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

Open to Public Inspection

A For the 2010 calendar year, or tax year beginning 10/01 **, 2010, and ending** 09/30 **, 20** 11

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

C Name of organization
ALICE PECK DAY MEMORIAL HOSPITAL

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
125 MASCOMA STREET

City or town, state or country, and ZIP + 4
LEBANON, NH 03766-2647

D Employer identification number
02-0222791

E Telephone number
(603) 448-3121

G Gross receipts $ 52,744,048.

F Name and address of principal officer: HARRY G. DORMAN III
125 MASCOMA STREET LEBANON, NH 03766-2647

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)

H(c) Group exemption number ▶

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

J **Website:** ▶ WWW.ALICEPECKDAY.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶ **L** Year of formation: 1943 **M** State of legal domicile: NH

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:
CRITICAL ACCESS HOSPITAL

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	21.
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	18.
5	Total number of individuals employed in calendar year 2010 (Part V, line 2a)	5	494.
6	Total number of volunteers (estimate if necessary)	6	106.
7a	Total gross unrelated business revenue from Part VIII, column (C), line 12	7a	
b	Net unrelated business taxable income from Form 990-T, line 34	7b	

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	1,029,971.	462,323.
9	Program service revenue (Part VIII, line 2g)	42,411,307.	50,223,338.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	137,115.	106,115.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	48,297.	40,165.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	43,626,690.	50,831,941.

COPY FOR PUBLIC INSPECTION

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)		41,450.
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)	23,580,477.	28,733,724.
16a	Professional fundraising fees (Part IX, column (A), line 11e)		86,744.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 370,053.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24f)	17,285,987.	20,456,710.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	40,866,464.	49,318,628.
19	Revenue less expenses. Subtract line 18 from line 12	2,760,226.	1,513,313.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	28,392,505.	33,647,872.
21	Total liabilities (Part X, line 26)	15,278,155.	19,624,880.
22	Net assets or fund balances. Subtract line 21 from line 20	13,114,350.	14,022,992.

Part II Signature Block

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

Sign Here

▶ Signature of officer — Date

▶ EVALIE M. CROSBY VP FINANCE & CFO
Type or print name and title

Paid Preparer Use Only

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

Firm's name ▶ BAKER NEWMAN & NOYES — EIN ▶

Firm's address ▶ 650 ELM ST, SUITE 302 MANCHESTER, NH 03101 — Phone no. ▶ 800-244-7444

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2010)

JSA
0E1065 3.000

Part III **Statement of Program Service Accomplishments**
Check if Schedule O contains a response to any question in this Part III . . . . . ☐

1 Briefly describe the organization's mission:
THE MISSION OF ALICE PECK DAY MEMORIAL HOSPITAL IS TO PROVIDE PATIENT-FOCUSED HEALTH CARE SERVICES THAT ARE RESPONSIVE TO COMMUNITY NEEDS, TO PROMOTE WELLNESS, AND TO CONTINUALLY IMPROVE THE QUALITY OF HEALTHCARE SERVICES IN THE COMMUNITY.

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 $ 45,652,832. including grants of $ 41,450.) (Revenue $ 50,127,040.)
ATTACHMENT 1

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

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

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

4e Total program service expenses ▶ 45,652,832.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	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		
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—othersecurities 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	
12 a	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
14 a	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
20 a	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	

Part IV 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	
24 a	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
25 a	**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	

Part V **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	61		
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	494		
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			
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 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			
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			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			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

Check if Schedule O contains a response 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	21		
b	Enter the number of voting members included in line 1a, above, who are independent	1b	18		
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		

Section C. Disclosure

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

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.

[X] Own website [ ] Another's website [X] 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: ▶ ELIZABETH LOUDERMILK 125 MASCOMA STREET LEBANON, NH 03766-2647
603-448-3121

Part VII **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 X

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (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			
ATTACHMENT 3										
(1) MICHAEL R. HARRIS CHAIR	1.00	X		X						
(2) REV. DR. GUY J.D. COLLINS VICE CHAIR	1.00	X		X						
(3) JUDSON T. PIERSON TREASURER	2.00	X		X						
(4) KAREN G. KAYEN SECRETARY	1.00	X		X						
(5) BARBARA A. CALLAHAN, CRNA MEDICAL STAFF PRESIDENT	1.00	X		X						
(6) MICHAEL J. CRYANS TRUSTEE	.50	X								
(7) HARRY G. DORMAN III PRESIDENT AND CEO	60.00	X		X					308,651.	28,361.
(8) TERRI C. DUDLEY TRUSTEE EMERITUS (NON VOTING)	1.00	X								
(9) CLAUDIA C. GIBSON AUXILIARY PRESIDENT	.50	X								
(10) RICHARD S. JENNINGS TRUSTEE	1.00	X								
(11) BRUCE N. JOHNSTONE TRUSTEE	1.00	X								
(12) JENNIFER H. JUDKINS TRUSTEE	1.00	X								
(13) EDWARD T. KERRIGAN TRUSTEE	1.00	X								
(14) SARA L. KOBYLENSKI TRUSTEE	1.00	X								
(15) MIRIAM M. MAGUIRE TRUSTEE	.50	X								
(16) SUSAN E. MOONEY, MD VP & MEDICAL DIRECTOR	60.00	X		X				242,743.		34,892.

Part VII 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) MICHAEL P.W.H. PAINE, FRCS TRUSTEE	2.00	X								
(18) PAUL R. BOUCHER CHAIR- APD LIFECARE	1.00	X								
(19) MARTY P. CANDON TRUSTEE	1.00	X								
(20) MARK E. MELENDY TRUSTEE	1.00	X								
(21) SHELLY L. MOSES TRUSTEE	1.00	X								
(22) CLOSEY F. DICKEY TRUSTEE EMERITUS (NON VOTING)	1.00	X								
(23) BEVERLY A. RANKIN PART YEAR VP & CNO	60.00	X		X				8,087.		2,040.
(24) JAMES R. CALLAN PART YEAR TRUSTEE	1.00	X								
(25) J. TODD MILLER COO	60.00			X				133,757.		15,540.
(26) EVALIE M. CROSBY VP FINANCE AND CFO	60.00			X					150,189.	27,970.
(27) DOUGLAS CEDENO, MD PHYSICIAN	40.00					X		250,969.		23,854.
(28) CHRISTOPHER MAZUR, MD PHYSICIAN	40.00					X		241,303.		35,465.
1b Sub-total ▶								876,859.	458,840.	168,122.
c Total from continuation sheets to Part VII, Section A ATTACHMENT 2 ▶								801,895.		47,214.
d Total (add lines 1b and 1c) ▶								1,678,754.	458,840.	215,336.

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 ▶ 25

		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
ATTACHMENT 4		

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 ▶ 7

Part VIII 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				
	d Related organizations	1d				
	e Government grants (contributions)	1e				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	462,323.			
	g Noncash contributions included in lines 1a-1f: $					
	h **Total.** Add lines 1a-1f		462,323.			
Program Service Revenue		**Business Code**				
	2a PATIENT SERVICE REVENUE	621400	49,962,376.	49,962,376.		
	b OTHER OPERATING REVENUE	621400	164,664.	164,664.		
	c NUTRITIONAL REVENUE	900099	96,298.			96,298.
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a-2f		50,223,338.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ATTACHMENT 5		77,420.			77,420.
	4 Income from investment of tax-exempt bond proceeds		0.			
	5 Royalties		0.			
		(i) Real	(ii) Personal			
	6a Gross Rents	53,827.				
	b Less: rental expenses	13,662.				
	c Rental income or (loss)	40,165.				
	d Net rental income or (loss)		40,165.			
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory	1,909,789.	17,351.			
	b Less: cost or other basis and sales expenses	1,775,758.	122,687.			
	c Gain or (loss)	134,031.	-105,336.			
	d Net gain or (loss)		28,695.			
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18 a					
	b Less: direct expenses b					
	c Net income or (loss) from fundraising events		0.			
	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		0.			
	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		0.			
	Miscellaneous Revenue	**Business Code**				
	11a					
	b					
	c					
	d All other revenue					
	e **Total.** Add lines 11a-11d		0.			
	12 **Total revenue.** See instructions		50,831,941.	50,127,040.		173,718.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns.
All other organizations must complete column (A) 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	41,450.	41,450.		
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22	0.			
3 Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	610,657.	73,289.	537,368.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.			
7 Other salaries and wages	22,431,256.	21,641,484.	611,629.	178,143.
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	679,040.	640,175.	33,601.	5,264.
9 Other employee benefits	3,459,014.	3,298,555.	133,609.	26,850.
10 Payroll taxes	1,553,757.	1,442,041.	99,907.	11,809.
11 Fees for services (non-employees):				
a Management	0.			
b Legal	48,872.	6,833.	42,039.	
c Accounting	50,150.		50,150.	
d Lobbying	0.			
e Professional fundraising services. See Part IV, line 17	86,744.			86,744.
f Investment management fees	0.			
g Other	5,837,459.	5,392,445.	417,938.	27,076.
12 Advertising and promotion	2,178.	360.	1,814.	4.
13 Office expenses	1,350,990.	1,054,689.	277,561.	18,740.
14 Information technology	80,285.	76,608.	2,914.	763.
15 Royalties	0.			
16 Occupancy	978,255.	795,821.	174,687.	7,747.
17 Travel	201,365.	179,980.	19,655.	1,730.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	0.			
20 Interest	325,233.	252,446.	70,023.	2,764.
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	1,401,317.	1,097,091.	304,226.	
23 Insurance	452,859.	442,956.	9,527.	376.
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 BAD DEBT EXPENSE	2,596,394.	2,596,394.		
b MEDICAID ENHANCEMENT TAX	1,780,816.	1,780,816.		
c EQUIPMENT RENTAL/MAINTENANCE	498,631.	484,592.	13,995.	44.
d MEDICAL SUPPLIES/EQUIPMENT	4,298,449.	4,296,546.	1,678.	225.
e ADMIN EXPENSE PAID TO AHS	483,311.		483,311.	
f All other expenses	70,146.	58,261.	10,111.	1,774.
25 **Total functional expenses.** Add lines 1 through 24f	49,318,628.	45,652,832.	3,295,743.	370,053.
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				

