4,645,553
b Net unrelated business taxable income from Form 990-T, line 34	7b	0

	Prior Year	Current Year
Revenue		
8 Contributions and grants (Part VIII, line 1h)	4,414,557	1,075,912
9 Program service revenue (Part VIII, line 2g)	313,952,825	306,876,005
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,717,755	2,608,025
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,231,582	7,468,927
12 Total revenue – add lines 8 through 11 (must equal Part VIII, column (A), line 12)	323,316,719	318,028,869
Expenses		
13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	11,206	28,000
14 Benefits paid to or for members (Part IX, column (A), line 4)	0	
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	192,200,815	187,953,794
16a Professional fundraising fees (Part IX, column (A), line 11e)	0	
b Total fundraising expenses (Part IX, column (D), line 25) ▶ **957,179**		
17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24f)	124,658,256	123,878,772
18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	316,870,277	311,860,566
19 Revenue less expenses. Subtract line 18 from line 12	6,446,442	6,168,303

	Beginning of Current Year	End of Year
Net Assets or Fund Balances		
20 Total assets (Part X, line 16)	338,522,276	330,792,542
21 Total liabilities (Part X, line 26)	215,570,149	229,120,289
22 Net assets or fund balances. Subtract line 21 from line 20	122,952,127	101,672,253

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

Denis Conroy **CFO**

Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
		08/08/12		

Firm's name ▶ | Firm's EIN ▶

Firm's address ▶ | Phone no.

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

For Paperwork Reduction Act Notice, see the separate instructions.

DAA

Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III X

1 Briefly describe the organization's mission:

See Schedule O

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

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

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

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

4 Describe the exempt purpose achievements for each of the organization's three largest program services by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ **126,273,901** including grants of $ **28,000**) (Revenue $ **156,506,763**)

Inpatient Services - Northeast Hospital Corporation (NHC) is a non-profit community hospital providing high quality care to the sick and injured, regardless ofthe ability to pay. Inpatient care is available in the areas of critical care, general medicine, surgery, maternity/obstetrics, newborn special care,pediatrics and physchiatry. In FY 2011, the Hospital had approximately 22,000 inpatient admissions

4b (Code:) (Expenses $ **92,897,927** including grants of $) (Revenue $ **125,819,162**)

Outpatient Services - The Hospital provides a comprehensive range of outpatient services, providing high quality care to the sick and injured, regardless of the ability to pay, including (but not limited to) cardiology, oncology, radiology, geriatrics, woman's health, rehabilitation, endoscopy, mammography and cardiopulmonary services. The Hospital provided approximately $2 million in un-reimbursed Medicaid services during the year. In FY 2011, the Hospital had approximately 415,000 outpatient encounters.

4c (Code:) (Expenses $ **19,055,985** including grants of $) (Revenue $ **24,550,080**)

Emergency Room - The Hospital has a 24 hour Emergency Room, providing high quality care to the sick and injured, regardless of the ability to pay. In FY2011, the Hospital had approximately 63,000 Emergency Room visits.

4d Other program services. (Describe in Schedule O.)

(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses ▶ 238,227,813

Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	**1**	X	
2	Is the organization required to complete Schedule B, Schedule of Contributors? (see instructions)	**2**	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	**3**		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? If "Yes," complete Schedule C, Part II	**4**	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? If "Yes," complete Schedule C, Part III	**5**		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I	**6**		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? If "Yes," complete Schedule D, Part II	**7**		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	**8**	X	
9	Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV	**9**		X
10	Did the organization, directly or through a related organization, hold assets in term, permanent, or quasi-endowments? If "Yes," complete Schedule D, Part V	**10**	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? If "Yes," complete Schedule D, Part VI	**11a**	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? If "Yes," complete Schedule D, Part VII	**11b**		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? If "Yes," complete Schedule D, Part VIII	**11c**		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? If "Yes," complete Schedule D, Part IX	**11d**		X
e	Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	**11e**	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	**11f**		X
12a	Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI, XII, and XIII	**12a**	X	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional	**12b**	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	**13**		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	**14a**		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, and program service activities outside the United States? If "Yes," complete Schedule F, Parts I and IV	**14b**		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? If "Yes," complete Schedule F, Parts II and IV	**15**		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? If "Yes," complete Schedule F, Parts III and IV	**16**		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? If "Yes," complete Schedule G, Part I (see instructions)	**17**		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? If "Yes," complete Schedule G, Part II	**18**	X	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	**19**		X
20a	Did the organization operate one or more hospitals? If "Yes," complete Schedule H	**20a**	X	
b	If "Yes" to line 20a, did the organization attach its audited financial statements to this return? **Note.** Some Form 990 filers that operate one or more hospitals must attach audited financial statements (see instructions)	**20b**	X	

Checklist of Required Schedules (continued)

			Yes	No
21	Did the organization report more than $5,000 of grants and other assistance to governments and organizations in the United States on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	21		X
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III	22	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? If "Yes," complete Schedule J	23	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? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		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?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I	25a		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? If "Yes," complete Schedule L, Part I	25b		X
26	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? If "Yes," complete Schedule L, Part II	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? If "Yes," complete Schedule L, Part III	27		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, or key employee? If "Yes," complete Schedule L, Part IV	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? If "Yes," complete Schedule M	29	X	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II	32		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? If "Yes," complete Schedule R, Part I	33		X
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1	34	X	
35	Is any related organization a controlled entity within the meaning of section 512(b)(13)?	35		X
a	Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2 ☐ Yes ☒ No			
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2	36	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? If "Yes," complete Schedule R, Part VI	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response to any question in this Part V X

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	**1a**	**440**		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	**1b**	**0**		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		**1c**	X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	**2904**		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		**2b**	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file. (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?		**3a**	X	
b	If "Yes," has it filed a Form 990-T for this year? If "No," provide an explanation in Schedule O		**3b**	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		**4a**	X	
b	If "Yes," enter the name of the foreign country: ▶ **See Schedule O**				
	See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		**5a**		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		**5b**		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		**5c**		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible?		**6a**		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		**6b**		
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?		**7a**	X	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		**7b**	X	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		**7c**		X
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		**7e**		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		**7f**		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		**7g**		X
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		**7h**		X
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?		**8**		
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?		**9a**		
b	Did the organization make a distribution to a donor, donor advisor, or related person?		**9b**		
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?		**12a**		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?		**13a**		
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?		**14a**		X
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O		**14b**		

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

Check if Schedule O contains a response to any question in this Part VI X

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	26		
b	Enter the number of voting members included in line 1a, above, who are independent	1b	19		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Does the organization have members or stockholders?	6		X	
7a	Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?	7a		X	
b	Are any decisions of the governing body subject to approval by members, stockholders, or other persons?	7b		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		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 in Schedule O	9			X

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

			Yes	No
10a	Does the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization?	10b		
11a	Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form?	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Does the organization have a written conflict of interest policy? If "No," go to line 13	12a	X	
b	Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done	12c	X	
13	Does the organization have a written whistleblower policy?	13	X	
14	Does the organization have a written document retention and destruction policy?	14	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	15a	X	
b	Other officers or key employees of the organization	15b	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?	16a	X	
b	If "Yes," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken steps to safeguard the organization's exempt status with respect to such arrangements?	16b	X	

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply.

☐ Own website ☒ Another's website ☒ Upon request

19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶ **Northeast Hospital Corp 85 Herrick St Beverly MA 01915 978-922-3000**

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(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) **Kenneth Hanover** President/Trustee	38.00	X		X				510,207	274,727	32,608
(2) **Gregory Bazylewicz, M.D.** Trustee	2.00	X						0	82,385	0
(3) **Nancy Palmer** Chairwoman	2.00	X						0	0	0
(4) **David DiChiara, M.D.** Trustee	2.00	X						0	0	0
(5) **Charles Furlong** Trustee	2.00	X						0	0	0
(6) **Robert Irwin** Trustee	2.00	X						0	0	0
(7) **Paul McConnell** Trustee	2.00	X						0	0	0
(8) **Marc Meiches** Trustee	2.00	X						0	0	0
(9) **Heaton Robertson** Trustee	2.00	X						0	0	0
(10) **Kate Barrand** Trustee	2.00	X						0	0	0
(11) **Jeff Bistrong** Trustee	2.00	X						0	0	0
(12) **Charles Favazzo** Trustee	2.00	X						0	0	0
(13) **Joseph Haley** Trustee	2.00	X						0	0	0
(14) **Paul Muniz** Trustee	2.00	X						0	0	0
(15) **Jagruti Patel** Trustee	2.00	X						0	0	0
(16) **Michael Shea** Trustee	2.00	X						0	0	0

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(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			
(17) Kurt Melden Trustee	2.00	X						0	0	0
(18) George Burke Trustee	2.00	X						0	0	0
(19) Tom Grant Trustee	2.00	X						0	0	0
(20) Vincent Martelli Trustee	2.00	X						0	0	0
(21) Hugh O'Flynn, M.D. Trustee	2.00	X						0	0	0
(22) Austin O'Keeffe, M.D. Trustee	2.00	X						0	0	0
(23) Robert Rives Trustee	2.00	X						0	0	0
(24) David St. Laurent Trustee	2.00	X						0	0	0
(25) Michael Ruane Trustee	2.00	X						0	0	0
(26) Steven Defossez, M.D. Trustee	2.00	X						0	0	0
(27) Denis Conroy CFO,Treasurer	28.00			X				240,289	129,386	26,671
(28) William Donaldson VP Gen.Counsel/Clerk	27.00			X				147,088	98,058	35,268
1b **Sub-total** ▶								897,584	584,556	94,547
c **Total from continuation sheets to Part VII, Section A** ▶								4,191,486	218,234	439,869
d **Total (add lines 1b and 1c)** ▶								5,089,070	802,790	534,416

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 in reportable compensation from the organization ▶ **20**

		Yes	No
3 Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual	3	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? If "Yes," complete Schedule J for such individual	4	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? If "Yes," complete Schedule J for such person	5		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.

