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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter social security numbers on this form as it may be made public.

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

OMB No. 1545-0047

2019

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 10-01-2019 , and ending 09-30-2020

B Check if applicable:
☐ Address change
☐ Name change
☐ Initial return
☐ Final return/terminated
☐ Amended return
☐ Application pending

C Name of organization
CAPE COD HEALTHCARE INC & AFFILIATES
% LAURA RANZINGER
Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
297 NORTH ST Suite BLDG 3

City or town, state or province, country, and ZIP or foreign postal code
HYANNIS, MA 02601

D Employer identification number
90-0054984

E Telephone number
(508) 771-1800

G Gross receipts $ 942,736,501

F Name and address of principal officer:
MICHAEL K LAUF
88 LEWIS BAY ROAD
HYANNIS, MA 02601

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

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

H(c) Group exemption number ▶ 3901

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

J Website: ▶ WWW.CAPECODHEALTH.org

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

L Year of formation:

M State of legal domicile:

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
SEE SCHEDULE O

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

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	14
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	10
5	Total number of individuals employed in calendar year 2019 (Part V, line 2a)	**5**	6,131
6	Total number of volunteers (estimate if necessary)	**6**	516
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	320,050
b	Net unrelated business taxable income from Form 990-T, line 39	**7b**	-91,180

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	18,471,535	69,840,468
9	Program service revenue (Part VIII, line 2g)	946,855,987	856,644,181
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	19,832,534	14,606,621
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	2,175,510	1,567,803
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	987,335,566	942,659,073
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	1,006,781	1,008,026
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	513,672,399	512,925,879
16a	Professional fundraising fees (Part IX, column (A), line 11e)	70,431	59,071
b	Total fundraising expenses (Part IX, column (D), line 25) ▶3,597,855		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	418,938,620	415,810,545
18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	933,688,231	929,803,521
19	Revenue less expenses. Subtract line 18 from line 12	53,647,335	12,855,552

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	1,056,059,478	1,248,997,758
21	Total liabilities (Part X, line 26)	275,779,649	443,904,319
22	Net assets or fund balances. Subtract line 21 from line 20	780,279,829	805,093,439

Part II Signature Block

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

Sign Here

Signature of officer — Date: 2021-07-30

LAURA RANZINGER VP FINANCE&TREASURY
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
		2021-07-27		P00641463

Firm's name ▶ PricewaterhouseCoopers LLP — Firm's EIN ▶

Firm's address ▶ 101 SEAPORT BLVD SUITE 500
BOSTON, MA 02210

Phone no. (617) 530-5000

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

SEE SCHEDULE O

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

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

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

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 846,101,010 including grants of $ 1,008,026) (Revenue $ 856,644,181)

See Additional Data

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

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

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

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

4e Total program service expenses ▶ 846,101,010

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D,* Part I	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D,* Part III	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? *If "Yes," complete Schedule D, Part V*	10	Yes	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D,* Part VI.	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	Yes	
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	Yes	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f		No
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a	Yes	
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b	Yes	
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17	Yes	
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	Yes	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	Yes	

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	67		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		Yes	

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

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** 6,131			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)		**2b**	Yes	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .		**3a**	Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .		**3b**	Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .		**4a**		No
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .		**5a**		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		**5b**		No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		**5c**		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .		**6a**		No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		**6b**		
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?		**7a**	Yes	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		**7b**	Yes	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		**7c**		No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		**7e**		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .		**7f**		No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		**7g**		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		**7h**		
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		**8**		
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?		**9a**		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .		**9b**		
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?		**12a**		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? . . . . . **Note.** See the instructions for additional information the organization must report on Schedule O.		**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	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?		**14a**		No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .		**14b**		
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? . . . . . If "Yes," see instructions and file Form 4720, Schedule N.		**15**		No
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? . . If "Yes," complete Form 4720, Schedule O.		**16**		No

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	**1a**	14		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	**1b**	10		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?			**2**	Yes	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?			**3**		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?			**4**		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?			**5**		No
6	Did the organization have members or stockholders?			**6**	Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?			**7a**	Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?			**7b**	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:					
a	The governing body?			**8a**	Yes	
b	Each committee with authority to act on behalf of the governing body?			**8b**	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*			**9**		No

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

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

Section C. Disclosure

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

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

☐ Own website ☐ Another's website ☑ Upon request ☐ Other (explain in Schedule O)

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records:
▶LAURA RANZINGER 297 NORTH STREET BLDG 3 HYANNIS, MA 02601 (774) 470-5537

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

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

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

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

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

See instructions for the order in which to list the persons above.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (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			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								9,247,067	7,269,530	1,386,746

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 987

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

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
CAPE COD HEALTHCARE INC, 297 NORTH STREET BLDG 3 HYANNIS, MA 02601	PURCHASED SERVICES	70,060,946
CMG CIT ACQUISITION LLC, 655 SOUTH WILLOW ST STE 128 MANCHESTER, NH 03103	EMPLYMENT/STAFF SVCS	788,014
BOURNE MANOR, 146 MACARTHUR BLVD BOURNE, MA 02532	HOSPICE ROOM & BOARD	168,097

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 3

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts					
1a Federated campaigns	1a				
b Membership dues	1b				
c Fundraising events	1c	76,176			
d Related organizations	1d				
e Government grants (contributions)	1e	52,776,530			
f All other contributions, gifts, grants, and similar amounts not included above	1f	16,987,762			
g Noncash contributions included in lines 1a - 1f: $	1g	1,816,257			
h **Total.** Add lines 1a-1f		69,840,468			
Program Service Revenue	Business Code				
2a PATIENT SERVICE REVENUE	900099	827,050,609	827,050,609		
b LABORATORY SERVICES	621500	6,374,932	6,054,882	320,050	
c PROGRAM RELATED RENTAL INCOME	900099	3,190,300	3,190,300		
d JOINT VENTURE REVENUE	900099	2,807,616	2,807,616		
e QUALITY EARNED PAYMENTS	900099	13,205,322	13,205,322		
f All other program service revenue.		4,015,402	4,015,402		
g **Total.** Add lines 2a–2f	856,644,181				
3 Investment income (including dividends, interest, and other similar amounts)		8,025,505			8,025,505
4 Income from investment of tax-exempt bond proceeds		0			
5 Royalties		0			

		(i) Real	(ii) Personal				
6a Gross rents	6a						
b Less: rental expenses	6b						
c Rental income or (loss)	6c	0	0				
d Net rental income or (loss)				0			

		(i) Securities	(ii) Other				
7a Gross amount from sales of assets other than inventory	7a	6,581,116					
b Less: cost or other basis and sales expenses	7b						
c Gain or (loss)	7c	6,581,116					
d Net gain or (loss)				6,581,116			6,581,116

8a Gross income from fundraising events (not including $ 76,176 of contributions reported on line 1c). See Part IV, line 18	8a	123,459				
b Less: direct expenses	8b	77,428				
c Net income or (loss) from fundraising events			46,031			46,031
9a Gross income from gaming activities. See Part IV, line 19	9a	0				
b Less: direct expenses	9b	0				
c Net income or (loss) from gaming activities			0			
10a Gross sales of inventory, less returns and allowances	10a	0				
b Less: cost of goods sold	10b	0				
c Net income or (loss) from sales of inventory			0			
Miscellaneous Revenue	**Business Code**					
11a CAFETERIA INCOME	900099	1,414,445				1,414,445
b MEDICAL RECORDS	900099	107,327				107,327
c						
d All other revenue						
e **Total.** Add lines 11a–11d		1,521,772				
12 **Total revenue.** See instructions		942,659,073	856,324,131	320,050		16,174,424

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	1,008,026	1,008,026		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	3,469,864	3,469,864		
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	481,565	481,565		
7 Other salaries and wages	402,397,123	364,702,549	35,996,447	1,698,127
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	12,570,605	11,062,822	1,439,858	67,925
9 Other employee benefits	68,201,507	61,756,676	6,137,277	307,554
10 Payroll taxes	25,805,215	22,933,020	2,753,728	118,467
11 Fees for services (non-employees):				
a Management	6,767,398	3,087,069	3,680,329	
b Legal	1,056,899	22,204	1,029,695	5,000
c Accounting	990,859	216,303	774,556	
d Lobbying	0			
e Professional fundraising services. See Part IV, line 17	59,071			59,071
f Investment management fees	550,932	42,797	508,135	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	33,916,811	33,755,300	161,511	
12 Advertising and promotion	834,615	759,351	64,960	10,304
13 Office expenses	4,266,087	3,968,203	264,568	33,316
14 Information technology	4,578,023	4,335,040	165,664	77,319
15 Royalties	0			
16 Occupancy	14,294,702	13,436,389	733,977	124,336
17 Travel	5,486,935	5,031,676	406,350	48,909
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	0			
20 Interest	5,874,408	5,289,107	564,155	21,146
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	45,800,020	41,641,462	4,151,876	6,682
23 Insurance	5,962,892	5,564,937	397,955	
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 MEDICAL SUPPLIES	136,520,814	136,520,814		
b ADMIN OFFICE OVERHEAD	69,626,420	52,734,972	16,358,839	532,609
c PURCHASED SERVICES	35,407,413	32,993,110	2,292,962	121,341
d BAD DEBTS	16,525,789	16,525,789		
e All other expenses	27,349,528	24,761,965	2,221,814	365,749
25 **Total functional expenses.** Add lines 1 through 24e	929,803,521	846,101,010	80,104,656	3,597,855
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720).				

Part X Balance Sheet

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing		31,950,245	1	47,772,011
	2	Savings and temporary cash investments		1,423,924	2	1,428,120
	3	Pledges and grants receivable, net		8,121,530	3	12,528,497
	4	Accounts receivable, net		98,822,894	4	80,313,108
	5	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		0	6	0
	7	Notes and loans receivable, net		9,298,125	7	14,560,536
	8	Inventories for sale or use		12,942,908	8	13,978,076
	9	Prepaid expenses and deferred charges		3,300,556	9	2,858,696
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 711,231,599			
	b	Less: accumulated depreciation	10b 406,410,663	324,571,834	10c	304,820,936
	11	Investments—publicly traded securities		0	11	0
	12	Investments—other securities. See Part IV, line 11		495,557,462	12	664,591,293
	13	Investments—program-related. See Part IV, line 11		254,265	13	289,008
	14	Intangible assets		23,710,077	14	21,989,350
	15	Other assets. See Part IV, line 11		46,105,658	15	83,868,127
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		1,056,059,478	16	1,248,997,758
Liabilities	17	Accounts payable and accrued expenses		72,326,715	17	72,068,541
	18	Grants payable		0	18	0
	19	Deferred revenue		351,577	19	1,255,770
	20	Tax-exempt bond liabilities		122,580,260	20	112,816,029
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		0	21	0
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		0	22	0
	23	Secured mortgages and notes payable to unrelated third parties		19,479,163	23	17,937,868
	24	Unsecured notes and loans payable to unrelated third parties		0	24	0
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D		61,041,934	25	239,826,111
	26	**Total liabilities.** Add lines 17 through 25		275,779,649	26	443,904,319
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here ▶ ☑ and complete lines 27, 28, 32, and 33.**				
	27	Net assets without donor restrictions		710,386,474	27	729,454,739
	28	Net assets with donor restrictions		69,893,355	28	75,638,700
		Organizations that do not follow FASB ASC 958, check here ▶ ☐ and complete lines 29 through 33.				
	29	Capital stock or trust principal, or current funds			29	
	30	Paid-in or capital surplus, or land, building or equipment fund			30	
	31	Retained earnings, endowment, accumulated income, or other funds			31	
	32	Total net assets or fund balances		780,279,829	32	805,093,439
	33	Total liabilities and net assets/fund balances		1,056,059,478	33	1,248,997,758

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	942,659,073
2	Total expenses (must equal Part IX, column (A), line 25)	2	929,803,521
3	Revenue less expenses. Subtract line 2 from line 1	3	12,855,552
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	780,279,829
5	Net unrealized gains (losses) on investments	5	-1,647,831
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	13,279,200
9	Other changes in net assets or fund balances (explain in Schedule O)	9	326,689
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	805,093,439

Part XII Financial Statements and Reporting

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

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

Additional Data

Software ID:

Software Version:

EIN: 90-0054984

Name: CAPE COD HEALTHCARE INC & AFFILIATES

Form 990 (2019)

Form 990, Part III, Line 4a:

PATIENT SERVICES - SEE SCHEDULES H AND O

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MICHAEL K LAUF PRESIDENT/CEO/TRUSTEE	55.0 5.0	X		X				0	1,667,455	264,792
RICHARD B ZELMAN MD PHYSICIAN	40.0 0.0					X		1,682,890	0	43,868
PAUL HOULE MD TRUSTEE (UNTIL 1/20)	40.0 2.0	X						1,070,875	0	45,020
GORDON NAKATA MD PHYSICIAN	40.0 0.0					X		1,049,325	0	45,020
ACHILLES PAPAVASILIOU MD PHYSICIAN	40.0 0.0					X		1,049,125	0	45,170
NICHOLAS COPPA MD PHYSICIAN	40.0 0.0					X		1,051,539	0	42,210
KARL B COYNER MD PHYSICIAN	40.0 0.0					X		1,017,584	0	22,990
ROBERT WILSTERMAN MD TRUSTEE (UNTIL 1/20)	40.0 2.0	X						694,083	0	42,381
MICHAEL L CONNORS SENIOR VP FINANCE/CFO	55.0 5.0			X				0	566,015	73,488
DONALD A GUADAGNOLI MD Senior VP & CMO	45.0 5.0				X			0	541,968	64,452

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MOLLY SULLIVAN MD TRUSTEE (AS OF 1/20)	40.0 2.0	X						538,195	0	42,392
JOHN PAUL SOLVERSON SR VP & CIO	45.0 5.0				X			0	525,027	52,186
KEVIN MULROY SVP CHIEF QUALITY & SAFETY OFF	45.0 5.0				X			0	487,621	67,566
WILLIAM AGEL MD TRUSTEE (UNTIL 04/2020)	40.0 2.0	X						504,701	0	42,392
CHRISTIAN BROWN SR VP MANAGED CARE	45.0 5.0				X			0	439,640	61,410
MICHAEL G JONES ESQ SEE SCHEDULE O	55.0 5.0			X				0	427,594	64,733
ALEXANDER HEARD MD CMO FALMOUTH HOSPITAL	45.0 5.0				X			216,393	204,529	64,283
PATRICK J KANE SVP OF MRKTG,COMMUN AND DEVLP	45.0 5.0				X			0	424,663	45,107
THEODORE CALIANOS MD TRUSTEE	40.0 5.0	X						372,357	0	42,221
EMILY SCHORER SVP HUMAN RESOURCES	45.0 5.0				X			0	354,522	58,064

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JEFFREY S DYKENS VP FINANCE	45.0 5.0				X			0	356,971	50,640
SHERYL DECILIO SEE SCHEDULE O	45.0 5.0				X			0	345,307	9,076
JUDITH C QUINN VP OF PATIENT CARE	45.0 5.0				X			0	313,110	33,499
CHRISTOPHER M LAWSON SVP DEVELOPMENT	45.0 5.0				X			0	306,516	39,044
LORI JEWETT CEO - FH	45.0 5.0				X			0	308,592	24,742
JEAN BUTLER SVP EMPLYD PHY GRP(AS OF 4/19)	45.0 5.0				X			0	285,844	36,871
NOELENE CERVIN VP BUDGETING AND OPER. SUPPORT	45.0 5.0				X			0	269,775	47,205
ANNE MARIE PECKHAM PRESIDENT VNA	45.0 5.0				X			0	273,658	32,200
DEBRA ROBINSON ASSOC VP OF NRSNG	45.0 5.0				X			249,709	0	33,289
CARTER HUNT ADMIN SPEC&HOSP BASED CARE	45.0 5.0				X			0	225,084	53,335

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
CYNTHIA MARLIN VP PERIOPERATIVE & SURGICAL SV	45.0 5.0				X			0	228,069	44,010
ELIZABETH DUNTON COO EMPLOYED PHYSICIAN SVCS	45.0 5.0				X			0	232,927	21,041
THERESA M AHERN SVP STRATEGY & GOVT AFFAIRS	45.0 5.0				X			0	234,105	15,369
NATHAN RUDMAN MD TRUSTEE	5.0 5.0	X						0	21,120	0
LAWRENCE CAPODILUPO TRUSTEE	2.0 2.0	X						0	0	0
SHARON KENNEDY TRUSTEE	2.0 2.0	X						0	0	0
DEWITT DAVENPORT CHAIRMAN (UNTIL 5/20)	2.0 2.0	X		X				0	0	0
DIANE COLETTI TRUSTEE	2.0 2.0	X						0	0	0
SUMNER B TILTON JR TRUSTEE	2.0 2.0	X						0	0	0
E JAMES MULCAHY JR TRUSTEE	2.0 2.0	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ROBERT TALERMAN SEE SCHEDULE O	2.0 2.0	X		X				0	0	0
ROBERT BIRMINGHAM VICE CHAIR/TRUST (UNTIL 11/19)	2.0 2.0	X		X				0	0	0
RAMANI AYER SEE SCHEDULE O	5.0 5.0	X		X				0	0	0
BRUCE JOHNSTON SEE SCHEDULE O	5.0 5.0	X		X				0	0	0
CYNTHIA A HINES MD TRUSTEE (AS OF 01/20)	2.0 2.0	X						0	0	0
KEVIN VILSAINT MD TRUSTEE (AS OF 9/20)	2.0 2.0	X						0	0	0

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

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 12, 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 (Form 990 or 990-EZ).)

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 agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university:

10 ☐ An organization that normally receives: (1) more than 331/3% 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 331/3% 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.)

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

12 ☐ 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 in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**

b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

f Enter the number of supported organizations . . . . . _____

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . .	13,584,232	15,341,766	15,447,109	18,471,535	69,840,468	132,685,110
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						0
3 The value of services or facilities furnished by a governmental unit to the organization without charge..						0
4 **Total.** Add lines 1 through 3	13,584,232	15,341,766	15,447,109	18,471,535	69,840,468	132,685,110
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). .						1,210,386
6 **Public support.** Subtract line 5 from line 4.						131,474,724

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7 Amounts from line 4. .	13,584,232	15,341,766	15,447,109	18,471,535	69,840,468	132,685,110
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources . . .	5,368,273	5,985,405	7,272,965	14,133,036	8,025,505	40,785,184
9 Net income from unrelated business activities, whether or not the business is regularly carried on . .	798,057	408	-544,982	-986,182	-91,180	-823,879
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). .	2,353,977	2,422,397	2,647,341	2,299,730	1,645,231	11,368,676
11 **Total support.** Add lines 7 through 10						184,015,091

12 Gross receipts from related activities, etc. (see instructions) **12** 4,346,185,646

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) . . . . . **14** 71.448 %

15 Public support percentage for 2018 Schedule A, Part II, line 14 . . . . . **15** 57.341 %

16a **33 1/3% support test—2019.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☑

b **33 1/3% support test—2018.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test—2019.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year.						
c Add lines 7a and 7b. .						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9 Amounts from line 6. . .						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c Add lines 10a and 10b.						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . .						
13 **Total support.** (Add lines 9, 10c, 11, and 12.). .						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2018 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

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

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year **(see instructions)**:

- **a** ☐ The organization satisfied the Activities Test. Complete **line 2** below.
- **b** ☐ The organization is the parent of each of its supported organizations. Complete **line 3** below.
- **c** ☐ The organization supported a governmental entity. Describe in **Part VI** how you supported a government entity (see instructions)

2 Activities Test. **Answer (a) and (b) below.**

			Yes	No
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	**2a**		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	**2b**		

3 Parent of Supported Organizations. **Answer (a) and (b) below.**

a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	**3a**		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard.*	**3b**		

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

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

Section A - Adjusted Net Income

			(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	0	
2	Recoveries of prior-year distributions	2	0	
3	Other gross income (see instructions)	3	0	
4	Add lines 1 through 3	4	0	
5	Depreciation and depletion	5	0	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	0	
7	Other expenses (see instructions)	7	0	
8	**Adjusted Net Income** (subtract lines 5, 6 and 7 from line 4)	8	0	

Section B - Minimum Asset Amount

			(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1		
a	Average monthly value of securities	1a	0	
b	Average monthly cash balances	1b	0	
c	Fair market value of other non-exempt-use assets	1c	0	
d	**Total** (add lines 1a, 1b, and 1c)	1d	0	
e	**Discount** claimed for blockage or other factors (explain in detail in Part VI): 0			
2	Acquisition indebtedness applicable to non-exempt use assets	2	0	
3	Subtract line 2 from line 1d	3	0	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4	0	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	0	
6	Multiply line 5 by .035	6	0	
7	Recoveries of prior-year distributions	7	0	
8	**Minimum Asset Amount** (add line 7 to line 6)	8	0	

Section C - Distributable Amount

				Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1		0
2	Enter 85% of line 1	2		0
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3		0
4	Enter greater of line 2 or line 3	4		0
5	Income tax imposed in prior year	5		0
6	**Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		0

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)

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

Section D - Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	0
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	0
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	0
4 Amounts paid to acquire exempt-use assets	0
5 Qualified set-aside amounts (prior IRS approval required)	0
6 Other distributions (describe in **Part VI**). See instructions	0
7 **Total annual distributions.** Add lines 1 through 6.	0
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions	0
9 Distributable amount for 2019 from Section C, line 6	0
10 Line 8 amount divided by Line 9 amount	0 %

Section E - Distribution Allocations (see instructions)	**(i) Excess Distributions**	**(ii) Underdistributions Pre-2019**	**(iii) Distributable Amount for 2019**
1 Distributable amount for 2019 from Section C, line 6			0
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in **Part VI**). See instructions.		0	
3 Excess distributions carryover, if any, to 2019:			
a From 2014. 0			
b From 2015. 0			
c From 2016. 0			
d From 2017. 0			
e From 2018. 0			
f **Total** of lines 3a through e	0		
g Applied to underdistributions of prior years		0	
h Applied to 2019 distributable amount			0
i Carryover from 2014 not applied (see instructions)	0		
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.	0		
4 Distributions for 2019 from Section D, line 7: $ 0			
a Applied to underdistributions of prior years		0	
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.	0		
5 Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in **Part VI**. See instructions.		0	
6 Remaining underdistributions for 2019. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in **Part VI**. See instructions.			0
7 **Excess distributions carryover to 2020.** Add lines 3j and 4c.	0		
8 Breakdown of line 7:			
a Excess from 2015. 0			
b Excess from 2016. 0			
c Excess from 2017. 0			
d Excess from 2018. 0			
e Excess from 2019. 0			

Additional Data

Software ID:

Software Version:

EIN: 90-0054984

Name: CAPE COD HEALTHCARE INC & AFFILIATES

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493228039331

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶**Complete if the organization is described below.** ▶**Attach to Form 990 or Form 990-EZ.**
▶**Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

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

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

Name of the organization	Employer identification number
CAPE COD HEALTHCARE INC & AFFILIATES	90-0054984

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 (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

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

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

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

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2016	**(b)** 2017	**(c)** 2018	**(d)** 2019	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		37,408
j	Total. Add lines 1c through 1i			37,408
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
PART II-B, LINE 1I	CAPE COD HOSPITAL AND FALMOUTH HOSPITAL ASSOCIATION, INC. PAY MEMBERSHIP DUES TO THE MASSACHUSETTS HOSPITAL ASSOCIATION WHICH ENGAGES IN LOBBYING PURPOSES AS DEFINED BY MEDICARE. PER THE MHA ADVISORY, 11.08% OF DUES PAID SHOULD BE ALLOCATED TO LOBBYING ACTIVITY.