Part X Balance Sheet

				(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing		1,955.	1	296,478.
	2	Savings and temporary cash investments		4,464,824.	2	6,445,524.
	3	Pledges and grants receivable, net		8,764.	3	73,430.
	4	Accounts receivable, net		6,151,124.	4	7,551,295.
	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		1,158,009.	8	1,220,966.
	9	Prepaid expenses and deferred charges		194,503.	9	372,898.
	10 a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 34,488,976.			
	b	Less: accumulated depreciation	10b 22,113,583.	11,400,298.	10c	12,375,393.
	11	Investments - publicly traded securities		2,555,238.	11	2,827,079.
	12	Investments - other securities. See Part IV, line 11		8,500.	12	8,500.
	13	Investments - program-related. See Part IV, line 11			13	
	14	Intangible assets		150,291.	14	128,010.
	15	Other assets. See Part IV, line 11		2,298,999.	15	2,348,299.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		28,392,505.	16	33,647,872.
Liabilities	17	Accounts payable and accrued expenses		6,020,355.	17	6,379,747.
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities		9,021,000.	20	12,144,107.
	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			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	495,000.
	25	Other liabilities. Complete Part X of Schedule D		236,800.	25	606,026.
	26	**Total liabilities.** Add lines 17 through 25		15,278,155.	26	19,624,880.
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		11,576,659.	27	13,051,788.
	28	Temporarily restricted net assets		1,509,626.	28	945,364.
	29	Permanently restricted net assets		28,065.	29	25,840.
		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		13,114,350.	33	14,022,992.
	34	Total liabilities and net assets/fund balances		28,392,505.	34	33,647,872.

Part XI 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	50,831,941.
2	Total expenses (must equal Part IX, column (A), line 25)	2	49,318,628.
3	Revenue less expenses. Subtract line 2 from line 1	3	1,513,313.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	13,114,350.
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-604,671.
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	14,022,992.

Part XII 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

Open to Public Inspection

Name of the organization	**Employer identification number**
ALICE PECK DAY MEMORIAL HOSPITAL	02-0222791

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

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

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

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

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

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

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

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

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

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

9 ☐ An organization that normally receives: (1) more than 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									

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 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 organzation meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 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						
10 a 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	%

19 a **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 ▶ ☐

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

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ **Attach to Form 990, 990-EZ, or 990-PF.**

OMB No. 1545-0047

2010

Name of the organization
ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number
02-0222791

Organization type (check one):

Filers of:	**Section:**
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

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

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

[ ] For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not aggregate to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of $5,000 or more during the year . . . . . ▶ $ _____

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

Name of organization ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number 02-0222791

Part I **Contributors** (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
1		$ 6,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
2		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
3		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
4		$ 43,800.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
5		$ 22,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
6		$ 31,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number 02-0222791

Part I **Contributors** (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
7		$ 6,941.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
8		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
9		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
10		$ 10,100.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
11		$ 9,359.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
12		$ 9,665.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number 02-0222791

Part I **Contributors** (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
13		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
14		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
15		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
16		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
17		$ 5,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
18		$ 102,646.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

Name of organization ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number 02-0222791

Part I **Contributors** (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
19		$ 20,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
20		$ 30,624.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II if there is a noncash contribution.)

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

Open to Public Inspection

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part VI, 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
ALICE PECK DAY MEMORIAL HOSPITAL	02-0222791

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

1 Provide a description of the organization's direct and indirect political campaign activities on behalf of or in opposition to candidates for public office in Part IV.

2 Political expenditures . . . . . ▶ $ _____

3 Volunteer hours . . . . . _____

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

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

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

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

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

b If "Yes," describe in Part IV.

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

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

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

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

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

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

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

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

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

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.

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
2 a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

		(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	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i	Other activities? If "Yes," describe in Part IV	X		9,712.
j	Total. Add lines 1c through 1i			9,712.
2 a	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?		X	

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

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

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

Part IV **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.

PART II-B, LINE 1 (I), OTHER LOBBYING ACTIVITIES:

SCHEDULE C

THE ORGANIZATION PAYS DUES TO THE NEW HAMPSHIRE HOSPITAL ASSOCIATION AND

THE AMERICAN HOSPITAL ASSOCIATION, A PORTION OF WHICH ARE ATTRIBUTABLE TO

LOBBYING ACTIVITIES.

Part IV **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

Open to Public Inspection

Name of the organization

ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number

02-0222791

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

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

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

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

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

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

☐ Preservation of land for public use (e.g., recreation or education)
☐ 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 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.

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part 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 ▶ $

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

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

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

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part 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 ☐ No

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

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

b If "Yes," explain the arrangement in Part XI V 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 XI V.

Part V 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	28,065.	26,827.	26,456.		
b Contributions					
c Net investment earnings, gains, and losses	-2,225.	1,238.	371.		
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	25,840.	28,065.	26,827.		

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

- a Board designated or quasi-endowment ▶ _____ %
- b Permanent endowment ▶ 100.0000 %
- c Term endowment ▶ _____ %

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.

Part VI 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	0.	927,577.		927,577.
b Buildings	0.	13,343,955.	7,387,375.	5,956,580.
c Leasehold improvements	0.	191,748.	175,823.	15,925.
d Equipment	0.	17,219,287.	13,740,896.	3,478,391.
e Other	0.	2,806,409.	809,489.	1,996,920.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				12,375,393.

Part VII 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.)* ▶		

Part VIII 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.)* ▶		

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

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	2,348,299.
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	2,348,299.

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

1. (a) Description of liability	(b) Amount
(1) Federal income taxes	
(2) DEFERRED ANNUITY	61,218.
(3) ESTIMATED 3RD PARTY SETTLEMENTS	328,319.
(4) INTEREST RATE SWAP	216,489.
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	606,026.

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).

Part XI 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	50,831,941.
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	49,318,628.
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	1,513,313.
4	Net unrealized gains (losses) on investments	4	-234,459.
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	-370,212.
9	Total adjustments (net). Add lines 4 through 8	9	-604,671.
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	908,642.

Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements			1	50,598,246.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV.)	2d	13,662.		
e	Add lines **2a** through **2d**			2e	13,662.
3	Subtract line **2e** from line **1**			3	50,584,584.
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	247,357.		
c	Add lines **4a** and **4b**			4c	247,357.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	50,831,941.

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements			1	49,332,290.
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	13,662.		
e	Add lines **2a** through **2d**			2e	13,662.
3	Subtract line **2e** from line **1**			3	49,318,628.
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			
c	Add lines **4a** and **4b**			4c	
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	49,318,628.

Part XIV 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.

SEE PAGE 5

Part XIV Supplemental Information *(continued)*

FORM 990, SCHEDULE D, PART X:

THE SYSTEM CONSISTS OF NOT-FOR-PROFIT CORPORATIONS AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE, ALL OF WHICH ARE EXEMPT FROM FEDERAL INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE.

THE SYSTEM ADOPTED FASB INTERPRETATION NO. 48 (FIN 48), ACCOUNTING FOR UNCERTAINTY IN INCOME TAXES - AN INTERPRETATION OF FASB STATEMENT NO. 109, EFFECTIVE OCTOBER 1, 2007. THE SYSTEM HAS EVALUATED ITS TAX POSITIONS TAKEN IN ACCORDANCE WITH FIN 48 AND HAS DETERMINED THAT THERE IS NO IMPACT ON THE SYSTEM'S CURRENT TAX-EXEMPT STATUS, OR FINANCIAL POSITION OR RESULTS OF OPERATIONS FOR THE YEARS ENDED SEPTEMBER 30, 2011 AND 2010.

WITH FEW EXCEPTIONS, THE SYSTEM IS NO LONGER SUBJECT TO INCOME TAX EXAMINATION BY THE U.S. FEDERAL OR STATE TAX AUTHORITIES FOR YEARS PRIOR TO 2008.

FORM 990, SCHEDULE D, PART XI, LINE 8:

CHANGE IN INTEREST RATE SWAP: $216,489

LOSS ON EXTINGUISHMENT OF DEBT: $148,273

CHANGE IN ANNUITY LIABILITY: $ 5,450

Part XIV Supplemental Information *(continued)*

FORM 990, SCHEDULE D, PART XII, LINE 2D:

RENTAL EXPENSES: $13,662

FORM 990, SCHEDULE D, PART XII, LINE 4B:

TEMPORARILY RESTRICTED CONTRIBUTIONS: $241,908

CHANGE IN ANNUITY LIABILITY: $ 5,449

FORM 990, SCHEDULE D, PART XIII, LINE 2D:

RENTAL EXPENSES: $13,662

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
Open To Public Inspection

Name of the organization: ALICE PECK DAY MEMORIAL HOSPITAL
Employer identification number: 02-0222791

Part I **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** [X] Mail solicitations
- **b** [X] Internet and email solicitations
- **c** [ ] Phone solicitations
- **d** [X] In-person solicitations
- **e** [X] Solicitation of non-government grants
- **f** [X] 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? [X] **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 fundraiser have custody or control of contributions? Yes	(iii) 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 GRAHAM-PELTON CONSULTING INC	CONSULTING		X		44,000.	
2 J. DONOVAN ASSOCIATES	CONSULTING		X		42,744.	
3						
4						
5						
6						
7						
8						
9						
10						
Total ▶					86,744.	

