

Form **990**

**Return of Organization Exempt From Income Tax**

OMB No. 1545-0047

**2011**

Department of the Treasury  
Internal Revenue Service

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.

Open to Public Inspection

**A For the 2011 calendar year, or tax year beginning 10/01/11, and ending 09/30/12**

<b>B</b> Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C</b> Name of organization Stephens Memorial Hospital Assoc.		<b>D</b> Employer identification number 01-0219904
	Doing Business As		<b>E</b> Telephone number 207-743-5933
	Number and street (or P.O. box if mail is not delivered to street address) 181 Main Street	Room/suite	
	City or town, state or country, and ZIP + 4 Norway ME 04268		<b>G</b> Gross receipts \$ 59,157,428
<b>F</b> Name and address of principal officer: Timothy Churchill 181 Main Street Norway ME 04268			
<b>H(a)</b> Is this a group return for affiliates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>H(b)</b> Are all affiliates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)			
<b>I</b> Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			
<b>J</b> Website: ▶ www.wmhcc.org <b>H(c)</b> Group exemption number: ▶			
<b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			
<b>L</b> Year of formation: 1956		<b>M</b> State of legal domicile: ME	

**Part I Summary**

Activities & Governance	<b>1</b> Briefly describe the organization's mission or most significant activities: To ensure a high quality, accessible, affordable and appropriate integrated health care system to improve the health and well being of the community.			
	<b>2</b> Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.			
	<b>3</b>	Number of voting members of the governing body (Part VI, line 1a)	18	
	<b>4</b>	Number of independent voting members of the governing body (Part VI, line 1b)	14	
	<b>5</b>	Total number of individuals employed in calendar year 2011 (Part V, line 2a)	608	
	<b>6</b>	Total number of volunteers (estimate if necessary)	76	
	<b>7a</b>	Total unrelated business revenue from Part VIII, column (C), line 12	0	
<b>7b</b>	Net unrelated business taxable income from Form 990-T, line 34	0		
Revenue	<b>8</b>	Contributions and grants (Part VIII, line 1h)	Prior Year: 50,000 / Current Year: 117,000	
	<b>9</b>	Program service revenue (Part VIII, line 2g)	51,861,419 / 57,376,266	
	<b>10</b>	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	67,214 / 35,907	
	<b>11</b>	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	134,686 / 912,230	
	<b>12</b>	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	52,113,319 / 58,441,403	
	Expenses	<b>13</b>	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0 / 0
		<b>14</b>	Benefits paid to or for members (Part IX, column (A), line 4)	0 / 0
		<b>15</b>	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	25,919,792 / 30,218,966
		<b>16a</b>	Professional fundraising fees (Part IX, column (A), line 11e)	8,931 / 6,050
		<b>b</b>	Total fundraising expenses (Part IX, column (D), line 25) ▶	66,907
		<b>17</b>	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	20,836,788 / 23,543,932
		<b>18</b>	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	46,765,511 / 53,768,948
Net Assets or Fund Balances	<b>19</b>	Revenue less expenses. Subtract line 18 from line 12	5,347,808 / 4,672,455	
	<b>20</b>	Total assets (Part X, line 16)	Beginning of Current Year: 41,764,430 / End of Year: 45,798,163	
	<b>21</b>	Total liabilities (Part X, line 26)	12,321,027 / 11,824,606	
	<b>22</b>	Net assets or fund balances. Subtract line 21 from line 20	29,443,403 / 33,973,557	

**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: <i>John W Cox</i>		Date: 08/07/2013	
	Type or print name and title: John Cox		Senior VP - Fiscal	
Paid Preparer Use Only	Print/Type preparer's name:	Preparer's signature:	Date: 07/19/13	Check <input type="checkbox"/> if self-employed PTIN:
	Firm's name: MaineHealth			Firm's EIN:
	Firm's address: 110 Free St Portland, ME 04101-3908			Phone no.: 207-661-7110

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

For Paperwork Reduction Act Notice, see the separate instructions.

**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:

**To ensure a high quality, accessible, affordable and appropriate integrated health care system to improve the health and well being of 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 organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations 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 \$ **40,618,774** including grants of \$ ) (Revenue \$ **45,657,647** )

**Outpatient services: Stephens Memorial Hospital Association provided care during the course of 104,959 outpatient visits during 2012. Services provided include emergency services; diagnostic imaging and lab tests; ambulatory surgery; and physical rehabilitation.**

4b (Code: ) (Expenses \$ **10,425,327** including grants of \$ ) (Revenue \$ **11,718,619** )

**Inpatient services: In 2012 the Hospital provided inpatient nursing services to 1,600 Adults/Pediatrics, Intensive Care, and Nursery patients with a total of 5,109 patient days. 55 inpatients (3%) were uninsured, 895 (56%) were covered by Medicare and 328 (21%) were covered by Medicaid.**

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 **51,044,101**

**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	<b>X</b>	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<b>X</b>	
<b>3</b> Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I		<b>X</b>
<b>4 Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	<b>X</b>	
<b>5</b> Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III		<b>X</b>
<b>6</b> Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I		<b>X</b>
<b>7</b> Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II		<b>X</b>
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III		<b>X</b>
<b>9</b> 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		<b>X</b>
<b>10</b> Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V		<b>X</b>
<b>11</b> If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	<b>X</b>	
<b>b</b> Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII		<b>X</b>
<b>c</b> Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII		<b>X</b>
<b>d</b> Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	<b>X</b>	
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	<b>X</b>	
<b>f</b> Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	<b>X</b>	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI, XII, and XIII	<b>X</b>	
<b>b</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	<b>X</b>	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E		<b>X</b>
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?		<b>X</b>
<b>b</b> Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV		<b>X</b>
<b>15</b> 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		<b>X</b>
<b>16</b> 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		<b>X</b>
<b>17</b> Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)		<b>X</b>
<b>18</b> Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II		<b>X</b>
<b>19</b> 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		<b>X</b>
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	<b>X</b>	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<b>X</b>	

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

	Yes	No
21 Did the organization report more than \$5,000 of grants and other assistance to any government or organization in the United States on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II		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		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	X	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25		X
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
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?		
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
25a <b>Section 501(c)(3) and 501(c)(4) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I		X
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I		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		X
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III		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		X
b A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV		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	X	
29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M		X
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M		X
31 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I		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		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		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	X	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?		X
b 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		X
36 <b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2		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		X
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O	X	

**Part V Statements Regarding Other IRS Filings and Tax Compliance**

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

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable		
1a	38		
1b	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?	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	608		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	X	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?		X
3b	If "Yes," has it filed a Form 990-T for this year? If "No," provide an explanation in Schedule O		
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)?		X
b	If "Yes," enter the name of the foreign country: <b>▶</b> 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?		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
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?		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
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?		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
d	If "Yes," indicate the number of Forms 8282 filed during the year		
d	7d		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
8	<b>Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.</b> Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?		
9	<b>Sponsoring organizations maintaining donor advised funds.</b>		
a	Did the organization make any taxable distributions under section 4966?		
b	Did the organization make a distribution to a donor, donor advisor, or related person?		
10	<b>Section 501(c)(7) organizations.</b> Enter:		
a	Initiation fees and capital contributions included on Part VIII, line 12		
a	10a		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities		
b	10b		
11	<b>Section 501(c)(12) organizations.</b> Enter:		
a	Gross income from members or shareholders		
a	11a		
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)		
b	11b		
12a	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?		
12a	12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year		
b	12b		
13	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
a	Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O.		
13a	13a		
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		
b	13b		
c	Enter the amount of reserves on hand		
c	13c		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		X
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O		
b	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