(A) Name and business address	(B) Description of services	(C) Compensation
Northeast Emergency Associations 1342 Belmont St, Suite 205 Brockton MA 02301	ER Doctors	7,087,972
Full Contact Advertising 186 Lincoln St, Suite 801 Boston MA 02111	Advertising	1,656,670
Essex County OB 83 Herrick St, Suite 3002 Beverly MA 01915	OB Hospitalists	756,580
Donald Padre PO Box 1511 Gloucester MA 01931	Maintenance	180,704
Will & Emery McDermott PO Box 7247-6743 Philadelphia PA 19170	Legal Services	144,807

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 13

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(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			
(17) Joseph Porcello Ctrl, Asst.Trsr	11.00			X				50,275	117,308	33,776
(18) Maryellen Lear Assistant Clerk	39.00			X				83,071	0	6,124
(19) Pauline Pike Executive VP/COO	40.00				X			276,085	14,531	20,612
(20) Peter Short VP of Med Affairs	40.00				X			269,449	14,182	25,132
(21) Gary Marlow VP of Financial Srvs	40.00				X			228,711	0	25,410
(22) Gregory Bird VP Patient Care	40.00				X			218,684	0	33,911
(23) Johanna Rodgers VP Physician Srvs	27.00				X			186,354	16,205	28,008
(24) Althea Lyons VP of HR	40.00				X			173,699	9,142	33,222
(25) Cynthia Donaldson VP of Ancillary Srvs	40.00				X			169,861	0	14,617
(26) Bin He Hospitalist	40.00					X		321,991	0	34,898
(27) Irene Tsirozidou Hospitalist	40.00					X		315,974	0	30,654
(28) Sashikanth Kodali Hospitalist	40.00					X		306,371	0	10,409
1b **Sub-total** ▶								2,600,525	171,368	296,773
c **Total from continuation sheets to Part VII, Section A** ▶										
d **Total (add lines 1b and 1c)** ▶										

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

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

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization.

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(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			
(17) **Nilsson, Claes** **Hospitalist**	**40.00**					**X**		**301,685**	**0**	**33,361**
(18) **Muhammad Rizvi** **Hospitalist**	**40.00**					**X**		**280,137**	**0**	**21,177**
(19) **Steven Laverty** **Former President**	**0.00**						**X**	**559,237**	**0**	**14,111**
(20) **James Purdy** **Former VP**	**0.00**						**X**	**206,879**	**0**	**20,231**
(21) **Charles Payson** **Former VP**	**0.00**						**X**	**109,355**	**46,866**	**30,249**
(22) **Robert Laramie** **Former CIO**	**0.00**						**X**	**133,668**	**0**	**23,967**
(23)										
(24)										
(25)										
(26)										
(27)										
(28)										
1b Sub-total ▶								**1,590,961**	**46,866**	**143,096**
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

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

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

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization.

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

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

Statement of Revenue

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c	28,165			
	d Related organizations	1d				
	e Government grants (contributions)	1e	92,800			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	954,947			
	g Noncash contributions included in lines 1a-1f: $ 57,091					
	h **Total.** Add lines 1a–1f ▶		1,075,912			
Program Service Revenue		Busn. Code				
	2a Net Patient Service Revenue		306,876,005	306,876,005		
	b					
	c					
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a–2f ▶		306,876,005			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶		127,185	127,185		
	4 Income from investment of tax-exempt bond proceeds ▶		1,581,190	1,581,190		
	5 Royalties ▶					
		(i) Real	(ii) Personal			
	6a Gross Rents	419,351				
	b Less: rental exps.	569,782				
	c Rental inc. or (loss)	-150,431				
	d Net rental income or (loss) ▶		-150,431	-150,431		
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory	7,040,789	40,687			
	b Less: cost or other basis & sales exps.	6,013,613	168,213			
	c Gain or (loss)	1,027,176	-127,526			
	d Net gain or (loss) ▶		899,650	899,650		
	8a Gross income from fundraising events (not including $ 28,165 of contributions reported on line 1c). See Part IV, line 18 a		43,360			
	b Less: direct expenses b		25,244			
	c Net income or (loss) from fundraising events ▶		18,116			
	9a Gross income from gaming activities. See Part IV, line 19 a					
	b Less: direct expenses b					
	c Net income or (loss) from gaming activities ▶					
	10a Gross sales of inventory, less returns and allowances a					
	b Less: cost of goods sold b					
	c Net income or (loss) from sales of inventory ▶					
	Miscellaneous Revenue	Busn. Code				
	11a Lab SSI Income	900099	4,589,729		4,589,729	
	b Cafeteria Sales		1,552,114	1,552,114		
	c Other Operating Income		952,585	952,585		
	d All other revenue		506,814	450,990	55,824	
	e **Total.** Add lines 11a–11d ▶		7,601,242			
	12 **Total revenue.** See instructions. ▶		318,028,869	312,289,288	4,645,553	0

Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns.
All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21				
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22	28,000	28,000		
3 Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	3,221,870		3,221,870	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	152,424,011	128,253,217	24,170,794	
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	7,625,402	6,283,381	1,342,021	
9 Other employee benefits	14,821,557	12,213,059	2,608,498	
10 Payroll taxes	9,860,954	8,125,490	1,735,464	
11 Fees for services (non-employees):				
a Management				
b Legal	395,695		395,695	
c Accounting	207,800		207,800	
d Lobbying	38,602		38,602	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	73,034		73,034	
g Other				
12 Advertising and promotion	525,351		525,351	
13 Office expenses	64,887,565	39,581,415	25,306,150	
14 Information technology	2,513,293	1,533,109	980,184	
15 Royalties				
16 Occupancy	6,134,052	3,741,772	2,392,280	
17 Travel	531,547	324,244	207,303	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	2,359,497		2,359,497	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	17,098,418	10,430,035	6,668,383	
23 Insurance	745,246	454,600	290,646	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24f. If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O.)				
a Non-empl healthcare wrkrs	15,482,117	15,482,117		
b Provision for bad debt	9,283,019	9,283,019		
c Uncompensated care	2,466,357	2,466,357		
d all other expenses	957,179			957,179
e Unrelated business tax	180,000		180,000	
f All other expenses				
25 **Total functional expenses.** Add lines 1 through 24f	311,860,566	238,199,815	72,703,572	957,179
26 **Joint costs.** Check here ▶ ☐ if following SOP 98-2 (ASC 958-720). Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Balance Sheet

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest bearing			1	
	2	Savings and temporary cash investments		12,998,561	2	16,308,589
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		33,644,956	4	30,899,488
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			5	
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions)			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		5,822,168	8	5,885,327
	9	Prepaid expenses and deferred charges		6,170,220	9	5,545,326
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 373,373,458			
	b	Less: accumulated depreciation	10b 228,229,635	149,982,766	10c	145,143,823
	11	Investments—publicly traded securities		114,770,679	11	111,462,363
	12	Investments—other securities. See Part IV, line 11			12	
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets			14	
	15	Other assets. See Part IV, line 11		15,132,926	15	15,547,626
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		338,522,276	16	330,792,542
Liabilities	17	Accounts payable and accrued expenses		26,587,174	17	29,639,204
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities		108,243,272	20	102,332,998
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties		386,995	23	339,758
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities. Complete Part X of Schedule D		80,352,708	25	96,808,329
	26	**Total liabilities.** Add lines 17 through 25		215,570,149	26	229,120,289
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here** ☒ **and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		105,186,524	27	85,253,000
	28	Temporarily restricted net assets		7,638,317	28	6,528,093
	29	Permanently restricted net assets		10,127,286	29	9,891,160
		Organizations that do not follow SFAS 117, check here ☐ **and complete lines 30 through 34.**				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building, or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		122,952,127	33	101,672,253
	34	Total liabilities and net assets/fund balances		338,522,276	34	330,792,542

Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	318,028,869
2	Total expenses (must equal Part IX, column (A), line 25)	2	311,860,566
3	Revenue less expenses. Subtract line 2 from line 1	3	6,168,303
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	122,952,127
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-27,448,177
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	101,672,253

Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ 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?	2a		X
b	Were the organization's financial statements audited by an independent accountant?	2b	X	
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	X	
d	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	3b		

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

OMB No. 1545-0047

2010

Name of the organization
Northeast Hospital Corporation

Employer identification number
04-2121317

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

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

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

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

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

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

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

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

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

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

9 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

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

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

a ☐ Type I **b** ☐ Type II **c** ☐ Type III–Functionally integrated **d** ☐ Type III–Other

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

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

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

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

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

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

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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount 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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2010 (line 6, column (f) divided by line 11, column (f)) . . . . . **14** %

15 Public support percentage from 2009 Schedule A, Part II, line 14 . . . . . **15** %

16a **33 1/3% support test—2010.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support test—2009.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test—2010.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test—2009.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2010 (line 8, column (f) divided by line 13, column (f))	15	%
16	Public support percentage from 2009 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2010** (line 10c, column (f) divided by line 13, column (f))	17	%
18	Investment income percentage from **2009** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests—2010.** 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—2009.** 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 ▶ ☐

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

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527
▶ Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.
▶ See separate instructions.

OMB No. 1545-0047
2010

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

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

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

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

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

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

Name of organization	Employer identification number
Northeast Hospital Corporation	04-2121317

Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
2 Political expenditures ▶ $
3 Volunteer hours

Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No
4a Was a correction made? ☐ Yes ☐ No
b If "Yes," describe in Part IV.

Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $
2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $
3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $
4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No
5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

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

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

A Check ▶ ☐ if the filing organization belongs to an affiliated group.

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

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

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

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

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

4-Year Averaging Period Under Section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2007	**(b)** 2008	**(c)** 2009	**(d)** 2010	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		X	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c	Media advertisements?		X	
d	Mailings to members, legislators, or the public?		X	
e	Publications, or published or broadcast statements?		X	
f	Grants to other organizations for lobbying purposes?		X	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	X		38,602
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i	Other activities? If "Yes," describe in Part IV		X	
j	Total. Add lines 1c through 1i			38,602
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

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

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

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

Supplemental Information

Complete this part to provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; and Part II-B, line 1i. Also, complete this part for any additional information.

Supplemental Information (continued)

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ **Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11, or 12.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No. 1545-0047

2010

Name of the organization

Northeast Hospital Corporation

Employer identification number

04-2121317

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

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

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

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

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b Assets included in Form 990, Part X ▶ $ **1,800,000**

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

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

- a [X] Public exhibition
- b [ ] Scholarly research
- c [X] Preservation for future generations
- d [ ] Loan or exchange programs
- e [ ] Other

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIV.

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 [X] No

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

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

b If "Yes," explain the arrangement in Part XIV and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? [ ] Yes [ ] No

b If "Yes," explain the arrangement in Part XIV.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	17,765,603	13,090,008	13,681,714		
b Contributions	990,656	4,378,469	1,406,540		
c Net investment earnings, gains, and losses	-839,966	1,545,146	40,498		
d Grants or scholarships	87,321	105,855	165,189		
e Other expenditures for facilities and programs	1,409,809	1,142,165	1,873,555		
f Administrative expenses					
g End of year balance	16,419,163	17,765,603	13,090,008		

2 Provide the estimated percentage of the year end balance held as:

- a Board designated or quasi-endowment ▶ %
- b Permanent endowment ▶ 61.00 %
- c Term endowment ▶ 39.00 %

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

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

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

Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land	943,941	17,345,636		18,289,577
b Buildings	6,555,496	190,408,168	99,181,513	97,782,151
c Leasehold improvements				
d Equipment	516,361	157,603,859	129,048,122	29,072,098
e Other				
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) ▶				145,143,826

Investments—Other Securities. 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)		
(I)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶		

Investments—Program Related. See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 13.) ▶		

Other Assets. See Form 990, Part X, line 15.

	(a) Description	(b) Book value
(1)	Unamortized financing costs	3,088,052
(2)	Due from affiliates (short term)	4,610,670
(3)	Due from affiliates (long term)	1,931,693
(4)	Split $ life insurance	1,195,245
(5)	Other non current assets	1,146,966
(6)	Estimated 3rd party liability	3,575,000
(7)		
(8)		
(9)		
(10)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶		15,547,626

Other Liabilities. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Amount
(1) Federal income taxes	129,240
(2) Accrued Pension Liability	58,840,426
(3) Series G,H,I Liability Swaps	14,952,908
(4) Estimated 3rd Party Settlement	9,463,804
(5) Current Installment of LT Debt	9,160,250
(6) Post Retirement Medical Benefits	1,980,444
(7) Professional Liability Reserve	1,619,000
(8) Other Non Current Liabilities	409,837
(9) Current Post Retirement Med Benefits	252,420
(10) Due to Affiliates	
(11)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	96,808,329

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

Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	318,028,869
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	311,860,566
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	6,168,303
4	Net unrealized gains (losses) on investments	4	-4,978,862
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	-21,122,965
9	Total adjustments (net). Add lines 4 through 8	9	-26,101,827
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	-19,933,524

Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements			1	318,028,879
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a	0		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV.)	2d	0		
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	318,028,869
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 XIV.)	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	318,028,869

Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements			1	310,903,382
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 XIV.)	2d	0		
e	Add lines **2a** through **2d**			2e	
3	Subtract line **2e** from line **1**			3	0
4	Amounts included on Form 990, Part IX, line 25, but not on line **1:**				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIV.)	4b	957,179		
c	Add lines **4a** and **4b**			4c	957,179
5	Total expenses. Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18.)			5	311,860,566

Supplemental Information

Complete this part to 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, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

Part III, Line 4 - Collections and Relation to Exempt Purpose

The artwork "Old Fort and Ten Pound Island" by Fitz Hugh Lane, c. 1850 is by a local artist, depicting a scene, which when displayed serves to strengthen the link with community residents who utilized the Hospital.

Part V, Line 4 - Intended Uses for Endowment Funds

Endowment funds are used as earmarked by donors to cover costs of ongoing

Supplemental Information (continued)

programs of the Hospital

Part XI, Line 8 - Reconciliation of Changes - Other

Net assets released from restriction used for operations	**$ 931,394**
Net assets release from restrictions used for PPE	**$ 565,646**
Other	**$ 25,801**
Transfer to Affiliates	**$ -6,318,000**
Minimum Pension Liability Adjustment	**$ -16,327,805**

Part XIII, Line 4b - Expense Amounts Included on Return - Other

Northeast Foundation fundraising expense	**$ 957,184**

Part XIII, Line 4b - Expense Amounts Included on Return - Other

Northeast Foundation fundraising expense	**$ 957,184**

SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a.
▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

OMB No. 1545-0047

2010

Name of the organization
Northeast Hospital Corporation

Employer identification number
04-2121317

Fundraising Activities. Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

- **a** ☐ Mail solicitations
- **b** ☐ Internet and email solicitations
- **c** ☐ Phone solicitations
- **d** ☐ In-person solicitations
- **e** ☐ Solicitation of non-government grants
- **f** ☐ Solicitation of government grants
- **g** ☐ Special fundraising events

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ **Yes** ☐ **No**

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

	(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fund-raiser have custody or control of contributions? Yes	No	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
Total ▶							

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

Fundraising Events. Complete if the organization answered "Yes" to 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 BH Classic Golf (event type)	(b) Event #2 Lyons Ambulance (event type)	(c) Other events None (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	46,180	25,345		71,525
	2 Less: Charitable contributions	19,930	8,235		28,165
	3 Gross income (line 1 minus line 2)	26,250	17,110		43,360
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs	7,080	18,164		25,244
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses				
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				(25,244)
	11 Net income summary. Combine line 3, column (d), and line 10 ▶				18,116

Gaming. Complete if the organization answered "Yes" to 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	☐ Yes % ☐ No	☐ Yes % ☐ No	☐ Yes % ☐ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				( )
	8 Net gaming income summary. Combine line 1, column d, and line 7 ▶				

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

a Is the organization licensed to operate gaming activities in each of these states? **9a** ☐ **Yes** ☐ **No**

b If "No," explain:

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

b If "Yes," explain:

11 Does the organization operate gaming activities with nonmembers? ☐ Yes ☐ No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No

13 Indicate the percentage of gaming activity operated in:

a The organization's facility	**13a**	%
b An outside facility	**13b**	%

14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶

Address ▶

15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No

b If "Yes," enter the amount of gaming revenue received by the organization ▶ $ and the amount of gaming revenue retained by the third party ▶ $.

c If "Yes," enter name and address of the third party:

Name ▶

Address ▶

16 Gaming manager information:

Name ▶

Gaming manager compensation ▶ $

Description of services provided ▶

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No

b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $

Supplemental Information. Complete this part to provide the explanations required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2010

Name of the organization
Northeast Hospital Corporation

Employer identification number
04-2121317

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	X	
b	If "Yes," is it a written policy?	X	
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. [X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities [ ] Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a	Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing free care to low income individuals? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: [ ] 100% [ ] 150% [ ] 200% [X] Other 400%	X	
b	Did the organization use FPG to determine eligibility for providing discounted care to low income individuals? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: [ ] 200% [ ] 250% [ ] 300% [ ] 350% [ ] 400% [ ] Other ____%		X
c	If the organization does not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization uses an asset test or other threshold, regardless of income, to determine 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"?	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		X
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a	Did the organization prepare a community benefit report during the tax year?	X	
b	If "Yes," does the organization make it available to the public?	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

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheets 1 and 2)			5,939,305	2,006,000	3,933,305	1.26
b Unreimbursed Medicaid (from Worksheet 3, column a)			40,965,038	34,721,041	6,243,997	2.00
c Unreimbursed costs—other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			46,904,343	36,727,041	10,177,302	3.26
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			1,802,991	5,555	1,797,436	0.58
f Health professions education (from Worksheet 5)			169,099	38,045	131,054	0.04
g Subsidized health services (from Worksheet 6)			12,823,532	9,594,026	3,229,506	1.04
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)			121,793		121,793	0.04
j **Total.** Other Benefits			14,917,415	9,637,626	5,279,789	1.69
k **Total.** Add lines 7d and 7j			61,821,758	46,364,667	15,457,091	4.96

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development			25,000		25,000	0.01
3 Community support			15,000		15,000	
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy			35,550		35,550	0.01
8 Workforce development						
9 Other						
10 Total			75,550		75,550	0.02

Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Does the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		X
2 Enter the amount of the organization's bad debt expense (at cost)	2	2,884,517	
3 Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy	3	553,191	

4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit.