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.

NH,

Part II **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 (event type)	(b) Event #2 (event type)	(c) Other Events (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts				
	2 Less: Charitable contributions				
	3 Gross income (line 1 minus line 2)				
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs				
	7 Food and beverages				
	8 Entertainment				
	9 Other direct expenses				
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				( )
	11 Net income summary. Combine line 3, column (d), and line 10 ▶				

Part III **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? ☐ Yes ☐ No

b If "No," explain: _____

10 a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ 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 ▶ _____

15 a 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 ▶ $

Part IV **Supplemental Information.** Complete this part to provide the explanation 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

Open to Public Inspection

Name of the organization
ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number
02-0222791

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b	If "Yes," was 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. ☐ 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% ☐ Other _____ %	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 212.0000 %	X	
c	If the organization did 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 used 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?		X
6a	Did the organization prepare a community benefit report during the tax year?	X	
b	If "Yes," did 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)			629,484.		629,484.	1.35
b Unreimbursed Medicaid (from Worksheet 3, column a)			6,028,361.	4,034,124.	1,994,237.	4.27
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			6,657,845.	4,034,124.	2,623,721.	5.62
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			142,681.		142,681.	.31
f Health professions education (from Worksheet 5)			94,827.		94,827.	.20
g Subsidized health services (from Worksheet 6)			8,973,501.	5,676,080.	3,297,421.	7.06
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)			79,917.		79,917.	.17
j **Total.** Other Benefits			9,290,926.	5,676,080.	3,614,846.	7.74
k **Total.** Add lines 7d and 7j			15,948,771.	9,710,204.	6,238,567.	13.36

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development			6,778.		6,778.	.01
3 Community support			8,475.		8,475.	.02
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			1,667.		1,667.	
7 Community health improvement advocacy			13,029.		13,029.	.03
8 Workforce development						
9 Other						
10 Total			29,949.		29,949.	.06

Part III **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 1,735,949.			
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 3 100,000.			
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 in community benefit.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME) 5 14,850,102.			
6	Enter Medicare allowable costs of care relating to payments on line 5 6 14,703,883.			
7	Subtract line 6 from line 5. This is the surplus (or shortfall) 7 146,219.			
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other			

Section C. Collection Practices

9a	Does 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	

Part IV **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					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 1

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 ALICE PECK DAY MEMORIAL HOSPITAL 125 MASCOMA ST LEBANON NH 03766	X	X			X		X		PHYSICIAN CLINICS
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									

Part V 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: ALICE PECK DAY MEMORIAL 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: 200 %			

Part V Facility Information *(continued)* ALICE PECK DAY MEMORIAL HOSPITAL

			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: 212 %			
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	[X] Income level			
b	[X] Asset level			
c	[X] Medical indigency			
d	[X] Insurance status			
e	[X] Uninsured discount			
f	[X] Medicaid/Medicare			
g	[ ] State regulation			
h	[X] 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	[X] The policy was posted on the hospital facility's website			
b	[ ] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[X] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[X] 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	[X] Reporting to credit agency			
b	[X] 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	[X] Reporting to credit agency			
b	[X] 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	[X] Notified patients of the financial assistance policy on admission			
b	[X] Notified patients of the financial assistance policy prior to discharge			
c	[X] Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d	[X] 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)			

Part V Facility Information *(continued)* ALICE PECK DAY MEMORIAL HOSPITAL

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.			

Part V **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? 9

	Name and address	Type of Facility (describe)
1	R.A.M. CENTER FOR COMMUNITY CARE 125 MASCOMA ST. #5 LEBANON NH 03766	PRIMARY CARE PHYSICIAN CLINIC
2	WOMEN'S CARE CENTER 141 MASCOMA ST. LEBANON NH 03766	OB/GYN PHYSICIAN CLINIC
3	APD ORTHOPAEDIC CLINIC 125 MASCOMA ST. #17-C LEBANON NH 03766	ORTHOPAEDIC PHYSICIAN CLINIC
4	GENERAL SURGERY CLINIC 125 MASCOMA ST. LEBANON NH 03766	GENERAL SURGEON CLINIC
5	PAIN MANAGEMENT CLINIC 127 MASCOMA ST., 3RD FLOOR LEBANON NH 03766	PAIN MANAGEMENT CLINIC
6	MIDWIFERY SERVICES 57 MECHANIC ST., SUITE 2 LEBANON NH 03766	MIDWIFERY CLINIC
7	APD HAND & UPPER EXTREMITY CLINIC 205 BILLINGS FARM RD. UNIT 3A WHITE RIVER JUNCTION VT 05001	HAND & UPPER EXTREMITY ORTHOPAEDIC PHYSICIAN CLINIC
8	OCCUPATIONAL HEALTH SERVICES 127 MASCOMA ST. LEBANON NH 03766	OCCUPATIONAL HEALTH PHYSICIAN CLINIC
9	NEUROSURGERY SERVICES AT APD (NSAPD) 106 HANOVER STREET LEBANON NH 03766	NEUROSURGERY PHYSICIAN CLINIC
10		

Part VI 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 hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART I, LINE 7:

THE COSTS OF CHARITY CARE, MEANS-TESTED PROGRAMS AND SUBSIDIZED HEALTH SERVICES ARE CALCULATED USING THE COST TO CHARGE RATIOS CALCULATED USING A STEP-DOWN COST ALLOCATION METHODOLOGY CONSISTENT WITH MEDICARE COST REPORT METHODOLOGY.

THE COST OF FINANCIAL ASSISTANCE AND OTHER COMMUNITY BENEFITS AT COST ARE 13.36% OF TOTAL EXPENDITURES ON FORM 990, PART IX, COLUMN A, LINE 26, EXCLUDING BAD DEBT EXPENSE.

SCHEDULE H, PART I, LINE 7, COLUMN (F):

BAD DEBT EXPENSE REPORTED ON FORM 990 PART IX, LINE 25 WAS EXCLUDED FROM TOTAL EXPENSES FOR THE CALCULATION OF NET COMMUNITY BENEFIT EXPENSES AS A PERCENT OF TOTAL EXPENSE.

Part VI 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 hospitals facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART II

ALICE PECK DAY MEMORIAL HOSPITAL PARTICIPATES IN VARIOUS COMMUNITY BUILDING ACTIVITIES TO PROMOTE AND ADVOCATE FOR THE HEALTH NEEDS OF THE COMMUNITY. SIGNIFICANT ACTIVITIES INCLUDE PARTICIPATION IN THE UPPER VALLEY INTERFAITH PROJECT WHICH PROMOTES ADEQUATE PUBLIC TRANSPORTATION IN THE REGION, INCLUDING AVAILABILITY OF TRANSPORTATION FOR HOSPITAL AND CLINIC VISITS FOR AREA RESIDENTS. APD'S SOCIAL SERVICES DEPARTMENT WORKS WITH PATIENTS WHO SEEK ASSISTANCE WITH LIVING WILLS AND ADVANCE MEDICAL DIRECTIVES. APD PERSONNEL ARE ACTIVELY INVOLVED IN DISASTER AND EMERGENCY PREPAREDNESS PLANNING AND TRAINING ACTIVITIES. THESE ACTIVITIES ARE DESIGNED TO PROMOTE THE HEALTH AND SAFETY OF THE COMMUNITY IN THE EVENT OF WIDESPREAD OR LARGE NATURAL OR OTHER DISASTER, OR IN THE EVENT OF WIDESPREAD VIRAL OUTBREAKS, SUCH AS INFLUENZA. FINALLY, APD PERSONNEL ARE ACTIVE PARTICIPANTS IN THE NEW HAMPSHIRE HOSPITAL ASSOCIATION (NHHA). NHHA ADVOCATES FOR THE CARE AND PROTECTION OF NH HOSPITAL PATIENTS, INCLUDING MAKING QUALITY HEALTH CARE AVAILABLE, AFFORDABLE AND ACCESSIBLE TO ALL REGARDLESS OF ABILITY TO PAY.

Part VI 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.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H PART III, LINE 4:

BAD DEBT COST IS CALCULATED USING A COST TO CHARGE RATIO USING A STEP-DOWN COST ALLOCATION METHODOLOGY CONSISTENT WITH MEDICARE COST REPORTING. IN FY 11, ACCOUNTS WRITTEN OFF TO BAD DEBT INCLUDED GROSS CHARGES BEING WRITTEN OFF LESS ANY PAYMENTS RECEIVED AGAINST THOSE CHARGES. ANY CASH COLLECTED ON ACCOUNTS PREVIOUSLY WRITTEN OFF IS INCLUDED AS AN OFFSET TO BAD DEBT EXPENSE AS RECOVERIES OF BAD DEBT.

BASED ON LACK OF COMPLETED DOCUMENTATION, WE ESTIMATED THE AMOUNT OF CHARITY CARE IN BAD DEBT EXPENSE BASED ON THE NUMBER OF APPLICATIONS FOR CHARITY CARE. WE BELIEVE THE AMOUNT IS MINIMAL BASED ON OUR EXTENSIVE EFFORTS TO EDUCATE OUR PATIENTS AND STAFF ABOUT OUR VARIOUS PAYMENT PLANS AND CHARITY CARE TO ENSURE THAT PATIENTS WHO QUALIFY FOR ANY OF OUR PROGRAMS UTILIZE THEM. DEPENDING ON THE SPECIFIC CIRCUMSTANCES, A PATIENT MAY BE ELIGIBLE FOR CHARITY CARE, DISCOUNTED CARE, PAYMENT PROGRAMS OR A COMBINATION OF THE ABOVE. DUE TO THESE EFFORTS, WE FEEL THAT AMOUNTS WRITTEN OFF TO BAD DEBT THAT COULD QUALIFY AS CHARITY CARE ARE MINIMAL.