**Section A. Governing Body and Management**

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

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

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

**Section C. Disclosure**

- 17** List the states with which a copy of this Form 990 is required to be filed **ME**
- 18** Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
 Own website  Another's website  Upon request
- 19** Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, physical address, and telephone number of the person who possesses the books and records of the organization: **Senior VP - Fiscal** **181 Main Street** **ME 04268** **207-743-5933**  
**Norway**

**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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) <b>Gregory Hardy, M.D.</b> Med staff president	2.00	X						0	350,220	24,868
(2) <b>Timothy Churchill</b> Presid & CEO	30.00	X		X				0	317,808	34,286
(3) <b>Eugene Benner</b> Chair	2.00	X		X				0	0	0
(4) <b>Andrea Burns</b> Trustee	2.00	X						0	0	0
(5) <b>Peter Chapman</b> Secretary/Treasurer	2.00	X		X				0	0	0
(6) <b>C. Bradley Cummings</b> Trustee	2.00	X		X				0	0	0
(7) <b>Tom Morton</b> Trustee	2.00	X						0	0	0
(8) <b>Larry Farmer, O.D.</b> Trustee	2.00	X						0	0	0
(9) <b>David Hoisington</b> Chair	2.00	X		X				0	0	0
(10) <b>David Kumaki, M.D.</b> Trustee	2.00	X						0	0	0
(11) <b>William L. Medd, M.D.</b> Trustee	2.00	X						0	0	0
(12) <b>Ola Melhus, M.D.</b> Trustee	2.00	X						0	0	0
(13) <b>Lynn Hamper</b> Trustee	2.00	X						0	0	0
(14) <b>David J. Preble</b> Vice Chair	2.00	X		X				0	0	0

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

(A) Name and title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) <b>Ted Moccia</b> Trustee	2.00	X					0	0	0	
(16) <b>Rev. Anne Stanley</b> Trustee	2.00	X					0	0	0	
(17) <b>Robin J. Zinchuk</b> Trustee	2.00	X					0	0	0	
(18) <b>Wendy Penley</b> Trustee	2.00	X					0	0	0	
(19) <b>Pat Weigel</b> Trustee	2.00	X					0	0	0	
(20) <b>John Cox</b> Sr VP-Fiscal	30.00			X			0	166,598	23,383	
(21) <b>M. Patricia Cook</b> Sr VP-Clinical	42.00			X			0	142,450	26,047	
(22) <b>Thomas J. Hewson</b> Physician	38.00				X		279,603	0	21,884	
(23) <b>Tobin M. Piker</b> Physician	34.00				X		239,212	0	24,777	
(24) <b>Russell D. Florenz</b> Physician	30.00				X		238,669	0	27,737	
(25) <b>Clifford R. Peck</b> Physician	32.00				X		224,385	0	10,815	
<b>1b Sub-total</b>							<b>981,869</b>	<b>977,076</b>	<b>193,797</b>	
<b>c Total from continuation sheets to Part VII, Section A</b>							<b>199,162</b>	<b>385,202</b>	<b>70,100</b>	
<b>d Total (add lines 1b and 1c)</b>							<b>1,181,031</b>	<b>1,362,278</b>	<b>263,897</b>	

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 **▶ 18**

	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	<b>X</b>	
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	<b>X</b>	
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		<b>X</b>

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
<b>Oxford Hills Internal Medicine</b> <b>Norway ME 04268</b>	<b>193 Main Street</b> <b>Physician svcs</b>	<b>702,032</b>
<b>Spectrum Medical Group, PA</b> <b>Scarborough ME 04074</b>	<b>300 Professional Drive</b> <b>Anesthesia svcs</b>	<b>484,308</b>
<b>Maine Orthopaedic Center</b> <b>Portland ME 04102</b>	<b>1601 Congress Street</b> <b>Physician svcs</b>	<b>394,900</b>
<b>H.P. Cummings Construction</b> <b>Winthrop ME 04364</b>	<b>P.O. Box 297</b> <b>Contractor svcs</b>	<b>293,063</b>
<b>NorDx</b> <b>Scarborough ME 04074</b>	<b>P.O. Box 607</b> <b>Lab processing</b>	<b>126,597</b>

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

**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 (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) <b>Roberta F. Metivier</b> VP-Human Resources	42.00					X		199,162	0	24,668
(16) <b>Adam M. Kazimierczak</b> Physician	0.00						X	0	217,867	22,126
(17) <b>Kathleen A. Herlihy</b> Physician	0.00						X	0	167,335	23,306
(18) .....										
(19) .....										
(20) .....										
(21) .....										
(22) .....										
(23) .....										
(24) .....										
(25) .....										
<b>1b Sub-total</b> .....								199,162	385,202	70,100
<b>c Total from continuation sheets to Part VII, Section A</b> .....										
<b>d Total (add lines 1b and 1c)</b> .....										

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

	Yes	No
<b>3</b> Did the organization list any <b>former</b> officer, director, or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual .....	3	
<b>4</b> 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	
<b>5</b> Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person .....	5	

**Section B. Independent Contractors**

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

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

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

**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	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns	<b>1a</b>					
	<b>b</b> Membership dues	<b>1b</b>					
	<b>c</b> Fundraising events	<b>1c</b>					
	<b>d</b> Related organizations	<b>1d</b>					
	<b>e</b> Government grants (contributions)	<b>1e</b>					
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	117,000				
	<b>g</b> Noncash contributions included in lines 1a-1f \$						
	<b>h Total.</b> Add lines 1a-1f			117,000			
<b>Program Service Revenue</b>	<b>2a</b> Net patient service revenue	Busn. Code 623000	57,376,266	57,376,266			
	<b>b</b>						
	<b>c</b>						
	<b>d</b>						
	<b>e</b>						
	<b>f</b> All other program service revenue						
	<b>g Total.</b> Add lines 2a-2f			57,376,266			
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts)		32,340			32,340	
	<b>4</b> Income from investment of tax-exempt bond proceeds						
	<b>5</b> Royalties						
	<b>6a</b> Gross rents	(i) Real	447,911				
		(ii) Personal					
		<b>b</b> Less: rental exps.	701,339				
		<b>c</b> Rental inc. or (loss)	-253,428				
	<b>d</b> Net rental income or (loss)			-253,428		-253,428	
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities					
		(ii) Other	18,253				
		<b>b</b> Less: cost or other basis & sales exps.	14,686				
		<b>c</b> Gain or (loss)	3,567				
	<b>d</b> Net gain or (loss)			3,567		3,567	
	<b>8a</b> Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18	<b>a</b>					
	<b>b</b> Less: direct expenses	<b>b</b>					
<b>c</b> Net income or (loss) from fundraising events							
<b>9a</b> Gross income from gaming activities. See Part IV, line 19	<b>a</b>						
<b>b</b> Less: direct expenses	<b>b</b>						
<b>c</b> Net income or (loss) from gaming activities							
<b>10a</b> Gross sales of inventory, less returns and allowances	<b>a</b>						
<b>b</b> Less: cost of goods sold	<b>b</b>						
<b>c</b> Net income or (loss) from sales of inventory							
Miscellaneous Revenue		Busn. Code					
<b>11a</b> Other revenue		621990	1,165,658	1,165,658			
<b>b</b>							
<b>c</b>							
<b>d</b> All other revenue							
<b>e Total.</b> Add lines 11a-11d			1,165,658				
<b>12 Total revenue.</b> See instructions.			58,441,403	58,541,924	0	-217,521	