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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

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

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

Part II Conservation Easements.

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

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

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

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

		Held at the End of the Year
a Total number of conservation easements	2a	
b Total acreage restricted by conservation easements	2b	
c Number of conservation easements on a certified historic structure included in (a)	2c	
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d	

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

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

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

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

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

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

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

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

(i) Revenue included on 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 Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

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

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

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

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

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

5 During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?. . . ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements.

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

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

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

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

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . . ☐ Yes ☐ No

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

Part V Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	42,236,761	42,450,666	41,606,730	38,809,089	37,495,620
b Contributions	846,322	1,510,214	504,886	30,699	57,261
c Net investment earnings, gains, and losses	1,612,515	-670,422	1,353,728	3,061,173	2,000,285
d Grants or scholarships					
e Other expenditures for facilities and programs	1,074,167	1,053,697	1,014,678	759,148	744,077
f Administrative expenses				-464,917	
g End of year balance	43,621,431	42,236,761	42,450,666	41,606,730	38,809,089

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 ▶ 83.360 %
- c Temporarily restricted endowment ▶ 16.640 %

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

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

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

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		23,635,113		23,635,113
b Buildings		421,002,311	201,692,248	219,310,063
c Leasehold improvements		5,032,242	2,691,660	2,340,582
d Equipment		231,449,167	186,056,052	45,393,115
e Other		30,112,766	15,970,703	14,142,063
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				304,820,936

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) INVESTMENTS SHORT TERM	163,636,519	F
(B) RESTRICTED CASH - ST	2,159,963	F
(C) SERIES 2013 CURRENT	848,530	F
(D) SERIES 2012A CURRENT	2,195,837	F
(E) INVESTMENTS LT	299,439,453	F
(F) INTERESTS IN FDN - UNRESTRICTD	144,525,728	F
(G) RESTRICTED CASH - LT	225,684	F
(H) INTEREST IN FDN - TEMP	17,180,887	F
(I) INTEREST IN FDN - PERM	34,378,692	F
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶	664,591,293	

Part VIII Investments—Program Related.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

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

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

(a) Description	(b) Book value
(1)DUE FROM AFFILIATES	83,868,127
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* ▶	83,868,127

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	0
(2) DUE TO AFFILIATES	43,095,745
(3) OTHER CURRENT LIABILITIES	25,796,677
(4) ABANDONED PROPERTY	139,469
(5) INTEREST RATE SWAPS	665,048
(6) COVID19 ADVANCED PAYMENTS	170,129,172
(7)	
(8)	
(9)	
(10)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 25.)* ▶	239,826,111

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII ☐

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 90-0054984
Name: CAPE COD HEALTHCARE INC & AFFILIATES

Form 990, Schedule D, Part VII - Investments Other Securities

(a) Description of security or category (including name of security)	**(b)**Book value	**(c)** Method of valuation: Cost or end-of-year market value
INVESTMENTS SHORT TERM	163,636,519	F
RESTRICTED CASH - ST	2,159,963	F
SERIES 2013 CURRENT	848,530	F
SERIES 2012A CURRENT	2,195,837	F
INVESTMENTS LT	299,439,453	F
INTERESTS IN FDN - UNRESTRICTD	144,525,728	F
RESTRICTED CASH - LT	225,684	F
INTEREST IN FDN - TEMP	17,180,887	F
INTEREST IN FDN - PERM	34,378,692	F

Supplemental Information

Return Reference	Explanation
SCHEDULE D, PART V, LINE 4	THE INTENDED USE OF THE ORGANIZATION'S ENDOWMENT FUNDS IS TO FURTHER THE HEALTHCARE MISSION OF CAPE COD HEALTHCARE AND ITS AFFILIATES.

Supplemental Information

Return Reference	Explanation
SCHEDULE D, PART X, LINE 2	THE ORGANIZATION DOES NOT HAVE A FIN 48 FOOTNOTE AS ANY UNCERTAIN TAX POSITIONS WERE DEEMED IMMATERIAL.

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SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
► Attach to Form 990.
► Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

1 **For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☐ Yes ☐ No

2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.

3 Activites per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in the region	(d) Activities conducted in region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in the region	(f) Total expenditures for and investments in the region
Central America and the Caribbean	1	0	Program Services	CAPTIVE INSURANCE	6,520,553
3a Sub-total	1	0			6,520,553
b Total from continuation sheets to Part I . . .					
c Totals (add lines 3a and 3b)	1	0			6,520,553

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of noncash assistance	(h) Description of noncash assistance	(i) Method of valuation (book, FMV, appraisal, other)

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter . . . . . ▶ _____

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

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of noncash assistance	(g) Description of noncash assistance	(h) Method of valuation (book, FMV, appraisal, other)

Part IV Foreign Forms

1	Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	☐ Yes	☑ No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; don't file with Form 990)*	☐ Yes	☑ No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons with Respect to Certain Foreign Corporations. (see Instructions for Form 5471)*	☐ Yes	☑ No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund. (see Instructions for Form 8621)* .	☐ Yes	☑ No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)*	☐ Yes	☑ No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713; don't file with Form 990).*	☐ Yes	☑ No

Part V **Supplemental Information**

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information. See instructions.

990 Schedule F, Supplemental Information

Return Reference	Explanation
SCHEDULE F, PART I, COLUMN F	EXPENSES ARE CODED IN THE GENERAL LEDGER TO THE CAPTIVE INSURANCE COMPANY.

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SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

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

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

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

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

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

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

b If "Yes," list the 10 highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? Yes	**(iii)** No	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
Five Maples 78 RIVER ROAD SOUTH PUTNEY, VT 05346	Direct Mail		No	332,553	59,071	273,483
Total . . . . . ▶				332,553	59,071	273,483

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

CA, CT, FL, IL, KS, MA, MI, MO, NH, NJ, NY, NC, PA, RI, SC, WI

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

Revenue / Direct Expenses		(a) Event #1 Soiree on the B (event type)	(b) Event #2 (event type)	(c) Other events 0 (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	199,635			199,635
	2 Less: Contributions	76,176			76,176
	3 Gross income (line 1 minus line 2)	123,459			123,459
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs	2,500			2,500
	7 Food and beverages	36,042			36,042
	8 Entertainment	1,600			1,600
	9 Other direct expenses	37,286			37,286
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				77,428
	11 Net income summary. Subtract line 10 from line 3, column (d) ▶				46,031

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

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

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

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

b If "No," explain: _____

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

b If "Yes," explain: _____

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

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

13 Indicate the percentage of gaming activity conducted in:

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

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

Name ▶ ----------

Address ▶ ----------

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

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

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

Name ▶ ----------

Address ▶ ----------

16 Gaming manager information:

Name ▶ ----------

Gaming manager compensation ▶ $----------

Description of services provided ▶ ----------

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

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

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

Part IV **Supplemental Information.** Provide the explanations required by Part I, line 2b, columns (iii) and (v); and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional information. See instructions.

Return Reference	Explanation

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493228039331

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990EZ* for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.			
	☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☑ 200% ☐ Other _____ %	3a	Yes	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☑ 400% ☐ Other _____ %	3b	Yes	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		No
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b	If "Yes," did the organization make it available to the public?	6b	Yes	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			6,298,606	2,091,727	4,206,879	0.460 %
b Medicaid (from Worksheet 3, column a)			108,380,550	93,794,021	14,586,529	1.600 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			14,163,698	12,223,688	1,940,010	0.210 %
d **Total** Financial Assistance and Means-Tested Government Programs			128,842,854	108,109,436	20,733,418	2.270 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			2,545,987	0	2,545,987	0.280 %
f Health professions education (from Worksheet 5)			723,321	232,379	490,942	0.050 %
g Subsidized health services (from Worksheet 6)			631,810,894	571,945,811	59,865,083	6.550 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			1,194,262		1,194,262	0.130 %
j **Total.** Other Benefits			636,274,464	572,178,190	64,096,274	7.010 %
k **Total.** Add lines 7d and 7j			765,117,318	680,287,626	84,829,692	9.280 %

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			100,000		100,000	
2 Economic development						
3 Community support						
4 Environmental improvements			25,000		25,000	
5 Leadership development and training for community members						
6 Coalition building			11,750		11,750	
7 Community health improvement advocacy						
8 Workforce development			16,973		16,973	
9 Other						
10 Total			153,723		153,723	

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		1	Yes	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	16,525,789		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3	9,390,456		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	100,299,613		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	48,846,764		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	51,452,849		
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:				

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?		9a	Yes	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI		9b	Yes	

Part IV Management Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

Part V Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)

How many hospital facilities did the organization operate during the tax year?
2

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

A

Name of hospital facility or letter of facility reporting group _____

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

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

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

A

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Billing and Collections

A

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

A

Name of hospital facility or letter of facility reporting group

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

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

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

Form and Line Reference	Explanation
See Add'l Data	

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

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility (list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? **87**

Name and address	Type of Facility (describe)
1 See Additional Data Table	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

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

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

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

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 3C	N/A

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 6A	N/A

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7, COLUMN F	THE AMOUNT OF BAD DEBT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN LINE 7, COLUMN F WAS $ 16,525,789. THE AMOUNTS REPORTED IN THE TABLE WERE CALCULATED USING THE RATIO OF PATIENT CARE COST TO CHARGES AND BY FOLLOWING THE FORM 990, SCHEDULE H INSTRUCTIONS. THE TOTAL PERCENTAGE OF CHARITY CARE AND CERTAIN OTHER COMMUNITY BENEFITS AT COST IN THE TABLE WAS CALCULATED ON A GROUP RETURN BASIS AS REQUIRED BY THE FORM 990 INSTRUCTIONS, AND NOT ON A HOSPITAL-ONLY BASIS.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II LINES 1, 4, 6 AND 8	COALITION BUILDING ACTIVITIES CCHC CLINICAL, COMMUNITY BENEFITS AND SUPPORT STAFF PARTICIPATED IN A VARIETY OF COALITION BUILDING ACTIVITIES TO ADDRESS AND IMPROVE CARE RELATED TO BEHAVIORAL HEALTH, CARE COORDINATION DISEASE PREVENTION, HOMELESSNESS AND SUBSTANCE USE. REGIONAL COALITIONS SERVE AS ALLIANCES FOR COMBINED AND COORDINATED ACTION TO IMPROVE KEY HEALTH ISSUES. COALITION ACTIVITIES RANGED FROM IMPLEMENTATION OF NEW PROGRAMS TO PROVIDER COORDINATION TO THE DEVELOPMENT OF MULTI-SECTOR PARTNERSHIPS. WORKFORCE DEVELOPMENT CCHC'S PHYSICAL RECRUITMENT PROGRAM STRIVES TO IDENTIFY AREAS OF UNMET NEED AND IMPROVE ACCESS TO PRIMARY AND SPECIALTY CARE FOR VULNERABLE POPULATIONS, ESPECIALLY THOSE OVER 65 WITH PUBLIC HEALTH INSURANCE COVERAGE. THROUGH RIGOROUS EFFORTS, HIGHLY QUALIFIED PHYSICIANS AND PHYSICIAN EXTENDERS ARE RECRUITED AND RETAINED TO MEET THE HEALTH CARE NEEDS OF RESIDENTS OF CAPE COD. PHYSICAL IMPROVEMENTS & HOUSING CCHC PARTNERED WITH THE HOUSING ASSISTANCE CORPORATION (HAC) AND OUTER CAPE HEALTH SERVICES ON THE HOUSING FOR HEALTH PARTNERSHIP TO PROVIDE HOUSING FUNDING TO PATIENTS WHOSE HEALTH MAY BE IMPACTED BY HOUSING INSTABILITY AND MAY NOT MEET ELIGIBILITY CRITERIA FOR EXISTING SERVICES. SINCE THE START OF THE PANDEMIC, HAC HAS SEEN A 400% INCREASE IN REQUESTS FOR FINANCIAL ASSISTANCE FOR HOUSING. WITHOUT A STABLE PLACE TO LIVE, PATIENTS HAVE DIFFICULTY IN ADHERING TO MEDICAL TREATMENT AND DISCHARGE PLANS. LACK OF STABLE HOUSING HAS ALSO BEEN DEMONSTRATED TO DRAMATICALLY INCREASE THE RISKS OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS. PROVIDING PATIENTS WITH A SOURCE OF FUNDS TO STABILIZE THEIR HOUSING PROVIDES A STRONG FOUNDATION FOR PATIENTS TO MORE EFFECTIVELY PARTICIPATE IN THEIR HEALTH TREATMENT PLAN AND IMPROVE THEIR MEDICAL AND BEHAVIORAL HEALTH. ENVIRONMENTAL IMPROVEMENTS CCHC PARTNERED WITH THE ASSOCIATION TO PRESERVE CAPE COD ON THE POND HEALTH PROGRAM TO EXPAND MONITORING AND INCREASE PUBLIC AWARENESS OF THE HEALTH RISKS OF CYANOTOXIN EXPOSURE IN LOCAL PONDS THAT ARE POPULAR FOR RECREATION. CYANOTOXIN EXPOSURE IS LINKED TO ALZHEIMER'S DISEASE AND OTHER NEUROLOGICAL CONDITIONS.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINES 2-3	THE ORGANIZATION IS REPORTING $9,390,456 OF BAD DEBT EXPENSE THAT MEETS ITS FINANCIAL ASSISTANCE POLICY. THIS AMOUNT IS RELATED TO BAD DEBT FROM BOTH HOSPITALS DURING FY20 OF UNINSURED PATIENTS WHO WERE SEEN IN THE ER AND RECEIVED MEDICALLY NECESSARY SERVICES. CAPE COD HEALTHCARE RECEIVES PAYMENTS FOR SERVICES RENDERED FROM FEDERAL AND STATE AGENCIES (UNDER THE MEDICARE AND MEDICAID PROGRAMS), MANAGED CARE PAYORS, COMMERCIAL INSURANCE COMPANIES, AND PATIENTS. PATIENT ACCOUNTS RECEIVABLE ARE REPORTED NET OF CONTRACTUAL ALLOWANCES AND RESERVES FOR DENIALS, UNCOMPENSATED CARE, AND DOUBTFUL ACCOUNTS. THE LEVEL OF RESERVES IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS, BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN FEDERAL AND STATE GOVERNMENTAL AND PRIVATE EMPLOYER HEALTH CARE COVERAGE AND OTHER COLLECTION INDICATORS. IF A PATIENT IS INELIGIBLE FOR CHARITY CARE BECAUSE HIS OR HER INCOME EXCEEDS THE ELIGIBILITY GUIDELINES, ANY UNCOLLECTIBLE ACCOUNTS RECEIVABLE BALANCE IS WRITTEN OFF TO BAD DEBT AS REPORTED IN PART III, LINE 2.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4	THE AUDITED FINANCIAL STATEMENTS DO NOT INCLUDE A FOOTNOTE RELATED TO BAD DEBT OR ALLOWANCE FOR DOUBTFUL ACCOUNTS.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III LINE 9(B)	HOSPITAL FINANCIAL ASSISTANCE PROGRAMS PATIENTS WHO ARE ELIGIBLE FOR ENROLLMENT IN A STATE PUBLIC ASSISTANCE PROGRAM, LIKE THE MASSACHUSETTS MASSHEALTH OR HEALTH SAFETY NET PROGRAMS, ARE DEEMED ENROLLED IN A FINANCIAL ASSISTANCE PROGRAM. FOR ALL PATIENTS THAT ARE ENROLLED IN THESE STATE PUBLIC ASSISTANCE PROGRAMS, THE HOSPITAL MAY ONLY BILL THOSE PATIENTS FOR THE SPECIFIC CO-PAYMENT, CO-INSURANCE, OR DEDUCTIBLE THAT IS OUTLINED IN THE APPLICABLE STATE REGULATIONS AND WHICH MAY FURTHER BE INDICATED ON THE STATE MEDICAID MANAGEMENT INFORMATION SYSTEM.THE HOSPITAL WILL SEEK A SPECIFIED PAYMENT FOR THOSE PATIENTS THAT DO NOT QUALIFY FOR ENROLLMENT IN A MASSACHUSETTS STATE PUBLIC ASSISTANCE SUCH AS OUT-OF-STATE RESIDENTS, BUT WHO MAY OTHERWISE MEET THE GENERAL FINANCIAL ELIGIBILITY CATEGORIES OF A STATE PUBLIC ASSISTANCE PROGRAM. FOR THESE PATIENTS, THE PAYMENT AMOUNT WILL BE SET AT THE HOSPITAL, WHEN REQUESTED BY THE PATIENT AND BASED ON AN INTERNAL REVIEW OF EACH PATIENT'S FINANCIAL STATUS, MAY OFFER A PATIENT AN ADDITIONAL DISCOUNT ON AN UNPAID BILL. ANY SUCH REVIEW SHALL BE PART OF A SEPARATE HOSPITAL FINANCIAL ASSISTANCE PROGRAM THAT IS APPLIED ON A UNIFORM BASIS TO PATIENTS, AND WHICH TAKES INTO CONSIDERATION THE PATIENT'S DOCUMENTED FINANCIAL SITUATION AND THE PATIENT'S INABILITY TO MAKE A PAYMENT AFTER REASONABLE COLLECTION ACTIONS. ANY DISCOUNT THAT IS PROVIDED BY THE HOSPITAL IS CONSISTENT WITH FEDERAL AND STATE REQUIREMENTS, AND DOES NOT INFLUENCE A PATIENT TO RECEIVE SERVICES FROM THE HOSPITAL. POPULATIONS EXEMPT FROM COLLECTION ACTIVITIES: THERE ARE SEVERAL SITUATIONS WHERE A PATIENT CAN BE EXEMPTED FROM FURTHER BILLING AND COLLECTION PROCEDURES ONCE THE DETERMINATION IS MADE THAT THE PATIENT IS EXEMPT PURSUANT TO STATE REGULATIONS: A) PATIENTS ENROLLED IN A PUBLIC HEALTH INSURANCE PROGRAM, INCLUDING BUT NOT LIMITED TO, MASSHEALTH, EMERGENCY AID TO THE ELDERLY, DISABLED AND CHILDREN, HEALTHY START, CHILDREN'S MEDICAL SECURITY PLAN, OR DESIGNATED A "LOW INCOME PATIENT" BY THE OFFICE OF MEDICAID, SUBJECT TO THE FOLLOWING EXCEPTIONS: (I) THE HOSPITAL MAY SEEK TO BILL AND COLLECT THE CO-PAYMENTS AND DEDUCTIBLES THAT ARE SET FORTH BY EACH SPECIFIC PROGRAM. (II) THE HOSPITAL MAY ALSO INITIATE BILLING AND COLLECTION EFFORTS FOR A PATIENT WHO ALLEGES THAT HE OR SHE IS A PARTICIPANT IN A FINANCIAL ASSISTANCE PROGRAM THAT COVERS THE COSTS OF THE HOSPITAL SERVICES, BUT FAILS TO PROVIDE PROOF OF SUCH PARTICIPATION. UPON RECEIPT OF SATISFACTORY PROOF THAT A PATIENT IS A PARTICIPANT IN A FINANCIAL ASSISTANCE PROGRAM, (INCLUDING RECEIPT OR VERIFICATION OF THE SIGNED APPLICATION) THE HOSPITAL SHALL CEASE ITS BILLING AND COLLECTION ACTIVITIES. (III) THE HOSPITAL WILL NOT CONTINUE COLLECTION ACTION ON ANY LOW INCOME PATIENT FOR SERVICES RENDERED BY THE HOSPITAL DURING THE PERIOD FOR WHICH HE OR SHE HAS BEEN DETERMINED TO BE A LOW INCOME PATIENT BY THE OFFICE OF MEDICAID. HOWEVER, THE HOSPITAL MAY CONTINUE COLLECTION ACTION ON A LOW INCOME PATIENT FOR SERVICES RENDERED PRIOR TO THE LOW INCOME PATIENT DETERMINATION, PROVIDED THAT THE CURRENT LOW INCOME PATIENT STATUS HAS BEEN TERMINATED, EXPIRED, OR NOT OTHERWISE IDENTIFIED ON THE STATE'S VIRTUAL GATEWAY OR RECIPIENT ELIGIBILITY VERIFICATION SYSTEM. ONCE A LOW INCOME PATIENT IS DETERMINED ELIGIBLE AND ENROLLED IN THE HEALTH SAFETY NET, MASSHEALTH, OR CERTAIN COMMONWEALTH CARE PROGRAMS, THE HOSPITAL WILL CEASE ITS BILLING AND COLLECTION EFFORTS FOR SERVICES PROVIDED PRIOR TO THE BEGINNING OF THEIR ELIGIBILITY. (IV) THE HOSPITALS MAY SEEK COLLECTION ACTION AGAINST ANY OF THE PATIENTS PARTICIPATING IN THE PROGRAMS LISTED ABOVE FOR NON-COVERED SERVICES THAT THE PATIENT HAS AGREED TO BE RESPONSIBLE FOR, PROVIDED THAT THE HOSPITAL OBTAINED THE PATIENT'S PRIOR WRITTEN CONSENT TO BE BILLED FOR THE SERVICE.