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	90,098,223
6 Enter Medicare allowable costs of care relating to payments on line 5	6	102,568,930
7 Subtract line 6 from line 5. This is the surplus or (shortfall)	7	-12,470,707

8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:

[X] Cost accounting system [ ] Cost to charge ratio [ ] Other

Section C. Collection Practices

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

Management Companies and Joint Ventures

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 Aurora MRI of BH	Breast Imaging Technology	10	0	10
2 NS P.E.T. Imaging	Medical Imaging Services	40	0	10
3 NS MRI Imaging	Medical Imaging Services	50	0	0
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Facility Information

Section A. Hospital Facilities

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? **4**

Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1 **Beverly Hospital** **85 Herrick St** **Beverly MA 01915**	X	X					X		
2 **Bayridge Hospital** **60 Granite St** **Lynn MA 01904**	X								**Phychiatric Hospital**
3 **Addison Gilbert Hospital** **298 Washington St** **Gloucester MA 01930**	X	X					X		
4 **Beverly Hospital at Danvers** **480 Maple St** **Danvers MA 01923**		X							

Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: Beverly Hospital

Line Number of Hospital Facility (from Schedule H, Part V, Section A) 1

			Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)				
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1		
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	☐ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☐ How data was obtained			
e	☐ The health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☐ The process for consulting with persons representing the community's interests			
i	☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j	☐ Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20			
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5	Did the hospital facility make its Needs Assessment widely available to the public?	5		
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a	☐ Hospital facility's website			
b	☐ Available upon request from the hospital facility			
c	☐ Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a	☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b	☐ Execution of the implementation strategy			
c	☐ Participation in the development of a community-wide community benefit plan			
d	☐ Participation in the execution of a community-wide community benefit plan			
e	☐ Inclusion of a community benefit section in operational plans			
f	☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g	☐ Prioritization of health needs in its community			
h	☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	☐ Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X	
9	Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 400 %			

Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: **Bayridge Hospital**

Line Number of Hospital Facility (from Schedule H, Part V, Section A) **2**

			Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)				
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1		
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a ☐	A definition of the community served by the hospital facility			
b ☐	Demographics of the community			
c ☐	Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☐	How data was obtained			
e ☐	The health needs of the community			
f ☐	Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☐	The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☐	The process for consulting with persons representing the community's interests			
i ☐	Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j ☐	Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20			
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5	Did the hospital facility make its Needs Assessment widely available to the public?	5		
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a ☐	Hospital facility's website			
b ☐	Available upon request from the hospital facility			
c ☐	Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a ☐	Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b ☐	Execution of the implementation strategy			
c ☐	Participation in the development of a community-wide community benefit plan			
d ☐	Participation in the execution of a community-wide community benefit plan			
e ☐	Inclusion of a community benefit section in operational plans			
f ☐	Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g ☐	Prioritization of health needs in its community			
h ☐	Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i ☐	Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X	
9	Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: **400** %			

Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: **Addison Gilbert Hospital**

Line Number of Hospital Facility (from Schedule H, Part V, Section A) **3**

			Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)				
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1		
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a ☐	A definition of the community served by the hospital facility			
b ☐	Demographics of the community			
c ☐	Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☐	How data was obtained			
e ☐	The health needs of the community			
f ☐	Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☐	The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☐	The process for consulting with persons representing the community's interests			
i ☐	Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j ☐	Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20			
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5	Did the hospital facility make its Needs Assessment widely available to the public?	5		
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a ☐	Hospital facility's website			
b ☐	Available upon request from the hospital facility			
c ☐	Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a ☐	Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b ☐	Execution of the implementation strategy			
c ☐	Participation in the development of a community-wide community benefit plan			
d ☐	Participation in the execution of a community-wide community benefit plan			
e ☐	Inclusion of a community benefit section in operational plans			
f ☐	Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g ☐	Prioritization of health needs in its community			
h ☐	Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i ☐	Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X	
9	Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: **400** %			

Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: Beverly Hospital at Danvers

Line Number of Hospital Facility (from Schedule H, Part V, Section A) 4

			Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)				
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1		
	If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	☐ A definition of the community served by the hospital facility			
b	☐ Demographics of the community			
c	☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☐ How data was obtained			
e	☐ The health needs of the community			
f	☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☐ The process for consulting with persons representing the community's interests			
i	☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j	☐ Other (describe in Part VI)			
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20			
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5	Did the hospital facility make its Needs Assessment widely available to the public?	5		
	If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):			
a	☐ Hospital facility's website			
b	☐ Available upon request from the hospital facility			
c	☐ Other (describe in Part VI)			
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):			
a	☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b	☐ Execution of the implementation strategy			
c	☐ Participation in the development of a community-wide community benefit plan			
d	☐ Participation in the execution of a community-wide community benefit plan			
e	☐ Inclusion of a community benefit section in operational plans			
f	☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g	☐ Prioritization of health needs in its community			
h	☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	☐ Other (describe in Part VI)			
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7		
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
8	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	X	
9	Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 400 %			

Facility Information (continued)

			Yes	No
10	Used FPG to determine eligibility for providing discounted care to low income individuals?	10		X
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: ____ %			
11	Explained the basis for calculating amounts charged to patients?	11	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	☐ Income level			
b	☐ Asset level			
c	☐ Medical indigency			
d	☐ Insurance status			
e	☒ Uninsured discount			
f	☐ Medicaid/Medicare			
g	☐ State regulation			
h	☐ Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12	X	
13	Included measures to publicize the policy within the community served by the hospital facility?	13	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☒ The policy was posted on the hospital facility's website			
b	☒ The policy was attached to billing invoices			
c	☒ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	☒ The policy was posted in the hospital facility's admissions offices			
e	☒ The policy was provided, in writing, to patients on admission to the hospital facility			
f	☒ The policy was available on request			
g	☒ Other (describe in Part VI)			

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14	X	
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☒ Other actions (describe in Part VI)			
16	Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year?	16	X	
	If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☒ Other actions (describe in Part VI)			
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply):			
a	☒ Notified patients of the financial assistance policy on admission			
b	☐ Notified patients of the financial assistance policy prior to discharge			
c	☒ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	☒ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e	☐ Other (describe in Part VI)			

Facility Information (continued)

			Yes	No
10	Used FPG to determine eligibility for providing discounted care to low income individuals?	10		X
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: ____ %			
11	Explained the basis for calculating amounts charged to patients?	11	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	☐ Income level			
b	☐ Asset level			
c	☐ Medical indigency			
d	☐ Insurance status			
e	☒ Uninsured discount			
f	☐ Medicaid/Medicare			
g	☐ State regulation			
h	☐ Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12	X	
13	Included measures to publicize the policy within the community served by the hospital facility?	13	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☒ The policy was posted on the hospital facility's website			
b	☒ The policy was attached to billing invoices			
c	☒ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	☒ The policy was posted in the hospital facility's admissions offices			
e	☒ The policy was provided, in writing, to patients on admission to the hospital facility			
f	☒ The policy was available on request			
g	☒ Other (describe in Part VI)			

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14	X	
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☒ Other actions (describe in Part VI)			
16	Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year?	16	X	
	If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☒ Other actions (describe in Part VI)			
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply):			
a	☒ Notified patients of the financial assistance policy on admission			
b	☐ Notified patients of the financial assistance policy prior to discharge			
c	☒ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	☒ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e	☐ Other (describe in Part VI)			

Facility Information (continued)

			Yes	No
10	Used FPG to determine eligibility for providing discounted care to low income individuals?	10		X
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: ____ %			
11	Explained the basis for calculating amounts charged to patients?	11	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	☐ Income level			
b	☐ Asset level			
c	☐ Medical indigency			
d	☐ Insurance status			
e	☒ Uninsured discount			
f	☐ Medicaid/Medicare			
g	☐ State regulation			
h	☐ Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12	X	
13	Included measures to publicize the policy within the community served by the hospital facility?	13	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☒ The policy was posted on the hospital facility's website			
b	☒ The policy was attached to billing invoices			
c	☒ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	☒ The policy was posted in the hospital facility's admissions offices			
e	☒ The policy was provided, in writing, to patients on admission to the hospital facility			
f	☒ The policy was available on request			
g	☒ Other (describe in Part VI)			

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14	X	
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☒ Other actions (describe in Part VI)			
16	Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year?	16	X	
	If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☒ Other actions (describe in Part VI)			
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply):			
a	☒ Notified patients of the financial assistance policy on admission			
b	☐ Notified patients of the financial assistance policy prior to discharge			
c	☒ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	☒ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e	☐ Other (describe in Part VI)			

Facility Information (continued)

			Yes	No
10	Used FPG to determine eligibility for providing discounted care to low income individuals?	10		X
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: ____ %			
11	Explained the basis for calculating amounts charged to patients?	11	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	☐ Income level			
b	☐ Asset level			
c	☐ Medical indigency			
d	☐ Insurance status			
e	☒ Uninsured discount			
f	☐ Medicaid/Medicare			
g	☐ State regulation			
h	☐ Other (describe in Part VI)			
12	Explained the method for applying for financial assistance?	12	X	
13	Included measures to publicize the policy within the community served by the hospital facility?	13	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☒ The policy was posted on the hospital facility's website			
b	☒ The policy was attached to billing invoices			
c	☒ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	☒ The policy was posted in the hospital facility's admissions offices			
e	☒ The policy was provided, in writing, to patients on admission to the hospital facility			
f	☒ The policy was available on request			
g	☒ Other (describe in Part VI)			

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14	X	
15	Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year:			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☒ Other actions (describe in Part VI)			
16	Did the hospital facility engage in or authorize a third party to perform any of the following collection actions during the tax year?	16	X	
	If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply):			
a	☐ Reporting to credit agency			
b	☐ Lawsuits			
c	☐ Liens on residences			
d	☐ Body attachments			
e	☒ Other actions (describe in Part VI)			
17	Indicate which actions the hospital facility took before initiating any of the collection actions checked in line 16 (check all that apply):			
a	☒ Notified patients of the financial assistance policy on admission			
b	☐ Notified patients of the financial assistance policy prior to discharge			
c	☒ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	☒ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e	☐ Other (describe in Part VI)			

Facility Information (continued)

Policy Relating to Emergency Medical Care

		Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**18** X	
	If "No," indicate the reasons why (check all that apply):		
a ☐	The hospital facility did not provide care for any emergency medical conditions		
b ☐	The hospital facility did not have a policy relating to emergency medical care		
c ☐	The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d ☐	Other (describe in Part VI)		

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):			
a ☐	The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b ☐	The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c ☐	The hospital facility used the Medicare rate for those services			
d ☒	Other (describe in Part VI)			
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?	**20**		X
	If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient?	**21**	X	
	If "Yes," explain in Part VI.			