**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).

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21				
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	290,190		290,190	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	23,112,785	22,042,367	1,026,161	44,257
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	966,426	917,547	48,879	
9 Other employee benefits	4,281,456	4,066,510	207,267	7,679
10 Payroll taxes	1,568,109	1,489,704	75,019	3,386
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting	73,745		73,745	
d Lobbying				
e Professional fundraising services. See Part IV, line 17	6,050			6,050
f Investment management fees				
g Other	7,073,835	6,677,228	396,607	
12 Advertising and promotion	97,108	92,393	4,715	
13 Office expenses	6,603,707	6,531,446	68,456	3,805
14 Information technology	973,209	898,680	74,529	
15 Royalties				
16 Occupancy	1,233,723	1,173,058	60,665	
17 Travel	88,950	83,385	5,565	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	133,140	124,582	7,618	940
20 Interest	64,937	61,690	3,247	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	1,830,995	1,739,445	91,550	
23 Insurance	701,428	549,203	152,225	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <b>Bad debt</b>	2,956,753	2,956,753		
b <b>Provider tax</b>	1,109,651	1,109,651		
c <b>Recruitment</b>	317,631	273,889	43,742	
d <b>Dues and subscriptions</b>	166,945	154,747	11,408	790
e All other expenses	118,175	101,823	16,352	
25 <b>Total functional expenses.</b> Add lines 1 through 24e	53,768,948	51,044,101	2,657,940	66,907
26 <b>Joint costs.</b> Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

**Part X Balance Sheet**

		(A) Beginning of year		(B) End of year
<b>Assets</b>	1 Cash—non-interest bearing	1,900	1	1,900
	2 Savings and temporary cash investments	9,342,947	2	9,786,771
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	6,824,644	4	6,595,627
	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	1,093,414	8	1,064,314
	9 Prepaid expenses and deferred charges	458,978	9	455,794
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 43,094,281		
	b Less: accumulated depreciation	10b 29,638,455	10c	13,455,826
	11 Investments—publicly traded securities	1,193,583	11	1,295,243
	12 Investments—other securities. See Part IV, line 11	409,752	12	528,396
	13 Investments—program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	8,270,791	15	12,614,292
16 <b>Total assets.</b> Add lines 1 through 15 (must equal line 34)	41,764,430	16	45,798,163	
<b>Liabilities</b>	17 Accounts payable and accrued expenses	4,185,262	17	4,486,912
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities		20	
	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	3,816,494	23	3,505,479
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	4,319,271	25	3,832,215
	26 <b>Total liabilities.</b> Add lines 17 through 25	12,321,027	26	11,824,606
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>			
	27 Unrestricted net assets	28,418,521	27	32,828,109
	28 Temporarily restricted net assets	472,728	28	593,294
	29 Permanently restricted net assets	552,154	29	552,154
	<b>Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.</b>			
	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	29,443,403	33	33,973,557	
34 <b>Total liabilities and net assets/fund balances</b>	41,764,430	34	45,798,163	

**Part XI Reconciliation of Net Assets**

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	58,441,403
2	Total expenses (must equal Part IX, column (A), line 25)	2	53,768,948
3	Revenue less expenses. Subtract line 2 from line 1	3	4,672,455
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	29,443,403
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-142,301
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	33,973,557

**Part XII Financial Statements and Reporting**

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

- 1 Accounting method used to prepare the Form 990:  Cash  Accrual  Other  
 If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.
- 2a Were the organization's financial statements compiled or reviewed by an independent accountant?
- b Were the organization's financial statements audited by an independent accountant?
- 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.
- 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?
- b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits

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

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

**Public Charity Status and Public Support**

OMB No. 1545-0047

**2011**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

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.

Name of the organization

**Stephens Memorial Hospital Assoc.**

Employer identification number

**01-0219904**

**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?

- (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? .....
- (ii) A family member of a person described in (i) above? .....
- (iii) A 35% controlled entity of a person described in (i) or (ii) above? .....

	Yes	No
11g(i)		
11g(ii)		
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. (f) listed in your governing document?		(v) Did you notify the organization in col. (f) of your support?		(vi) Is the organization in col. (f) organized in the U.S.?		(vii) Amount of support
			Yes	No	Yes	No	Yes	No	
(A)									
(B)									
(C)									
(D)									
(E)									
<b>Total</b>									

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

Schedule A (Form 990 or 990-EZ) 2011

**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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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 <b>Total.</b> 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 <b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in)▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(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 <b>Total support.</b> Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 <b>First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> <input type="checkbox"/>						

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

14 Public support percentage for 2011 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2010 Schedule A, Part II, line 14	15	%
16a <b>33 1/3% support test—2011.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization <input type="checkbox"/>		
<b>b 33 1/3% support test—2010.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization <input type="checkbox"/>		
17a <b>10%-facts-and-circumstances test—2011.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization <input type="checkbox"/>		
<b>b 10%-facts-and-circumstances test—2010.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization <input type="checkbox"/>		
18 <b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions <input type="checkbox"/>		

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

(Complete only if you checked the box on line 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) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6 Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
<b>c</b> Add lines 7a and 7b						
<b>8 Public support</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in)▶	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
<b>9</b> Amounts from line 6						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b> Add lines 10a and 10b						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.)						

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

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

<b>15</b> Public support percentage for 2011 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	%
<b>16</b> Public support percentage from 2010 Schedule A, Part III, line 15	<b>16</b>	%

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

<b>17</b> Investment income percentage for 2011 (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	%
<b>18</b> Investment income percentage from 2010 Schedule A, Part III, line 17	<b>18</b>	%

**19a 33 1/3% support tests—2011.** 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—2010.** 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



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

**Political Campaign and Lobbying Activities**

OMB No. 1545-0047

**2011**

**Open to Public Inspection**

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.

Department of the Treasury  
Internal Revenue Service

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

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

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

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

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

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

Name of organization

**Stephens Memorial Hospital Assoc.**

Employer identification number

**01-0219904**

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

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

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

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

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

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

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

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

- A** Check  if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).  
**B** Check  if the filing organization checked box A and "limited control" provisions apply.