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Form and Line Reference	Explanation
PART VI, LINE 2	NEEDS ASSESSMENT: THE 2020-2022 CAPE COD HOSPITAL AND FALMOUTH HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT REPORT (CHNA REPORT) AND IMPLEMENTATION PLAN WAS RELEASED AND MADE WIDELY AVAILABLE TO THE PUBLIC IN SEPTEMBER, 2019. THE GOALS OF THE COMMUNITY HEALTH NEEDS ASSESSMENT PROJECT ARE TO MONITOR REGIONAL HEALTH DATA, ENGAGE HOSPITAL STAKEHOLDERS, PROMOTE PARTNERSHIPS BETWEEN THE HOSPITALS AND COMMUNITY ORGANIZATIONS AND DEVELOP MULTI-YEAR IMPLEMENTATION STRATEGIES TO GUIDE HOSPITAL INITIATIVES TO IMPROVE THE HEALTH OF BARNSTABLE COUNTY RESIDENTS. Many sources and data collection methodologies were used to obtain a comprehensive view of the health and health care needs of the region and the people served by CCH and FH. Input on the design of data collection instruments was solicited from public health experts, health care consumers, and persons representing vulnerable and medically underserved populations and minorities. Conscientious efforts were made to reach a wide-ranging population of residents during data collection to ensure broad representation of community interests and perspectives. 1. Secondary Data. A comprehensive review of existing data drawn from national, state, and local sources was conducted. Data sources included, but were not limited to, the U.S. Census Bureau, the Centers for Disease Control and Prevention, the Massachusetts Department of Public Health, among others. Types of data included demographics, vital statistics, public health surveillance, as well as self-report of select health behaviors from large, population-based surveys such as the Massachusetts Behavioral Risk Factor Surveillance Survey (BRFSS). The selection of secondary data points was generally based on the prior CHNAs to allow for examination of trends over time. However, additional secondary data sources were explored when major themes or issues arose from qualitative data collection. When available, data were stratified by age group or by income/poverty level to identify areas of disparity. 2. Community Stakeholder Dialogues. Two facilitated "stakeholder dialogues" were held with staff from a broad array of agencies and organizations actively working in the health and human services sectors of Barnstable County. Approximately 70 people attended these sessions. 3. Key Informant Interviews. Key informant interviews were conducted via phone with 25 community leaders from organizations across all of Barnstable County, representing health centers, public safety organizations, housing organizations, and other human service groups. Key informants were identified for participation based on their in-depth knowledge of the health needs and resources of the region. Discussions focused on health strengths and needs in the community and opportunities and challenges to addressing community needs. They were also asked to describe organizational partnerships within Barnstable County, perceptions of community services, and perceptions of CCHC. 4. Focus Groups. Two focus groups, one conducted in Spanish and one in Portuguese, were held with residents to gather information about the community, health challenges and needs, existing services, and suggestions for the future. One focus group of Portuguese-speaking residents was conducted at IPR Cape Cod Church and involved 14 participants. The other involved six Spanishspeaking participants and was held at the Immigration Resource Center at Community Action Committee of Cape Cod. 5. Community Survey. A community survey asking about community and individual health and health care needs was developed and made available on-line and on paper to residents of Barnstable County. The survey was conducted in English, Spanish, and Portuguese and was completed by 2,011 total residents.

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Form and Line Reference	Explanation
PART VI, LINE 3	PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE: FOR THOSE PATIENTS THAT ARE UNINSURED OR UNDERINSURED, THE HOSPITAL WILL WORK WITH THEM TO ASSIST WITH APPLYING FOR AVAILABLE FINANCIAL ASSISTANCE PROGRAMS THAT MAY COVER THEIR UNPAID HOSPITAL BILLS. IN ORDER TO ASSIST UNINSURED AND UNDERINSURED PATIENTS IN FINDING AVAILABLE AND APPROPRIATE FINANCIAL ASSISTANCE PROGRAMS, THE HOSPITAL WILL PROVIDE ALL PATIENTS WITH A GENERAL NOTICE OF THE AVAILABILITY OF PROGRAMS IN BOTH THE INITIAL BILL THAT IS SENT TO PATIENTS AS WELL AS IN GENERAL NOTICES POSTED THROUGHOUT THE HOSPITAL. THE GOAL OF THESE NOTICES IS TO INFORM PATIENTS THAT THEY MAY BE ELIGIBLE TO APPLY FOR COVERAGE WITHIN A FINANCIAL ASSISTANCE PROGRAM, SUCH AS, BUT NOT LIMITED TO, MASSHEALTH, COMMONWEALTH CARE, CHILDREN'S MEDICAL SECURITY PLAN, HEALTHY START, HEALTH SAFETY NET, OR MEDICAL HARDSHIP THROUGH THE HEALTH SAFETY NET. THE HOSPITAL WILL PROVIDE, UPON REQUEST, SPECIFIC INFORMATION ABOUT THE ELIGIBILITY PROCESS TO BE DESIGNATED A LOW INCOME PATIENT UNDER EITHER THE STATE HEALTH SAFETY NET PROGRAM OR THROUGH THE HOSPITAL'S OWN INTERNAL CHARITY CARE PROGRAM. THE HOSPITAL WILL ALSO NOTIFY THE PATIENT ABOUT PAYMENT PLANS THAT MAY BE AVAILABLE TO HIM OR HER BASED ON THE SIZE OF HIS OR HER FAMILY AND FAMILY INCOME.

Form and Line Reference	Explanation
PART VI, LINE 4	DEMOGRAPHICS OF THE SERVICE AREA CCHC's primary service area is Barnstable County. Barnsta ble County is a geographically isolated region located on the eastern seaboard of Massachu setts. The narrow peninsula spans over 70 miles in length and hosts a year-round populatio n of 214,703 residents. Barnstable County consists of 15 towns that vary in population siz e from about 45,000 residents (Barnstable) to slightly more than 1,500 residents (Truro). In addition to serving year-round residents, the regional community infrastructure, includ ing CCH and FH, must meet the demands of a significant influx of seasonal residents and vi sitors each year which, by one estimate, is equivalent to about seven million visitors and residents on Cape Cod in a given summer season. Population Demographic Trends Nearly half of the total population of Barnstable County reside in the three largest towns (Barnstabl e, Falmouth, and Yarmouth) and population size becomes increasingly smaller in towns of th e lower (Harwich, Brewster, Chatham, and Orleans) and outer cape (Eastham, Wellfleet, Trur o, and Provincetown), many of which are considered rural. Between 2011 and 2016, the overa ll population of Barnstable County remained stable with a slight decrease of -0.9%. In com parison, the state population grew by 3.5% during that time period. The overall population of Barnstable County and the islands of Nantucket and Martha's Vineyard is projected to d ecline in coming decades (an estimated -13.0% between 2010 and 2035), attributed to outmig ration of younger residents and to the fact that deaths currently outnumber births. Consis tent with the previous CHNA, the population of Barnstable County is older than for the sta te overall. The median age in Barnstable County is 51.8 years compared to 39. years for th e state overall. Proportionally, residents age 65 years and older comprise 27.8% of the po pulation in Barnstable County, compared to the state at 15.1%. In contrast, the proportion of residents under 18 years is lower in Barnstable County than in the state at 15.9% vs. 20.6%, respectively. Similarly, the proportion of residents between 18 and 24 years is low er in Barnstable County than in the state at 7.3% vs. 10.4%, respectively. Several towns o n the lower and outer cape have a notably higher proportions of residents age 65 years and older, including Chatham (38.9%), Orleans (38.7%), and Wellfleet (38.0%), compared to the County average. More detailed data on the age of residents reveal that Barnstable County also has a higher proportion of residents who are within the 'oldest' age categories compa red to Massachusetts overall, including those age 75 to 84 (8.8% vs. 4.4%, respectively) a nd those age 85 years and older (3.9% vs. 2.3%, respectively). Concern about meeting the n eeds of an aging population was a prominent theme in key informant interviews, stakeholder dialogues, and the community survey. 'Aging health concerns' was the most frequently iden tified health concern for the community by survey respondents (72.6%) with 'health care se rvices focused on seniors'support to older adults to maintain independent living' ranking among the most frequently selected health and social service priorities by survey responde nts. Key informant interviewees also noted that the population in the region is older and aging, which affects and will continue to affect the health and social service infrastruct ure. One phenomenon discussed by key informant interviewees and substantiated by existing data is the large and growing number of seniors who are caring for grandchildren. Between 2011 and 2016, the proportion of grandchildren residing with their grandparents, who are r esponsible for them, declined in Massachusetts from 29.8% to 28.0%, while it increased sub stantially in Barnstable County from 27.0% to 42.8%. This increase occurred in parallel ti ming with the inception of the opioid epidemic in 2012, which has disproportionally impact ed Barnstable County. While grandparents' homes can provide stability and support when par ents are unable to care for their children, caring for grandchildren can be physically and emotionally demanding for seniors, create financial challenges, and strain social and fam ily relationships. These all contribute to poorer mental and physical health among grandpa rents. Related in part to the older age of the population, Barnstable County has a larger proportion of veterans and residents with disabilities than the state overall. Eleven perc ent (11.0%) of county residents identified as veterans compared to 6.4% for the state over all. The largest proportion of veterans residing in Barnstable County is of the Vietnam er a (36.2%). Approximately 14% of residents in Barnstable have a disability, compared to 11. 6% for the state. Between about 5% to 7% of Barnstable County residents have a hearing, co gnitive, ambulatory, or independent living disability. In terms of race and ethnicity, the population of Barnstable County is less diverse t

Form and Line Reference	Explanation
PART VI, LINE 4	han the state overall. Ninety percent (90.6%) of Barnstable County residents identify as W hite, non-Hispanic compared to 73.7% in the state overall. Though comprising a small propo rtion of the overall population, approximately 20,000 Barnstable County residents identify as a racial or ethnic minority. Similarly, smaller proportions (7.8%) of Barnstable Count y residents speak a language other than English compared to the state overall (22.7%). Whi le language minorities comprise a small portion of the county's population, Spanish and Po rtuguese-speaking focus group participants shared those language barriers are a substantia l barrier to economic advancement and the ability to access some health and social service s. Focus group participants further reported that limited spaces in English as a Second La nguage (ESL) classes make it difficult for immigrants to learn English.

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Form and Line Reference	Explanation
PART VI, LINE 5	PROMOTION OF COMMUNITY HEALTH: CAPE COD HEALTHCARE, INC., (CCHC) THROUGH ITS COMMUNITY BENEFITS INITIATIVES, IS COMMITTED TO ENHANCING THE QUALITY OF AND ACCESS TO COMPREHENSIVE HEALTH CARE SERVICES FOR ALL RESIDENTS OF CAPE COD. THROUGH CONTINUOUS ASSESSMENT OF COMMUNITY NEEDS, COORDINATED PLANNING AND THE ALLOCATION OF RESOURCES, THIS COMMITMENT INCLUDES A SPECIAL FOCUS ON THE UNMET NEEDS OF THE FINANCIALLY DISADVANTAGED AND UNDERSERVED POPULATIONS. WE WILL TAKE A LEADERSHIP ROLE IN COLLABORATIVE EFFORTS JOINING OUR RESOURCES, TALENT, AND COMMITMENT WITH THAT OF OTHER PROVIDERS, ORGANIZATIONS AND COMMUNITY MEMBERS. THE COMMUNITY BENEFITS MISSION STATEMENT WAS AFFIRMED BY THE CCHC COMMUNITY HEALTH COMMITTEE AND THE BOARD OF TRUSTEES IN 2000 AND REMAINS IN EFFECT. THE FOLLOWING IS A LIST OF FY 20 TARGET POPULATIONS: - RESIDENTS ACROSS BARNSTABLE COUNTY WITH FOCUS ON SPECIFIC REGIONS OF THE CAPE MOST ACUTELY IMPACTED BY GEOGRAPHIC ISOLATION, ACCESS TO SERVICES, TRANSPORTATION BARRIERS, AND ECONOMIC OPPORTUNITY. - POPULATIONS MANAGING MENTAL HEALTH AND/OR BEHAVIORAL HEALTH DISORDERS. - RESIDENTS OVER THE AGE OF 65. - TRANSITIONAL-AGED YOUTH (18-24 YEARS OLD). - LOW-INCOME INDIVIDUALS AND FAMILIES. KEY ACCOMPLISHMENTS OF REPORTING YEAR CCHC COMMUNITY BENEFITS PROVIDED FINANCIAL AND SERVICE SUPPORT TO HEALTH AND HUMAN SERVICES ORGANIZATIONS AND HOSPITAL-BASED PROGRAMS AND SERVICES THAT WERE ALIGNED WITH THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) 2020-2022. WE ADDRESSED BARRIERS TO CARE BY ADDING SUPPORTIVE CONNECTORS IN THE CONTINUUM OF CARE. EXAMPLES: ALZHEIMER'S SUPPORT GROUPS, RECOVERY COACHES, COMMUNITY NAVIGATORS, OUTREACH, INTEGRATIVE THERAPIES AND TRANSPORTATION SOLUTIONS. CCHC COMMUNITY BENEFITS EXPANDED CROSS-SECTOR COMMUNITY PARTNERSHIPS AND LEADERSHIP WITHIN AND THROUGHOUT THE CAPE COD NON-PROFIT HEALTH AND HUMAN SERVICE SYSTEM. THE MAJOR ACCOMPLISHMENT THIS YEAR WAS THE PUBLICATION OF THE 2020-2022 CCH AND FH CHNA AND IMPLEMENTATION PLAN. THIS PLAN SERVED AS THE FOUNDATION FOR CCHC'S FY20 COMMUNITY BENEFITS PROGRAM, WHICH FOCUSED ON THESE 5 PRIORITIES: PHYSICAL HEALTH CONDITIONS, BEHAVIORAL HEALTH, TRANSPORTATION, HOUSING, AND WORKFORCE DEVELOPMENT. NEW AND EXPANDED HOSPITAL PROGRAMS WERE DELIVERED IN ALIGNMENT WITH IMPLEMENTATION GOALS, OBJECTIVES AND STRATEGIES FOR EACH PRIORITY. CCHC SUPPORTED PARTNERSHIPS WITH OVER 50 LOCAL NONPROFIT HEALTH AND HUMAN SERVICE ORGANIZATIONS, AND A NETWORK OF FEDERALLY QUALIFIED HEALTH CENTERS THROUGH PROJECT SUPPORT AND GRANT INVESTMENTS TO IMPROVE THE HEALTH OF BARNSTABLE COUNTY RESIDENTS. HOSPITAL STAFF DEDICATED TIME AND EXPERTISE TO STRATEGIC PARTNERSHIPS, COALITIONS, AND TASK FORCE EFFORTS LOCALLY, REGIONALLY AND ACROSS MASSACHUSETTS. A SECOND MAJOR ACCOMPLISHMENT OF THIS YEAR IS THE ORGANIZATION'S RESPONSE TO OUR COMMUNITY NEEDS STEMMING FROM COVID-19. OUR HOSPITALS CONTINUED TO PROVIDE MEDICAL CARE, WHILE PROVIDING NEW SERVICES TO FIGHT COVID IN OUR COMMUNITY. IN 2020, CCHC: - EXPANDED ICU CAPACITIES AT BOTH HOSPITALS TO HANDLE AN INCREASE IN COVID PATIENTS - BUILT TRIAGE TENTS AT BOTH HOSPITALS - ESTABLISHED 3 TESTING SITES ACROSS THE REGION - UTILIZED THE EXPERTISE OF THE VNA TO LEAD THE COMMUNITY'S CONTACT TRACING PROGRAM - HELPED TO HOUSE HOMELESS PEOPLE WHO NEEDED TO BE QUARANTINED - CREATED A COVID-19 HOTLINE FOR THE COMMUNITY - SET UP A FIELD HOSPITAL AT JOINT BASE CAPE COD - ADMINISTERED COVID-19 VACCINES TO THE COMMUNITY.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 7	ALL STATES WHERE ORGANIZATION FILES A COMMUNITY BENEFITS REPORT: MA

Additional Data

Software ID:
Software Version:
EIN: 90-0054984
Name: CAPE COD HEALTHCARE INC & AFFILIATES

Form 990 Schedule H, Part V Section A. Hospital Facilities

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **2** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	CAPE COD HOSPITAL 27 PARK STREET HYANNIS, MA 02601 SEE PART V, SECTION C 2135	X	X					X			A
2	FALMOUTH HOSPITAL ASSOCIATION INC 100 TER HEUN DRIVE FALMOUTH, MA 02540 SEE PART V, SECTION C 2289	X	X					X			A

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
PART V, SECTION A	WEBSITES PART V, SECTION A, LINE 1 - CAPE COD HOSPITAL WWW.CAPECODHEALTH.ORG/LOCATIONS/CAPE-COD-HOSPITAL

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
PART V, SECTION A, LINE 2 - FALMOUTH HOSPITAL	WWW.CAPECODHEALTH.ORG/LOCATIONS/FALMOUTH-HOSPITAL

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 5	Many sources and data collection methodologies were used to obtain a comprehensive view of the health and health care needs of the region and the people served by CCH and FH. Input on the design of data collection instruments was solicited from public health experts, he alth care consumers, and persons representing vulnerable and medically underserved populat ions and minorities. Conscientious efforts were made to reach a wide-ranging population of residents during data collection to ensure broad representation of community interests an d perspectives. The data sources and methodologies included: 1. Secondary Data. A comprehe nsive review of existing data drawn from national, state, and local sources was conducted. Data sources included, but were not limited to, the U.S. Census Bureau, the Centers for D isease Control and Prevention, the Massachusetts Department of Public Health, among others . Types of data included demographics, vital statistics, public health surveillance, as we ll as self-report of select health behaviors from large, population-based surveys such as the Massachusetts Behavioral Risk Factor Surveillance Survey (BRFSS). The selection of sec ondary data points was generally based on the prior CHNAs to allow for examination of tren ds over time. However, additional secondary data sources were explored when major themes o r issues arose from qualitative data collection. When available, data were stratified by a ge group or by income/poverty level to identify areas of disparity. 2. Community Stakehold er Dialogues. Two facilitated "stakeholder dialogues" were held with staff from a broad ar ray of agencies and organizations actively working in the health and human services sector s of Barnstable County. Approximately 70 people attended these sessions. 3. Key Informant Interviews. Key informant interviews were conducted via phone with 25 community leaders fr om organizations across all of Barnstable County, representing health centers, public safe ty organizations, housing organizations, and other human service groups. Key informants we re identified for participation based on their in-depth knowledge of the health needs and resources of the region. Discussions focused on health strengths and needs in the communit y and opportunities and challenges to addressing community needs. They were also asked to describe organizational partnerships within Barnstable County, perceptions of community se rvices, and perceptions of CCHC. 4. Focus Groups. Two focus groups, one conducted in Spani sh and one in Portuguese, were held with residents to gather information about the communi ty, health challenges and needs, existing services, and suggestions for the future. One fo cus group of Portuguese-speaking residents was conducted at IPR Cape Cod Church and involv ed 14 participants. The other involved six Spanish speaking participants and was held at t he Immigration Resource Center at Community Action Committee of Cape Cod. 5. Community Sur vey. A community survey asking

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 5	about community and individual health and health care needs was developed and made availa ble on-line and on paper to residents of Barnstable County. The survey was conducted in En glish, Spanish, and Portuguese and was completed by 2,011 total residents.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 6 (A)	CAPE COD HOSPITAL AND FALMOUTH HOSPITAL JOINTLY CONDUCTED THE MOST RECENT COMMUNITY HEALTH NEEDS ASSESSMENT REPORT.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 7 (A)	https://www.capecodhealth.org/app/files/public/9327/community-health-needs -assessment-2020-2022.pdf

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 10 (A)	https://www.capecodhealth.org/app/files/public/9327/community-health-needs -assessment-2020-2022.pdf

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11	In early February 2019, HRiA led a facilitated process with leadership from Cape Cod Healthcare and community stakeholders including Barnstable County Human Services and behavioral health and infectious disease representatives from CCHC, to identify the priorities, goals and objectives for the Strategic Implementation Plan (SIP). HRiA presented the key health issues identified in the FY2020-FY2022 community health needs assessment (CHNA) project, including the magnitude and severity of these issues and their impact on priority populations. The following key health issues emerged most frequently from a review of the available data and community input and were considered in the selection of the Strategic Implementation Plan (SIP) health priorities: Housing, Transportation, Seasonal Economy and Employment Variation, Behavioral Health (including Substance Use and Mental Health), Aging Population, Physical Health Conditions, Healthcare Access. To address these needs, CCHC collaborates with community partners across the region to assess community needs, identifies promising programs, and implements strategies to improve people's health. Through an open and competitive Annual Strategic Grants program, CCHC funds projects addressing a variety of health needs. Additionally, CCHC has invested in new and expanded hospital programs in areas such as cancer support, chronic disease self-management, case management for individuals living with HIV/AIDS, suicide prevention, and support for new families, among others. CCHC community benefits' funding also supports medical interpreter services for limited English-speaking patients, hospital social workers and case managers, and financial counselors. Finally, CCHC plays a leadership role through participation in, among others, the Barnstable County Economic Development Council, the Barnstable County Human Services Advisory Council, the Barnstable County Regional Substance Use Council, the Cape Cod Chamber of Commerce, and the Cape and Islands Community Health Area Network (CHNA 27) Steering Committee. Regarding Seasonal Economy & Employment Variation: CCHC is best positioned to support and collaborate on initiatives that aim to develop the regional healthcare workforce as part of this SIP. In this way, CCHC is hoping to have a positive influence on the economy and employment opportunities in Barnstable County. Addressing the complex challenges created by a seasonal economy and employment variation in the region in industries outside of healthcare is beyond the core competencies of CCHC and our mission.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 13(B)	IN SOME CASES, THE MASSACHUSETTS HEALTHCONNECTOR CALCULATOR OR MODIFIED ADJUSTED GROSS INCOME IS USED TO DETERMINE FINANCIAL ASSISTANCE ELIGIBILITY.