Facility Information (continued)

Policy Relating to Emergency Medical Care

		Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**18** X	
	If "No," indicate the reasons why (check all that apply):		
a ☐	The hospital facility did not provide care for any emergency medical conditions		
b ☐	The hospital facility did not have a policy relating to emergency medical care		
c ☐	The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d ☐	Other (describe in Part VI)		

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):			
a ☐	The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b ☐	The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c ☐	The hospital facility used the Medicare rate for those services			
d ☒	Other (describe in Part VI)			
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?	**20**		X
	If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient?	**21**	X	
	If "Yes," explain in Part VI.			

Facility Information (continued)

Policy Relating to Emergency Medical Care

		Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**18** X	
	If "No," indicate the reasons why (check all that apply):		
a ☐	The hospital facility did not provide care for any emergency medical conditions		
b ☐	The hospital facility did not have a policy relating to emergency medical care		
c ☐	The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d ☐	Other (describe in Part VI)		

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):			
a ☐	The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b ☐	The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c ☐	The hospital facility used the Medicare rate for those services			
d ☒	Other (describe in Part VI)			
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?	**20**		X
	If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient?	**21**	X	
	If "Yes," explain in Part VI.			

Facility Information (continued)

Policy Relating to Emergency Medical Care

		Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**18** X	
	If "No," indicate the reasons why (check all that apply):		
a ☐	The hospital facility did not provide care for any emergency medical conditions		
b ☐	The hospital facility did not have a policy relating to emergency medical care		
c ☐	The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d ☐	Other (describe in Part VI)		

Charges for Medical Care

19	Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply):			
a ☐	The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b ☐	The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c ☐	The hospital facility used the Medicare rate for those services			
d ☒	Other (describe in Part VI)			
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?	**20**		X
	If "Yes," explain in Part VI.			
21	Did the hospital facility charge any of its patients an amount equal to the gross charge for any service provided to that patient?	**21**	X	
	If "Yes," explain in Part VI.			

Facility Information (continued)

Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many non-hospital facilities did the organization operate during the tax year? **0**

Name and address	Type of Facility (describe)

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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 - Other Testing Methods for Free or Discounted Care

The Hospital did not use FPG to determine eligibility for providing discounted care to low income individuals. There are two circumstances where the Hospital will offer discounted care to low income individuals:

1.Patients who do not qualify for enrollment in a Massachusetts state public assistance program, such as out-of-state residents, but who may otherwise meet the general financial eligibility categories of a state public assistance program, may receive a discounted bill. The Hospital will provide an appropriate discount on the bill once the determination is made.

2.When a patient requests a discount on an unpaid bill the Hospital will review the patient's documented financial situation and payment activity. This review is considered a separate financial program offered by the Hospital and is applied on a uniform basis to all patients. Any discount the Hospital provides is consistent with federal and state tax requirements and does not influence a patient to receive services from the Hospital.

Part I, Line 6a - Related Organization Information

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

Northeast Health System (parent holding company of Northeast Hospital Corporation) prepares the community benefit report.

Part I, Line 7 - Costing Methodology Explanation

Line 7a was calculated using Worksheet #1.

Line 7b was calculated using an internal cost accounting system. The internal cost accounting system provides management financial information across all payers and services of the organization.

A cost to charge ratio was used to calculate 7a and 7b and was derived from Worksheet #2.

Lines 7e, 7f, and 7i were calculated by taking community and charity care program revenues and expenses from the general ledger, plus related direct and indirect costs. These costs were calculated by taking the number of employee hours spent on each program multiplied by a standard rate, plus a fringe factor to calculate benefit costs.

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

Line 7g was calculated by taking qualifying subisized health services net revenue, less related direct and indirect costs (excluding any amounts related to bad debt, financial assistance, Medicaid and other means-tested government programs) from an internal financial reporting system, which we reconcile to the general ledger.

Part II - Community Building Activities

Part II: Northeast Hospital Corporation has several building activities that promote the health of the communities the organization serves. These include health screenings, clinics and seminars developed for breast cancer, skin cancer, depression, diabetes, bone density, blood pressure, flu and CPR. In addition, risk assessments are developed for cardiovascular, osteoporosis, diabetes, body mass index and breast cancer. A number of disease management initiatives have been instituted including cardiac rehabilitation, heart failure management, pulmonary rehabilitation, osteoporosis management, vascular health and women's health screenings. The Hospital also holds free support groups to the community for residents with breast cancer, melanoma, prostate cancer, Alzheimer's, early state of memory loss, post-partum depression, epilepsy, diabetes or have experienced

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

a stroke, infant loss and loss of a family member.

In 2003, NHC created the Lifestyle Management Institute (LMI). The LMI provides programs and education on how to live a healthy lifestyle, and proactively identifies populations with, or at risk of, established medical conditions. The LMI offers a full range of services to the community including risk assessment, prevention education, diagnostic testing, coordinated medical treatment and continuous monitoring. Effective disease management using appropriate medical protocols reduces the number of hospital admissions and emergency room visits, shortens the length of hospital stays and improves the overall health and quality of life for people with chronic illness.

Part III, Line 4 - Bad Debt Expense Explanation

Part III, line 4 The Hospital includes its bad debt expense as a line item "provision for bad debts, net" in the audited statement of operations. NHC does not have a bad debt expense footnote on its financial statements.

These amounts represent community benefits because they were provided to

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

patients that ultimately qualified for charity care.

Part III, Line 8 - Medicare Explanation

Part III, line 8:

These costs represent a community benefit because the payment from Medicare is less than the cost to provide care and that shortfall is absorbed by the Hospital.

In addition, the Hospital provides care to a substantial population of Medicaid patients at payment levels well below cost.

Part III, Line 9b - Collection Practices Explanation

Part III, line 9b:

The Hospital's credit and collection policies are developed to ensure compliance with applicable criteria required under (1) the Massachusetts Health Safety Net Eligibility Regulation (114.6 CMR 13.00), (2) the Centers for Medicare and Medicaid Services Medicare Bad Debt Requirements (42 CFR 413.89), and (3) the Medicare

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

Provider Reimbursement Manual (Part I, Chapter 3). This policy is available to all patients upon request. For any patients who are uninsured or underinsured the Hospital's financial counselors will work with these patients and assist them with finding a financial assistance program that may cover some or all of unpaid bills. Once the Hospital knows patients qualify for charity care, all collection procedures end and the full balance or the amount that qualifies under free care is written off. Financial assistance is intended to help low-income patients who do not otherwise have the ability to pay for their health care services. Financial assistance programs include, but are not limited to MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start and Healthy Safety Net. Patients under these programs will receive an initial bill but are exempt from any further collection or billing procedures, pursuant to Massachusetts state regulations.

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

Beverly Hospital, Line Number 1 - Part V, Line 13g

The Hospital has financial counselors available for any patient who requires help filing for financial assistance. The counselors perform financial screening and help patients with MassHealth, Commonwealth Care, Health Safety Net, Medical Hardship, Disability and Long Term Care applications. The Hospital is also involved with community liason outreach activities. In addition to helping patients who are admitted to the Hospital, financial counselors help screen and enroll patients in the community when they are referred to the Hospital. Agencies the Hospital has established relationships with include Councils on Aging, SHINE (Serving Health Insurance Needs of Elders), CHEC (Community Health Education Center), public schools, homeless shelters, food pantries, Board of Health in Gloucester and Beverly, Police Dept in Gloucester and Beverly and local physician offices.

Beverly Hospital, Line Number 1 - Part V, Line 15e

Permissible collection activities include sending out statements, collection letters and making telephone calls to patients.

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

Beverly Hospital, Line Number 1 - Part V, Line 16e

Permissible collection activities include sending out statements, collection letters and making telephone calls to patients.

Beverly Hospital, Line Number 1 - Part V, Line 19d

Patient Accounts will offer up to a 30% reduction in charges for self-pay or under-insured patients for all ancillary and emergency room charges.

Beverly Hospital, Line Number 1 - Part V, Line 21

All patients are billed at gross charges.

Bayridge Hospital, Line Number 2 - Part V, Line 13g

The Hospital has financial counselors available for any patient who requires help filing for financial assistance. The counselors perform financial screening and help patients with MassHealth, Commonwealth Care, Health Safety Net, Medical Hardship, Disability and Long Term Care applications. The Hospital is also involved with community liason outreach activities. In addition to helping patients who are admitted to the Hospital, financial counselors help screen and enroll patients in the

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

community when they are referred to the Hospital. Agencies the Hospital has established relationships with include Councils on Aging, SHINE (Serving Health Insurance Needs of Elders), CHEC (Community Health Education Center), public schools, homeless shelters, food pantries, Board of Health in Gloucester and Beverly, Police Dept in Gloucester and Beverly and local physician offices.

Bayridge Hospital, Line Number 2 - Part V, Line 15e

Permissible collection activities include sending out statements, collection letters and making telephone calls to patients.

Bayridge Hospital, Line Number 2 - Part V, Line 16e

Permissible collection activities include sending out statements, collection letters and making telephone calls to patients.