<b>Limits on Lobbying Expenditures</b> (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals
<b>1a</b> Total lobbying expenditures to influence public opinion (grass roots lobbying) .....			
<b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying) .....			
<b>c</b> Total lobbying expenditures (add lines 1a and 1b) .....			
<b>d</b> Other exempt purpose expenditures .....			
<b>e</b> Total exempt purpose expenditures (add lines 1c and 1d) .....			
<b>f</b> Lobbying nontaxable amount. Enter the amount from the following table in both columns.			
<b>If the amount on line 1e, column (a) or (b) is:</b>	<b>The lobbying nontaxable amount is:</b>		
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.		
<b>g</b> Grassroots nontaxable amount (enter 25% of line 1f) .....			
<b>h</b> Subtract line 1g from line 1a. If zero or less, enter -0- .....			
<b>i</b> Subtract line 1f from line 1c. If zero or less, enter -0- .....			
<b>j</b> 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? .....		<input type="checkbox"/> Yes	<input type="checkbox"/> 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.)

<b>Lobbying Expenditures During 4-Year Averaging Period</b>					
Calendar year (or fiscal year beginning in)	(a) 2008	(b) 2009	(c) 2010	(d) 2011	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

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

For each "Yes" response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.

	(a)		(b)
	Yes	No	Amount
<b>1</b> 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:			
<b>a</b> Volunteers?		X	
<b>b</b> Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
<b>c</b> Media advertisements?		X	
<b>d</b> Mailings to members, legislators, or the public?		X	
<b>e</b> Publications, or published or broadcast statements?		X	
<b>f</b> Grants to other organizations for lobbying purposes?		X	
<b>g</b> Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
<b>h</b> Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
<b>i</b> Other activities?	X		9,094
<b>j</b> Total. Add lines 1c through 1i			9,094
<b>2a</b> Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
<b>b</b> If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b> If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b> If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

<b>1</b> Dues, assessments and similar amounts from members	1	
<b>2</b> Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
<b>a</b> Current year	2a	
<b>b</b> Carryover from last year	2b	
<b>c</b> Total	2c	
<b>3</b> Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
<b>4</b> 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	
<b>5</b> 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; Part II-A; and Part II-B, line 1. Also, complete this part for any additional information.

**Schedule C, Part II-B, Line 1**

Dues paid to the American Hospital Association of \$15,492 and to the Maine Hospital Association of \$31,258. The American Hospital Association and Maine Hospital Association used 24.60% and 16.90% respectively of their dues revenue for lobbying activity.



SCHEDULE D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization

Employer identification number

Stephens Memorial Hospital Assoc.

01-0219904

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.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 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... Yes/No, 6 Did the organization inform all grantees... Yes/No.

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

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements (checkboxes for public use, natural habitat, open space, historic area, structure), 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution... 2a Total number of conservation easements, 2b Total acreage restricted by conservation easements, 2c Number of conservation easements on a certified historic structure included in (a), 2d Number of conservation easements included in (c) acquired after 8/17/06... 3 Number of conservation easements modified... 4 Number of states where property subject to conservation easement is located, 5 Does the organization have a written policy regarding the periodic monitoring... Yes/No, 6 Staff and volunteer hours devoted to monitoring... 7 Amount of expenses incurred in monitoring... \$, 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B) (i) and section 170(h)(4)(B)(ii)? Yes/No, 9 In Part XIV, describe how the organization reports conservation easements...

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.

Table with 2 columns: \$, \$. Rows include: 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 XIV and complete the following table:

	Amount
1c	
1d	
1e	
1f	

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

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

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

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

- a Board designated or quasi-endowment  %
- b Permanent endowment  %
- c Temporarily restricted endowment  %

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

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

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

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

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

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 property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,230,517		1,230,517
b Buildings		19,673,329	11,522,839	8,150,490
c Leasehold improvements				
d Equipment		20,544,287	16,927,666	3,616,621
e Other		1,646,148	1,187,950	458,198
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				<b>13,455,826</b>

**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)		
<b>Total.</b> (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)		
<b>Total.</b> (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) <b>Interest in net assets of SCHC Found</b>	<b>5,451,571</b>
(2) <b>AR under reimbursement regulations</b>	<b>5,084,000</b>
(3) <b>Prepaid capital costs</b>	<b>1,613,772</b>
(4) <b>Other receivables</b>	<b>259,084</b>
(5) <b>Due from affiliates</b>	<b>189,484</b>
(6) <b>CSV-life insurance</b>	<b>16,381</b>
(7)	
(8)	
(9)	
(10)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.)	<b>12,614,292</b>

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) <b>AP under reimbursement regulations</b>	<b>1,336,843</b>
(3) <b>Due to affiliates</b>	<b>1,331,328</b>
(4) <b>Professional liability claim accrual</b>	<b>1,087,964</b>
(5) <b>Accrued asset obligation</b>	<b>76,080</b>
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.)	<b>3,832,215</b>

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	58,441,403
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	53,768,948
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	4,672,455
4	Net unrealized gains (losses) on investments	4	189,066
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	-331,367
9	Total adjustments (net). Add lines 4 through 8	9	-142,301
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	4,530,154

**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	58,299,102
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains on investments	2a	189,066
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIV.)	2d	-331,367
e	Add lines 2a through 2d	2e	-142,301
3	Subtract line 2e from line 1	3	58,441,403
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIV.)	4b	
c	Add lines 4a and 4b	4c	
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)	5	58,441,403

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

1	Total expenses and losses per audited financial statements	1	53,768,948
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	
e	Add lines 2a through 2d	2e	
3	Subtract line 2e from line 1	3	53,768,948
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	53,768,948

**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.

**Part X - FIN 48 Footnote**

The organization is a not-for-profit organization and has been recognized as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code. The organization has evaluated the position taken on its filed tax returns. The organization has concluded no uncertain income tax positions exist at September 30, 2012. The organization's tax years from 2010 through 2012 may be subject to examination

**Part XIV Supplemental Information** (continued)

**Part XI, Line 8 - Reconciliation of Changes - Other**

Change in interest-Stephens Community Healthcare Found	\$	726,955
Net transfer to affiliates	\$	-1,058,322

**Part XII, Line 2d - Revenue Amounts Included in Financials - Other**

Change in interest-Stephens Community Healthcare Found	\$	726,955
Net transfer to affiliates	\$	-1,058,322

**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

**2011**

Open to Public  
Inspection

Name of the organization

**Stephens Memorial Hospital Assoc.**

Employer identification number

**01-0219904**

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

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>175%</u>	<input checked="" type="checkbox"/>	
<b>b</b> Did the organization use FPG to determine eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>225%</u>	<input checked="" type="checkbox"/>	
<b>c</b> 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.		
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<input checked="" type="checkbox"/>	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		<input checked="" type="checkbox"/>
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," does the organization make it available to the public?	<input checked="" type="checkbox"/>	