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 13(H)	STATE REGULATIONS

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 16(A), 16(B), 16(C)	HTTPS://WWW.CAPECODHEALTH.ORG/PATIENTS-VISITORS/PAYING-FOR-CARE/FINANCIAL- ASSISTANCE/

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

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

	Name and address	Type of Facility (describe)
1	Visiting Nurse Association of Cape Cod 255 Independence Drive Hyannis, MA 02601	home health
1	CAPE COD HEALTHCARE INC 297 NORTH STREET BLDG 3 HYANNIS, MA 02601	ADMINISTRATIVE
2	Fontaine Primary Care 525 Long Pond Drive HARWICH, MA 02645	medical group practice
3	CCHC Neurosurgery 46 NORTH ST STE 4 HYANNIS, MA 02601	medical group practice
4	Bramblebush Medical Group 21 Bramblebush Park FALMOUTH, MA 02540	medical group practice
5	Seaside Pediatrics 150 Ansel Hallet Road West Yarmouth, MA 02673	medical group practice
6	Fontaine OUTPATIENT CENTER 525 Long Pond Drive Harwich, MA 02645	medical group practice
7	Guo X Y David MD PhD-GASTROENTEROLOGY 90 TER HEUN DRIVE STE 302 Falmouth, MA 02540	medical group practice
8	CCHC Stoneman Primary Care 2 Jan Sebastian Way Suite 100 Sandwich, MA 02563	medical group practice
9	CCHC Gastroenterology - Hyannis 700 ATTUCKS LANE STE 1E Hyannis, MA 02601	medical group practice
10	CCHC Plastic Surgery 160 Falmouth Road Suite B MASHPEE, MA 02649	medical group practice
11	CAPE COD OBSTETRICS & GYNECOLOGY 90 Ter Heun Drive SUITE 100 Falmouth, MA 02540	medical group practice
12	Endocrine Center of Cape Cod - Hyannis 1030 FALMOUTH RD STE 201 Hyannis, MA 02601	medical group practice
13	Fal Specialty Care Practice 90 Ter Heun Drive Suite 302 Falmouth, MA 02540	medical group practice
14	NEUROLOGISTS OF CAPE COD 46 North Street SUITE 7 Hyannis, MA 02601	medical group practice

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

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

	Name and address	Type of Facility (describe)
16	Nauset Family Practice 81 Old Colony Way STE D ORLEANS, MA 02653	medical group practice
1	Cape Health Insurance Company - FOREIGN 297 NORTH ST 3 HYANNIS, MA 02601	administrative
2	Healthcare Foundation 32 MAIN STREET Hyannis, MA 02601	administrative
3	Healthcare Foundation 348 GIFFORD ST STE 4 FALMOUTH, MA 02540	ADMINISTRATIVE
4	JML Care Center 184 Ter Heun Drive falmouth, MA 02540	skilled nur & rehab
5	Cape & Islands Health Services II Inc 14 Yellow Brick Road HYANNIS, MA 02601	COLLECTION CENTER
6	Cape & Islands Health Services II 5 Industrial Drive Suite 102 MASHPEE, MA 02649	COLLECTION CENTER
7	Cape & Islands Health Services II 525 Long Pond Drive HARWICH, MA 02645	COLLECTION CENTER
8	Cape & Islands Health Services II 81 Old Colony Way ORLEANS, MA 02653	COLLECTION CENTER
9	Cape & Islands Health Services II 2 Jan Sebastian Way Route 130 SANDWICH, MA 02563	COLLECTION CENTER
10	Cape & Islands Health Services II 860 Route 134 Unit 2 South Dennis, MA 02660	COLLECTION CENTER
11	Cape & Islands Health Services II 1 Trowbridge Road Bourne, MA 02532	COLLECTION CENTER
12	Cape & Islands Health Services II 1629 MAIN STREET CHATHAM, MA 02633	COLLECTION CENTER
13	Cape & Islands Health Services II 27 PARK STREET HYANNIS, MA 02601	COLLECTION CENTER
14	Heritage at Falmouth 140 Ter Heun Drive FALMOUTH, MA 02540	ASSISTED LIVING

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

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

	Name and address	Type of Facility (describe)
31	Cape Cod Human Services 460 West Main Street HYANNIS, MA 02601	outpatient clinic
1	Cape Cod Human Services 525 Long Pond Drive HARWICH, MA 02645	outpatient clinic
2	Cape Cod Medical Office Building Inc 20 Gleason Street HYANNIS, MA 02601	administrative
3	Orleans Medical CENTER 204 Main Street Orleans, MA 02653	Medical Group Practice
4	CAPE COD Dermatology 134 Ansel Halet Road W Yarmouth, MA 02673	Medical Group Practice
5	Cape Cod Rheumatology Center - Falmouth 1030 FALMOUTH RD STE 201 HYANNIS, MA 02601	MEDICAL GROUP PRACTICE
6	CCHC Cardiovascular Center - Hyannis 25 Main Street HYANNIS, MA 02601	MEDICAL GROUP PRACTICE
7	Endocrine Center of Cape Cod - Harwich 525 Long Pond Drive HARWICH, MA 02645	MEDICAL GROUP PRACTICE
8	Fontaine Urgent Care Center 525 Long Pond Drive HARWICH, MA 02645	MEDICAL GROUP PRACTICE
9	Park Street Primary Care 62 Park Street HYANNIS, MA 02601	MEDICAL GROUP PRACTICE
10	Stoneman Primary Care 2 JAN SEBASTIAN WAY SUITE 100 SANDWICH, MA 02563	MEDICAL GROUP PRACTICE
11	Vascular & Vein Center Of Cape Cod - FAL 90 Ter Heun Drive 3RD Fl MOB STE Falmouth, MA 02540	Medical Group Practice
12	CCHC General & Specialty Surgery 105 Park Street Hyannis, MA 02601	Medical Group Practice
13	Cape Cod Sports Medicine 360 Gifford Street Unit 2B Falmouth, MA 02540	Medical Group Practice
14	CARDIOVASCULAR CENTER - FALMOUTH 90 TER HEUN DRIVE SUITE 300 FALMOUTH, MA 02540	Medical Group Practice

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

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

	Name and address	Type of Facility (describe)
46	GASTROENTEROLOGY HYANNIS - PARK STREET 105 PARK STREET HYANNIS, MA 02601	Medical Group Practice
1	STONEMAN OUTPATIENT CENTER - URGENT CARE 2 JAN SEBASTIAN DRIVE SUITE 101 SANDWICH, MA 02563	Medical Group Practice
2	MASHPEE SURGICAL CENTER 160 FALMOUTH ROAD SUITE A MASHPEE, MA 02649	MEDICAL GROUP PRACTICE
3	SOUTHEASTERN SURGICAL ASSOCIATES 100 CAMP STREET HYANNIS, MA 02601	MEIDCAL GROUP PRACTICE
4	FALMOUTH URGENT CARE 273 TEATICKET HIGHWAY FALMOUTH, MA 02536	MEDICAL GROUP PRACTICE
5	URGI CENTER MEDICAL GROUP - HYANNIS 1220 IYANNOUGH ROAD HYANNIS, MA 02601	MEDICAL GROUP PRACTICE
6	UPPER CAPE EAR NOSE THROAT 200 A JONES ROAD FALMOUTH, MA 02540	MEDICAL GROUP PRACTICE
7	Orthopedic Specialists Falmouth 5 BRAMBLEBUSH PARK FALMOUTH, MA 02540	Medical group practice
8	CCHC DEMENTIA&ALZHEIMER'S CAREGIVER SUPP 4 BAYVIEW ST WEST YARMOUTH, MA 02673	ADMINISTRATIVE
9	CCHC PODIATRIC MEDICINE & FOOT SURGERY 1030 FALMOUTH RD RTE 28 SUITE 20 HYANNIS, MA 02601	MEDICAL GROUP PRACTICE
10	IDCS-INFECTIOUS DISEASE CLINICAL SERV 34 PARK ST HYANNIS, MA 02601	MEDICAL GROUP PRACTICE
11	CCH OBGYN SATELLITE 60A PARK ST HYANNIS, MA 02601	MEDICAL GROUP PRACTICE
12	MACCMSSP REFERRAL DEPT 25 COMMUNICATION WAY HYANNIS, MA 02601	ADMINISTRATIVE
13	DIABETIC EDUCATION 1010 FALMOUTH ROAD HYANNIS, MA 02601	EDUCATIONAL
14	DIABETIC EDUCATION 1629 MAIN ST CHATHAM, MA 02633	EDUCATIONAL

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

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

	Name and address	Type of Facility (describe)
61	VNA of Cape Cod - Harwich 1 AUSTON RD F HARWICH, MA 02645	HOME HEALTH
1	VNA OF CAPE COD - EASTHAM 3960 STATE HWY RD 6 2 EASTHAM, MA 02642	HOME HEALTH
2	VNA OF CAPE COD - FALMOUTH 67 TER HEUN DR FALMOUTH, MA 02540	HOME HEALTH
3	VNA OF CAPE COD - MARTHA'S VINEYARD 49 STATE RD VINEYARD HAVEN, MA 02568	HOME HEALTH
4	VNA OF CAPE COD - NANTUCKET 40 Sherburne Commons Sherburne Hou NANTUCKET, MA 02554	HOME HEALTH
5	VNA OF CAPE COD - PROVINCETOWN 26 ALDEN ST PROVINCETOWN, MA 02657	HOME HEALTH
6	VNA OF CAPE COD - SOUTH DENNIS 434 ROUTE 134 BLDG D 3 SOUTH DENNIS, MA 02660	HOME HEALTH
7	CAPE & ISLANDS HEALTH SERVICES II 35 WILKENS LANE HYANNIS, MA 02601	COLLECTION CENTER
8	ORLEANS MEDICAL CENTER 204 MAIN ST ORLEANS, MA 02653	OUTPATIENT CLINIC
9	CAPE COD RESEARCH INSTITUTE 27 PARK ST HYANNIS, MA 02601	RESEARCH
10	North Falmouth Primary Care 33 Edgerton Drive Falmouth, MA 02556	MEDICAL GROUP PRACTICE
11	North Street Primary Care 130 North Street Hyannis, MA 02601	MEDICAL GROUP PRACTICE
12	Cape Cod Ear Nose and Throat Specialist 65 Cedar Street Hyannis, MA 02601	MEDICAL GROUP PRACTICE
13	CCH Pulmonary Medicine 51 Bayview Street Hyannis, MA 02601	MEDICAL GROUP PRACTICE
14	VNA of Cape Cod - Sagamore Beach 110 State Road Unit 3 Sagamore Beach, MA 02562	Home Health

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

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

	Name and address	Type of Facility (describe)
76	William J Manning Jr MD 700 Attucks Lane Suite 1A Hyannis, MA 02601	Medical Group Practice
1	CAPE & ISLANDS HEALTH SERVICES II 200 JONES ROAD FALMOUTH, MA 02540	COLLECTION CENTER
2	CAPE & ISLANDS HEALTH SERVICES II 68B ROUTE 6A SANDWICH, MA 02563	COLLECTION CENTER
3	Orthopedic Specialists North Falmouth 26 Edgerton Drive Suite C North Falmouth, MA 02556	Medical group practice
4	CAPE COD RHEUMATOLOGY CENTER - FALMOUTH 90 TER HEUN DRIVE SUITE 302 3RD FALMOUTH, MA 02540	MEDICAL GROUP PRACTICE
5	FALMOUTH PRIMARY CARE 90 TER HEUN DRIVE SUITE 2300 FALMOUTH, MA 02540	MEDICAL GROUP PRACTICE
6	MASHPEE PRIMARY CARE 5 INDUSTRIAL DRIVE SUITE 205 MASHPEE, MA 02649	MEDICAL GROUP PRACTICE
7	OSTERVILLE PRIMARY CARE 770 MAIN STREET OSTERVILLE, MA 02655	MEDICAL GROUP PRACTICE
8	STRAWBERRY HILL PRIMARY CARE 1030 FALMOUTH ROAD 1ST FLOOR STE HYANNIS, MA 02601	MEDICAL GROUP PRACTICE
9	TOTAL ORTHOPEDIC CARE 360 GIFFORD STREET FALMOUTH, MA 02540	MEDICAL GROUP PRACTICE
10	YARMOUTH PRIMARY CARE 495 STATION AVE SOUTH YARMOUTH, MA 02664	MEDICAL GROUP PRACTICE
11	OPPENHEIMIN CHATHAM 1629 Main St CHATHAM, MA 02633	REHABILITATION

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

Part I General Information on Grants and Assistance

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

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

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 24

3 Enter total number of other organizations listed in the line 1 table . . . . . ▶ 2

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

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

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

Return Reference	Explanation
SCHEDULE I, PART I, LINE 2	Cape Cod Healthcare monitors the use of grant funds it provides to other organizations through documentation and measurement requirements and metric reporting. The recipient organization agrees to submit an Annual Summary & Outcomes Report to Cape Cod Healthcare for inclusion in Cape Cod Healthcare's Community Benefits State Attorney General's reporting. An outline of specific reporting requirements is included as an attachment in each agreement and a reporting template is provided to each organization. The recipient organization agrees to send a completed template to Cape Cod Healthcare by October 31st of the year the grant is awarded (CCHC grant program schedules run from January 1 - September 30). Additionally, Cape Cod Healthcare may request an Annual Summary & Outcomes Report or documentation of outcomes related to services outlined in the agreement at any time during the duration of the grant.

Additional Data

Software ID:
Software Version:
EIN: 90-0054984
Name: CAPE COD HEALTHCARE INC & AFFILIATES

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
Harbor Health Center 1135 MORTON ST MATTAPAN, MA 02126	23-7100550	501(c)(3)	100,000		FMV	N/A	Access to Care
Duffy Health Center Inc 94 MAIN ST HYANNIS, MA 02452	04-3373741	501(c)(3)	70,000		FMV	N/A	Access to Care

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
Outer Cape Health Services PO Box 1413 Wellfleet, MA 02667	04-2509828	501(c)(3)	123,000		FMV	N/A	Access to Care
Alzheimer's Family Caregiver Support Center Inc 309 Waverly Oaks Rd Waltham, MA 02452	13-3039601	501(c)(3)	30,000		FMV	N/A	Prevention & Wellness

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
Cape Cod Commercial Fisherman's Alliance 1566 Main St Chatham, MA 02633	04-3138784	501(c)(3)	30,000		FMV	N/A	Prevention & Wellness
Cape Wellness Collaborative 11 Potter Ave Hyannis, MA 02601	47-2360979	501(c)(3)	30,000		FMV	N/A	Chronic & Infectious Disease

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
The Family Pantry of Cape Cod 133 Queen Anne Rd Harwich, MA 02645	22-3079904	501(c)(3)	30,000		FMV	N/A	Prevention & Wellness
YMCA Cape Cod 12245 IYANNOUGH RD W BARNSTABLE, MA 02668	04-2394925	501(c)(3)	30,000		FMV	N/A	Chronic & Infectious Disease

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
Cape Cod Times Needy Fund Inc PO BOX 804 HYANNIS, MA 02601	22-2480332	501(c)(3)	30,000		FMV	N/A	Access to Care
Stratus Video LLC 33 N Garden Ave STE 100 Clearwater, FL 33755	47-2949558		12,444		FMV	N/A	Access to Care

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
Barnstable County Sheriff's Office 6000 Sheriffs PL Bourne, MA 02532	04-6002284	GOV'T	30,000		FMV	N/A	Access to Care
HEALTH IMPERATIVES INC 942 W CHESTNUT ST BROCKTON, MA 02301	04-2609177	501(c)(3)	30,000		FMV	N/A	Prevention & Wellness

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
Team Maureen PO Box 422 N Falmouth, MA 02556	45-2473500	501(c)(3)	27,776		FMV	N/A	Chronic & Infectious Disease
Samaritans on Cape Cod & the Islands PO BOX 65 falmouth, MA 02541	04-2738811	501(c)(3)	15,831		FMV	N/A	Behavioral Health

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
Boston Cancer Support Org Inc 831 Beacon St Newton, MA 02459	30-0863587	501(c)(3)	20,000		FMV	N/A	Chronic & Infectious Disease
NAMI Cape Cod Inc 5 MARK LANE HYANNIS, MA 02601	04-2785229	501(c)(3)	25,000		FMV	N/A	Behavioral Health

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
LC CREATIVE INC 62 Old Stone Ch Rd Little Compton, RI 02837	03-7507635		7,415		FMV	N/A	Access To Care
Housing Assistance Corporation 460 W Main Street Hyannis, MA 02601	23-7431255	501(C)(3)	100,000		FMV	N/A	SDOH

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
Cape & Islands Plastic Surgery 26 Gleason Street Hyannis, MA 02601	45-2182632	501(C)(3)	64,047		FMV	N/A	Access to Care
Association To Preserve Cape Cod 482 Main Street Route 6A Dennis, MA 02638	04-2462788	501(C)(3)	25,000		FMV	N/A	SDOH - Built Environment

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
Town of Barnstable 367 Main Street Hyannis, MA 02601	04-6001079	GOV'T	25,000		FMV	N/A	Access to Care
Barnstable County PO Box 427 Barnstable, MA 02630	04-6001419	GOV'T	25,000		FMV	N/A	Access to Care

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
Helping Our Women 34 Conwell St Provincetown, MA 02657	04-3179955	501 (C)(3)	23,200		FMV	N/A	Chronic & Infectious Disease
Cape Cod Literacy Council PO Box 550 Hyannis, MA 02601	22-3098035	501(C)(3)	14,399		FMV	N/A	Prevention & Wellness

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
PASTORAL MINISTRY 786 DARTMOUTH ST DARTMOUTH, MA 02748	04-3096332	501(C)(3)	30,000				BEHAVIORAL HEALTH
FAMILY TO FAMILY 500 MAIN STREET HYANNIS, MA 02601	27-4058389	501(C)(3)	5,500				PREVENTION AND WELLNESS

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax idemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a?	**2**		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☐ Compensation committee	☐ Written employment contract		
	☐ Independent compensation consultant	☐ Compensation survey or study		
	☐ Form 990 of other organizations	☐ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**	Yes	
8	Were any amounts reported on Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

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

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

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

(A) Name and Title	**(B)** Breakdown of W-2 and/or 1099-MISC compensation			**(C)** Retirement and other deferred compensation	**(D)** Nontaxable benefits	**(E)** Total of columns (B)(i)-(D)	**(F)** Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	**(ii)** Bonus & incentive compensation	**(iii)** Other reportable compensation				
See Additional Data Table							

Part III Supplemental Information

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

Return Reference	Explanation
SCHEDULE J, PART I, LINE 4B - 457(F)	CAPE COD HEALTHCARE, INC. AND AFFILIATES SPONSORS A 457(F) VOLUNTARY PERSONAL DEFERRAL PLAN ("THE PLAN") FOR KEY EXECUTIVES. VESTING IS DEFERRED FOR AT LEAST TWO YEARS FROM THE DATE OF THE AWARD. THE PLAN OFFERS PARTICIPATING EMPLOYEES AN ANNUAL DEFERRAL OF CASH COMPENSATION. AMOUNTS DEFERRED UNDER THE PLAN ARE INCLUDED IN SCHEDULE J, PART II, COLUMN (C) AND AMOUNTS PAID UNDER THE PLAN DURING CALENDAR YEAR 2019 WERE AS FOLLOWS: - MICHAEL K. LAUF - $82,576 - MICHAEL G. JONES - $17,269 - MICHAEL L. CONNORS - $22,423 - JEFFREY S. DYKENS - $16,021 - PATRICK KANE - $16,558 - THERESA AHERN - $13,409 - DONALD GUADAGNOLI MD - $22,215 - EMILY SCHORER - $13,735 - KEVIN MULROY - $19,834 - CHRISTIAN BROWN - $15,965 - LORI JEWETT - $11,621 - JUDITH C. QUINN - $39,701 - NOELENE CERVIN - $5,490 - ANNE MARIE PECKHAM - $22,314 - ELIZABETH DUNTON - $855 - CARTER HUNT - $803 - CYNTHIA MARLIN - $339 - DEBRA ROBINSON - $11,969 CAPE COD HEALTHCARE, INC. AND AFFILIATES ALSO SPONSOR A NONQUALIFIED PENSION RESTORATION ACCOUNT PLAN FOR KEY EXECUTIVES. THE ORGANIZATION MAKES CONTRIBUTIONS OF TWO PERCENT OF THE INDIVIDUAL'S ANNUAL SALARY (INCLUDING BONUS) THROUGHOUT THE PLAN YEAR. AMOUNTS DEFERRED ARE INCLUDED IN SCHEDULE J, PART II, COLUMN (C) AND UNDER THE PLAN, PARTICIPANTS ARE ENTITLED TO CERTAIN BENEFITS UPON RETIREMENT, TERMINATION, OR DEATH. DURING CALENDAR YEAR 2019, MICHAEL LAUF ALSO PARTICIPATED IN A SECTION 457(F) PLAN. TWELVE PERCENT OF HIS BASE SALARY WAS CONTRIBUTED AND EACH CONTRIBUTION IS SUBJECT TO A THREE YEAR VESTING SCHEDULE. THE AMOUNT DEFERRED IN CALENDAR YEAR 2019 WAS $120,000 AND IS INCLUDED IN SCHEDULE J, PART II, COLUMN (C). IN ADDITION, $118,703 WAS PAID OUT FROM HIS CEO SUPPLEMENTAL PLAN, AND IS INCLUDED IN SCHEDULE J, PART II, COLUMN B(III).
SCHEDULE J, PART I, LINE 7	DISCRETIONARY BONUSES ARE AWARDED ANNUALLY BASED UPON BOTH THE PERFORMANCE OF THE ORGANIZATION AND THE INDIVIDUAL. BONUSES ARE REFLECTED IN SCHEDULE J, PART II, COLUMN B(II).THE INDIVIDUALS REPORTED IN SCHEDULE J, PART II REPORTED AS BEING PAID FROM A RELATED ORGANIZATION WERE EMPLOYEES OF, AND COMPENSATED BY CAPE COD HEALTHCARE, INC., THE PARENT CORPORATION.