Bayridge Hospital, Line Number 2 - Part V, Line 19d

Patient Accounts will offer up to a 30% reduction in charges for self-pay or under-insured patients for all ancillary and emergency room charges

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

Bayridge Hospital, Line Number 2 - Part V, Line 21

All patients are billed at gross charges.

Addison Gilbert Hospital, Line Number 3 - Part V, Line 13g

The Hospital has financial counselors available for any patient who requires help filing for financial assistance. The counselors perform financial screening and help patients with MassHealth, Commonwealth Care, Health Safety Net, Medical Hardship, Disability and Long Term Care applications. The Hospital is also involved with community liason outreach activities. In addition to helping patients who are admitted to the Hospital, financial counselors help screen and enroll patients in the community when they are referred to the Hospital. Agencies the Hospital has established relationships with include Councils on Aging, SHINE (Serving Health Insurance Needs of Elders), CHEC (Community Health Education Center), public schools, homeless shelters, food pantries, Board of Health in Gloucester and Beverly, Police Dept in Gloucester and Beverly and local physician offices.

Addison Gilbert Hospital, Line Number 3 - Part V, Line 15e

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

Permissible collection activities include sending out statements, collection letters and making telephone calls to patients.

Addison Gilbert Hospital, Line Number 3 - Part V, Line 16e

Permissible collection activities include sending out statements, collection letters and making telephone calls to patients.

Addison Gilbert Hospital, Line Number 3 - Part V, Line 19d

Patient Accounts will offer up to a 30% reduction in charges for self-pay or under-insured patients for all ancillary and emergency room charges

Addison Gilbert Hospital, Line Number 3 - Part V, Line 21

All patients are billed at gross charges.

Beverly Hospital at Danvers, Line Number 4 - Part V, Line 13g

The Hospital has financial counselors available for any patient who requires help filing for financial assistance. The counselors perform financial screening and help patients with MassHealth, Commonwealth Care, Health Safety Net, Medical Hardship, Disability and Long Term Care

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

applications. The Hospital is also involved with community liason outreach activities. In addition to helping patients who are admitted to the Hospital, financial counselors help screen and enroll patients in the community when they are referred to the Hospital. Agencies the Hospital has established relationships with include Councils on Aging, SHINE (Serving Health Insurance Needs of Elders), CHEC (Community Health Education Center), public schools, homeless shelters, food pantries, Board of Health in Gloucester and Beverly, Police Dept in Gloucester and Beverly and local physician offices.

Beverly Hospital at Danvers, Line Number 4 - Part V, Line 15e
Permissible collection activities include sending out statements, collection letters and making telephone calls to patients.

Beverly Hospital at Danvers, Line Number 4 - Part V, Line 16e
Permissible collection activities include sending out statements, collection letters and making telephone calls to patients.

Beverly Hospital at Danvers, Line Number 4 - Part V, Line 19d

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

Patient Accounts will offer up to a 30% reduction in charges for self-pay or under-insured patients for all ancillary and emergency room charges

Beverly Hospital at Danvers, Line Number 4 - Part V, Line 21

All patients are billed at gross charges.

Needs Assessment

The Community Benefits Program at Northeast Hospital Corporation (NHC) is a program established to partner with community leaders and organizations to assess the health care needs of the community. NHC incorporates the Community Health concepts of wellness, adaptation, self-care and health promotion. Strategies used in Community Benefits health activities include prevention, early detection, early intervention, long-term management and collaborative efforts with the affiliate organizations that make up Northeast Health System (the parent holding company of NHC). Health issues addressed encompass safety, chronic disease, infectious disease, substance abuse and behavioral health.

The importance of the community health needs assessment and the Hospital's

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

collective efforts to address the healthcare needs of the North Shore have never been greater. The economic downturn has had a tremendous impact on thousands of individuals and families throughout the region. NHC continues to work in partnership with the communities it serves and with health-related organizations throughout the North Shore to meet the area's healthcare needs and improve the overall health status of the community.

The Community Benefits Committee at NHC ensures that the organization conducts health needs assessments for its 16 town/city primary service area as mandated by the Massachusetts Attorney General. NHC with the help of Northeast Health System affiliates will focus the community benefits plan around the four state-wide priorities, set forth by the Attorney General's Office, which include chronic disease management for disadvantaged populations, reducing health disparities, promoting wellness of vulnerable populations and supporting health care reform.

NHC's most recent health needs assessment was conducted from August 2007 through February 2009. The Hospital is in the process of conducting its 2010-2012 Community Assessment, which will be finalized in September 2012.

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

The Hospital's internal committee (NHC Internal Steering Committee) oversees the assessment along with an outside contractor, John Snow, Inc (JSI). JSI and NHC Internal Steering Committee developed a final approach and set of methods, including data collection, community involvement, strategic planning and reporting activities that will meet IRS and State Community Benefit requirements and that are customized to the service area and the needs of the Hospital.

JSI proposed a three-phased approach that will 1) identify and clarify the healthcare needs and priorities of the residents in NHC's core service area, 2) engage people throughout the service area, and 3) facilitate the development of a detailed Community Health Strategic Plan that will help guide how NHC engages with the community and other collaborating organizations with respect to its community benefit initiatives.

The Hospital found in its previous work that a phased approach results in concrete final recommendations, as well as more solid buy-in among stakeholders. In Phase I the Hospital will conduct a preliminary needs assessment that relies heavily on information collected through existing

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

health-related data from local, state, and national sources and will engage the community through a series of key informational interviews. These interviews will include a representative cross section of health department officials, health and social service providers, advocacy groups, elected officials and other community leaders. These interviews will include a cross section of clinical and administrative staff, including the hospital's leadership team so that we can get their buy-in on the assessment as well as their input on community health priorities.

At the end of Phase I, the Steering Committee and possibly other key stakeholders will discuss and clarify the findings from the preliminary assessment and also explore the extent to which we need to collect additional secondary data and agree on an exact methodology for phase II of the needs assessment.

In Phase II, the preliminary analysis will be refined by compiling additional secondary data that may be needed, but the main focus will be on collecting primary data from community residents through a community health survey. The culmination of Phase II will be a final Needs Assessment

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

Report that compiles, integrates and analyzes all of the data collected in Phases I and II. At this point, the Steering Committee, along with other key stakeholders as appropriate, will come to together once again for a Community Health "Retreat" to discuss the findings from Phases I and II and to begin to develop NHC's Community Health Strategic Plan.

In Phase III, the JSI Project Team will work closely with the Steering Committee to develop a Community Health Strategic Plan that will guide NHC's community health efforts. More specifically, the plan will; 1) identify the most pressing health care needs for NHC's primary service area (overall and by selected communities), 2) identify the Hospital's community health priorities with respect to health topics, special populations, or geographic communities, 3) outline a set of initiatives NHC should explore to work with the community to address the issues highlighted through this work, and 4) recommend a series of systems and/or organizational infrastructure that will allow NHC to sustain and build on the community engagement activities initiated through this project.

Patient Education of Eligibility for Assistance

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

The Hospital provides patients with information about the availability of financial assistance programs that are available through the State of Massachusetts or through the Hospital's own financial assistance program, which may cover all or some of their unpaid bill. For every patient that requires any kind of financial assistance, the Hospital has financial counselors available to assist low-income patients who do not have the ability to pay for their health care services. Such assistance takes into account each individual's ability to contribute to the cost of his or her care. Financial assistance programs include, but are not limited to, MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start and Healthy Safety Net. Each patient requiring assistance completes an application through the Virtual Gateway (an internet portal designed by the Massachusetts Executive Office of Health & Human Services to provide the general public, medical providers and community based organizations with an online application for the programs offered by the state) or through a standard paper application that also gets sent to the Massachusetts Executive Office. This office solely manages the application process for the programs listed above. The Hospital also informs and educates patients about state and federal insurance assistance programs by

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

making this information available on patient hospital bills, on notices posted at every registration site, in brochures at registration desks and waiting rooms, via phone patient phone calls, through community events and health fairs and by establishing relationships with community agencies such as senior citizen centers, shelters, food pantries, board of health and school nurses.

Community Information

The Hospital serves the North Shore Community in Massachusetts, which has a population of approximately 300,000. This area includes Beverly, Danvers, Peabody, Saugus, Lynn, Marblehead, Salem, Hamilton, Ipswich, Essex, Manchester, Gloucester and Rockport but anyone who comes to one of the facilities and requires care will receive it, regardless of whether they live in this community. Eighty percent of the community is white, 81.3% have English has a first language, and 90% have graduated from high school. As reported in our Public Health Assessment Report, 87% of the adults in the Hospital's service area have a personal health care provider and 80% have health insurance.

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

Health of Community in Relation to Exempt Purpose

In addition to the Hospital's community benefits programs, initiatives and activities as noted throughout Schedule H, NHC has further promoted the health of the community by encouraging its managers and staff to actively participate in other not-for-profit community organizations, either as board members or supporters. The Hospital responsibly manages facility updates and technological improvement that enables NHC to provide the North Shore with convenient, safe and effective healthcare.

Affiliated Health Care Information

Northeast Health System, Inc. (NHS) is an integrated healthcare system comprised of a network of hospitals, behavioral health, long-term care and human service affiliates offering North Shore residents general and specialized medical care. NHS has a commitment to both patients and their families to provide high-quality care in a comforting setting. The organizations that make up this network include; NHC (organized for the purpose of operating a hospital), Northeast Medical Practice (organized to manage and operate accessible physician practices), Seacoast Nursing and Rehabilitation Center (organized for purpose of operating a nursing home),

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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.