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
<b>a</b> Financial Assistance at cost (from Worksheet 1)			<b>2,213,724</b>		<b>2,213,724</b>	<b>4.12</b>
<b>b</b> Medicaid (from Worksheet 3, column a)			<b>11,167,017</b>	<b>9,694,808</b>	<b>1,472,209</b>	<b>2.74</b>
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)						
<b>d</b> Total Financial Assistance and Means-Tested Government Programs			<b>13,380,741</b>	<b>9,694,808</b>	<b>3,685,933</b>	<b>6.86</b>
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			<b>161,376</b>	<b>48,670</b>	<b>112,706</b>	<b>0.21</b>
<b>f</b> Health professions education (from Worksheet 5)			<b>100,162</b>	<b>90,585</b>	<b>9,577</b>	<b>0.02</b>
<b>g</b> Subsidized health services (from Worksheet 6)			<b>8,884,047</b>	<b>7,998,808</b>	<b>885,239</b>	<b>1.65</b>
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)						
<b>j</b> Total Other Benefits			<b>9,145,585</b>	<b>8,138,063</b>	<b>1,007,522</b>	<b>1.88</b>
<b>k</b> Total. Add lines 7d and 7j			<b>22,526,326</b>	<b>17,832,871</b>	<b>4,693,455</b>	<b>8.74</b>

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support			6,210		6,210	0.00
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			6,210		6,210	

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

**Section A. Bad Debt Expense**

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<input checked="" type="checkbox"/>	
2 Enter the amount of the organization's bad debt expense		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit.		

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME)	15,535,825
6 Enter Medicare allowable costs of care relating to payments on line 5	15,382,005
7 Subtract line 6 from line 5. This is the surplus or (shortfall)	153,820
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: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other	

**Section C. Collection Practices**

9a Did the organization have a written debt collection policy during the tax year?	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>

**Part IV Management Companies and Joint Ventures (see instructions)**

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

Part V Facility Information

Section A. Hospital Facilities

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

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

Name and address

Other (describe)

1 Stephens Memorial Hospital Assoc.

181 Main Street

Norway

ME 04268

X

X

X

**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: Stephens Memorial Hospital Assoc.

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

	Yes	No
<b>Community Health Needs Assessment</b> (Lines 1 through 7 are optional for tax year 2011)		
<b>1</b> 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		
If "Yes," indicate what the Needs Assessment describes (check all that apply):		
<b>a</b> <input type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input type="checkbox"/> Demographics of the community		
<b>c</b> <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input type="checkbox"/> How data was obtained		
<b>e</b> <input type="checkbox"/> The health needs of the community		
<b>f</b> <input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
<b>j</b> <input type="checkbox"/> Other (describe in Part VI)		
<b>2</b> Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 _____		
<b>3</b> 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		
<b>4</b> 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		
<b>5</b> Did the hospital facility make its Needs Assessment widely available to the public?		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):		
<b>a</b> <input type="checkbox"/> Hospital facility's website		
<b>b</b> <input type="checkbox"/> Available upon request from the hospital facility		
<b>c</b> <input type="checkbox"/> Other (describe in Part VI)		
<b>6</b> If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):		
<b>a</b> <input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
<b>b</b> <input type="checkbox"/> Execution of the implementation strategy		
<b>c</b> <input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
<b>d</b> <input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
<b>e</b> <input type="checkbox"/> Inclusion of a community benefit section in operational plans		
<b>f</b> <input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
<b>g</b> <input type="checkbox"/> Prioritization of health needs in its community		
<b>h</b> <input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
<b>i</b> <input type="checkbox"/> Other (describe in Part VI)		
<b>7</b> 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		
<b>Financial Assistance Policy</b>		
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
<b>8</b> Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?		
<b>9</b> Used federal poverty guidelines (FPG) to determine eligibility for providing free care?		
If "Yes," indicate the FPG family income limit for eligibility for free care: <u>175</u> %		
If "No," explain in Part VI the criteria the hospital facility used.		

**Part V Facility Information (continued)**

	Yes	No
10 Used FPG to determine eligibility for providing discounted care? ..... If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>225</u> % If "No," explain in Part VI the criteria the hospital facility used.	<b>X</b>	
11 Explained the basis for calculating amounts charged to patients? ..... If "Yes," indicate the factors used in determining such amounts (check all that apply):		<b>X</b>
a <input type="checkbox"/> Income level		
b <input type="checkbox"/> Asset level		
c <input type="checkbox"/> Medical indigency		
d <input type="checkbox"/> Insurance status		
e <input type="checkbox"/> Uninsured discount		
f <input type="checkbox"/> Medicaid/Medicare		
g <input type="checkbox"/> State regulation		
h <input type="checkbox"/> Other (describe in Part VI)		
12 Explained the method for applying for financial assistance? .....	<b>X</b>	
13 Included measures to publicize the policy within the community served by the hospital facility? ..... If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	<b>X</b>	
a <input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b <input type="checkbox"/> The policy was attached to billing invoices		
c <input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d <input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e <input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f <input checked="" type="checkbox"/> The policy was available on request		
g <input type="checkbox"/> 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 (FAP) that explained actions the hospital facility may take upon non-payment? .....	<b>X</b>	
15 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other similar actions (describe in Part VI)		
16 Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? .....		<b>X</b>
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency		
b <input type="checkbox"/> Lawsuits		
c <input type="checkbox"/> Liens on residences		
d <input type="checkbox"/> Body attachments		
e <input type="checkbox"/> Other similar actions (describe in Part VI)		
17 Indicate which efforts the hospital facility made before initiating any of the actions checked in line 16 (check all that apply):		
a <input type="checkbox"/> Notified patients of the financial assistance policy on admission		
b <input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge		
c <input checked="" type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills		
d <input checked="" type="checkbox"/> Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy		
e <input type="checkbox"/> Other (describe in Part VI)		

**Part V Facility Information (continued)**

**Policy Relating to Emergency Medical Care**

	Yes	No
<p><b>18</b> 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? .....</p> <p>If "No," indicate why:</p> <p><b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions</p> <p><b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing</p> <p><b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)</p> <p><b>d</b> <input type="checkbox"/> Other (describe in Part VI)</p>	<b>X</b>	
<b>18</b>	<b>X</b>	

**Individuals Eligible for Financial Assistance**

<p><b>19</b> Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.</p> <p><b>a</b> <input checked="" type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged</p> <p><b>b</b> <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged</p> <p><b>c</b> <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged</p> <p><b>d</b> <input type="checkbox"/> Other (describe in Part VI)</p>		
<p><b>20</b> 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? .....</p> <p>If "Yes," explain in Part VI.</p>		<b>X</b>
<p><b>21</b> Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for any service provided to that patient? .....</p> <p>If "Yes," explain in Part VI.</p>		<b>X</b>
<b>20</b>		<b>X</b>
<b>21</b>		<b>X</b>



**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, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

**Part I, Line 7g - Subsidized Health Services Explanation**

Subsidized health services include the net operating loss of PACE Paramedic Service, a department of Stephens Memorial Hospital, and direct subsidies and support of local school-based health clinics, a psychiatry consultation service and other clinical programs that are not revenue-producing. If these services were not provided or subsidized by the Hospital, they would not be available in the community.