Additional Data

Software ID:
Software Version:
EIN: 90-0054984
Name: CAPE COD HEALTHCARE INC & AFFILIATES

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1MICHAEL K LAUF PRESIDENT/CEO/TRUSTEE	(i)	0	0	0	0	0	0	0
	(ii)	977,346	450,000	240,109	233,600	31,192	1,932,247	182,000
1ROBERT WILSTERMAN MD TRUSTEE (UNTIL 1/20)	(i)	672,311	0	21,772	7,561	34,820	736,464	0
	(ii)	0	0	0	0	0	0	0
2WILLIAM AGEL MD TRUSTEE (UNTIL 04/2020)	(i)	441,169	47,326	16,206	11,200	31,192	547,093	0
	(ii)	0	0	0	0	0	0	0
3THEODORE CALIANOS MD TRUSTEE	(i)	370,551	0	1,806	11,200	31,021	414,578	0
	(ii)	0	0	0	0	0	0	0
4PAUL HOULE MD TRUSTEE (UNTIL 1/20)	(i)	914,309	116,000	40,566	11,200	33,820	1,115,895	0
	(ii)	0	0	0	0	0	0	0
5MICHAEL L CONNORS SENIOR VP FINANCE/CFO	(i)	0	0	0	0	0	0	0
	(ii)	412,159	101,200	52,656	38,347	35,141	639,503	19,250
6MICHAEL G JONES ESQ SEE SCHEDULE O	(i)	0	0	0	0	0	0	0
	(ii)	312,542	80,400	34,652	30,592	34,141	492,327	15,219
7 DONALD A GUADAGNOLI MD Senior VP & CMO	(i)	0	0	0	0	0	0	0
	(ii)	393,304	96,600	52,064	36,860	27,592	606,420	19,957
8ALEXANDER HEARD MD CMO FALMOUTH HOSPITAL	(i)	179,971	33,300	3,122	5,657	17,174	239,224	0
	(ii)	160,048	0	44,481	24,656	16,796	245,981	0
9PATRICK J KANE SVP OF MRKTG,COMMUN AND DEVLP	(i)	0	0	0	0	0	0	0
	(ii)	325,733	79,600	19,330	30,284	14,823	469,770	15,514
10CHRISTIAN BROWN SR VP MANAGED CARE	(i)	0	0	0	0	0	0	0
	(ii)	316,357	79,200	44,083	30,218	31,192	501,050	15,250
11EMILY SCHORER SVP HUMAN RESOURCES	(i)	0	0	0	0	0	0	0
	(ii)	263,136	66,960	24,426	25,923	32,141	412,586	12,950
12THERESA M AHERN SVP STRATEGY & GOVT AFFAIRS	(i)	0	0	0	0	0	0	0
	(ii)	205,482	0	28,623	9,927	5,442	249,474	12,000
13KEVIN MULROY SVP CHIEF QUALITY & SAFETY OFF	(i)	0	0	0	0	0	0	0
	(ii)	361,610	90,500	35,511	33,575	33,991	555,187	18,750
14JOHN PAUL SOLVERSON SR VP & CIO	(i)	0	0	0	0	0	0	0
	(ii)	420,721	102,500	1,806	37,351	14,835	577,213	0
15JEFFREY S DYKENS VP FINANCE	(i)	0	0	0	0	0	0	0
	(ii)	242,242	84,126	30,603	23,983	26,657	407,611	13,500
16NOELENE CERVIN VP BUDGETING AND OPER. SUPPORT	(i)	0	0	0	0	0	0	0
	(ii)	216,812	44,700	8,263	21,419	25,786	316,980	5,500
17LORI JEWETT CEO - FH	(i)	0	0	0	0	0	0	0
	(ii)	220,990	51,400	36,202	23,217	1,525	333,334	12,375
18ANNE MARIE PECKHAM PRESIDENT VNA	(i)	0	0	0	0	0	0	0
	(ii)	201,227	37,087	35,344	9,806	22,394	305,858	10,963
19CARTER HUNT ADMIN SPEC&HOSP BASED CARE	(i)	0	0	0	0	0	0	0
	(ii)	178,158	22,551	24,375	19,194	34,141	278,419	828

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
21JUDITH C QUINN VP OF PATIENT CARE	(i)	0	0	0	0	0	0	0
	(ii)	197,990	46,835	68,285	9,607	23,892	346,609	27,625
1DEBRA ROBINSON ASSOC VP OF NRSNG	(i)	168,045	39,310	42,354	8,759	24,530	282,998	11,137
	(ii)	0	0	0	0	0	0	0
2CYNTHIA MARLIN VP PERIOPERATIVE & SURGICAL SV	(i)	0	0	0	0	0	0	0
	(ii)	190,323	36,460	1,286	19,098	24,912	272,079	358
3ELIZABETH DUNTON COO EMPLOYED PHYSICIAN SVCS	(i)	0	0	0	0	0	0	0
	(ii)	205,001	26,651	1,275	19,516	1,525	253,968	828
4JEAN BUTLER SVP EMPLYD PHY GRP(AS OF 4/19)	(i)	0	0	0	0	0	0	0
	(ii)	188,563	77,100	20,181	22,749	14,122	322,715	1,438
5CHRISTOPHER M LAWSON SVP DEVELOPMENT	(i)	0	0	0	0	0	0	0
	(ii)	245,550	60,000	966	7,933	31,111	345,560	0
6SHERYL DECILIO SEE SCHEDULE O	(i)	0	0	0	0	0	0	0
	(ii)	264,923	79,530	854	7,727	1,349	354,383	0
7RICHARD B ZELMAN MD PHYSICIAN	(i)	1,466,656	100,000	116,234	11,200	32,668	1,726,758	0
	(ii)	0	0	0	0	0	0	0
8NICHOLAS COPPA MD PHYSICIAN	(i)	916,119	116,000	19,420	11,200	31,010	1,093,749	0
	(ii)	0	0	0	0	0	0	0
9 ACHILLES PAPAVASILIOU MD PHYSICIAN	(i)	913,159	116,000	19,966	11,200	33,970	1,094,295	0
	(ii)	0	0	0	0	0	0	0
10GORDON NAKATA MD PHYSICIAN	(i)	914,309	116,050	18,966	11,200	33,820	1,094,345	0
	(ii)	0	0	0	0	0	0	0
11KARL B COYNER MD PHYSICIAN	(i)	671,237	324,575	21,772	11,200	11,790	1,040,574	0
	(ii)	0	0	0	0	0	0	0
12MOLLY SULLIVAN MD TRUSTEE (AS OF 1/20)	(i)	496,550	20,839	20,806	11,200	31,192	580,587	0
	(ii)	0	0	0	0	0	0	0

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	MHEFA REVENUE BONDS SERIES E	04-2456011	000000000	01-12-2012	29,440,000	REISSUE SER E (6/18/08 & 2/12/09)		X		X		X
B	MHEFA REVENUE BONDS SERIES 2012A	04-3431814	000000000	02-24-2012	25,800,000	REFUND SER B(8/15/98)& C (11/15/01)		X		X		X
C	MDFA REVENUE BONDS SERIES 2013	04-3431814	57584VAH8	07-11-2013	50,831,729	REFUND SER C(10/9/01) & CAP.IMPR.		X		X		X
D	MDFA REVENUE BONDS SERIES 2014	04-3431814	000000000	09-29-2014	24,000,000	RENOVATION & REAL ESTATE PURCHASE		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	25,514,666	20,640,000	0	3,400,000
2	Amount of bonds legally defeased	0	0	0	0
3	Total proceeds of issue	29,440,000	25,800,000	50,834,109	24,001,267
4	Gross proceeds in reserve funds	0	0	0	0
5	Capitalized interest from proceeds	0	0	1,295,804	0
6	Proceeds in refunding escrows	0	0	0	0
7	Issuance costs from proceeds	0	336,100	803,269	0
8	Credit enhancement from proceeds	0	0	0	241,456
9	Working capital expenditures from proceeds	0	0	0	0
10	Capital expenditures from proceeds	0	0	27,999,813	0
11	Other spent proceeds	29,440,000	25,463,900	20,735,223	23,759,811
12	Other unspent proceeds	0	0	0	0
13	Year of substantial completion	2012	2012	2014	2015

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X		X		X			X
15	Were the bonds issued as part of an advance refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X		X		X		X
16	Has the final allocation of proceeds been made?	X		X		X		X	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III Private Business Use

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

Part III Private Business Use (Continued)

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

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?		X		X		X		X
b	Exception to rebate?	X		X		X			X
c	No rebate due?	X		X		X		X	
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?	X			X		X		X
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X		X		X
b	Name of provider	0		0		0		0	
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								

Part IV Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
b	Name of provider	0		0		0		0	
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
7	Has the organization established written procedures to monitor the requirements of section 148?	X		X		X		X	

Part V Procedures To Undertake Corrective Action

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

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

Return Reference	Explanation
PART IV, LINE 2(C)	THE DATE THE REBATE COMPUTATIONS WERE LAST PERFORMED FOR EACH BOND ARE BELOW: MDFA, REVENUE BONDS, SERIES E - 07/12/2012 MDFA, REVENUE BONDS, SERIES 2012A - 06/30/2016 MDFA, REVENUE BONDS, SERIES 2013 - 06/30/2018 MDFA, REVENUE BONDS, SERIES 2014 - 08/31/2015 MDFA, REVENUE BONDS, SERIES 2017 - 11/15/2019 SINCE THE BOND PROCEEDS HAVE BEEN SPENT FOR EACH BOND AND THE DEBT SERVICE FUND WAS OPERATED ON A BONA FIDE BASIS, NO FURTHER REBATE CALCULATIONS ARE NECESSARY.

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	MDFA REVENUE BONDS SERIES 2017	04-3431814	000000000	02-01-2017	52,315,359	REFUND SERIES D(2/16/2010)		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	8,893,203			
2	Amount of bonds legally defeased	0			
3	Total proceeds of issue	54,216,669			
4	Gross proceeds in reserve funds	0			
5	Capitalized interest from proceeds	0			
6	Proceeds in refunding escrows	0			
7	Issuance costs from proceeds	302,138			
8	Credit enhancement from proceeds	0			
9	Working capital expenditures from proceeds	0			
10	Capital expenditures from proceeds	106,973			
11	Other spent proceeds	0			
12	Other unspent proceeds	53,807,558			
13	Year of substantial completion	2017			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?		X						
15	Were the bonds issued as part of an advance refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?	X							
16	Has the final allocation of proceeds been made?	X							
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use

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

Part III Private Business Use (Continued)

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

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X						
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?		X						
b	Exception to rebate?		X						
c	No rebate due?	X							
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?	X							
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X						
b	Name of provider	0							
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								

Part IV Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
b	Name of provider	0							
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X						
7	Has the organization established written procedures to monitor the requirements of section 148? . . .	X							

Part V Procedures To Undertake Corrective Action

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

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

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and section 501(c)(29) organizations only).

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

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected? Yes	No

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

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

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	No	(h) Approved by board or committee? Yes	No	(i) Written agreement? Yes	No
Total . . . . . ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) DR KATHRYN RUDMAN	SPOUSE OF TRUSTEE	321,010	MACC EMPLOYEE		No
(2) Sarah K Guadagnoli RN	DAUGHTER OF KEY EMPLOYEE	75,660	CCH EMPLOYEE		No
(3) KIRA JONES	SPOUSE OF OFFICER	84,895	FH EMPLOYEE		No

Part V Supplemental Information

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

Return Reference	Explanation

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SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art—Works of art				
2	Art—Historical treasures				
3	Art—Fractional interests				
4	Books and publications				
5	Clothing and household goods				
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities—Publicly traded	X	14	1,816,257	VALUE OF STOCK REC'D
10	Securities—Closely held stock				
11	Securities—Partnership, LLC, or trust interests				
12	Securities—Miscellaneous				
13	Qualified conservation contribution—Historic structures				
14	Qualified conservation contribution—Other				
15	Real estate—Residential				
16	Real estate—Commercial				
17	Real estate—Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies				
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ (_____)				
26	Other ▶ (_____)				
27	Other ▶ (_____)				
28	Other ▶ (_____)				

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

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

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

Return Reference	Explanation
SCHEDULE M, PART I, COLUMN (B)	THE ORGANIZATION IS REPORTING THE NUMBER OF ITEMS RECEIVED. SCHEDULE M, PART I, LINE 32(A) ON OCCASION THE ORGANIZATION UTILIZES A BROKER TO DISPOSE OF NONCASH CONTRIBUTIONS (OTHER THAN PUBLICLY TRADED SECURITIES).

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

▶ **Attach to Form 990 or 990-EZ.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART I, LINE 1 AND PART III, LINE 1	WE WILL BE THE HEALTH SERVICE PROVIDER OF CHOICE FOR CAPE COD RESIDENTS BY ACHIEVING AND M AINTAINING THE HIGHEST STANDARDS IN HEALTH CARE DELIVERY AND SERVICE QUALITY. TO DO SO, WE WILL PARTNER WITH OTHER HEALTH AND HUMAN SERVICE PROVIDERS AS WELL AS INVEST IN NEEDED ME DICAL TECHNOLOGIES, HUMAN RESOURCES AND CLINICAL SERVICES. ABOVE ALL, WE WILL HELP IDENTIF Y AND RESPOND TO THE NEEDS OF OUR COMMUNITY. COMMUNITY BENEFITS MISSION STATEMENT CAPE COD HEALTHCARE, INC., (CCHC) THROUGH ITS COMMUNITY BENEFITS INITIATIVES, IS COMMITTED TO ENHA NCING THE QUALITY OF AND ACCESS TO COMPREHENSIVE HEALTH CARE SERVICES FOR ALL RESIDENTS OF CAPE COD. THROUGH CONTINUOUS ASSESSMENT OF COMMUNITY NEEDS, COORDINATED PLANNING AND THE ALLOCATION OF RESOURCES, THIS COMMITMENT INCLUDES A SPECIAL FOCUS ON THE UNMET NEEDS OF TH E FINANCIALLY DISADVANTAGED AND UNDERSERVED POPULATIONS. WE WILL TAKE A LEADERSHIP ROLE IN COLLABORATIVE EFFORTS JOINING OUR RESOURCES, TALENT, AND COMMITMENT WITH THAT OF OTHER PR OVIDERS, ORGANIZATIONS AND COMMUNITY MEMBERS. THE COMMUNITY BENEFITS MISSION STATEMENT WAS AFFIRMED BY THE CCHC COMMUNITY HEALTH COMMITTEE AND THE BOARD OF TRUSTEES IN 2000 AND REM AINS IN EFFECT. TARGET POPULATIONS 1. NAME OF TARGET POPULATION: RESIDENTS ACROSS BARNSTAB LE COUNTY WITH FOCUS ON SPECIFIC REGIONS OF THE CAPE MOST ACUTELY IMPACTED BY GEOGRAPHIC I SOLATION, ACCESS TO SERVICES, TRANSPORTATION BARRIERS, AND ECONOMIC OPPORTUNITY. BASIS FOR SELECTION: CCHC'S PRIMARY SERVICE AREA IS BARNSTABLE COUNTY, WHICH IS A GEOGRAPHICALLY IS OLATED REGION LOCATED ON THE EASTERN SEABOARD OF MASSACHUSETTS AND IS MADE UP OF 15 TOWNS. NEARLY HALF THE POPULATION OF BARNSTABLE COUNTY RESIDE IN THE THREE LARGEST TOWNS. POPULA TION SIZE BECOMES INCREASINGLY SMALLER IN TOWNS OF THE LOWER AND OUTER CAPE, AND MANY OF T HESE TOWNS ARE CONSIDERED RURAL. LACK OF ACCESS TO HEALTHCARE AND OTHER SUPPORTIVE SERVICE S IS A MAJOR BARRIER TO HEALTH FOR RESIDENTS OF THESE TOWNS. 2. NAME OF TARGET POPULATION: POPULATIONS MANAGING MENTAL HEALTH AND/OR BEHAVIORAL HEALTH DISORDERS. BASIS FOR SELECTIO N: ACCESS TO, AND AVAILABILITY OF, COMMUNITY-BASED BEHAVIORAL HEALTH CARE IN BARNSTABLE CO UNTY IS AN AREA OF CONCERN. THIS IS EVIDENCED BY HIGH RATES OF PATIENTS PRESENTING WITH ME NTAL HEALTH AND SUBSTANCE USE DISORDERS IN HOSPITAL EMERGENCY DEPARTMENTS. SPECIFIC CHALLE NGES REPORTED BY THE COMMUNITY AND INCLUDED IN THE 2020-2022 CAPE COD HOSPITAL AND FALMOUT H HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT REPORT INCLUDE ACCESS TO SERVICES, LACK OF ME NTAL HEALTH SERVICES, SUBSTANCE USE, LACK OF PREVENTATIVE SERVICES AND STIGMA. 3. NAME OF TARGET POPULATION: RESIDENTS OVER THE AGE OF 65. BASIS FOR SELECTION: CONSISTENT WITH THE PREVIOUS CHNA, THE POPULATION OF BARNSTABLE COUNTY IS OLDER THAN FOR THE STATE OVERALL (27 .8% VS. 15.1%). BARNSTABLE COUNTY ALSO HAS A HIGHER PROPORTION OF RESIDENTS WHO ARE WITHIN THE "OLDEST" AGE CATEGORIES COMPARED TO MASSACHUSETTS OVERALL, INCLUDING THOSE AGE 75-84 (8.8% VS. 4.4%) AND THOSE AGE

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART I, LINE 1 AND PART III, LINE 1	85 AND OLDER (3.9% VS. 2.3%). "AGING HEALTH CONCERNS" WAS THE MOST FREQUENTLY IDENTIFIED H EALTH CONCERN FOR THE COMMUNITY BY SURVEY RESPONDENTS, WITH "HEALTH CARE SERVICES FOCUSED ON SENIORS"SUPPORT TO OLDER ADULTS TO MAINTAIN INDEPENDENT LIVING" RANKING AMONG THE MOST FREQUENTLY SELECTED HEALTH AND SOCIAL SERVICE PRIORITIES BY SURVEY RESPONDENTS. 4. NAME OF TARGET POPULATION: TRANSITIONAL-AGED YOUTH (18-24 YEARS OLD). BASIS FOR SELECTION: THE PR OPORTION OF RESIDENTS OF BARNSTABLE COUNTY BETWEEN 18 AND 24 IS LOWER THAN IN THE STATE (7 .3% VS. 10.4%). TRANSITIONAL-AGED YOUTH WERE IDENTIFIED IN THE 2020-2022 CAPE COD HOSPITAL AND FALMOUTH HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT REPORT AS A SPECIFIC AT-RISK POPU LATION DUE TO INCREASING RATES OF SUBSTANCE USE TREATMENT ADMISSIONS AND CONCERNING HEALTH RISK BEHAVIORS. THE CHNA ALSO IDENTIFIED THE FOLLOWING NEEDS THAT IMPACT THIS POPULATION: WORKFORCE DEVELOPMENT, EMPLOYMENT, EDUCATION AND ECONOMIC OPPORTUNITIES. 5. NAME OF TARGE T POPULATION: LOW-INCOME INDIVIDUALS AND FAMILIES. BASIS FOR SELECTION: ONE THIRD OF COMMU NITY SURVEY RESPONDENTS IDENTIFIED POVERTY AS ONE OF THEIR TOP SOCIAL CONCERNS. THE OVERAL L MEDIAN HOUSEHOLD INCOME FOR BARNSTABLE COUNTY IS SLIGHTLY BELOW THE STATE ($65,382 VS. $ 70,954), AND GENERALLY MUCH LOWER IN NON-FAMILY AND RENTER-OCCUPIED HOUSEHOLDS. THE INDIVI DUAL POVERTY RATE FOR BARNSTABLE COUNTY IS LOWER THAN FOR THE STATE (5.4% VS. 9%). HOWEVER , THERE IS VARIABILITY BETWEEN TOWNS, WITH PROVINCETOWN (13.2%) AND CHATHAM (12.7%) HAVING HIGHER RATES OF POVERTY THAN THE STATE. PUBLICATION OF TARGET POPULATIONS MARKETING COLLA TERAL, WEBSITE COMMUNITY HEALTH NEEDS ASSESSMENT DATE LAST ASSESSMENT COMPLETED CHNA REPOR T 2020-2022 PUBLISHED TO CCHC CARING COMMUNITIES WEBSITE SEPTEMBER 2020. DATA SOURCES COMM UNITY FOCUS GROUPS, HOSPITAL, INTERVIEWS, OTHER, SURVEYS, CHNA DOCUMENT COMMUNITY-HEALTH-N EEDS-ASSESSMENT-2020-2022.PDF IMPLEMENTATION STRATEGY IMPLEMENTATION STRATEGY DOCUMENT: FY 20_SIP.PDF KEY ACCOMPLISHMENTS OF REPORTING YEAR CCHC COMMUNITY BENEFITS PROVIDED FINANCIA L AND SERVICE SUPPORT TO HEALTH AND HUMAN SERVICES ORGANIZATIONS AND HOSPITAL-BASED PROGRA MS AND SERVICES THAT WERE ALIGNED WITH THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) 2020-2 022. WE ADDRESSED BARRIERS TO CARE BY ADDING SUPPORTIVE CONNECTORS IN THE CONTINUUM OF CAR E. EXAMPLES: ALZHEIMER'S SUPPORT GROUPS, RECOVERY COACHES, COMMUNITY NAVIGATORS, OUTREACH, INTEGRATIVE THERAPIES AND TRANSPORTATION SOLUTIONS. CCHC COMMUNITY BENEFITS EXPANDED CROS S-SECTOR COMMUNITY PARTNERSHIPS AND LEADERSHIP WITHIN AND THROUGHOUT THE CAPE COD NON-PROF IT HEALTH AND HUMAN SERVICE SYSTEM. THE MAJOR ACCOMPLISHMENT THIS YEAR WAS THE PUBLICATION OF THE 2020-2022 CCH AND FH CHNA AND IMPLEMENTATION PLAN. THIS PLAN SERVED AS THE FOUNDAT ION FOR CCHC'S FY20 COMMUNITY BENEFITS PROGRAM, WHICH FOCUSED ON THESE 5 PRIORITIES: PHYSI CAL HEALTH CONDITIONS, BEHAVIORAL HEALTH, TRANSPORTATION, HOUSING, AND WORKFORCE DEVELOPME NT. NEW AND EXPANDED HOSPITAL

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART I, LINE 1 AND PART III, LINE 1	PROGRAMS WERE DELIVERED IN ALIGNMENT WITH IMPLEMENTATION GOALS, OBJECTIVES AND STRATEGIES FOR EACH PRIORITY. CCHC SUPPORTED PARTNERSHIPS WITH OVER 50 LOCAL NONPROFIT HEALTH AND HUM AN SERVICE ORGANIZATIONS, AND A NETWORK OF FEDERALLY QUALIFIED HEALTH CENTERS THROUGH PROJ ECT SUPPORT AND GRANT INVESTMENTS TO IMPROVE THE HEALTH OF BARNSTABLE COUNTY RESIDENTS. HO SPITAL STAFF DEDICATED TIME AND EXPERTISE TO STRATEGIC PARTNERSHIPS, COALITIONS, AND TASK FORCE EFFORTS LOCALLY, REGIONALLY AND ACROSS MASSACHUSETTS. A SECOND MAJOR ACCOMPLISHMENT OF THIS YEAR IS THE ORGANIZATION'S RESPONSE TO OUR COMMUNITY NEEDS STEMMING FROM COVID-19. OUR HOSPITALS CONTINUED TO PROVIDE MEDICAL CARE, WHILE PROVIDING NEW SERVICES TO FIGHT CO VID IN OUR COMMUNITY. IN 2020, CCHC: . EXPANDED ICU CAPACITIES AT BOTH HOSPITALS TO HANDLE AN INCREASE IN COVID PATIENTS . BUILT TRIAGE TENTS AT BOTH HOSPITALS . ESTABLISHED 3 TEST ING SITES ACROSS THE REGION . UTILIZED THE EXPERTISE OF THE VNA TO LEAD THE COMMUNITY'S CO NTACT TRACING PROGRAM . HELPED TO HOUSE HOMELESS PEOPLE WHO NEEDED TO BE QUARANTINED . CRE ATED A COVID-19 HOTLINE FOR THE COMMUNITY . SET UP A FIELD HOSPITAL AT JOINT BASE CAPE COD . ADMINISTERED COVID-19 VACCINES TO THE COMMUNITY.