Northeast Senior Health Corporation (organized for the purpose of providing elderly and assisted living housing), Northeast Behavioral Health (organized to provide outpatient services, cross-cultural programs, community support services, youth residential services, substance abuse services, prevention services, trauma services, early childhood services and medical services in the greater Northshore) and CAB Health & Recovery (organized for the purpose of providing treatment for substance abuse). Through this continuum of services, NHS provides for a wide range of the health needs of the residents of the North Shore in a coordinated, efficient and comprehensive manner.

List of States Where Community Benefit Report is Filed

Massachusetts

Additional Information

Part III, line 2 (bad debt expense at cost) was determined by multiplying the hospital's bad debt provision from the general ledger by the cost ratio (calculated as noted above), less recoveries of bad debt from the general ledger.

Supplemental Information

Complete this part to provide the following information.

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

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's 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 III, line 3 (bad debt patients eligible for charity care) was determined by reviewing specific patient balances. This amount consists of patients with a balance from a prior visit (who did not qualify for free care at that time) who later came to the Hospital for a visit and now qualifies for free care. Charges related to this previous visit are written off as bad debt, since they were not eligible for free care at that time.

Part III, line 6 was calculated using an internal cost accounting system, which provides management financial information across all payers and services of the organization.

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments, and Individuals in the United States

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

OMB No. 1545-0047

2010

Name of the organization
Northeast Hospital Corporation

Employer identification number
04-2121317

General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . [X] Yes [ ] No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Grants and Other Assistance to Governments and Organizations in the United States.

Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than $5,000. Check this box if no one recipient received more than $5,000. Part II can be duplicated if additional space is needed . . . . . ▶ [ ]

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							

2 Enter total number of section 501(c)(3) and government organizations . . . . . ▶

3 Enter total number of other organizations . . . . . ▶

Grants and Other Assistance to Individuals in the United States. Complete if the organization answered "Yes" to 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 non-cash assistance
1	E. Torrey Johnson Schlshp	17	24,000			
2	Medical Staff Scholarship	2	4,000			
3						
4						
5						
6						
7						

Supplemental Information. Complete this part to provide the information required in Part I, line 2, and any other additional information.

Part I, Line 2 - Procedures for Monitoring the Use of Grant Funds

The Elizabeth Torrey Johnson Scholarship Fund is maintained by the Friends of Beverly Hospital (a group who creates and supports programs and activities that enrich Beverly Hospital). The Fund was established in 1964 and since then has provided annual scholarships to numerous applicants. All eligible applicants must submit an application that includes the cost of tuition, room & board, fees and all available financial resources they have been awarded. Recipients are high school students who have volunteered a minimum of 100 hours at the Hospital and plan to have careers in health care. Confirmation of enrollment in college is required. The Medical Staff

Grants and Other Assistance to Individuals in the United States. Complete if the organization answered "Yes" to 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 non-cash assistance
1						
2						
3						
4						
5						
6						
7						

Supplemental Information. Complete this part to provide the information required in Part I, line 2, and any other additional information.

scholarships awards $2,000 to several students in the Hospital's primary care service area. After students apply for the scholarships their applications are reviewed and the recipients are chosen by a committee of the medical staff.

SCHEDULE J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047
2010

Name of the organization
Northeast Hospital Corporation

Employer identification number
04-2121317

Questions Regarding Compensation

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

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

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

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

	(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)–(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	Kenneth Hanover	(i)	510,207	0	0	0	21,195	531,402	0
		(ii)	274,727	0	0	0	11,413	286,140	0
2	Denis Conroy	(i)	240,289	0	0	0	17,336	257,625	0
		(ii)	129,386	0	0	0	9,335	138,721	0
3	William Donaldson	(i)	147,088	0	0	0	21,161	168,249	0
		(ii)	98,058	0	0	0	14,107	112,165	0
4	Joseph Porcello	(i)	50,275	0	0	0	10,133	60,408	0
		(ii)	117,308	0	0	0	23,643	140,951	0
5	Pauline Pike	(i)	276,085	0	0	0	19,581	295,666	0
		(ii)	14,531	0	0	0	1,031	15,562	0
6	Peter Short	(i)	269,449	0	0	0	23,875	293,324	0
		(ii)	14,182	0	0	0	1,257	15,439	0
7	Gary Marlow	(i)	228,711	0	0	0	25,410	254,121	0
		(ii)	0	0	0	0	0	0	0
8	Gregory Bird	(i)	218,684	0	0	0	33,911	252,595	0
		(ii)	0	0	0	0	0	0	0
9	Johanna Rodgers	(i)	186,354	0	0	0	25,767	212,121	0
		(ii)	16,205	0	0	0	2,241	18,446	0
10	Althea Lyons	(i)	173,699	0	0	0	31,561	205,260	0
		(ii)	9,142	0	0	0	1,661	10,803	0
11	Cynthia Donaldson	(i)	169,861	0	0	0	14,617	184,478	0
		(ii)	0	0	0	0	0	0	0
12	Bin He	(i)	309,987	12,004	0	0	34,898	356,889	0
		(ii)	0	0	0	0	0	0	0
13	Irene Tsirozidou	(i)	312,086	3,888	0	0	30,654	346,628	0
		(ii)	0	0	0	0	0	0	0
14	Sashikanth Kodali	(i)	302,367	4,004	0	0	10,409	316,780	0
		(ii)	0	0	0	0	0	0	0
15	Nilsson, Claes	(i)	294,697	6,988	0	0	33,361	335,046	0
		(ii)	0	0	0	0	0	0	0
16	Muhammad Rizvi	(i)	277,327	2,810	0	0	21,177	301,314	0
		(ii)	0	0	0	0	0	0	0

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

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

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

	(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)–(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	Steven Laverty	(i)	0	0	559,237	0	14,111	573,348	0
		(ii)	0	0	0	0	0	0	0
2	James Purdy	(i)	158,237	0	48,642	0	20,231	227,110	0
		(ii)	0	0	0	0	0	0	0
3	Charles Payson	(i)	78,258	0	31,097	0	21,174	130,529	0
		(ii)	33,539	0	13,327	0	9,075	55,941	0
4	Robert Laramie	(i)	133,668	0	0	0	23,967	157,635	0
		(ii)	0	0	0	0	0	0	0
5		(i)							
		(ii)							
6		(i)							
		(ii)							
7		(i)							
		(ii)							
8		(i)							
		(ii)							
9		(i)							
		(ii)							
10		(i)							
		(ii)							
11		(i)							
		(ii)							
12		(i)							
		(ii)							
13		(i)							
		(ii)							
14		(i)							
		(ii)							
15		(i)							
		(ii)							
16		(i)							
		(ii)							

Supplemental Information

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

Part I, Line 1a - Fringe or Expense Explanation

Ken Hanover, CEO, was provided a housing allowance of $3,000 per month from January 2010 through September 2010.

Part I, Line 4 - Severance, Nonqualified, and Equity-Based Payments

	Severance	Nonqualified	Equity-based
Steven Laverty	559,237	0	0
James Purdy	48,462	0	0
Charles Payson	44,424	0	0

SCHEDULE K
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part V.**

▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No. 1545-0047

2010

Name of the organization

Northeast Hospital Corporation

Employer identification number
04-2121317

Bond Issues

	(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	Mass Hlth & Edu Fac's Auth Series H	04-2456011	57586CQJ7	08/03/06	23,000,000	Const. Ambul Fac		X		X		X
B	Mass Hlth & Edu Fac's Auth Series G	04-2456011	57586CDV4	10/27/04	55,000,000	Cons/Reno BH ER/GAR		X		X		X
C	Mass Hlth & Edu Fac's Auth Srs M-2	04-2456011	57585KA57	05/30/03	13,410,000	Renov BH Endo,PACU		X		X		X
D												

Proceeds

		A	B	C	D
1	Amount of bonds retired	23,000,000	55,000,000	13,410,000	
2	Amount of bonds legally defeased				
3	Total proceeds of issue				
4	Gross proceeds in reserve funds		4,064,143	1,341,000	
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows		9,375,639		
7	Issuance costs from proceeds	406,011	3,190,198	67,050	
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	22,593,989	3,837,020	12,001,950	
11	Other spent proceeds				
12	Other unspent proceeds				
13	Year of substantial completion	2007	2007	2004	

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X	X			X		
15	Were the bonds issued as part of 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			

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		

Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		
b Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		
c Does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts or research agreements relating to the financed property?	X		X		X			
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	0.00 %		0.00 %		0.00 %		%	
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	0.00 %		0.00 %		0.00 %		%	
6 Total of lines 4 and 5	0.00 %		0.00 %		0.00 %		%	
7 Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?								

Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has a Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate, been filed with respect to the bond issue?		X		X		X		
2 Is the bond issue a variable rate issue?	X		X		X			
3a 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	Bank of America		Merrill Lynch CS					
c Term of hedge	30.0		29.8					
d Was the hedge superintegrated?		X		X		X		
e Was the hedge terminated?		X		X		X		
4a Were gross proceeds invested in a 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?								
5 Were any gross proceeds invested beyond an available temporary period?		X		X		X		
6 Did the bond issue qualify for an exception to rebate?		X		X		X		

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

SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶ **Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.**

▶ **Attach to Form 990.**

OMB No. 1545-0047

2010

Name of the organization
Northeast Hospital Corporation

Employer identification number
04-2121317

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	X		0	
2	Art—Historical treasures				
3	Art—Fractional interests				
4	Books and publications				
5	Clothing and household goods	X		0	
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities—Publicly traded	X		57,091	Selling Price
10	Securities—Closely held stock				
11	Securities—Partnership, LLC, or trust interests				
12	Securities—Miscellaneous				
13	Qualified conservation contribution—Historic structures				
14	Qualified conservation contribution—Other				
15	Real estate—Residential				
16	Real estate—Commercial				
17	Real estate—Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies				
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶(Publishing Srvs)	X		0	
26	Other ▶(Event Tickets)	X		0	
27	Other ▶( )				
28	Other ▶( )				

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

			Yes	No
30a	During the year, did the organization receive by contribution any property reported in Part I, lines 1–28 that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?	30a		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 non-standard 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 did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.			