Part VI Supplemental Information

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FOOTNOTE 1 TO THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS OF ALICE PECK

DAY HEALTH SYSTEMS CORP. INCLUDES THE FOLLOWING TO ADDRESS BAD DEBT:

ACCOUNTS RECEIVABLE ARE STATED AT THE AMOUNT MANAGEMENT EXPECTS TO

COLLECT ON OUTSTANDING BALANCES. MANAGEMENT PROVIDES FOR POSSIBLE

UNCOLLECTIBLE AMOUNTS THROUGH A CHARGE TO OPERATIONS AND A CREDIT TO THE

VALUATION ALLOWANCE BASED ON ITS ASSESSMENT OF INDIVIDUAL ACCOUNTS AND

HISTORICAL ADJUSTMENTS. ACCOUNTS DEEMED UNCOLLECTIBLE ARE WRITTEN OFF

THROUGH A CHARGE AGAINST THE ESTABLISHED ALLOWANCE.

SCHEDULE H, PART III, LINE 8:

MEDICARE ALLOWABLE COSTS FOR THE MEDICARE COST REPORT ARE REPORTED IN

ACCORDANCE WITH CMS GUIDELINES USING THE COST TO CHARGE RATIO

METHODOLOGY.

SCHEDULE H, PART III, LINE 9B:

OUR BAD DEBTS COLLECTION POLICY APPLIES TO ALL PATIENT ACCOUNTS IN A

CONSISTENT MANNER. THE POLICY SPECIFICALLY INDICATES THAT, AFTER A SECOND

STATEMENT IS SENT WITH NO PAYMENT RECEIVED, A PATIENT ACCOUNTS

Part VI Supplemental Information

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REPRESENTATIVE WILL CONTACT THE PATIENT BY PHONE TO DETERMINE IF A FINANCIAL ASSISTANCE APPLICATION OR PAYMENT PLAN IS APPROPRIATE. THIS IS COMPLETED TO AVOID FURTHER ESCALATION OF PAST DUE ACCOUNT(S)IF THE PATIENT MAY QUALIFY FOR FULL OR PARTIAL RELIEF UNDER THE CHARITY CARE POLICY. IF THE APPLICATION IS SUCCESSFUL, THEN THE QUALIFYING BALANCE OR BALANCES ARE CLASSIFIED AS CHARITY CARE AND NO LONGER PURSUED FOR COLLECTIONS. ONCE A PATIENT BALANCE IS CLASSIFIED AS CHARITY CARE, IT IS NOT SUBJECT TO COLLECTION ACTIVITIES. ALICE PECK DAY IS COMMITTED TO HELPING OUR PATIENTS ATTAIN QUALITY HEALTHCARE, REGARDLESS OF ABILITY TO PAY. OUR FINANCIAL ASSISTANCE PROGRAMS PROVIDE, ENCOURAGE AND ENABLE OUR PATIENTS TO MAKE HEALTHCARE DECISIONS FREE OF FINANCIAL BARRIERS. WE EDUCATE OUR PATIENTS ABOUT OUR PROGRAMS AND PROVIDE ASSISTANCE PRIOR TO RECEIVING SERVICES, AT REGISTRATION FOR SERVICES AND DURING OUR BILLING PROCESS TO ENSURE THAT ANY AND ALL PATIENTS IN NEED OF ASSISTANCE ARE PROVIDED WITH THE HELP THEY NEED. BROCHURES AND SIGNS ARE PLACED IN HIGH TRAFFIC AREAS SUCH AS THE ER AND REGISTRATION. OUR STAFF IS TRAINED TO IDENTIFY PATIENTS DURING REGISTRATION, PROVIDE INFORMATION AND OFFER HELP IN COMPLETING THE NECESSARY FORMS. DURING OUR BILLING PROCESS, CALLS ARE

Part VI Supplemental Information

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MADE TO PATIENTS WITH OUTSTANDING BALANCES. OUR STAFF WORKS WITH

PATIENTS TO IDENTIFY PROBLEMS THEY ARE FACING IN DEALING WITH OUTSTANDING

BALANCES. PATIENTS ARE NOTIFIED AGAIN OF THE MANY TYPES OF FINANCIAL

ASSISTANCE AVAILABLE FOR WHICH THEY MAY QUALIFY. PROGRAMS ARE EXPLAINED,

AND ASSISTANCE IS OFFERED IF NEEDED, IN COMPLETING THE APPLICATIONS. DUE

TO THIS MULTI-LEVEL APPROACH AND STAFF THAT IS TRAINED TO IDENTIFY

CLIENTS THAT MAY NEED FINANCIAL ASSISTANCE, VERY FEW QUALIFYING PATIENTS

REACH THE POINT OF BAD DEBT. OUR COLLECTION POLICIES AND PROCEDURES IN

CONJUCTION WITH OUR SMALL SIZE, ALLOW OUR ORGANIZATION TO PLACE GREAT

EMPHASIS ON HELPING ALL PATIENTS WHO MAY BE IN NEED TO APPLY FOR, AND

ATTAIN, THE APPROPRIATE LEVEL OF FINANCIAL ASSISTANCE.

SCHEDULE H, PART V, LINE 11:

ALICE PECK DAY MEMORIAL HOSPITAL OFFERS FINANCIAL ASSISTANCE TO PATIENTS

DEMONSTRATING NEED. IN MAKING THE NEED DETERMINATION, APD PARTICIPATES

WITH AND HONORS THE FOUNDING PRINCIPLES AND GUIDELINES OF THE NEW

HAMPSHIRE HEALTH ACCESS NETWORK (NHHAN). ACCORDINGLY, DECISIONS

REGARDING THE GRANTING OF FINANCIAL ASSISTANCE WILL BE BASED PRIMARILY ON

Part VI Supplemental Information

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A PATIENT AND HIS OR HER HOUSEHOLD'S INCOME AND ASSETS. THERE WILL BE

MINIMAL CONSIDERATION OF EXPENSES EXCEPT WHEN THEY IDENTIFY AREAS FOR

FURTHER INVESTIGATION OR INCOMPLETE OR INACCURATE INFORMATION. THE VALUE

OF A PATIENT'S PRINCIPAL RESIDENCE IS NOT CONSIDERED IN QUALIFYING A

PATIENT FOR IN-HOUSE ASSISTANCE. APD REQUIRES EXHAUSTION OF OTHER

PAYMENT METHODOLOGIES, INCLUDING BUT NOT LIMITED TO: WORKER'S

COMPENSATION, VETERANS BENEFITS, MEDICAID, LIABILITY (AUTO ACCIDENTS),

VICTIMS OF CRIME AND COBRA. WHEN APPLICABLE, PROOF OF DETERMINATION MAY

BE REQUIRED PRIOR TO CONSIDERATION FOR FINANCIAL ASSISTANCE.

SCHEDULE H, PART V, LINE 13:

PLEASE SEE PART V LINE 3 FOR A DESCRIPTION OF THE FINANCIAL ASSISTANCE

PROGRAM AND THE EFFORTS MADE TO PUBLICIZE AND PROMOTE THE PROGRAM.

SCHEDULE H, PART V, LINE 19D:

THE HOSPITAL FACILITY PROVIDES UNINSURED PATIENTS WITH A 15% DISCOUNT. AT

THE TIME THE DISCOUNT WAS ESTABLISHED THE DISCOUNT APPROXIMATED THE

AVERAGE OF THE THREE LOWEST NEGOTIATED COMMERCIAL INSURANCE RATES FOR

Part VI Supplemental Information

Complete this part to provide the following information.

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SERVICES AT THE HOSPITAL FACILTY. THE AVERAGE OF THE THREE LOWEST

COMMERICAL INSURANCE RATES WAS APPROXIMATELY 87.5%, THE RATE APPLIED TO

UNINSURED PATIENTS WAS LOWER THAN THAT RATE, AT 85%, REPRESENTING A 15%

DISCOUNT.

SCHEDULE H, PART VI, LINE 2:

DUE TO OUR RURAL LOCATION AND SIZE, A COLLABORATIVE EFFORT BETWEEN THE

UNITED WAY, DARTMOUTH HITCHCOCK MEMORIAL HOSPITAL AND ALICE PECK DAY

MEMORIAL HOSPITAL CREATED THE FY 2009 COMMUNITY BENEFITS PLAN. PRIORITY

NEEDS AND HEALTH CONCERNS FOR OUR COMMUNITY WERE BASED UPON INFORMATION

COLLECTED FROM COMMUNITY NEEDS ASSESSMENTS AND COMMUNITY SURVEYS.

IDENTIFIED NEEDS INCLUDED: AVAILABILITY OF ORAL HEALTH, AVAILABILITY OF

PRIMARY CARE, PRESCRIPTION ASSISTANCE, TRANSPORTATION, AVAILABILITY OF

BEHAVIORAL HEALTH AND ACCESS TO ALCOHOL/DRUG TREATMENT. ALICE PECK DAY

USED ITS INFORMATION TO HELP FOCUS ITS COMMUNITY BENEFIT EFFORTS TO MEET

THE PRIORITY NEEDS IDENTIFIED IN THE COMMUNITY BENEFIT PLAN. OF SPECIAL

NOTE IS THE UPPER VALLEY SMILES PROGRAM THAT HAS SERVED A PRIORITY NEED

FOR ORAL HEALTH WITHIN OUR LOCAL COMMUNITY. UPPER VALLEY SMILES HAS

Part VI Supplemental Information

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TOUCHED THE LIVES OF MANY CHILDREN IN OUR COMMUNITY AND PROVIDED MUCH

NEEDED CARE FOR A VERY VULNERABLE POPULATION.