990 Schedule O, Supplemental Information

Return Reference	Explanation
PLANS FOR NEXT REPORTING YEAR	IN FY21, CCHC COMMUNITY BENEFITS WILL FOLLOW THE CHNA 2020-2022 GOALS AND STRATEGIC IMPLEM ENTATION PLAN. THIS PLAN WAS PUT TOGETHER WITH CCHC LEADERSHIP AND OTHER COMMUNITY STAKEHO LDERS INCLUDING BARNSTABLE COUNTY HUMAN SERVICES AND BEHAVIORAL HEALTH AND INFECTIOUS DISE ASE EXPERTS. IT IDENTIFIES THE PRIORITIES, POTENTIAL PARTNERS, AND GOALS AND OBJECTIVES FO R THE IMPLEMENTATION PLAN, WHICH WILL BE FOLLOWED FOR OUR NEXT REPORTING YEAR. THE PRIORIT Y AREAS AND GOALS FOR THE IMPLEMENTATION PLAN ARE: 1) PHYSICAL HEALTH CONDITIONS - REDUCE AND PREVENT THE OCCURRENCE AND SEVERITY OF CHRONIC AND INFECTIOUS DISEASE IN BARNSTABLE CO UNTY THROUGH COLLABORATIVE APPROACHES. 2) BEHAVIORAL HEALTH - BE A LEADING PARTNER IN PROV IDING COMPREHENSIVE REGIONAL HEALTH SERVICES AND COMMUNITY RESOURCES FOR INDIVIDUALS WITH MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS. 3) SOCIAL DETERMINANTS OF HEALTH: TR ANSPORTATION - WORK WITH REGIONAL TRANSPORTATION SYSTEMS TO INCREASE ACCESS TO HEALTH CARE AND OTHER HEALTH RELATED SERVICES IN BARNSTABLE COUNTY. HOUSING - WORK WITH REGIONAL PART NERS TO ENSURE THAT VULNERABLE POPULATIONS SHOW IMPROVED HEALTH INDICATORS THROUGH ACCESS TO STABLE AND QUALITY HOUSING. HEALTHCARE WORKFORCE DEVELOPMENT - WORK WITH REGIONAL PARTN ERS TO ENSURE OUR COMMUNITY IS SERVED BY A STRONG, ADEQUATE HEALTHCARE WORKFORCE. FOOD/NUT RITION - FOSTER REGIONAL PARTNERS TO DEVELOP OF FOOD SECURITY ASSESSMENT PROCESS. SELF-ASS ESSMENT FORM: HOSPITAL SELF-ASSESSMENT UPDATE FORM - YEARS 2 AND 3 COMMUNITY BENEFITS PROG RAMS ANNUAL STRATEGIC GRANTS PROGRAM: CHRONIC AND INFECTIOUS DISEASE AND PREVENTION AND WE LLNESS PROJECTS . PROGRAM TYPE: COMMUNITY-CLINICAL LINKAGES. . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUTSIDE ORGANIZATION: YES . PROGRAM DESCRIPTIONS: THE FY20 ANNUA L STRATEGIC GRANTS PROGRAM WAS A COMPETITIVE GRANT INITIATIVE WITH THE OBJECTIVE TO SUPPOR T COMMUNITY-BASED CHRONIC AND INFECTIOUS DISEASE AND PREVENTION AND WELLNESS PROJECTS ALIG NED WITH THE HEALTH PRIORITIES IDENTIFIED IN THE 2020-2022 CAPE COD HOSPITAL AND FALMOUTH HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT REPORT AND IMPLEMENTATION PLAN. GRANTS WERE AWA RDED TO ORGANIZATIONS WITH PROJECTS THAT REACHED VULNERABLE POPULATIONS, MAXIMIZED PARTNER SHIP COLLABORATION AND FEATURED EVIDENCE-BASED PROGRAMS OR PROMISING PRACTICES WITH THE OB JECTIVE TO IMPROVE THE HEALTH OF BARNSTABLE COUNTY RESIDENTS. . PROGRAM HASHTAGS: COMMUNIT Y EDUCATION, HEALTH SCREENING, PREVENTION, SUPPORT GROUP . EOHHS FOCUS ISSUE(S) (OPTIONAL) : CHRONIC DISEASE WITH FOCUS ON CANCER, HEART DISEASE, AND DIABETES, HOUSING STABILITY/HOM ELESSNESS, MENTAL ILLNESS AND MENTAL HEALTH, SUBSTANCE USE DISORDERS, . DON HEALTH PRIORIT IES (OPTIONAL): BUILT ENVIRONMENT, EDUCATION, HOUSING, SOCIAL ENVIRONMENT. . HEALTH ISSUES : CANCER-BREAST, CANCER-CERVICAL, CANCER-COLORECTAL, CANCER-LUNG, CANCER-MULTIPLE MYELOMA, CANCER-OTHER, CANCER-OVARIAN, CANCER-PROSTATE, CANCER-SKIN, CHRONIC DISEASE-ALZHEIMER'S D ISEASE, CHRONIC DISEASE-ARTHRI

990 Schedule O, Supplemental Information

Return Reference	Explanation
PLANS FOR NEXT REPORTING YEAR	TIS, CHRONIC DISEASE-CARDIAC DISEASE, CHRONIC DISEASE-DIABETES, CHRONIC DISEASE-HYPERTENSI ON, HEALTH BEHAVIORS/MENTAL HEALTH-DEPRESSION, HEALTH BEHAVIORS/MENTAL HEALTH-MENTAL HEALT H, HEALTH BEHAVIORS/MENTAL HEALTH-RESPONSIBLE SEXUAL BEHAVIOR, INFECTIOUS DISEASE-HEPATITI S, INFECTIOUS DISEASE-LYME DISEASE, INJURY-AUTO/PASSENGER INJURIES, MATERNAL/CHILD HEALTH- CHILD CARE, MATERNAL/CHILD HEALTH-REPRODUCTIVE AND MATERNAL HEALTH, OTHER-SENIOR HEALTH CH ALLENGES/CARE COORDINATION, SOCIAL DETERMINANTS OF HEALTH-ACCESS TO HEALTH CARE, SOCIAL DE TERMINANTS OF HEALTH-ACCESS TO HEALTHY FOOD, SOCIAL DETERMINANTS OF HEALTH-ACCESS TO TRANS PORTATION, SOCIAL DETERMINANTS OF HEALTH-AFFORDABLE HOUSING, SOCIAL DETERMINANTS OF HEALTH -EDUCATION/LEARNING, SOCIAL DETERMINANTS OF HEALTH-ENVIRONMENTAL QUALITY, SOCIAL DETERMINA NTS OF HEALTH-HOMELESSNESS, SOCIAL DETERMINANTS OF HEALTH-INCOME AND POVERTY, SOCIAL DETER MINANTS OF HEALTH-LANGUAGE/LITERACY, SOCIAL DETERMINANTS OF HEALTH-NUTRITION, SOCIAL DETER MINANTS OF HEALTH-PUBLIC SAFETY, SUBSTANCE ADDICTION-ALCOHOL USE, SUBSTANCE ADDICTION-OPIO ID USE, SUBSTANCE ADDICTION-SUBSTANCE USE . TARGET POPULATION: REGIONS SERVED: COUNTY-BARN STABLE - ENVIRONMENTS SERVED: ALL GENDER: ALL AGE GROUP: ALL RACE/ETHNICITY: ALL LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STATUS: INCARCERATION HISTORY, LGBT STATUS GOAL DESCRI PTION GRANT AWARDS TO LOCAL NON-PROFIT ORGANIZATIONS OPERATING QUALITY PROGRAMS WITH ANTIC IPATED OUTCOMES ALIGNED WITH CAPE COD HOSPITAL AND FALMOUTH HOSPITAL IMPLEMENTATION STRATE GIES RELATED TO CHRONIC AND INFECTIOUS DISEASES AND PREVENTION AND WELLNESS. GOAL STATUS E XECUTION OF AWARDING GRANTS AND EVALUATING PROGRAMS COMPLETED AS SCHEDULED. PARTNERS PARTN ER NAME, DESCRIPTION AND WEB ADDRESS ALZHEIMER'S FAMILY CAREGIVER SUPPORT CENTER - FREE IN -HOME CARE CONSULTATIONS FOR FAMILIES LIVING WITH ALZHEIMER'S AND DEMENTIA DISEASE - WWW.A LZHEIMERSCAPECOD.ORG A BABY CENTER - BABY BOXES AND CAR SEATS FOR LOW INCOME FAMILIES- WWW .ABABYCENTER.ORG CAPE COD TIMES NEEDY FUND - BASIC NEEDS SAFETY NET FOR INDIVIDUALS WITH C HRONIC AND INFECTIOUS DISEASES - WWW.NEEDYFUND.ORG HOUSING ASSISTANCE CORPORATION ON CAPE COD - OUTER CAPE HEALTH SERVICES HOUSING FOR HEALTH PARTNERSHIP - WWW.HACONCAPECOD.ORG CAP E WELLNESS COLLABORATIVE - WELLNESS CARDS FOR INTEGRATIVE SERVICES- WWW.CAPEWELLNESS.ORG T EAM MAUREEN - HPV PREVENTION THROUGH CAPE - WIDE EDUCATION - WWW.TEAMMAUREEN.ORG NATIONAL ALLIANCE ON MENTAL ILLNESS CAPE COD - MENTAL WELLNESS IN THE PORTUGUESE COMMUNITY- WWW.NAM ICAPECOD.ORG SAMARITANS ON CAPE COD & THE ISLANDS - ELDER SUICIDE OUTREACH PREVENTION PROG RAM- WWW.CAPESAMARITANS.ORG YMCA CAPE COD - CHRONIC DISEASE PROGRAM COORDINATOR- WWW.YMCAC APECOD.ORG BOSTON CANCER SUPPORT - TREATMENT TRANSPORT PROGRAM - WWW.BOSTONCANCERSUPPORT.O RG CAPE COD COMMERCIAL FISHERMAN'S ALLIANCE - FISH FOR FAMILIES - WWW.CAPECODFISHERMEN.ORG THE FAMILY PANTRY OF CAPE COD - HEALTHY MEALS IN MOTION - WWW.THEFAMILYPANTRY.COM BARNSTA BLE COUNTY SHERIFF - EDUCATION

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Return Reference	Explanation
PLANS FOR NEXT REPORTING YEAR	AL INTERVENTIONS FOR CORRECTIONS - WWW.BSHERIFF.NET HEALTH IMPERATIVES - IMPROVING ACCESS TO WIC NUTRITION SERVICES - WWW.HEALTHIMPERATIVES.ORG ASSOCIATION TO PRESERVE CAPE COD - P OND HEALTH PROGRAM - WWW.APCC.ORG HELPING OUR WOMEN - ACCESS AND EQUITY FOR OUTER CAPE WOM EN - HTTP://WWW.HELPINGOURWOMEN.ORG BRAIN INJURY ASSOCIATION OF MA - ANNUAL CERE-BRATION - HTTP://WWW.BIAMA.ORG ST. PETER THE APOSTLE CHURCH - ALZHEIMER'S AND DEMENTIA TRAINING FOR FIRST RESPONDERS AND COMMUNITY MEMBERS. - HTTP://WWW.STPETERS-PTOWN.ORG ROAR - RIDE FOR O PIOID ADDICTION RECOVERY - HTTP://WWW.ROARCAPECOD.COM CAPE COD LITERACY COUNCIL - HEALTH L ITERACY - HTTP://WWW.CAPECODLITERACYCOUNCIL.ORG BARNSTABLE COUNTY SCHOOL DISTRICT - MEALS PROGRAM - HTTP://WWW.BARNSTABLE.K12.MA.US CAPE COD NATIONAL SEASHORE - HEALTHY PARKS HEALT HY PEOPLE EVENT CAPE COD HEALTHCARE COLLABORATED WITH THE CAPE COD NATIONAL SEASHORE AND T HE NATIONAL PARK SERVICES TO PROMOTE COMMUNITY OPEN SPACE FOR WELLNESS, EXERCISE AND PHYSI CAL ACTIVITY TO IMPROVE THE HEALTH OF CAPE COD RESIDENTS AND VISITORS. - HTTPS://WWW.NPS.G OV/CACO/INDEX.HTM DETAILED DESCRIPTION THE FY20 ANNUAL STRATEGIC GRANTS PROGRAM WAS A COMP ETITIVE GRANT INITIATIVE WITH THE OBJECTIVE TO SUPPORT COMMUNITY-BASED CHRONIC AND INFECTI OUS DISEASE AND PREVENTION AND WELLNESS PROJECTS ALIGNED WITH THE HEALTH PRIORITIES IDENTI FIED IN THE 2020-2022 CAPE COD HOSPITAL AND FALMOUTH HOSPITAL COMMUNITY HEALTH NEEDS ASSES SMENT REPORT AND IMPLEMENTATION PLAN. GRANTS WERE AWARDED TO ORGANIZATIONS WITH PROJECTS T HAT REACHED VULNERABLE POPULATIONS, MAXIMIZED PARTNERSHIP COLLABORATION AND FEATURED EVIDE NCE-BASED PROGRAMS OR PROMISING PRACTICES WITH THE OBJECTIVE TO IMPROVE THE HEALTH OF BARN STABLE COUNTY RESIDENTS. SUBSTANCE USE DISORDER PROGRAMS INCLUDING RECOVERY SPECIALIST PRO GRAM IN THE EMERGENCY DEPARTMENTS AT CAPE COD HOSPITAL AND FALMOUTH HOSPITAL . PROGRAM TYP E: COMMUNITY-CLINICAL LINKAGES . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUTS IDE ORGANIZATION: YES . PROGRAM HASHTAGS: COMMUNITY HEALTH CENTER PARTNERSHIP, MENTORSHIP/ CAREER TRAINING/INTERNSHIP, PREVENTION . EOHHS FOCUS ISSUE(S) (OPTIONAL): MENTAL ILLNESS A ND MENTAL HEALTH, SUBSTANCE USE DISORDERS. . DON HEALTH PRIORITIES (OPTIONAL): BUILT ENVIR ONMENT, EDUCATION, SOCIAL ENVIRONMENT. . HEALTH ISSUES: HEALTH BEHAVIORS/MENTAL HEALTH-MEN TAL HEALTH, SOCIAL DETERMINANTS OF HEALTH-ACCESS TO HEALTH CARE, SOCIAL DETERMINANTS OF HE ALTH-ACCESS TO TRANSPORTATION, SOCIAL DETERMINANTS OF HEALTH-EDUCATION/LEARNING, SUBSTANCE ADDICTION-ALCOHOL USE, SUBSTANCE ADDICTION-OPIOID USE, SUBSTANCE ADDICTION-SUBSTANCE USE. . TARGET POPULATION: REGIONS SERVED: COUNTY-BARNSTABLE - ENVIRONMENTS SERVED: ALL - GENDE R: ALL - RACE/ETHNICITY: ALL - LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STATUS: NOT SP ECIFIED

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GOAL DESCRIPTION	ENGAGE AND CONSULT WITH AT LEAST 250 PATIENTS WITH SUBSTANCE USE DISORDERS TREATED IN THE EMERGENCY DEPARTMENTS AT CAPE COD HOSPITAL AND FALMOUTH HOSPITAL. GOAL STATUS EXCEEDED GOA L GOAL DESCRIPTION MOTIVATE AND ASSIST 40% OF PATIENTS WHO RECEIVE A CONSULTATION FROM THE RECOVERY SPECIALIST TO ACCEPT A TRANSFER TO TREATMENT OR DIRECT REFERRAL TO TREATMENT PRI OR TO DISCHARGE FROM THE EMERGENCY DEPARTMENT. GOAL STATUS EXCEEDED GOAL GOAL DESCRIPTION OFFER POST - DISCHARGE FOLLOW-UP AND ASSISTANCE TO PATIENTS WITH SUBSTANCE USE DISORDERS W HO REFUSED SERVICES WHILE IN THE EMERGENCY DEPARTMENTS. GOAL STATUS ONGOING GOAL DESCRIPTI ON RAISE AWARENESS: SUD IS PART OF MENTAL HEALTH AND MENTAL HEALTH ISSUES IN OUR BEHAVIORA L HEALTH PROGRAMS. GOAL STATUS ONGOING GOAL DESCRIPTION PROVIDE SUPPORT FOR SAFE OPPORTUNI TIES FOR YOUTH IN BARNSTABLE COUNTY TO ENGAGE IN MEANINGFUL ACTIVITIES INCLUDING PHYSICAL ACTIVITIES AND MENTORSHIP. GOAL STATUS ONGOING GOAL DESCRIPTION PROVIDE SUPPORT FOR RECOVE RY SERVICES IN THE COMMUNITY FOR PATIENTS WITH SUBSTANCE USE DISORDERS. GOAL STATUS ONGOIN G PARTNER NAME, DESCRIPTION AND WEB ADDRESS GOSNOLD, INC. - RECOVERY SPECIALISTS - WWW.GOS NOLD.ORG BARNSTABLE COUNTY REGIONAL SUBSTANCE USE COUNCIL - WWW.BCHUMANSERVICES.NET/INITIA TIVES/REGIONAL-SUBSTANCE-USE-COUNCIL/ OUTER CAPE HEALTH SERVICES - OFFICE BASED ADDICTION TREATMENT - WWW.OUTERCAPE.ORG DUFFY HEALTH CENTER - RECOVERY COACH / NAVIGATOR PROGRAM - W WW.DUFFYHEALTHCENTER.ORG BIG BROTHERS BIG SISTERS - MENTORING PROGRAM FOR CHILDREN AT RISK FOR SUBSTANCE USE DISORDER - HTTPS://EMASSBIGS.ORG/CAPE-COD/ PAUSE A WHILE - PROVIDING AC CESS TO LONG TERM TREATMENT FOR SUD AS A COMPONENT OF THE TREATMENT FOR AND ITS RELATED IM PACT ON PHYSICAL WELLNESS - HTTPS://PAUSEAWHILE.ORG/ PROGRAM DESCRIPTION - CAPE COD HEALTH CARE HAS IDENTIFIED A SIGNIFICANT NEED FOR SUBSTANCE USE DISORDER PREVENTION AND TREATMENT IN OUR COMMUNITY. THROUGH A VARIETY OF PROGRAMS AND PARTNERSHIPS, CCHC HAS MADE A COMMITM ENT TO DIRECT RESOURCES TOWARDS THIS COMMUNITY HEALTH ISSUE. PROGRAMS INCLUDE: - CAPE COD HOSPITAL AND FALMOUTH HOSPITAL PARTNERED WITH GOSNOLD, INC. TO PROVIDE PEER-LED RECOVERY S PECIALIST SERVICES IN THE EMERGENCY DEPARTMENTS AT BOTH HOSPITALS. RECOVERY SPECIALISTS HA VE THE LIVED EXPERIENCE OF ADDICTION AND RECOVERY AND ENGAGE PATIENTS WITH SUBSTANCE USE D ISORDERS PRIOR TO DISCHARGE FROM THE EMERGENCY DEPARTMENTS. RECOVERY SPECIALISTS WORK AS P ART OF THE HOSPITAL CARE TEAM WITH THE OBJECTIVE TO MOTIVATE PATIENTS TO ACCEPT TREATMENT FOR SUBSTANCE USE DISORDERS THROUGH A TRANSFER TO AN INPATIENT TREATMENT PROGRAM OR DIRECT REFERRALS TO OUTPATIENT TREATMENT PROGRAMS. - INVESTMENTS IN PREVENTION PROGRAMS INCLUDIN G MENTORING FOR AT RISK YOUTH - INNOVATIVE TREATMENTS INCLUDING OFFICE BASED ADDICTION TRE ATMENT - SUPPORT SERVICES TO MEET COMMUNITY MEMBERS WHERE THEY ARE, INCLUDING MATERNITY DE PARTMENT TOURS FOR MOTHERS EXPERIENCING SUBSTANCE USE DISORDER. SUPPORT TO FEDERALLY QUALI FIED HEALTH CENTERS . PROGRAM