Supplemental Information. Complete this part to provide the information required by Part I, lines 30b, 32b, and 33. Also complete this part for any additional information.

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.

OMB No. 1545-0047
2010

Name of the organization
Northeast Hospital Corporation

Employer identification number
04-2121317

Form 990 - Organization's Mission or Most Significant Activities

Committed to providing the highest quality medical care to all individuals who can benefit from our continuum of care. Our concept of care broadly embraces the health, well-being and dignity of the patients we serve, regardless of ability to pay.

Form 990, Part I, Line 6

Volunteers support the services of the Hospital's staff. They are trained and supervised by employees of the deparment to which they are assigned. Individual volunteer schedules may vary depending on department needs and may include evening and weekend hours.

Volunteers receive training specific to their duties prior to performing their job and are often paired with a veteran volunteer or staff member until they are comfortable working on their own. Volunteers attend hospital orientation to learn safety, infection control, and patient confidentiality including HIPAA requirements prior to being placed. They are also given health screenings and receive yearly safety updates.

Form 990, Part V, Line 4b - Financial Accounts in Foreign Countries

Bermuda, Cayman Islands, British Virgin Islands

Form 990, Part VI, Line 2 - Related Party Information Among Officers

William Donaldson	**Cynthia Donaldson**
VP	**VP**

Name of the organization: Northeast Hospital Corporation

Employer identification number: 04-2121317

husband & wife

Form 990, Part VI, Line 6 – Classes of Members or Stockholders

Northeast Health System is the sole member of Northeast Hospital Corporation

Form 990, Part VI, Line 7a - Election of Members and Their Rights

Northeast Health System is the sole member of Northeast Hospital Corporation and elects the Northeast Hospital Corporation Board of Trustees

Form 990, Part VI, Line 7b - Decisions Subject to Approval of Members

Northeast Health System reserves to itself the power to approve certain actions taken by the Board of Northeast Hospital Corporation

Form 990, Part VI, Line 11b - Organization's Process to Review Form 990

A copy of the Form 990, along with a review guide, was provided to all members of the Board of Trustees prior to the filing. This return was also reviewed by members of the finance and compensation committee prior to filing.

Form 990, Part VI, Line 12c - Enforcement of Conflicts Policy

Each year the members of the Board are provided with a copy of the conflict of interest policy and asked to list any potential conflicts. This signed form is kept on file with the corporate records and the Chair and CEO are made aware of any potentional conflicts. If any conflicts exist, the Trustee is excused from the discussions and the vote.

Name of the organization: Northeast Hospital Corporation

Employer identification number: 04-2121317

Form 990, Part VI, Line 15a - Compensation Process for Top Official

The Compensation Committee, comprised of independent trustees, meets annually review executive goals, salaries, incentives, payment programs and benefits. The committe uses comparative data from Sullivan & Cotter & Lawrence Associates to make sure executive compensation and benefits are in line with the rest of the industry.

Form 990, Part VI, Line 15b - Compensation Process for Officers

The Compensation Committee, comprised of independent trustees, meets annually review executive goals, salaries, incentives, payment programs and benefits. The committe uses comparative data from Sullivan & Cotter & Lawrence Associates to make sure executive compensation and benefits are in line with the rest of the industry.

Form 990, Part VI, Line 19 - Governing Documents Disclosure Explanation

The Articles of Organization is a public document filed with the Secretary of State of the Commonwealth of Massachusetts. The Articles of Organization, By-Laws and Conflict of Interest Policy are available upon request. The Organization publishes an Annual Report, which contains audited financial statements and listings of board members. The Federal Form 990 and Massachusetts Form PC are available upon request

Form 990, Part XI, Line 5 - Other Changes in Net Assets Explanation

Other changes in net assets include:
transfer to affiliate (6,318,000),
minimum pension liability (16,327,805),
foundation expense allocation (389,156),

Name of the organization **Northeast Hospital Corporation**

Employer identification number **04-2121317**

change in net unrealized gains (4,978,862), and

net assets released from restricted PPE, 565,646

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No. 1545-0047

2010

Name of the organization

Northeast Hospital Corporation

Employer identification number

04-2121317

Identification of Disregarded Entities (Complete if the organization answered "Yes" to Form 990, Part IV, line 33.)

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					

Identification of Related Tax–Exempt Organizations (Complete if the organization answered "Yes" to 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	(g) No
(1) Northeast Medical Practice 85 Herrick St 04-3201853 Beverly MA 01915	Physicians	MA	501(c)	9	NEHS		X
(2) Northeast Health System 85 Herrick St 04-3240453 Beverly MA 01915	Parent Co.	MA	501(c)	11c	NEHS		X
(3) CAB Health & Recovery 0 Centennial Drive 04-2400270 Peabody MA 01960	Subs abuse	MA	501(c)	9	NEHS		X
(4) Seacoast Nursing & Rehab 300 Washington St 04-1305001 Gloucester MA 01930	Healthcare	MA	501(c)	9	NEHS		X
(5) NE Professional Reg of Nurses 800 Cummings Ctr 04-1287349 Beverly MA 01915	Healthcare	MA	501(c)	9	NEHS		X

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ **Attach to Form 990.** ▶ **See separate instructions.**

OMB No. 1545-0047

2010

Name of the organization

Northeast Hospital Corporation

Employer identification number

04-2121317

Identification of Disregarded Entities (Complete if the organization answered "Yes" to Form 990, Part IV, line 33.)

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					

Identification of Related Tax–Exempt Organizations (Complete if the organization answered "Yes" to 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	(g) No
(1) Northeast Senior Health 85 Herrick St 04-2731137 Beverly MA 01915	Healthcare	MA	501(c)	9	NEHS		X
(2) Northeast Behavioral Health 131 Rantoul St 04-2777145 Beverly MA 01915	Mental Ill	MA	501(c)	7	NEHS		X
(3)							
(4)							
(5)							

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1) **Cable Properties County Road Ipswich MA 01938 04-3033832**	**Cable dev**		**NEHS**	**C**			
(2) **Northeast Proprietary Corp 85 Herrick St Beverly MA 01915 04-2855191**	**Med srvs**		**NEHS**	**C**			
(3) **Northeast PHO 500 Cummings Ctr, Suite 6500 Beverly MA 01915 04-3258053**	**Med srvs**		**NEHS**	**C**			
(4)							

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

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

		Yes	No
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II–IV?		
a	Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	X	
b	Gift, grant, or capital contribution to other organization(s)	X	
c	Gift, grant, or capital contribution from other organization(s)		X
d	Loans or loan guarantees to or for other organization(s)	X	
e	Loans or loan guarantees by other organization(s)		X
f	Sale of assets to other organization(s)		X
g	Purchase of assets from other organization(s)		X
h	Exchange of assets		X
i	Lease of facilities, equipment, or other assets to other organization(s)	X	
j	Lease of facilities, equipment, or other assets from other organization(s)		X
k	Performance of services or membership or fundraising solicitations for other organization(s)		X
l	Performance of services or membership or fundraising solicitations by other organization(s)	X	
m	Sharing of facilities, equipment, mailing lists, or other assets		X
n	Sharing of paid employees	X	
o	Reimbursement paid to other organization for expenses		X
p	Reimbursement paid by other organization for expenses		X
q	Other transfer of cash or property to other organization(s)		X
r	Other transfer of cash or property from other 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 other organization	(b) Transaction type (a–r)	(c) Amount involved	(d) Method of determining amount involved
(1)	Northeast Medical Practice	a	249,353	
(2)	Northeast Senior Health	a	114,040	
(3)	Northeast Medical Practice	b	6,318,000	
(4)	Northeast Senior Health	d	6,090,000	
(5)	Northeast Behavioral Health	d	5,264,000	
(6)	Seacoast Nursing & Rehab	d	6,056,000	

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

		Yes	No
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?			
a Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	1a	X	
b Gift, grant, or capital contribution to other organization(s)	1b	X	
c Gift, grant, or capital contribution from other organization(s)	1c		X
d Loans or loan guarantees to or for other organization(s)	1d	X	
e Loans or loan guarantees by other organization(s)	1e		X
f Sale of assets to other organization(s)	1f		X
g Purchase of assets from other organization(s)	1g		X
h Exchange of assets	1h		X
i Lease of facilities, equipment, or other assets to other organization(s)	1i	X	
j Lease of facilities, equipment, or other assets from other organization(s)	1j		X
k Performance of services or membership or fundraising solicitations for other organization(s)	1k		X
l Performance of services or membership or fundraising solicitations by other organization(s)	1l	X	
m Sharing of facilities, equipment, mailing lists, or other assets	1m		X
n Sharing of paid employees	1n	X	
o Reimbursement paid to other organization for expenses	1o		X
p Reimbursement paid by other organization for expenses	1p		X
q Other transfer of cash or property to other organization(s)	1q		X
r Other transfer of cash or property from other organization(s)	1r		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 other organization	(b) Transaction type (a–r)	(c) Amount involved	(d) Method of determining amount involved
(1)	Northeast Health System	l	892,623	
(2)	Northeast Behavioral Health	l	14,989,640	
(3)	Northeast Medical Practice	n	104,169	
(4)				
(5)				
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Are all partners section 501(c)(3) organizations?		(e) Share of end-of-year assets	(f) Disproportionate allocations?		(g) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(h) General or managing partner?	
			Yes	No		Yes	No		Yes	No
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
(11)										

Supplemental Information

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