SCHEDULE H, PART VI, LINE 3:

ALICE PECK DAY BELIEVES THAT QUALITY HEALTH CARE SHOULD BE AVAILABLE TO

ALL, REGARDLESS OF ABILITY TO PAY. OUR FINANCIAL ASSISTANCE PROGRAMS AND

STAFF ARE DEDICATED TO HELPING PEOPLE OBTAIN THE CARE THEY NEED. WE

REACH OUT TO OUR PATIENTS IN MANY DIFFERENT WAYS TO ENSURE THAT THEY ARE

AWARE THAT HELP IS AVAILABLE AND TO HELP GUIDE THEM THROUGH THE PROCESS.

BROCHURES AND SIGNAGE ARE POSTED IN HIGH TRAFFIC AREAS SUCH AS THE

EMERGENCY ROOM, REGISTRATION AND THE LOBBY. REGISTRATION STAFF ARE

TRAINED TO IDENTIFY PATIENTS WHO MAY BE IN NEED OF FINANCIAL ASSISTANCE.

ONCE IDENTIFIED, THE STAFF NOTIFY THE PATIENT THAT APD HAS VARIOUS FORMS

OF FINANCIAL ASSISTANCE AND EXPLAIN THAT ASSISTANCE IS AVAILABLE FOR

ANYONE WHO MIGHT REQUIRE HELP OR GUIDANCE IN COMPLETING ANY NECESSARY

PAPERWORK. IN ADDITION TO THE ABOVE, OUR BILLING STAFF ARE TRAINED TO

HELP IDENTIFY AND OFFER ASSISTANCE TO ANY ONE WHO MIGHT REQUIRE FINANCIAL

ASSISTANCE. PATIENTS WITH OUTSTANDING CLAIMS ARE CONTACTED BY OUR

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CREDIT COORDINATOR WHO WORKS WITH THEM TO CLEAR UP BALANCES THROUGH THE VARIETY OF PROGRAMS WE OFFER. ASSISTANCE IS ALSO PROVIDED IN APPLYING FOR FEDERAL/STATE PROGRAMS TO THOSE WHO QUALIFY. SPECIALLY TRAINED STAFF GUIDE APPLICANTS THROUGH THE PROCESS TO ENSURE FORMS ARE FILLED OUT CORRECTLY, ALL REQUIRED DOCUMENTATION IS ATTACHED AND THE APPLICANTS UNDERSTAND WHAT THEY CAN EXPECT TO HAPPEN ALONG THE WAY.

SCHEDULE H, PART VI, LINE 4:

ALICE PECK DAY MEMORIAL HOSPITAL IS PART OF THE LEBANON HEALTH CARE SERVICE AREA. THE LEBANON SERVICE AREA COMPRISES CITIES AND TOWNS IN NEW HAMPSHIRE AND VERMONT. APD'S SERVICE AREA IN NH COMPRISES 15 TOWNS IN ADDITION TO THE CITY OF LEBANON, INCLUDING CANAAN, CORNISH, CROYDON, DORCHESTER, ENFIELD, GRAFTON, GRANTHAM, HANOVER, LYME, NEWPORT, ORANGE, ORFORD, PIERMONT, PLAINFIELD AND WARREN. VERMONT TOWNS INCLUDE EAST THETFORD, FAIRLEE, HARTFORD, HARTLAND, NORTH HARTLAND, NORTH THETFORD, POST MILLS, QUECHEE, SHARON, SOUTH STRAFFORD, STRAFFORD, THETFORD, THETFORD CENTER, VERSHIRE, WEST VERSHIRE, WEST FAIRLEE, WEST HARTFORD, WHITE RIVER JUNCTION AND WOODSTOCK.

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SCHEDULE H, PART VI, LINE 5:

ALICE PECK DAY ACTIVELY PROMOTES COMMUNITY-BASED LEADERSHIP DEVELOPMENT.

STAFF MEMBERS PARTICIPATE IN TWO LOCAL CHAMBERS OF COMMERCE, LEADERSHIP

UPPER VALLEY, FOUNDATION FOR HEALTHY COMMUNITIES, THE RURAL HEALTH

COALITION AND THE ADVOCACY TASK FORCE. AS AN ACTIVE MEMBER OF THE

COMMUNITY, APD WORKS TO BE PROACTIVE CONCERNING DISASTER READINESS. STAFF

HAVE PARTICIPATED IN ONSITE TRAINING FOR DISASTER PREPAREDNESS AS WELL AS

OFF-SITE TRAINING WITH OTHER REGIONAL HOSPITALS. COLLABORATIVE EFFORTS

INCLUDE ALL HAZARD REGIONAL TRAINING, EMERGENCY RESPONSE TRAINING, AND A

REGIONAL MASS CASUALTY RESPONSE PROGRAM TO HELP FACILITATE COOPERATIVE

EFFORTS IF SUCH NEEDS ARISE.

SCHEDULE H, PART VI, LINE 6:

ALICE PECK DAY MEMORIAL HOSPITAL IS A CRITICAL ACCESS HOSPITAL LOCATED IN

LEBANON NH. THE HOSPITAL IS SERVED BY A BOARD OF TRUSTEES CONSISTING OF

LOCAL CITIZENS ACTIVE IN COMMUNITY ACTIVITIES AND ORGANIZATIONS. THE

MAJORITY OF BOARD MEMBERS ARE NOT EMPLOYED BY THE HOSPITAL, AND INCLUDE

LOCAL GOVERNMENT AND BUSINESS REPRESENTATIVES AS WELL AS PRACTICING

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INDEPENDENT PHYSICIANS. DESPITE ITS SMALL SIZE, APD IS COMMITTED TO GIVING BACK TO THE COMMUNITY TO THE GREATEST EXTENT POSSIBLE. DURING FY 2011, CASH DONATIONS WERE GIVEN TO MANY PROGRAMS TO HELP THOSE IN NEED. LOCAL FINANCIAL CONTRIBUTIONS HELPED SUPPORT FREE PRIMARY CARE CLINICS FOR THE UNINSURED, PROVIDED TRANSPORTATION FOR THE ELDERLY AND DISABLED TO RECEIVE MEDICAL CARE, AND PROVIDED LOCAL NON PROFIT ORGANIZATIONS WITH MEETING SPACE AND REFRESHMENTS. ALICE PECK DAY SUPPORTED COMMUNITY FLU CLINICS, PROVIDED EMERGENCY PRESCRIPTION DRUG VOUCHERS, SUBSIDIZED SENIOR EXERCISE PROGRAMS, PROVIDED SUPPLIES FOR HURRICANE IRENE RELIEF, AND WORKED TOWARD THE EXPANSION OF LOCAL PUBLIC TRANSPORTATION TO ENSURE ALL THOSE IN NEED OF MEDICAL CARE COULD RECEIVE IT.

ONE OF APD'S MOST EXCITING AND CELEBRATED PROGRAMS IS THE UPPER VALLEY SMILES PROGRAM. THIS PROGRAM PROVIDES AN ORAL HEALTH SAFETY NET FOR DISADVANTAGED RESIDENTS WITHIN OUR SERVICE AREA. IN 6 DIFFERENT SCHOOLS OVER 783 STUDENTS RECEIVED ORAL HEALTH EDUCATION. DENTAL SCREENINGS WERE PROVIDED TO 239 OF THOSE CHILDREN, WITH 157 RECEIVING DENTAL SEALANTS AND 126 REFERRED TO DENTISTS FOR RESTORATIVE TREATMENT. NINETEEN CHILDREN

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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 hospitals 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.

REQUIRING URGENT CARE RECEIVED REFERRALS AND HAD THEIR CARE PAID FOR BY APD. ALICE PECK DAY HOSTED TWO FREE ORAL HEALTH CLINICS FOR 18 HOMELESS CHILDREN WHO RECEIVED ORAL HEALTH EDUCATION, A DENTAL CLEANING AND FLUORIDE APPLICATIONS.

WITH THE HELP OF TWO GRANTS, APD CONTINUED ITS PILOT WOMEN, INFANTS AND CHILDREN (WIC) ORAL HEALTH INITIATIVE IN LEBANON AND ENFIELD, NH. A TOTAL OF 177 LOW-INCOME CHILDREN AGED 0-10 RECEIVED ORAL HEALTH EDUCATION, A DENTAL SCREENING AND PREVENTATIVE CARE. AS A RESULT OF THIS SUCCESS, AN ADDITIONAL GRANT FROM AN ADDITIONAL FUNDING SOURCE WAS SECURED, ENABLING THE HOSPITAL TO EXPAND ITS WIC ORAL HEALTH PROGRAM INTO THE HARTFORD, VERMONT AREA BEGINNING IN 2012.

INDIVIDUALS WERE PROVIDED WITH ASSISTANCE IN APPLYING FOR NH/VT MEDICAID TO ENSURE INCREASED ACCESS TO MEDICAL CARE FOR THIS NEEDY POPULATION. AS A RESULT, A SIGNIFICANT NUMBER OF PEOPLE WERE SUCCESSFULLY ENROLLED AND RECEIVED ONGOING CARE.

Part VI 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 hospitals 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.