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GOAL DESCRIPTION	TYPE: ACCESS/COVERAGE SUPPORTS. . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUT SIDE ORGANIZATION: YES . PROGRAM HASHTAGS: COMMUNITY HEALTH CENTER PARTNERSHIP . EOHHS FOC US ISSUE (S) (OPTIONAL): MENTAL ILLNESS AND MENTAL HEALTH. . DON HEALTH PRIORITIES (OPTIONA L): BUILT ENVIRONMENT, SOCIAL ENVIRONMENT. . HEALTH ISSUES: HEALTH BEHAVIORS/MENTAL HEALTH -MENTAL HEALTH, INFECTIOUS DISEASES, COVID-19, OTHER-DENTAL HEALTH, OTHER-SENIOR HEALTH CH ALLENGES/CARE COORDINATION, SOCIAL DETERMINANTS OF HEALTH-ACCESS TO HEALTH CARE, SOCIAL DE TERMINANTS OF HEALTH-HOMELESSNESS, SOCIAL DETERMINANTS OF HEALTH-UNINSURED/UNDERINSURED, S UBSTANCE ADDICTION-SUBSTANCE USE. . TARGET POPULATION: REGIONS SERVED: BARNSTABLE - ENVIRO NMENTS SERVED: ALL GENDER: ALL AGE GROUP: ALL RACE/ETHNICITY: ALL LANGUAGE: ALL - ADDITION AL TARGET POPULATION STATUS: NOT SPECIFIED GOAL DESCRIPTION PROVIDE FUNDING SUPPORT TO THE FEDERALLY QUALIFIED HEALTH CENTERS PER PROPOSALS AND PRIORITIES SET BY EACH OF THE FOUR E NTITIES ON CAPE COD IN ALIGNMENT WITH CHNA 2020-2022. GOAL STATUS COMPLETE. CCHC WILL CONT INUE TO SUPPORT FQHCS IN BARNSTABLE COUNTY TO EXPAND THE CONTINUUM OF CARE AND INCREASE AC CESS TO SERVICES. PARTNER NAME, DESCRIPTION AND WEB ADDRESS HARBOR - JONES DENTAL - HTTPS: //WWW.HHSI.US/LOCATIONS/HARBOR-COMMUNITY-HEALTHCENTER-HYANNIS/ DUFFY - NAVIGATORS AND BEHA VIORAL HEALTH - HTTPS://WWW.DUFFYHEALTHCENTER.ORG/ OUTERCAPE HEALTH SERVICES - COMMUNITY N AVIGATORS - HTTPS://OUTERCAPE.ORG/ PROGRAM DESCRIPTION - CAPE COD HEALTHCARE COMMUNITY BEN EFITS PROVIDES SUPPORT TO FEDERALLY QUALIFIED HEALTH CENTERS ON CAPE COD TO INCREASE HEALT HCARE ACCESS TO THOSE WHO ARE UN- OR UNDERINSURED. PROGRAMS ALIGN WITH THE PRIORITIES IDEN TIFIED IN THE 2020-2022 CHNA. CCHC CANCER SUPPORT SERVICES AND SURVIVORSHIP ACTIVITIES . P ROGRAM TYPE: DIRECT CLINICAL SERVICES. . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUTSIDE ORGANIZATION: YES . PROGRAM HASHTAGS: COMMUNITY EDUCATION, HEALTH SCREENING, P REVENTION, SUPPORT GROUP. . EOHHS FOCUS ISSUE(S) (OPTIONAL): CHRONIC DISEASE WITH FOCUS ON CANCER, HEART DISEASE, AND DIABETES. . DON HEALTH PRIORITIES (OPTIONAL): EDUCATION, SOCIA L ENVIRONMENT. . HEALTH ISSUES: CANCER-BREAST, CANCER-CERVICAL, CANCER-COLORECTAL, CANCER- LUNG, CANCER-MULTIPLE MYELOMA, CANCER-OTHER, CANCER-OVARIAN, CANCER-PROSTATE, CANCER-SKIN, HEALTH BEHAVIORS/MENTAL HEALTH-DEPRESSION, OTHER-HOSPICE, SOCIAL DETERMINANTS OF HEALTH-A CCESS TO HEALTH CARE, SOCIAL DETERMINANTS OF HEALTH-ACCESS TO HEALTHY FOOD, SOCIAL DETERMI NANTS OF HEALTH-ACCESS TO TRANSPORTATION, SOCIAL DETERMINANTS OF HEALTH-EDUCATION/LEARNING , SOCIAL DETERMINANTS OF HEALTH-NUTRITION, SOCIAL DETERMINANTS OF HEALTH-UNINSURED/UNDERIN SURED. . TARGET POPULATION: REGIONS SERVED: COUNTY-BARNSTABLE - ENVIRONMENTS SERVED: ALL G ENDER: ALL AGE GROUP: ALL RACE/ETHNICITY: ALL LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STATUS: NOT SPECIFIED GOAL DESCRIPTION ONCOLOGY SOCIAL WORKERS WILL PROVIDE PSYCHO-SOCIAL SUPPORT TO OVER 3,000 PATIENT

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GOAL DESCRIPTION	S. TIMEFRAME: YEAR 1 OF 3 GOAL STATUS EXCEEDED GOAL. GOAL DESCRIPTION SUPPORT GROUPS WILL BE PROVIDED TO PATIENTS AND FAMILIES. TIMEFRAME: YEAR 1 OF 3 GOAL STATUS ALTHOUGH COVID IM PACTED NUMBERS, THIS GOAL WAS MET. GOAL DESCRIPTION CCHC WILL OFFER AN ONCOLOGY NUTRITION PROGRAM TO IMPROVE PATIENTS' QUALITY OF LIFE AND OUTCOMES. TIMEFRAME: YEAR 1 OF 3 GOAL STA TUS GOAL ACHIEVED. PARTNER NAME, DESCRIPTION AND WEB ADDRESS AMERICAN CANCER SOCIETY - WWW .CANCER.ORG/ABOUT-US/LOCAL/MASSACHUSETTS.HTML YMCA CAPE COD LIVESTRONG - WWW.YMCACAPECOD.O RG/PROGRAMS/HEALTH-WELLBEING/LIVESTRONG/ CAPE WELLNESS COLLABORATIVE - WWW.CAPEWELLNESS.OR G/ VISITING NURSE ASSOCIATION OF CAPE COD - WWW.VNACAPECOD.ORG TEAM MAUREEN - WWW.TEAMMAUR EEN.ORG BOSTON CANCER SUPPORT - WWW.BOSTONCANCERSUPPORT.ORG PROGRAM DESCRIPTION - CCHC CAN CER SUPPORT SERVICES PROVIDES ONCOLOGY PATIENTS AND THEIR FAMILIES' PSYCHOLOGICAL AND SOCI AL SUPPORT DURING THEIR TREATMENT JOURNEY. A TEAM OF ONCOLOGY SOCIAL WORKERS PROVIDE ONGOI NG COUNSELING AND SUPPORT GROUPS AND DIRECT REFERRALS TO SERVICES SUCH AS TRANSPORTATION, HOME CARE, AND COMMUNITY-BASED WELLNESS SERVICES SUCH AS REIKI, ACUPUNCTURE AND MASSAGE. S ERVICES INCLUDE AN ONCOLOGY NUTRITION PROGRAM AND THE LIVING FIT FOR YOU! CANCER WELLNESS PROGRAM. CANCER SURVIVORSHIP IS CELEBRATED, SUPPORTED AND RECOGNIZED WITHIN HOSPITAL DEPAR TMENTS AND IN THE COMMUNITY. CCHC ALSO OFFERS SPECIAL FINANCIAL NAVIGATORS IN THE CANCER C ENTERS SPECIALLY TRAINED IN CANCER TREATMENT EXPENSES.

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HEALTH EDUCATION	. PROGRAM TYPE: TOTAL POPULATION OR COMMUNITY-WIDE INTERVENTIONS. . PROGRAM IS PART OF A G RANT OR FUNDING PROVIDED TO AN OUTSIDE ORGANIZATION: NO . PROGRAM HASHTAGS: COMMUNITY EDUC ATION, PREVENTION. . EOHHS FOCUS ISSUE(S) (OPTIONAL): CHRONIC DISEASE WITH FOCUS ON CANCER , HEART DISEASE, AND DIABETES, MENTAL ILLNESS AND MENTAL HEALTH. . DON HEALTH PRIORITIES (OPTIONAL): EDUCATION. . HEALTH ISSUES: CANCER-BREAST, CANCER-CERVICAL, CANCER-COLORECTAL, CANCER-LUNG, CANCER-MULTIPLE MYELOMA, CANCER-OTHER, CANCER-OVARIAN, CANCER-PROSTATE, CANCE R-SKIN, CHRONIC DISEASE-ALZHEIMER'S DISEASE, CHRONIC DISEASE-CARDIAC DISEASE, CHRONIC DISE ASE-DIABETES, CHRONIC DISEASE-HYPERTENSION, CHRONIC DISEASE-OVERWEIGHT AND OBESITY, CHRONI C DISEASE-PULMONARY DISEASE, CHRONIC DISEASE-STROKE, HEALTH BEHAVIORS/MENTAL HEALTH-BEREAV EMENT, HEALTH BEHAVIORS/MENTAL HEALTH-DEPRESSION, HEALTH BEHAVIORS/MENTAL HEALTH-IMMUNIZAT ION, HEALTH BEHAVIORS/MENTAL HEALTH-MENTAL HEALTH, HEALTH BEHAVIORS/MENTAL HEALTH-PHYSICAL ACTIVITY, HEALTH BEHAVIORS/MENTAL HEALTH-STRESS MANAGEMENT, INFECTIOUS DISEASES, COVID-19 , INJURY-HOME INJURIES, MATERNAL/CHILD HEALTH-PARENTING SKILLS, MATERNAL/CHILD HEALTH-REPR ODUCTIVE AND MATERNAL HEALTH, OTHER-SENIOR HEALTH CHALLENGES/CARE COORDINATION, SOCIAL DET ERMINANTS OF HEALTH-ACCESS TO HEALTH CARE, SOCIAL DETERMINANTS OF HEALTH-EDUCATION/LEARNIN G. . TARGET POPULATION: REGIONS SERVED: BARNSTABLE - ENVIRONMENTS SERVED: ALL GENDER: ALL AGE GROUP: ALL RACE/ETHNICITY: ALL LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STATUS: NO T SPECIFIED GOAL DESCRIPTION AT CAPE COD HOSPITAL AND FALMOUTH HOSPITAL, HEALTH EDUCATION AND OUTREACH ACTIVITIES ARE OFFERED TO THE COMMUNITY ACROSS A NUMBER OF DIFFERENT HEALTH A REAS. FROM MATERNITY DEPARTMENT TOURS AND NEW PARENTING CLASSES, TO COMMUNITY-BASED DIABET ES AND STROKE EDUCATION, FALL PREVENTION CLASSES, AND ADVANCE CARE PLANNING PRESENTATIONS, THE HOSPITALS DEDICATE CLINICAL STAFF AND RESOURCES TO SUPPORT THE EDUCATION AND HEALTH L ITERACY OF BARNSTABLE COUNTY RESIDENTS. TIMEFRAME: YEAR 1 OF 3 GOAL STATUS EDUCATIONAL OFF ERINGS ARE ONGOING. DUE TO COVID-RELATED RESTRICTIONS, MANY OFFERINGS PIVOTED TO VIRTUAL E VENTS. STAFF IS READY TO CONTINUE WITH IN-PERSON OFFERINGS WHEN APPROPRIATE. PARTNER NAME, DESCRIPTION AND WEB ADDRESS AMERICAN CANCER SOCIETY - WWW.CANCER.ORG VISITING NURSES ASSO CIATION OF CAPE COD - WWW.VNACAPECOD.ORG PROGRAM DESCRIPTION - AT CAPE COD HOSPITAL AND FA LMOUTH HOSPITAL, HEALTH EDUCATION AND OUTREACH ACTIVITIES ARE OFFERED TO THE COMMUNITY ACR OSS A NUMBER OF DIFFERENT HEALTH AREAS. FROM MATERNITY DEPARTMENT TOURS, BREASTFEEDING AND NEW PARENTING CLASSES, TO COMMUNITY-BASED DIABETES, AND STROKE EDUCATION, THE HOSPITALS D EDICATE CLINICAL STAFF AND RESOURCES TO SUPPORT THE EDUCATION AND HEALTH LITERACY OF BARNS TABLE COUNTY RESIDENTS. THIS YEAR WE ALSO ENGAGED IN AWARENESS CAMPAIGNS ON ISSUES RELATED TO WOMEN'S HEALTH, HEART HEALTH, AND COVID-19. POPULAR PROGRAMS THIS YEAR INCLUDED AN ADV ANCED CARE PLANNING PRESENTATI

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HEALTH EDUCATION	ON, COMMUNITY EDUCATION ON GENETIC TESTING AND CANCER SCREENINGS AND VARIOUS BEHAVIORAL HE ALTH COMMUNITY EDUCATION EVENTS. COMMUNITY-BASED INTERPRETER SERVICES . PROGRAM TYPE: ACCE SS/COVERAGE SUPPORTS. . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUTSIDE ORGAN IZATION: YES . PROGRAM HASHTAGS: HEALTH PROFESSIONAL/STAFF TRAINING. . EOHHS FOCUS ISSUE(S) (OPTIONAL): CHRONIC DISEASE WITH FOCUS ON CANCER, HEART DISEASE, AND DIABETES, HOUSING S TABILITY/HOMELESSNESS, MENTAL ILLNESS AND MENTAL HEALTH, SUBSTANCE USE DISORDERS,. . DON H EALTH PRIORITIES (OPTIONAL): BUILT ENVIRONMENT, SOCIAL ENVIRONMENT. . HEALTH ISSUES: CANCE R-BREAST, CANCER-CERVICAL, CANCER-COLORECTAL, CANCER-LUNG, CANCER-MULTIPLE MYELOMA, CANCER -OTHER, CANCER-OVARIAN, CANCER-PROSTATE, CANCER-SKIN, CHRONIC DISEASE-ALZHEIMER'S DISEASE, CHRONIC DISEASE-ARTHRITIS, CHRONIC DISEASE-ASTHMA/ALLERGIES, CHRONIC DISEASE-CARDIAC DISE ASE, CHRONIC DISEASE-CHRONIC PAIN, CHRONIC DISEASE-COLITIS/CROHN'S DISEASE, CHRONIC DISEAS E-DIABETES, CHRONIC DISEASE-HYPERTENSION, CHRONIC DISEASE-OSTEOPOROSIS, CHRONIC DISEASE-OV ERWEIGHT AND OBESITY, CHRONIC DISEASE-PULMONARY DISEASE, CHRONIC DISEASE-SICKLE CELL DISEA SE, CHRONIC DISEASE-STROKE, HEALTH BEHAVIORS/MENTAL HEALTH-BEREAVEMENT, HEALTH BEHAVIORS/M ENTAL HEALTH-DEPRESSION, HEALTH BEHAVIORS/MENTAL HEALTH-IMMUNIZATION, HEALTH BEHAVIORS/MEN TAL HEALTH-MENTAL HEALTH, HEALTH BEHAVIORS/MENTAL HEALTH-PHYSICAL ACTIVITY, HEALTH BEHAVIO RS/MENTAL HEALTH-RESPONSIBLE SEXUAL BEHAVIOR, HEALTH BEHAVIORS/MENTAL HEALTH-STRESS MANAGE MENT, INFECTIOUS DISEASE-HEPATITIS, INFECTIOUS DISEASE-HIV/AIDS, INFECTIOUS DISEASE-LYME D ISEASE, INFECTIOUS DISEASE-SEXUALLY TRANSMITTED DISEASES, INFECTIOUS DISEASE-TUBERCULOSIS, INJURY-AUTO/PASSENGER INJURIES, INJURY-FIRST AID/ACLS/CPR, INJURY-HOME INJURIES, INJURY-O THER, INJURY-SPORTS INJURIES, MATERNAL/CHILD HEALTH-CHILD CARE, MATERNAL/CHILD HEALTH-FAMI LY PLANNING, MATERNAL/CHILD HEALTH-MENOPAUSE, MATERNAL/CHILD HEALTH-PARENTING SKILLS, MATE RNAL/CHILD HEALTH-REPRODUCTIVE AND MATERNAL HEALTH, OTHER-CULTURAL COMPETENCY, OTHER-DENTA L HEALTH, OTHER-EMERGENCY PREPAREDNESS, OTHER-HEARING, OTHER-HOSPICE, OTHER-SENIOR HEALTH CHALLENGES/CARE COORDINATION, OTHER-VISION, SOCIAL DETERMINANTS OF HEALTH-ACCESS TO HEALTH CARE, SOCIAL DETERMINANTS OF HEALTH-ACCESS TO HEALTHY FOOD, SOCIAL DETERMINANTS OF HEALTH -ACCESS TO TRANSPORTATION, SOCIAL DETERMINANTS OF HEALTH-AFFORDABLE HOUSING, SOCIAL DETERM INANTS OF HEALTH-DOMESTIC VIOLENCE, SOCIAL DETERMINANTS OF HEALTH-EDUCATION/LEARNING, SOCI AL DETERMINANTS OF HEALTH-ENVIRONMENTAL QUALITY, SOCIAL DETERMINANTS OF HEALTH-HOMELESSNES S, SOCIAL DETERMINANTS OF HEALTH-INCOME AND POVERTY, SOCIAL DETERMINANTS OF HEALTH-LANGUAG E/LITERACY, SOCIAL DETERMINANTS OF HEALTH-NUTRITION, SOCIAL DETERMINANTS OF HEALTH-PUBLIC SAFETY, SOCIAL DETERMINANTS OF HEALTH-RACISM AND DISCRIMINATION, SOCIAL DETERMINANTS OF HE ALTH-UNINSURED/UNDERINSURED, SOCIAL DETERMINANTS OF HEALTH-VIOLENCE AND TRAUMA, SUBSTANCE ADDICTION-ALCOHOL USE, SUBSTAN

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HEALTH EDUCATION	CE ADDICTION-DRIVING UNDER THE INFLUENCE, SUBSTANCE ADDICTION-OPIOID USE, SUBSTANCE ADDICT ION-SMOKING/TOBACCO USE, SUBSTANCE ADDICTION-SUBSTANCE USE. . TARGET POPULATION: REGIONS S ERVED: COUNTY-BARNSTABLE - ENVIRONMENTS SERVED: ALL GENDER: ALL AGE GROUP: ALL RACE/ETHNIC ITY: ALL LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STATUS: NOT SPECIFIED.

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GOAL DESCRIPTION	ASSIST MORE THAN 800 INDIVIDUALS WITH FREE MEDICAL INTERPRETERS IN COMMUNITY-BASED PRIMARY CARE AND SPECIALTY CARE SETTINGS. GOAL STATUS WE CONTINUED TO ASSIST INDIVIDUALS WITH FRE E INTERPRETER SERVICES, ALTHOUGH NUMBERS ARE DOWN THIS YEAR DUE TO COVID. GOAL DESCRIPTION ANALYZE PROGRAM UTILIZATION DATA TO ASSESS REGIONAL MEDICAL INTERPRETATION NEEDS FOR PROG RAM EVALUATION. GOAL STATUS COMPLETED. GOAL DESCRIPTION REACH MORE AREAS THROUGHOUT THE CA PE BY IMPLEMENTING A VIDEO INTERPRETER PROGRAM GOAL STATUS COMPLETED: IMPLEMENTED 10 VIDEO REMOTE UNITS TO ENSURE THAT LIMITED SPEAKING PATIENTS HAVE BETTER ACCESS FOR AN INTERPRET ER PARTNER NAME, DESCRIPTION AND WEB ADDRESS COMMUNITY BASED MEDICAL OFFICES ON CAPE COD - VARIOUS HARBOR COMMUNITY HEALTH CENTER HYANNIS - WWW.HHSI.US/CAPE-COD/HARBOR-COMMUNITY-HE ALTH-CENTERHYANNIS/ COMMUNITY BASED MEDICAL OFFICES ON CAPE COD - VARIOUS OFFICE OF MULTIC ULTURAL AFFAIRS - DPH - HTTPS://WWW.MASS.GOV/OREI PROGRAM DESCRIPTION - CCHC PROVIDES FREE MEDICAL LANGUAGE INTERPRETERS TO COMMUNITY-BASED PHYSICIAN OFFICES AND HOSPITALS TO ASSIS T LIMITED AND NON-ENGLISH SPEAKING PATIENTS AND THEIR FAMILIES. THE AVAILABILITY OF PROFIC IENT AND PROFESSIONAL INTERPRETER SERVICES ENSURES THE DELIVERY OF SAFE, QUALITY HEALTH CA RE AND POSITIVE CLINICAL OUTCOMES. CHILDREN'S COVE PARTNERSHIP . PROGRAM TYPE: DIRECT CLIN ICAL SERVICES. . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUTSIDE ORGANIZATION : NO . PROGRAM HASHTAGS: HEALTH PROFESSIONAL/STAFF TRAINING. . EOHHS FOCUS ISSUE(S) (OPTIO NAL): VIOLENCE. . DON HEALTH PRIORITIES (OPTIONAL): HEALTH BEHAVIORS/MENTAL HEALTH-DEPRESS ION, HEALTH BEHAVIORS/MENTAL HEALTH-MENTAL HEALTH, INJURY-HOME INJURIES, SOCIAL DETERMINAN TS OF HEALTH-VIOLENCE AND TRAUMA,. . TARGET POPULATION: REGIONS SERVED: BARNSTABLE - ENVIR ONMENTS SERVED: ALL GENDER: ALL AGE GROUP: CHILDREN, INFANTS, TEENAGERS RACE/ETHNICITY: AL L, HYANNIS LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STATUS: DOMESTIC VIOLENCE HISTORY GOAL DESCRIPTION THE NURSE PRACTITIONER WILL: PROVIDE AN ONSITE VISUAL MEDICAL EXAM IN A C HILD-FRIENDLY SETTING ENSURE THE HEALTH AND SAFETY OF CHILD THROUGH A NON-INVASIVE EXAM "U SING A DO NO HARM APPROACH" IDENTIFY, EDUCATE AND PROVIDE REFERRALS FOR INSTANCES OF SEXUA LLY TRANSMITTED INFECTIONS AND/OR PREGNANCY PHOTO-DOCUMENT AND COLLECT EVIDENCE IF INDICAT ED. SUPPORT THE CHILD IN THEIR WELLNESS. GOAL STATUS ALL MEDICAL EXAMS ARE COMPLETED PRIVA TELY AT CHILDREN'S COVE AND WITH PARENTAL PERMISSION. CHILDREN ARE ALWAYS TREATED WITH DIG NITY AND RESPECT, AND THE FOCUS OF THE EXAM IS TO SUPPORT THE CHILD IN THEIR WELLNESS. DUR ING THE EXAM, THE NURSE PRACTITIONER DOES NOT: USE ANY INVASIVE TOOLS CAUSE ANY PAIN INTER VIEW THE CHILD SPECULATE IF ANYTHING DID OR DID NOT HAPPEN. PARTNER NAME, DESCRIPTION AND WEB ADDRESS CHILDREN'S COVE - HTTP://WWW.CHILDRENSCOVE.ORG PROGRAM DESCRIPTION - FUNDING F OR A SPECIALTY TRAINED NURSE PRACTITIONER TO PROVIDE A NON-INVASIVE PHYSICAL EXAM TO CHILD VICTIMS OF ABUSE AND SEXUAL A