**Part I, Line 7, Column (f) - Exclusions from Percent of Total Expense**

Bad debt expense of \$2,956,751 was removed from total expenses when calculating the percentage of total expenses in column (f).

**Part II - Community Building Activities**

In addition to the subsidized health services and community health services described above, Western Maine Health Care sponsors or participates in a variety of other community activities and programs. These community-building activities include:

-We are the lead agency for Healthy Oxford Hills, a community coalition to promote partnerships, policies and programs to protect and enhance the

**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, 9, 10, 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.
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- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

### health of residents of Oxford Hills

-Our Vial of Life Program allows individuals in the community to record and safely store their current health information at home, in case that information needs to be retrieved in an emergency situation

-Safe Sitter courses, a medically-accurate instructional program designed for young adolescents 11 to 13 years of age

-Community-wide emergency preparedness planning

-Regional health planning and pandemic planning

-We provide a clinical site for local Registered Nurses and Certified Nurses Aide programs

-Annual Conference - Alcoholism and Drug Addiction: Disease, Treatment and Recovery

-Free community blood pressure screenings and clinics

-Blood drives

-Sibling classes for children expecting new family members

-Nutrition open houses for the general public

-"Relay for Life" to support the American Cancer Society

-"Bowl for Kids Sake" to benefit the local Big Brothers/Big Sisters program

-We provide community outreach services to educate families about the

**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, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

Alfond Scholarship for babies, and assist families in preparing the grant application

-We provide meeting space at no charge for local non-profit support groups including Alcoholics Anonymous, smoking cessation, Gear Parent Network Support Group, Take Off Pounds Sensibly (TOPS), the Shriners annual health screening day and support groups for those affected by depression/bipolar conditions, diabetes, grief, and Parkinson's Disease

Part III, Line 4 - Bad Debt Expense Explanation

The Hospital accepts all patients regardless of their ability to pay. A patient qualifies for free care based upon certain established policies of the Hospital. These policies define free care as those services for which no payment is anticipated. Free care provided is not included in net patient service revenue and is measured based on the Hospital's charges. Costs and expenses incurred in providing these services are included in operating expenses. Charges for services rendered to individuals from whom payment is expected and ultimately not received are written off and included in expenses as part of the provision for bad debts.

Bad debt expense represents healthcare services that the Hospital has

**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, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

provided without compensation. As a tax-exempt hospital, the Hospital provides necessary patient care regardless of the patient's ability to pay for the services. A portion of the Hospital's bad debt expense is attributable to patients eligible for financial assistance that, for a variety of reasons, do not complete the financial assistance application process. The Hospital cannot determine the amount of bad debt expense that could be reasonably attributable to patients who likely would qualify for financial assistance under the Hospital free care policy. In addition, bad debt expense also includes amounts for services provided to individuals experiencing difficult personal or economic circumstances related to a portion of our community based patient population. Their medical bills often place these individuals in untenable positions where they are not able to handle their personal debt and then their new medical debt. However, because of their income level, they do not qualify for free care. By providing necessary healthcare services to those individuals either who fail to apply for financial assistance or who are experiencing difficult personal or economic circumstances, the Hospital believes that bad debt expense should be included as a community benefit.

The reserve for uncollectible accounts is provided based on an analysis by

**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, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

management of the collectability of outstanding balances. Management considers the age of outstanding balances and past collection efforts in determining the reserve for uncollectible accounts. Accounts deemed uncollectible are charged off against the established reserve.

The \$1,550,817 of bad debt expense (at cost) was calculated using the Hospital's cost to charge ratio.

#### Part III, Line 8 - Medicare Explanation

Medicare allowable costs were taken from the Hospital's as-filed 2012 Medicare cost reports. The cost report utilizes a sophisticated, detailed step-down cost allocation approach. The cost report excludes revenue, expenses and reimbursement for professional fees such as Emergency Department Physicians. If the cost to provide these services and payments for the services were included in the Part III Section B analysis, the Medicare shortfall would be greater than amounts reported.

Stephens Memorial Hospital Association believes that the Medicare shortfall should be included as a community benefit because the Hospital has a clear mission commitment to serving elderly patients and adults with disabilities through the provision of specific subsidized programs developed to help

**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, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

improve the health status of these patients. If these critical subsidized programs were not provided by the Hospital, they would become the obligation of the Federal Government.

**Part III, Line 9b - Collection Practices Explanation**

Patients who apply for and qualify for charity care/ financial assistance based on the State of Maine Free Hospital Care guidelines will have the self pay portion of their account balance adjusted at time of approval. Future self pay balances will be adjusted during their eligibility period at the point of billing, prior to sending bills to patients. For those who apply for assistance but whose income exceeds the limit for 100% assistance, a 50% reduction will be applied if their income is between 176% and 200% of the Federal Poverty Limits. Patients whose family income ranges from 201% to 225% of the Federal Poverty Limits qualify for a 25% reduction. If requested, a monthly payment plan will be set up for the remainder of the patient's balance.

**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, 9, 10, 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.
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- 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.

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**Needs Assessment**


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Stephens Memorial Hospital's Board of Trustees is made up of a diverse set of community members. The Board requires a thorough Community Needs Assessment on behalf of the organization, and directs the organization to analyze and respond to the current needs assessment. Stephens Memorial Hospital and its parent Western Maine Health Care also participate in various initiatives to help support and provide updates to community needs assessment planning. Some of these initiatives include:

- Clinical Strategic Planning
- Financial Strategic Planning
- Facility Planning
- Manpower Planning
- Physician Recruitment Strategic Planning
- Emergency Preparedness Planning

Along with the internal assessments, most member organizations also review and act on many of the recommendations provided by external groups such as the Maine Center for Disease Control and Prevention and the "State Health Plan" created by the Advisory Committee for Health Systems Development.

**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, 9, 10, 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.

In addition, MaineHealth and its partners in the OneMaine Health Collaborative, Eastern Maine Health System and MaineGeneral Health, released the OneMaine Health Community Health Needs Assessment Report in March 2011. The report is a comprehensive compilation and analysis containing primary and secondary health data sources. The report contains a Health Status Profile for the state as a whole and for each of Maine's sixteen counties. The primary data source was a randomized telephone survey; the sampling methodology was designed to permit comparisons at the county level. Secondary data sources include numerous state and federal sources. This report provides baseline data on hundreds of health indicators that are relevant to hospitals and communities to inform planning and evaluation activities. Plans call for the Community Health Needs Assessment to be replicated every three years. MaineHealth will hold community forums in partnership with each member and affiliate hospital in order to increase understanding and use of the Community Health Needs Assessment and to inform identification and action on local, community-based health priorities.