TO PROMOTE HEALTH PROFESSIONAL EDUCATION, APD PROVIDED CLINICAL UNDERGRADUATE TRAINING TO DARTMOUTH MEDICAL SCHOOL, RIVER VALLEY COMMUNITY COLLEGE, VERMONT TECHNICAL COLLEGE AND LEBANON COLLEGE. APD ANNUALLY SPONSORS DISTRICT-WIDE PROFESSIONAL DEVELOPMENT FOR SCHOOL NURSES IN OUR LOCAL AREA AND FOR OTHERS WITHIN OUR REGION. THESE INITIATIVES AND ONGOING EFFORTS CONTINUE TO ADDRESS SEVERAL OF THE MOST PRESSING COMMUNITY NEEDS AS IDENTIFIED IN OUR COMMUNITY NEEDS ASSESSMENT.

SCHEDULE H, PART VI, LINE 7:

APD FILES A COMMUNITY BENEFIT REPORT IN NEW HAMPSHIRE.

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

Open to Public Inspection

Name of the organization

ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number

02-0222791

Part I 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.

Part II 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) GOOD NEIGHBOR HEALTH CLINIC 70 N. MAIN ST W.R.J., VT 05001	030346949	501(C)3	20,000.				OPERATIONAL SUPPORT
(2) GRAFTON COUNTY SENIOR CITIZENS COUNCIL PO BOX 433 LEBANON, NH 03766	237248316	501(C)3	20,000.				OPERATIONAL SUPPORT
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

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

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

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

Schedule I (Form 990) (2010)

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

	(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1						
2						
3						
4						
5						
6						
7						

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

SCHEDULE I, PART 1, LINE 2

AS PART OF APD'S ACCESS IMPROVEMENT PLAN DEVELOPED IN 2003, HOSPITAL STAFF AND BOARD MEMBERS IDENTIFIED THE GRAFTON COUNTY SENIOR CITIZENS COUNCIL AND THE GOOD NEIGHBOR HEALTH CLINIC (WHICH ALSO INCLUDES THE RED LOGAN DENTAL CLINIC) AS ESSENTIAL TO PROVIDING ACCESS TO HEALTH CARE IN THE UPPER VALLEY NH AND WHITE RIVER VT AREAS. BASED ON THE NEEDED SERVICES PROVIDED, THE BOARD APPROVED ON-GOING MONETARY SUPPORT FOR THESE ORGANIZATIONS. THE ANNUAL AMOUNT TO BE CONTRIBUTED BY APD TO THESE ORGANIZATIONS IS APPROVED ANNUALLY THROUGH THE ANNUAL BUDGET PROCESS. APD RECEIVES AND REVIEWS EACH YEAR THE ORGANIZATIONS' PUBLISHED ANNUAL

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

	(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1						
2						
3						
4						
5						
6						
7						

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

REPORTS AND ALSO MAINTAINS INFORMAL CONTACTS THROUGHOUT THE YEAR TO

MONITOR THE ORGANIZATIONS' OPERATIONS AND SERVICES.

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

Open to Public Inspection

Name of the organization: ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number: 02-0222791

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	**2**		
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	☐ Written employment contract		
	☐ Independent compensation consultant	☐ Compensation survey or study		
	☐ Form 990 of other organizations	☐ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment from the organization or a related organization?	**4a**		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**		X
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		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?	**5a**		X
b	Any related organization?	**5b**		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?	**6a**		X
b	Any related organization?	**6b**		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	**7**	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	**8**		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

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

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

Note. The sum of columns (B)(i)-(iii) 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 HARRY G. DORMAN III	(i)							
	(ii)	263,689.		44,962.	9,800.	18,561.	337,012.	
2 SUSAN E. MOONEY, MD	(i)	224,617.		18,126.	9,800.	25,092.	277,635.	
	(ii)							
3 EVALIE M. CROSBY	(i)							
	(ii)	136,678.		13,511.	4,810.	23,160.	178,159.	
4 DOUGLAS CEDENO, MD	(i)	223,821.		27,148.	9,800.	14,054.	274,823.	
	(ii)							
5 CHRISTOPHER MAZUR, MD	(i)	225,366.		15,937.	9,100.	26,365.	276,768.	
	(ii)							
6 DAVID KRONER MD	(i)	263,484.		21,688.	9,800.	16,501.	311,473.	
	(ii)							
7 VIRGINIA MCDOUGALL MD	(i)	270,593.		2,193.		11,094.	283,880.	
	(ii)							
8 ANDREW BEST MD	(i)	243,385.		552.	2,682.	7,137.	253,756.	
	(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)							

Part III 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.

FORM 990, SCHEDULE J, PART I, LINE 7:

IN FISCAL YEAR 2011, CERTAIN PROVIDERS WERE PAID THROUGH AN RVU (RELATIVE VALUE UNIT) SYSTEM, A PRODUCTIVITY MEASUREMENT SET BY MEDICARE TO ASSIGN VALUE TO SERVICES.

FORM 990, SCHEDULE J, PART II:

SALARY AND BENEFIT EXPENSE FOR THE CEO AND CFO ARE CHARGED TO APD HEALTH SYSTEMS AND THEN ALLOCATED TO ALICE PECK DAY MEMORIAL HOSPITAL AND ALICE PECK DAY LIFECARE INC. BASED ON THE RELATIVE SHARE OF SERVICES PERFORMED FOR THOSE ENTITIES. ON THE AUDITED CONSOLIDATED FINANCIAL STATEMENTS THESE EXPENSES ARE INCLUDED IN SALARIES AND BENEFITS EXPENSE. ON LINE 24(E) OF FORM 990, SCHEDULE IX , THESE EXPENSES ($483,311) HAVE BEEN RECLASSIFIED FROM SALARY AND BENEFIT EXPENSE TO LINE 24(E).

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 on Schedule O (Form 990).

▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization

ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number

02-0222791

Part I 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	BUSINESS FINANCE AUTHORITY OF THE STATE OF NH	52-1304598		11/30/2010	12,282,000.	CURRENT REFUND EXISTING BONDS		X		X		X
B												
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	12,282,000.			
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows	12,237,068.			
7	Issuance costs from proceeds	44,932.			
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds				
11	Other spent proceeds				
12	Other unspent proceeds				
13	Year of substantial completion	2010			

		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							
15	Were the bonds issued as part of an advance refunding issue?		X						
16	Has the final allocation of proceeds been made?	X							
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use

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

Part III 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						
b Are there any research agreements that may result in private business use of bond-financed property?		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							
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 ▶	0.0000 %		%		%		%	
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 ▶	0.0000 %		%		%		%	
6 Total of lines 4 and 5	0.0000 %		%		%		%	
7 Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?	X							

Part IV 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						
2 Is the bond issue a variable rate issue?	X							
3a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X							
b Name of provider	TD BANK, N.A.							
c Term of hedge	5.000							
d Was the hedge superintegrated?		X						
e Was the hedge terminated?		X						
4a Were gross proceeds invested in a GIC?		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						
6 Did the bond issue qualify for an exception to rebate?	X							

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

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

Open to Public Inspection

Name of the organization	Employer identification number
ALICE PECK DAY MEMORIAL HOSPITAL	02-0222791

FORM 990, PART I, LINE 5 AND PART V, LINE 2A:

FOR ADMINISTRATIVE PURPOSES, ALICE PECK DAY MEMORIAL HOSPITAL ACTS AS COMMON PAYMASTER FOR BOTH ALICE PECK DAY HEALTH SYSTEMS CORP. AND ALICE PECK DAY LIFECARE CENTER, INC.

FORM 990, PART IV, LINE 34:

INACTIVE ENTITIES

THE ORGANIZATION IS RELATED TO ALICE PECK DAY REALTY CORP. (EIN 02-0485369) AND ALICE PECK DAY HEALTH MANAGEMENT CORP.(EIN 02-0485370) THROUGH THE DIRECT CONTROLLING PARENT, ALICE PECK DAY HEALTH SYSTEMS CORP. BOTH ENTITIES ARE INACTIVE AND HOLD NO ASSETS.

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

ALICE PECK DAY HEALTH SYSTEMS CORP, A CHARITABLE CORPORATION, ACTING BY AND THROUGH ITS BOARD OF TRUSTEES, IS THE SOLE MEMBER OF THE ORGANIZATION.

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

ALL TRUSTEES SHALL BE ELECTED BY THE BOARD OF TRUSTEES OF THE MEMBER AT THE ANNUAL MEETING OF THE MEMBER. A NOMINATION SLATE FOR THE TRUSTEES SHALL BE SUBMITTED BY THE GOVERNANCE COMMITTEE OF THE MEMBER. ANY TRUSTEE MAY BE REMOVED AT ANY TIME, WITH OR WITHOUT CAUSE, BY THE MEMBER. VACANCIES ON THE BOARD OF TRUSTEES DUE TO DEATH, RESIGNATION, OR OTHER CAUSE EXCEPT REMOVAL SHALL BE FILLED BY ELECTION BY THE REMAINING MEMBERS

Name of the organization: ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number: 02-0222791

OF THE BOARD.VACANCIES CAUSED BY REMOVAL SHALL BE FILLED BY ELECTION BY THE MEMBER. TRUSTEES ELECTED TO FILL VACANCIES SHALL HOLD OFFICE UNTIL THE NEXT ANNUAL MEETING OF THE MEMBER, AT WHICH TIME SUCCESSORS SHALL BE ELECTED IN THE MANNER PROVIDED FOR IN THE CASE OF ORIGINAL ELECTIONS.

FORM 990, PART VI, SECTION A, LINE 7B:
THE ORGANIZATION'S ANNUAL OPERATING BUDGET AND ALL CAPITAL BUDGETS SHALL BE SUBJECT TO APPROVAL BY THE MEMBER. ANY OVERALL STRATEGIC PLAN FOR THE ORGANIZATION, INCLUDING THE DEVELOPMENT OF OFF-SITE FACILITIES, THE ADDITION OF NEW PROGRAMS AND AFFILIATIONS WITH OTHER INSTITUTIONS, SHALL BE CONSISTENT WITH THE STRATEGIC PLAN OF THE MEMBER AS DETERMINED BY THE MEMBER. THE BORROWING OF ANY SUM IN EXCESS OF $50,000 WHICH HAS A STATED TERM OF GREATER THAN ONE YEAR OR WHICH IS SECURED BY A MORTGAGE OF ALL OR ANY PORTION OF THE ORGANIZATION'S REAL PROPERTY OR BY A SECURITY INTEREST IN THE ORGANIZATION'S ASSETS OR REVENUES SHALL BE SUBJECT TO APPROVAL BY THE MEMBER, PROVIDED, HOWEVER, THAT THE APPROVAL BY THE MEMBER SHALL NOT BE NECESSARY FOR ANY BORROWING TO PURCHASE OR LEASE EQUIPMENT OR OTHER PERSONAL PROPERTY SECURED BY A PURCHASE MONEY LIEN OR TITLE RETENTION OR SECURITY AGREEMENT EXCEPT AS INCIDENT TO THE REVIEW OF THE CAPITAL BUDGET. ANY VOLUNTARY DISSOLUTION, MERGER OR CONSOLIDATION OF THE ORGANIZATION OR THE SALE OR TRANSFER OF ALL OR SUBSTANTIALLY ALL OF THE ORGANIZATION'S ASSETS OR THE CREATION OR ACQUISITION OF ANY SUBSIDIARY OR AFFILIATE CORPORATION SHALL BE SUBJECT TO APPROVAL BY THE MEMBER. THE BOARD SHALL SELECT AS CERTIFIED PUBLIC ACCOUNTANTS FOR THE ORGANIZATION THE FIRM WHICH AUDITS THE BOOKS AND RECORDS OF THE MEMBER. THE BOARD SHALL SELECT THE PRESIDENT WHO MUST BE CONFIRMED BY THE MEMBER.

Name of the organization	Employer identification number
ALICE PECK DAY MEMORIAL HOSPITAL	02-0222791

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

THE COMPLETED FORM 990 IS PROVIDED TO ALL MEMBERS OF THE FINANCE AND GOVERNANCE COMMITTEES OF THE BOARD OF TRUSTEES IN ADVANCE OF THE FILING DEADLINE TO ENABLE A DETAILED AND CONSCIENTIOUS REVIEW BY ALL MEMBERS OF BOTH COMMITTEES. THE COMPLETED FORM 990 IS ALSO DISTRIBUTED TO ALL MEMBERS OF THE FULL BOARD FOR REVIEW NO LATER THAN THE FINAL REGULARLY SCHEDULED BOARD MEETING PRIOR TO THE FILING DEADLINE. ALL QUESTIONS AND CONCERNS ARE ADDRESSED BY THE CHIEF FINANCIAL OFFICER AND INCORPORATED INTO THE FORM 990 AS DEEMED APPROPRIATE. AFTER ALL INPUT FROM THE BOARD, FINANCE, AND GOVERNANCE COMMITTEES HAS BEEN APPROPRIATELY ADDRESSED AND INCORPORATED INTO THE FINAL FORM 990, A VOTE OF ACCEPTANCE OF THE FINAL DOCUMENT IS REQUIRED. THE VOTE IS RECORDED IN THE MINUTES OF THE BOARD OF TRUSTEES PRIOR TO THE FILING OF THE FORM 990. ONCE APPROVED, SENIOR MANAGEMENT FILES THE FINAL FORM 990 WITH THE INTERNAL REVENUE SERVICE AS REQUIRED.

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

ALICE PECK DAY HAS A MULTI-FACETED CONFLICT OF INTEREST POLICY. THE BOARD OF TRUSTEES COMPLETES A CONFLICT OF INTEREST QUESTIONNAIRE ON AN ANNUAL BASIS AND ANY NEW MEMBERS COMPLETE THE QUESTIONNAIRE UPON JOINING THE BOARD. AS PART OF OUR ONGOING MONITORING PROCESS, OUR EXECUTIVE ASSISTANT REVIEWS ALL BOARD QUESTIONNAIRES AND DISCLOSURES TO IDENTIFY ANY POTENTIAL CONFLICTS BEFORE THEY ARISE. IN ADDITION, OUR EXECUTIVE ASSISTANT ATTENDS ALL BOARD MEETINGS TO ENSURE THAT IF ANY CONFLICTS ARISE, THEY ARE HANDLED APPROPRIATELY. IF SUCH CONFLICTS ARISE, THE ORGANIZATION COMPLIES WITH THE NEW HAMPSHIRE AND FEDERAL REQUIREMENTS FOR

Name of the organization: ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number: 02-0222791

DISCLOSURES OF SUCH EVENTS. THE ORGANIZATION IS COMMITTED TO CONDUCTING ITS BUSINESS IN A MANNER THAT IS BOTH ETHICAL AND LEGAL. AS PART OF THIS COMMITTMENT, A STANDARD OF CONDUCT FORM IS REQUIRED OF ALL EMPLOYEES OF THE ORGANIZATION. THIS IS REVIEWED WITH ALL STAFF UPON HIRE AND ON AN ANNUAL BASIS THEREAFTER. THE STANDARD OF CONDUCT COVERS CONFLICT OF INTEREST AND OTHER VITAL MATTERS TO ENSURE ALL BUSINESS ACTIVITY IS CONDUCTED IN A MANNER THAT IS CONSISTENT WITH THE HIGHEST STANDARDS OF HONESTY, INTEGRITY AND FAIRNESS.

FORM 990, PART VI, SECTION B, LINE 15:
THE COMPENSATION COMMITTEE OF THE ALICE PECK DAY HEALTH SYSTEMS BOARD OF TRUSTESS IS RESPONSIBLE FOR DETERMINING THE COMPENSATION OF THE CHIEF EXECUTIVE OFFICER/PRESIDENT. THE HUMAN RESOURCE DIRECTOR PROVIDES COMPENSATION DATA OF COMPARABLE ORGANIZATIONS WITH APPROXIMATELY THE SAME SIZE STAFF AND SPENDING IN A LOCATION OF SIMILIAR SIZE. THE COMMITTEE DETERMINES THE APPROPRIATE COMPENSATION AND APPROVES THE AMOUNT THAT IS THEN COMMUNICATED TO HUMAN RESOURCES FOR ADJUSTMENT. THE CEO/PRESIDENT IS RESPONSIBLE FOR REVIEWING THE PERFORMANCE OF SENIOR MANAGEMENT STAFF. THE INFORMATION IS BROUGHT TO THE COMPENSATION COMMITTEE OF THE BOARD OF TRUSTEES ALONG WITH A RECOMMENDATION FOR THE SALARY OF EACH INDIVIDUAL. THE COMPENSATION IS DETERMINED THROUGH A VARIETY OF ANALYSIS OF SALARY DATA AND PERFORMANCE. INDIVIDUAL SALARY INCREASES ARE THEN BASED ON OVERALL PERFORMANCE, WITHIN BUDGETED INCREASES FOR THE ORGANIZATION. THE COMPENSATION COMMITEE APPROVES THE BASE COMPENSATION AND SALARY INCREASE AMOUNT.

Name of the organization	Employer identification number
ALICE PECK DAY MEMORIAL HOSPITAL	02-0222791

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

THE ORGANIZATION MAKES IT GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.

FORM 990, PART VII, SECTION A, COLUMN E:

DR. SUSAN E. MOONEY IS A PRACTICING PHYSICIAN IN ADDITION TO BEING THE HOSPITAL'S CHIEF MEDICAL OFFICER. SHE WORKED AN AVERAGE OF 60 HOURS PER WEEK, OF WHICH AN AVERAGE OF 40 HOURS PER WEEK WERE SPENT ON EXECUTIVE MATTERS AND 20 IN HER ROLE AS A PHYSICIAN.

FORM 990, PART XI, LINE 2C:

OVERSIGHT OF AUDIT PROCESS

THE AUDIT COMMITTEE OVERSEES THE AUDIT PROCESS FOR THE ALICE PECK DAY ENTITIES. THE AUDIT PROCESS FOR THE FINANCIAL STATEMENTS DID NOT CHANGE FROM THE PRIOR YEAR. INDEPENDENT ACCOUNTANTS PERFORMED THE AUDIT FOR THE FISCAL YEARS ENDED 9/30/10 AND 9/30/11.

FORM 990, PART XI, LINE 5:

OTHER CHANGES IN NET ASSETS OR FUND BALANCE:

CHANGE IN INTEREST RATE SWAPS: -216,490

LOSS ON EARLY EXTINGUISHMENT OF DEBT: -148,273

UNREALIZED LOSS ON INVESTMENTS: -234,459

CHANGE IN ANNUITY VALUATION: -5,449

Name of the organization: ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number: 02-0222791

ATTACHMENT 1

FORM 990, PART III - PROGRAM SERVICE, LINE 4A

ALICE PECK DAY MEMORIAL HOSPITAL IS A COMMUNITY-BASED HOSPITAL OPERATING IN LEBANON NH. THE HOSPITAL BEGAN AS A SMALL COTTAGE HOSPITAL IN 1932. FROM ITS HUMBLE BEGINNINGS, ALICE PECK DAY HAS CONTINUALLY DEMONSTRATED ITS COMMITMENT TO PROVIDE PATIENT-FOCUSED HEALTH CARE SERVICES WHICH IMPROVE THE QUALITY OF LIFE WITHIN ITS COMMUNITY AND PROMOTE WELLNESS FOR ALL.