**Patient Education of Eligibility for Assistance**

**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, 9, 10, 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.

**Stephens Memorial Hospital's policy of charity care and financial**

**assistance is easily understood, prominently posted, and publicly**

**available. For patients whose family income is at or below 175% of the**

**Federal Poverty Level, charity care is 100% of their billed amounts.**

**Patients whose family income ranges from 176% to 200% of the Federal**

**Poverty Level qualify for a 50% charity care discount. Patients whose**

**family income ranges from 201% to 225% of the Federal Poverty Level qualify**

**for a 25% charity care discount. A process exists for offering charity**

**care or financial assistance to patients who are unable to pay after they**

**have already been billed. In addition to monitoring collection practices,**

**copies of the charity care policy are made available to patients at all**

**entry points (registration, ED, etc.) and with bill/collection notices.**

**The organization uses simple application procedures for charity care or**

**financial assistance that do not intimidate or confuse applicants.**

**Stephens Memorial Hospital's employees who work in admissions, billing,**

**accounts receivable, or patient financial services are fully informed and**

**educated about all financial assistance policies. These staff members**

**identify unpaid bills where persons are unable to pay, and separates these**

**potential "charity care" bills from other bad debt accounts.**

**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, 9, 10, 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.

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**Community Information**


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Stephens Memorial Hospital primarily serves southern Oxford County in Western Maine. Traditionally, the demographics of this region reflect a population that is older and poorer than the State of Maine average. Recent independent studies found Oxford County to be the second least healthy county in the State.

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**Health of Community in Relation to Exempt Purpose**


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In order to ensure access to primary care and certain specialty physician services, Western Maine Health Care owns and operates its subsidiaries Stephens Memorial Hospital Association and Western Maine Multi-Medical Specialists (WMMMS) including physician practices providing Cardiology, Family Medicine, General Surgery, Oncology, Pediatric, and Obstetric and Gynecology services. WMMMS also has partnered with physician groups to provide Urology services to the community. Due to the demographics of the population in Oxford County, most of these services would not be available if they were not provided by a system such as ours. Most local private physicians have closed to, or significantly limited access for, new

**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, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
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- 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.

Medicaid patients. Our practices continue to accept patients regardless of their insurance coverage or lack thereof. In the aggregate, 28% of patients served by Western Maine Multi Medical Specialists and Stephens Memorial Hospital were covered by the State of Maine Medicaid program. At September 30, 2012, physicians employed by Stephens Memorial Hospital included five Family Practitioners, three General Surgeons, four Pediatricians and three Obstetrician/ Gynecologists. There were five Internists employed by Western Maine Multi Medical Specialists. Western Maine Health Care owns and operates Market Square Health Care Center, a 98-bed long-term care facility comprised of 76 nursing home/skilled nursing facility beds and 22 residential care beds. Market Square accepts patients and residents whose clinical needs exceed the capabilities of other area nursing facilities. While we serve these patients at a financial loss, it is an important part of our mission to provide health care services that keep our local patients in the community. Market Square accepts all residents who meet clinical criteria, regardless of the source of expected payment for services.

Combined operating losses related to the mission-critical physician practices and nursing facility exceeded \$1,168,000 in 2012. These losses

**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, 9, 10, 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.

were supported by Stephens Memorial Hospital through net asset transfers.

**List of States Where Community Benefit Report is Filed**

Maine

**SCHEDULE J**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

**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

**2011**

Open to Public Inspection

**Stephens Memorial Hospital Assoc.**

Employer identification number  
**01-0219904**

**Part I Questions Regarding Compensation**

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

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

**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?

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

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

**4** During the year, did any person listed 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?
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
- c** Participate in, or receive payment from, an equity-based compensation arrangement?

If "Yes" to any of lines 4a–c, list the persons and provide the applicable amounts for each item in Part III.

**Only section 501(c)(3) 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?
- b** Any related organization?

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?
- b** Any related organization?

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

**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

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

	Yes	No
1a		
1b		
2		
3		
4a		X
4b		X
4c		X
5a		X
5b		X
6a		X
6b		X
7		X
8		X
9		

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

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

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

	(A) Name	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation		(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	(i) Retirement and other deferred compensation	(ii) Other reportable compensation			
1	Gregory Hardy, M.D.	(i) 277,465	0	0	0	72,755	21,872	375,088	0
		(ii) 0	47,000	0	0	0	0	0	0
2	Timothy Churchill	(i) 252,000	0	18,808	7,349	0	26,937	352,094	0
		(ii) 0	0	0	0	0	0	0	0
3	John Cox	(i) 166,234	0	364	2,082	0	21,301	189,981	0
		(ii) 0	0	0	0	0	0	0	0
4	M. Patricia Cook	(i) 130,958	0	11,492	5,312	0	20,735	168,497	0
		(ii) 0	0	16,455	0	0	21,884	301,487	0
5	Thomas J. Hewson	(i) 263,148	0	0	0	0	0	0	0
		(ii) 0	0	0	0	0	0	0	0
6	Tobin M. Piker	(i) 236,982	0	2,230	1,318	0	23,459	263,989	0
		(ii) 0	0	0	0	0	0	0	0
7	Russell D. Florenz	(i) 209,821	0	28,848	5,901	0	21,836	266,406	0
		(ii) 0	0	0	0	0	0	0	0
8	Clifford R. Peck	(i) 222,253	0	2,132	0	0	10,815	235,200	0
		(ii) 0	0	0	0	0	0	0	0
9	Roberta F. Metivier	(i) 144,208	0	54,954	3,818	0	20,850	223,830	0
		(ii) 0	0	0	0	0	0	0	0
10	Adam M. Kazimierczak	(i) 164,800	37,913	15,154	880	0	21,246	239,993	0
		(ii) 0	0	0	0	0	0	0	0
11	Kathleen A. Herlihy	(i) 161,766	0	5,569	2,344	0	20,962	190,641	0
		(ii) 0	0	0	0	0	0	0	0
12		(i) 0	0	0	0	0	0	0	0
		(ii) 0	0	0	0	0	0	0	0
13		(i) 0	0	0	0	0	0	0	0
		(ii) 0	0	0	0	0	0	0	0
14		(i) 0	0	0	0	0	0	0	0
		(ii) 0	0	0	0	0	0	0	0
15		(i) 0	0	0	0	0	0	0	0
		(ii) 0	0	0	0	0	0	0	0
16		(i) 0	0	0	0	0	0	0	0
		(ii) 0	0	0	0	0	0	0	0

**Part III** **Supplemental Information**

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

Area with horizontal dotted lines for supplemental information.

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

**Transactions With Interested Persons**

OMB No. 1545-0047

**2011**

Department of the Treasury  
Internal Revenue Service

▶ Complete if the organization answered  
"Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c,  
or Form 990-EZ, Part V, line 38a or 40b.

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

Open To Public  
Inspection

Name of the organization

**Stephens Memorial Hospital Assoc.**

Employer identification number

**01-0219904**

**Part I Excess Benefit Transactions** (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Description of transaction	(c) Corrected?	
			Yes	No
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

2 Enter the amount of tax imposed on the organization managers or disqualified persons during the year under section 4958

▶ \$ \_\_\_\_\_

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

▶ \$ \_\_\_\_\_

**Part II Loans to and/or From Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 26, or Form 990-EZ, Part V, line 38a.