ALICE PECK DAY MEMORIAL HOSPITAL IS A CHARITABLE HEALTH CARE ORGANIZATION WHICH IS DEDICATED TO SERVING ITS COMMUNITY. THIS COMMITMENT INCLUDES GRANTING CREDIT TO PATIENTS, SUBSTANTIALLY ALL OF WHOM ARE LOCAL RESIDENTS. THE HOSPITAL PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN THE ESTABLISHED RATES. COLLECTIONS ARE NOT PURSUED FOR AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE. THE HOSPITAL MAINTAINS RECORDS TO IDENTIFY AND MONITOR THE LEVEL OF CHARITY CARE IT PROVIDES. THESE RECORDS INCLUDE THE AMOUNT OF CHARGES FOREGONE FOR SERVICES AND SUPPLIES FURNISHED UNDER ITS CHARITY CARE POLICY, THE ESTABLISHED COSTS OF THE SERVICES AND SUPPLIES AND EQUIVALENT SERVICE STATISTICS. FOR THE YEAR ENDED SEPTEMBER 30, 2011: CHARGES FORGONE BASED ON ESTABLISHED RATES WERE $942,000 WITH CHARITY CARE AT COST OF $629,000. ESTIMATED COSTS INCURRED IN EXCESS OF PAYMENT FOR INPATIENT AND OUTPATIENT SERVICES FOR MEDICAID PATIENTS IN THE YEAR ENDED SEPTEMBER 30, 2011 WERE $1,994,000.

IN ADDITION TO THE CHARITY CARE SERVICES DESCRIBED ABOVE, THE HOSPITAL PROVIDED A NUMBER OF OTHER SERVICES FOR WHICH LITTLE OR

Name of the organization: ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number: 02-0222791

ATTACHMENT 1 (CONT'D)

NO PAYMENT WAS RECEIVED. SERVICES INCLUDED COMMUNITY HEALTH SERVICES, HEALTH PROFESSIONAL EDUCATION, COMMUNITY BUILDING ACTIVITIES, AND COMMUNITY BENEFIT PROGRAMS. SERVICES RANGED FROM COMMUNITY FLU CLINICS, UPPER VALLEY SMILES DENTAL PROGRAM, STUDENT AND PROFESSIONAL EDUCATION, EMERGENCY PHARMACY VOUCHERS AND INCLUDED MANY OTHER PROGRAMS WHICH CONTRIBUTED TO AND SUPPORTED OUR COMMUNITY.

AS A LOCAL HOSPITAL, ALICE PECK DAY WORKS CLOSELY WITH COMMUNITY ORGANIZATIONS TO ADDRESS COMMUNITY NEEDS. ORGANIZATIONS THAT WERE BENEFICIARIES OF THE HOSPITAL'S STAFF, TIME, AND/OR MATERIALS INCLUDE: ALCOHOLICS ANONYMOUS, AARP, AMERICAN LEGION, AMERICAN RED CROSS, AWAKE SUPPORT GROUP, BONNIE CLAC, BROOKSIDE NURSING HOME, CHILDBIRTH EDUCATION AND POSTPARTUM MASSAGE, COMMUNITY HEALTH DEPARTMENT, DARTMOUTH MEDICAL SCHOOL, ELMIRA COLLEGE, GOOD BEGINNINGS OF SULLIVAN COUNTY, GOOD NEIGHBOR HEALTH CLINIC, GRAFTON COUNTY SENIOR CENTER, GRAFTON COUNTY SENIOR CITIZENS COUNCIL, LEBANON AREA CHAMBER OF COMMERCE, LEBANON COLLEGE, LEBANON HOUSING AUTHORITY, LEBANON SCHOOL BIKE RODEO, LEBANON SCHOOL DISTRICT NATURE PROGRAM, OVER-EATERS ANONYMOUS, RIVER VALLEY COMMUNITY COLLEGE, ROGERS HOUSE, SAVVY SENIORS EXERCISE PROGRAM, STORRS HILL, UNITED VALLEY INTERFAITH PROJECT, UPPER VALLEY SMILES DENTAL PROGRAM, VERMONT INSTITUTE OF NATURAL SCIENCES, AND WEST CENTRAL BEHAVORIAL HEALTH. IN CERTAIN INSTANCES, ASSISTANCE WAS PROVIDED TO THE COMMUNITY FOR WHICH NO VALUE CAN BE PLACED. THIS ASSISTANCE INCLUDED LEADERSHIP IN

Name of the organization: ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number: 02-0222791

ATTACHMENT 1 (CONT'D)

IDENTIFYING COMMUNITY NEEDS, STAFF COMMITMENT TO VOLUNTEER FOR COMMUNITY ORGANIZATIONS, ADVOCACY AND SUPPORT FOR THE SOCIALY AND PHYSICALY DISADVANTAGED, AND SUPPORT FOR LOCAL PUBLIC SAFETY ORGANIZATIONS. ALICE PECK DAY CONSIDERS CARING FOR OUR COMMUNITY A SPECIAL RESPONSIBILITY THAT WE ARE HONORED TO FULFILL. THROUGH ITS MANY PROGRAMS, DEDICATED STAFF AND UNWAVERING COMMITMENT TO QUALITY CARE, ALICE PECK DAY WORKS TO EXCEED THESE EXPECTATIONS AND MAKE A REAL DIFFERENCE IN OUR COMMUNITY.

ATTACHMENT 2

PART VII - CONTINUATION OF OFFICERS, DIRECTORS, TRUSTEES, KEY EMPLOYEES AND HIGHEST COMPENSATED EMPLOYEES

(1)=IND.TRUSTEE/DIR. (2)=INS.TRUSTEE (3)=OFFICER (4)=KEY EMP. (5)=HIGHEST COMP. (6)=FORMER

	(A) NAME AND TITLE	(B) HOURS	(C) POSITION (1)(2)(3)(4)(5)(6)	(D) COMPENSATION FROM ORG.	(E) REL. ORG.	(F) OTHER
29	DAVID KRONER MD PHYSICIAN	40.00	X	285,172.		26,301.
30	VIRGINIA MCDOUGALL MD PHYSICIAN	40.00	X	272,786.		11,094.
31	ANDREW BEST MD PHYSICIAN	40.00	X	243,937.		9,819.

ATTACHMENT 3

FORM 990, PART VII, COLUMN B - ESTIMATED AVERAGE PER WEEK

NAME AND TITLE	HOURS DEVOTED FOR RELATED ORGANIZATION
PAUL R. BOUCHER CHAIR- APD LIFECARE	1.00

Name of the organization: ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number: 02-0222791

ATTACHMENT 4

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
MT ASCUTNEY HOSP AND HEALTH CTR 289 COUNTY RD WINDSOR, VT 05089	PROFESSIONAL SERVICE	554,930.
LAVALLEE BRENSINGER ARCHITECTS 155 DOW ST. SUITE 400 MANCHESTER, NH 03101	ARCHITECTS	523,136.
UPPER VALLEY NEUROLOGY 106 HANOVER ST LEBANON, NH 03766	PROFESSIONAL SERVICE	266,765.
VALLEY REGIONAL HOSPITAL 243 ELM ST CLAREMONT, NH 03743	LAB SERVICES	191,690.
COMBINED SERVICES PO BOX 1320 CONCORD, NH 03301	PLAN ADMINISTRATION	141,693.
TOTAL COMPENSATION		1,678,214.

ATTACHMENT 5

FORM 990, PART VIII - INVESTMENT INCOME

DESCRIPTION	(A) TOTAL REVENUE	(B) RELATED OR EXEMPT REVENUE	(C) UNRELATED BUSINESS REV.	(D) EXCLUDED REVENUE
INTEREST AND DIVIDENDS	77,420.			77,420.
TOTALS	77,420.			77,420.

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

Open to Public Inspection

Name of the organization
ALICE PECK DAY MEMORIAL HOSPITAL

Employer identification number
02-0222791

Part I Identification of Disregarded Entities (Complete if the organization answered "Yes" on 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)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) ALICE PECK DAY HEALTH SYSTEMS CORP 02-0479095 125 MASCOMA ST LEBANON, NH 03766	PROMOTE HEALT	NH	501(C)(3)	LINE 11B,II	N/A		X
(2) ALICE PECK DAY LIFECARE CENTER, INC. 02-0479094 125 MASCOMA ST LEBANON, NH 03766	ASSISTED LIVI	NH	501(C)(3)	LINE 9	APDHS	X	
(3) ALICE PECK DAY REALTY CORP. 02-0485369 125 MASCOMA STREET LEBANON, NH 03766-2647	INACTIVE	NH	501(C)(2)		APDHS	X	
(4)							
(5)							
(6)							
(7)							

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

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

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
(1)	ALICE PECK DAY HEALTH MANAGEMENT CORP. 02-0485370 125 MASCOMA ST LEBANON, NH 03766-2647	INACTIVE	NH	N/A	C CORP.			100.0000
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								

Part V **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	**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)	ALICE PECK DAY HEALTH SYSTEMS CORP,	D	1,117,757.	FMV
(2)	ALICE PECK DAY LIFECARE CENTER, INC.	P	3,648,954.	FMV
(3)	ALICE PECK DAY LIFECARE CENTER, INC.	D	1,230,536.	FMV
(4)				
(5)				
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) 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)										
(12)										
(13)										
(14)										
(15)										
(16)										

Part VII **Supplemental Information**

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