1	(a) Name of interested person and purpose	(b) Loan to or from the organization?		(c) Original principal amount	(d) Balance due	(e) In default?		(f) Approved by board or committee?		(g) Written agreement?	
		To	From			Yes	No	Yes	No	Yes	No
(1)											
(2)											
(3)											
(4)											
(5)											
(6)											
(7)											
(8)											
(9)											
(10)											
<b>Total</b>						▶ \$ _____					

**Part III Grants or Assistance Benefiting Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

1	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount and type of assistance
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			
(7)			
(8)			
(9)			
(10)			



**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

**2011**Open to Public  
Inspection

Name of the organization

Stephens Memorial Hospital Assoc.

Employer identification number

01-0219904

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

David Kumaki, M.D.

William Medd, M.D.

Shareholder

Shareholder

Shareholders in a medical practice providing services to the organization.

The operating assets of the medical practice was acquired by another  
related organization on 12/23/11.**Form 990, Part VI, Line 6 - Classes of Members or Stockholders**Western Maine Health Care, Corp. (EIN# 01-0411788) is the sole member of  
the organization.**Form 990, Part VI, Line 7a - Election of Members and Their Rights**The sole member has the responsibility for the election of the members  
of the governing body.**Form 990, Part VI, Line 7b - Decisions Subject to Approval of Members**All decisions by the Stephens Memorial Hospital Association's governing  
body are approved by default by the member organization's governing body  
since these two organizations share a common governing body.**Form 990, Part VI, Line 11b - Organization's Process to Review Form 990**

The 990 was reviewed in detail by a Committee of the Board of Trustees.

The President and Senior Vice President - Fiscal led the discussion.

Subsequent to that review, a copy of the organization's 990 was distributed  
to all Trustees. The 990 was reviewed in summary at a Board meeting prior

Name of the organization

Stephens Memorial Hospital Assoc.

Employer identification number

01-0219904

to filing.

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

Conflict of Interest statements are obtained annually. The President's Office collects and reviews the responses. Where any real or perceived conflicts exist, officers and trustees are expected to recuse themselves (1) from meetings during times when the topics of potential conflict are discussed and (2) from voting on such matters. Key employees may not use their positions to profit personally or to assist others in profiting in any way at the expense of Stephens Memorial Hospital Association.

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

The parent company of Stephens Memorial Hospital Association is Western Maine Health Care, Corp. (EIN# 01-0411788) who through its parent company MaineHealth, has a formal written compensation policy in place. In consultation with Sullivan Cotter, the MaineHealth Board Compensation Committee establishes appropriate compensation parameters for each organization's CEO and certain members of their Senior Management Team. Working within these parameters, the Western Maine Health Care Board determines the level of compensation for its CEO. The findings of the Compensation Committee are made transparent to, and voted on by, the full Governing Board. The "total executive compensation" is filed publicly by the organization, and includes "total cash compensation" and "total value of all benefits and perquisites" associated with the position. The Board takes necessary action to prevent the CEO from voting or directly participating in the final Committee determination of his own compensation. The organization's executive compensation procedures rely upon appropriate

Name of the organization

Stephens Memorial Hospital Assoc.

Employer identification number

01-0219904

data for comparability (e.g. compensation levels paid by both taxable and tax-exempt similarly situated organizations and independent surveys by nationally recognized independent firms). Finally, the organization refrains from allowing executive compensation to ever be based solely on Western Maine Health Care, Corp.'s revenues or other similar profit-sharing strategies.

Form 990, Part VI, Line 19 - Governing Documents Disclosure Explanation  
Documents that are required to be open for public inspection are made available upon request.

Form 990, Part VII - Related Organizations

Gregory Hardy	58 hours
Timothy Churchill	30 hours
John Cox	30 hours
M. Patricia Cook	3 hours
Kathleen Herlihy	60 hours
Adam Kazimierczak	60 hours

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

Other changes in net assets of \$142,301 is comprised of the following:

Net transfers to affiliates	(1,058,322)
Change in interest-SCHCF	726,955
Return on investments	189,066

**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service  
Name of the organization

**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

**2011**

**Open to Public  
Inspection**

Name of the organization

**Stephens Memorial Hospital Assoc.**

Employer identification number  
**01-0219904**

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

(1)	(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)						

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

(1)	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
							Yes	No
(1)	Western Maine Health Care, Corp. 181 Main Street Norway ME 04268 01-0411788	Healthcare	ME	501c3	11c	MeHealth		X
(2)	MaineHealth 110 Free Street Portland ME 04101 01-0431680	Healthcare	ME	501c3	11c	N/A		X
(3)	Western Maine Multi-Medical Special 181 Main Street Norway ME 04268 01-0489824	Phys Pract	ME	501c3	3	WMHCC		X
(4)	Western Maine Nursing Home, Inc. 3 Market Square South Paris ME 04281 22-2842655	Nursing Ho	ME	501c3	9	WMHCC		X
(5)	Stephens Community Healthcare Found 181 Main Street Norway ME 04268 31-1644144	Supp Org	ME	501c3	11a	WMHCC		X

**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

**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

**2011**

**Open to Public  
Inspection**

Employer identification number  
**01-0219904**

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) Chapel Valley Boarding Home Corp. 181 Main Street Norway ME 04268 01-0433206	Healthcare	ME	501c3	7	WMHCC		X
(2) .....							
(3) .....							
(4) .....							
(5) .....							

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

(1)	(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 alloc.?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1066)	(j) General or managing partner?		(k) Percentage ownership
								Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													

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

(1)	(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
(2)								
(3)								
(4)								

**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.

**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

**b** Gift, grant, or capital contribution to related organization(s)

**c** Gift, grant, or capital contribution from related organization(s)

**d** Loans or loan guarantees to or for related organization(s)

**e** Loans or loan guarantees by related organization(s)

**f** Sale of assets to related organization(s)

**g** Purchase of assets from related organization(s)

**h** Exchange of assets with related organization(s)

**i** Lease of facilities, equipment, or other assets to related organization(s)

**j** Lease of facilities, equipment, or other assets from related organization(s)

**k** Performance of services or membership or fundraising solicitations for related organization(s)

**l** Performance of services or membership or fundraising solicitations by related organization(s)

**m** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)

**n** Sharing of paid employees with related organization(s)

**o** Reimbursement paid to related organization(s) for expenses

**p** Reimbursement paid by related organization(s) for expenses

**q** Other transfer of cash or property to related organization(s)

**r** Other transfer of cash or property from related organization(s)

**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.

	Yes	No	(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
1a		X				
1b		X				
1c		X				
1d		X				
1e		X				
1f		X				
1g		X				
1h		X				
1i	X					
1j		X				
1k	X					
1l	X					
1m		X				
1n		X				
1o	X					
1p	X					
1q	X					
1r	X					
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						

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

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

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