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GOAL DESCRIPTION	SSAULT. AFTER A CHILD HAS MADE THE BRAVE CHOICE TO DISCLOSE THEIR ABUSE THERE IS OFTEN THE QUESTION "IS MY BODY OK?" WE WANT TO ALLEVIATE SOME OF THE STRESS FROM A CHILD AND CAREGI VERS MIND. BECAUSE OF THAT WE HAVE PARTNERED WITH CHILDREN'S COVE AND THE MASSACHUSETTS PE DIATRIC SEXUAL ASSAULT NURSE EXAMINER PROGRAM (PEDISANE) TO HAVE A SPECIALLY TRAINED NURSE PRACTITIONER ON STAFF TO ENSURE THE BEST HEALTH AND WELFARE OF THE CHILD. ALSO INCLUDED I S THE COST OF LAB TESTING SERVICES FOR THESE PATIENTS. MENTAL HEALTH SERVICES IN THE COMMU NITY . PROGRAM TYPE: DIRECT CLINICAL SERVICES. . PROGRAM IS PART OF A GRANT OR FUNDING PRO VIDED TO AN OUTSIDE ORGANIZATION: NO . PROGRAM HASHTAGS: COMMUNITY EDUCATION, COMMUNITY HE ALTH CENTER PARTNERSHIP, HEALTH PROFESSIONAL/STAFF TRAINING. . EOHHS FOCUS ISSUE(S) (OPTIO NAL): MENTAL ILLNESS AND MENTAL HEALTH. . DON HEALTH PRIORITIES (OPTIONAL): SOCIAL ENVIRON MENT. . HEALTH ISSUES: HEALTH BEHAVIORS/MENTAL HEALTH-BEREAVEMENT, HEALTH BEHAVIORS/MENTAL HEALTH-DEPRESSION, HEALTH BEHAVIORS/MENTAL HEALTH-MENTAL HEALTH, HEALTH BEHAVIORS/MENTAL HEALTH-STRESS MANAGEMENT. . TARGET POPULATION: REGIONS SERVED: BARNSTABLE - ENVIRONMENTS S ERVED: ALL GENDER: ALL AGE GROUP: ADULTS, CHILDREN, ELDERLY, TEENAGERS, RACE/ETHNICITY: AL L LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STATUS: NOT SPECIFIED. GOAL DESCRIPTION 90% OF PATIENTS SEEN BY THE DUFFY TEAM AT CAPE COD HOSPITAL CONNECT TO DUFFY SERVICES POST-DI SCHARGE. GOAL STATUS ACHIEVED. PARTNER NAME, DESCRIPTION AND WEB ADDRESS DUFFY HEALTH CENT ER - BRIDGE CLINIC PROGRAM - HTTPS://WWW.DUFFYHEALTHCENTER.ORG PROGRAM DESCRIPTION - CAPE COD HEALTHCARE BEHAVIORAL HEALTH PHYSICIANS AND CLINICIANS PROVIDE COMMUNITY-BASED MENTAL HEALTH SERVICES IN OUR REGION. THIS INCLUDES PSYCHIATRIC CONSULTS TO FIRST RESPONDERS, SER VING AS THE ON-CALL PSYCHIATRIST TO THE COMMUNITY, A BEHAVIORAL HEALTH COMMUNITY HELPLINE, AND THE BRIDGE CLINIC, WHICH CONNECTS PATIENTS IN INPATIENT TREATMENT WITH COMMUNITY SERV ICES. SHINE PROGRAM . PROGRAM TYPE: ACCESS/COVERAGE SUPPORTS. . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUTSIDE ORGANIZATION: YES . PROGRAM HASHTAGS: COMMUNITY EDUCATI ON, HEALTH PROFESSIONAL/STAFF TRAINING. . EOHHS FOCUS ISSUE(S) (OPTIONAL): N/A. . DON HEAL TH PRIORITIES (OPTIONAL): N/A. . HEALTH ISSUES: SOCIAL DETERMINANTS OF HEALTH-ACCESS TO HE ALTH CARE. . TARGET POPULATION: REGIONS SERVED: BARNSTABLE - ENVIRONMENTS SERVED: ALL GEND ER: ALL AGE GROUP: ELDERLY RACE/ETHNICITY: ALL, HYANNIS LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STATUS: NOT SPECIFIED. GOAL DESCRIPTION PROVIDE OVER 5,000 COUNSELING SESSIONS TO CAPE & ISLAND RESIDENTS. TIMEFRAME: YEAR 1 OF 3. GOAL STATUS EXCEEDED GOAL: IN FY20 SHI NE PROVIDED 6,197 COUNSELING SESSIONS RESULTING IN 4,513 COUNSELING HOURS. GOAL DESCRIPTIO N REACH 1500 RESIDENTS THROUGH COMMUNITY TRAININGS AND PRESENTATIONS. TIMEFRAME: YEAR 1 OF 3. GOAL STATUS EXCEEDED GOAL. PARTNER NAME, DESCRIPTION AND WEB ADDRESS BARNSTABLE COUNTY DEPARTMENT OF HEALTH & HUMAN

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Return Reference	Explanation
GOAL DESCRIPTION	SERVICES - HTTPS://WWW.BARNSTABLECOUNTYHEALTH.ORG/ PROGRAM DESCRIPTION - SHINE (SERVING TH E HEALTH INSURANCE NEEDS OF EVERYONE) PROVIDES FREE HEALTH INSURANCE INFORMATION, COUNSELI NG AND ASSISTANCE TO MEDICARE BENEFICIARIES. THESE COMMUNITY BENEFITS FUNDS ARE SPECIFICAL LY TARGETED TO HIRING PART TIME PROGRAM STAFF TO ASSIST THE PROGRAM MANAGER IN HANDLING TH E INCREASING NUMBER OF SENIORS SEEKING ASSISTANCE WITH MEDICARE ENROLLMENT, ESPECIALLY DUR ING THE SEVEN WEEKS OF OPEN ENROLLMENT (OCTOBER 15 -DECEMBER 7). SHINE ASSISTS HUNDREDS OF ADDITIONAL MEDICARE BENEFICIARIES IN BARNSTABLE COUNTY.

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ASSISTANCE PROGRAM FOR VULNERABLE POPULATIONS	. PROGRAM TYPE: ACCESS/COVERAGE SUPPORTS. . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUTSIDE ORGANIZATION: YES . PROGRAM HASHTAGS: HEALTH SCREENING, PREVENTION. . EOHHS FOCUS ISSUE(S) (OPTIONAL): CHRONIC DISEASE WITH FOCUS ON CANCER, HEART DISEASE, AND DIABE TES, HOUSING STABILITY/HOMELESSNESS, MENTAL ILLNESS AND MENTAL HEALTH, . DON HEALTH PRIORI TIES (OPTIONAL): SOCIAL DETERMINANTS OF HEALTH-ACCESS TO HEALTH CARE, SOCIAL DETERMINANTS OF HEALTH-ACCESS TO TRANSPORTATION, SOCIAL DETERMINANTS OF HEALTH-INCOME AND POVERTY. . TA RGET POPULATION: REGIONS SERVED: BARNSTABLE - ENVIRONMENTS SERVED: ALL GENDER: ALL AGE GRO UP: ALL RACE/ETHNICITY: ALL LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STATUS: NOT SPECI FIED. GOAL DESCRIPTION ASSIST PATIENTS WHO ARE UNABLE TO AFFORD OR ACCESS TRANSPORTATION T O ENSURE COMPLIANCE WITH THEIR DISCHARGE PLAN. TIMEFRAME: YEAR 1 OF 3. GOAL STATUS ACUITY/ LYFT AND VOUCHERS FOR LOCAL TAXI SERVICE USED AT BOTH HOSPITALS. GOAL DESCRIPTION ASSIST R ESIDENTS WHO ARE UNABLE TO AFFORD MEDICATIONS TO ENSURE COMPLIANCE WITH HOSPITAL DISCHARGE PLANNING. TIMEFRAME: YEAR 1 OF 3. GOAL STATUS ONGOING ASSISTANCE OCCURS THROUGH PHARMACIE S AT BOTH HOSPITALS GOAL DESCRIPTION ASSIST PATIENTS IN NEED WITH THEIR FINANCIAL QUESTION S AND NEEDS. TIMEFRAME: YEAR 1 OF 3. GOAL STATUS FINANCIAL COUNSELORS ARE AVAILABLE AT BOT H HOSPITALS. COUNSELORS ARE TRAINED IN THE SPECIFIC NEEDS OF THEIR DEPARTMENTS (EX. CANCER TREATMENT EXPENSES) PARTNER NAME, DESCRIPTION AND WEB ADDRESS CAPE COD HEALTHCARE PHARMAC IES AT CAPE COD HOSPITAL AND FALMOUTH HOSPITAL - HTTPS://WWW.CAPECODHEALTH.ORG/MEDICAL-SER VICES/PHARMACY/ ACUITY/LYFT - SCHEDULING & TRANSPORTATION - HTTPS://WWW.LYFT.COM/BLOG/POST S/RESEARCH-IMPROVING-ACCESS-TO-CARE-MEDICAID AMERICAN CANCER SOCIETY - HTTP://WWW.CANCER.O RG PROGRAM DESCRIPTION - IN AN EFFORT TO ASSIST LOW-INCOME AND VULNERABLE POPULATIONS, CAP E COD HOSPITAL AND FALMOUTH HOSPITAL PROVIDED VARIOUS SERVICES TO INCREASE ACCESS TO HEALT HCARE. THIS INCLUDES: - ACCESS TO TRANSPORTATION UPON DISCHARGE TO THOSE PATIENTS WITHOUT RESOURCES FOR TRANSPORTATION. - THE PRESCRIPTION ASSISTANCE PROGRAM: AN INITIATIVE OF CAPE COD HOSPITAL AND FALMOUTH HOSPITAL EMERGENCY, BEHAVIORAL HEALTH AND PHARMACY DEPARTMENTS AS A COMMUNITY BENEFIT ASSISTING UNINSURED, UNDER-INSURED AND FINANCIALLY DISADVANTAGED PA TIENTS WITH NO OTHER VIABLE MEANS TO PAY FOR MEDICATIONS UPON DISCHARGE FROM HOSPITAL FACI LITIES. THE ASSISTANCE PROGRAM FOR VULNERABLE POPULATIONS IS HIGHLY UTILIZED IN THE BEHAVI ORAL HEALTH CENTER, THE CANCER CENTERS, AND THE EMERGENCY DEPARTMENTS. - FINANCIAL COUNSEL ORS ASSIST PATIENTS WITH COMPLICATED MEDICAL BILLS AND CONNECT THOSE IN NEED TO COMMUNITY RESOURCES. WORKFORCE AND CAREER DEVELOPMENT INITIATIVES . PROGRAM TYPE: TOTAL POPULATION O R COMMUNITY-WIDE INTERVENTIONS. . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUT SIDE ORGANIZATION: NO . PROGRAM HASHTAGS: HEALTH PROFESSIONAL/STAFF TRAINING, MENTORSHIP/C AREER TRAINING/INTERNSHIP, PHY

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ASSISTANCE PROGRAM FOR VULNERABLE POPULATIONS	SICIAN/PROVIDER DIVERSITY, . EOHHS FOCUS ISSUE(S) (OPTIONAL): N/A. . DON HEALTH PRIORITIES (OPTIONAL): EDUCATION, EMPLOYMENT, SOCIAL ENVIRONMENT. . HEALTH ISSUES: SOCIAL DETERMINAN TS OF HEALTH-ACCESS TO HEALTH CARE, SOCIAL DETERMINANTS OF HEALTH-EDUCATION/LEARNING, SOCI AL DETERMINANTS OF HEALTH-INCOME AND POVERTY. . TARGET POPULATION: REGIONS SERVED: BARNSTA BLE - ENVIRONMENTS SERVED: ALL GENDER: ALL AGE GROUP: ADULTS, TEENAGERS, RACE/ETHNICITY: A LL LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STATUS: DISABILITY STATUS. GOAL DESCRIPTIO N CCHC STAFF IN VARIOUS DEPARTMENTS WILL PROVIDE CLINICAL OVERSIGHT AND SUPERVISION TO STU DENTS ENGAGED IN ALLIED HEALTH PROGRAMS AND VARIOUS JOB TRAINING INITIATIVES IN THE REGION . TIMEFRAME: YEAR 1 OF 3. GOAL STATUS COVID-19 RESTRICTIONS LIMITED STUDENT SUPERVISION OP PORTUNITIES THIS YEAR. GOAL DESCRIPTION CCHC WILL OFFER HIGH QUALITY AND DIVERSE TRAINING OPPORTUNITIES TO CLINICAL STAFF SERVING RESIDENTS OF BARNSTABLE COUNTY TO ENSURE RESIDENTS RECEIVE THE HIGHEST QUALITY HEALTHCARE. GOAL STATUS ALTHOUGH COVID-19 RESTRICTIONS REDUCE D THE NUMBER OF IN-PERSON TRAINING OPPORTUNITIES, TRAINING PROGRAMS PIVOTED TO VIRTUAL OFF ERINGS WHEN APPROPRIATE. PARTNER NAME, DESCRIPTION AND WEB ADDRESS THE RIVERVIEW SCHOOL - WWW.RIVERVIEWSCHOOL.ORG UPPER CAPE REGIONAL TECHNICAL SCHOOL - WWW.UPPERCAPETECH.COM/ CAPE COD COMMUNITY COLLEGE - HTTPS://WWW.CAPECOD.EDU/ DUFFY HEALTH CENTER - HTTP://WWW.DUFFYHE ALTHCENTER.ORG OUTER CAPE HEALTH - HTTP://WWW.OUTERCAPE.ORG HARBOR HEALTH CENTER - HTTPS:// /WWW.HHSI.US/LOCATION/CAPE-COD-SOUTH-SHORE-HEALTH-CENTERS/ COMMUNITY HEALTH CENTER OF CAPE COD - HTTPS://CHCOFCAPECOD.ORG/ PROGRAM DESCRIPTION - CCHC INVESTS IN PARTNERSHIPS WITH L OCAL HIGH SCHOOLS, VOCATIONAL SCHOOLS, COMMUNITY COLLEGES, AND ALLIED HEALTH PROGRAMS FOR JOB TRAINING AND SHADOWING AND INTERNSHIPS WITH HEALTH CARE PROVIDERS IN VARIOUS HOSPITAL DEPARTMENTS INCLUDING, BUT NOT LIMITED TO, PHLEBOTOMY, RADIOLOGY, BEHAVIORAL HEALTH, AND M ATERIALS MANAGEMENT. OUR EFFORTS CONTRIBUTED TO REGIONAL ECONOMIC DEVELOPMENT EFFORTS TO I NCREASE OPPORTUNITY FOR EDUCATIONAL ATTAINMENT AND PROVIDE EXPERIENCE FOR INDIVIDUALS TO O BTAIN STABLE, QUALITY, AND WELL-COMPENSATED JOBS IN OUR REGION. CCHC ALSO INVESTS IN TRAIN INGS FOR CLINICAL STAFF PRACTICING IN BARNSTABLE COUNTY. EXAMPLES INCLUDE CREDENTIALING FO R BARNSTABLE COUNTY'S FQHC MEDICAL STAFF, SPECIALTY TRAININGS SUCH AS "AGE SPECIFIC CONSID ERATIONS IN CARING FOR THE CANCER PATIENT,TECHNICAL TRAININGS SUCH AS "INTRA-AORTIC BALLOO N COUNTERPULSATION THERAPY." ADDITIONALLY, CCHC ENGAGES IN RECRUITMENT OF PROVIDERS FOR BA RNSTABLE COUNTY'S FQHCS, WHICH INCREASES ACCESS TO HEALTHCARE BY INCREASING THE NUMBER OF PROVIDERS AVAILABLE IN THE REGION. COMMUNITY LEADERSHIP IN HEALTHCARE . PROGRAM TYPE: COMM UNITY-CLINICAL LINKAGES. . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUTSIDE OR GANIZATION: NO . PROGRAM HASHTAGS: COMMUNITY EDUCATION, HEALTH PROFESSIONAL/STAFF TRAINING . . EOHHS FOCUS ISSUE(S) (OPTI

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Return Reference	Explanation
ASSISTANCE PROGRAM FOR VULNERABLE POPULATIONS	ONAL): CHRONIC DISEASE WITH FOCUS ON CANCER, HEART DISEASE, AND DIABETES, HOUSING STABILIT Y/HOMELESSNESS, MENTAL ILLNESS AND MENTAL HEALTH, SUBSTANCE USE DISORDERS. . DON HEALTH PR IORITIES (OPTIONAL): N/A. . HEALTH ISSUES: CANCER-BREAST, CANCER-CERVICAL, CANCER-COLORECT AL, CANCER-LUNG, CANCER-MULTIPLE MYELOMA, CANCER-OTHER, CANCER-OVARIAN, CANCER-PROSTATE, C ANCER-SKIN, CHRONIC DISEASE-ALZHEIMER'S DISEASE, HEALTH BEHAVIORS/MENTAL HEALTH-BEREAVEMEN T, HEALTH BEHAVIORS/MENTAL HEALTH-DEPRESSION, HEALTH BEHAVIORS/MENTAL HEALTH-IMMUNIZATION, HEALTH BEHAVIORS/MENTAL HEALTH-MENTAL HEALTH, HEALTH BEHAVIORS/MENTAL HEALTH-PHYSICAL ACT IVITY, HEALTH BEHAVIORS/MENTAL HEALTH-RESPONSIBLE SEXUAL BEHAVIOR, HEALTH BEHAVIORS/MENTAL HEALTH-STRESS MANAGEMENT, INFECTIOUS DISEASE?"COVID-19, INJURY-HOME INJURIES, INJURY-OTHE R, MATERNAL/CHILD HEALTH-CHILD CARE, MATERNAL/CHILD HEALTH-FAMILY PLANNING, MATERNAL/CHILD HEALTH-PARENTING SKILLS, MATERNAL/CHILD HEALTH-REPRODUCTIVE AND MATERNAL HEALTH, OTHER-SE NIOR HEALTH CHALLENGES/CARE COORDINATION, SOCIAL DETERMINANTS OF HEALTH-ACCESS TO HEALTH C ARE, SOCIAL DETERMINANTS OF HEALTH-AFFORDABLE HOUSING, SOCIAL DETERMINANTS OF HEALTH-HOMEL ESSNESS, SOCIAL DETERMINANTS OF HEALTH-UNINSURED/UNDERINSURED, SOCIAL DETERMINANTS OF HEAL TH-VIOLENCE AND TRAUMA, SUBSTANCE ADDICTION-ALCOHOL USE, SUBSTANCE ADDICTION-OPIOID USE, S UBSTANCE ADDICTION-SUBSTANCE USE. . TARGET POPULATION: REGIONS SERVED: BARNSTABLE, ENVIRON MENTS SERVED: ALL GENDER: ALL - AGE GROUP: ALL - RACE/ETHNICITY: ALL LANGUAGE: ALL - ADDIT IONAL TARGET POPULATION STATUS: NOT SPECIFIED.

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GOAL DESCRIPTION	CCHC STAFF WILL SERVE AS LEADERS FOR COMMUNITY COALITIONS AND INITIATIVES THAT ADDRESS NEE DS IDENTIFIED IN THE 2020-2022 CHNA. TIMEFRAME: YEAR 1 OF 3. GOAL STATUS ALTHOUGH SOME COA LITIONS PAUSED OPERATIONS DURING THE COVID-19 CRISIS, MANY CONTINUED TO WORK VIRTUALLY. CC HC STAFF CONTINUED IN THEIR ROLES ON VARIOUS BOARDS AND COALITIONS IN THE COMMUNITY. PARTN ER NAME, DESCRIPTION AND WEB ADDRESS ZERO SUICIDE INITIATIVE - HTTPS://ZEROSUICIDE.EDC.ORG / JML CARE CENTER - SKILLED NURSING FACILITY COORDINATION - HTTPS://WWW.CAPECODHEALTH.ORG/ LOCATIONS/PROFILE/JML-CARE-CENTER/ PROGRAM DESCRIPTION - CCHC STAFF ARE LEADERS IN OUR REG ION ON ISSUES RELATED TO COMMUNITY HEALTH AND WELLNESS. STAFF SERVE IN LEADERSHIP POSITION S ON A VARIETY OF COALITIONS AND INITIATIVES INCLUDING: THE ZERO SUICIDE INITIATIVE; VARIO US COALITIONS WORKING ON MENTAL HEALTH, WELLNESS AND SUBSTANCE USE; COUNTY-LEVEL BOARD AND COMMITTEE POSITIONS; REGIONAL NETWORK ON HOMELESSNESS; POSTPARTUM DEPRESSION TASK FORCE; AND COORDINATION BETWEEN SKILLED NURSING FACILITIES IN OUR AREA. CCHC STAFF ARE INSTRUMENT AL IN CREATING POLICY AND PROGRAMS TO SERVE THE HEALTH AND WELLNESS OF OUR COMMUNITY. SUPP ORT GROUPS AND COMMUNITY RESOURCES FOR WELLNESS . PROGRAM TYPE: DIRECT CLINICAL SERVICES. . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUTSIDE ORGANIZATION: NO . PROGRAM HASHTAGS: COMMUNITY EDUCATION, SUPPORT GROUP. . EOHHS FOCUS ISSUE(S) (OPTIONAL): CHRONIC D ISEASE WITH FOCUS ON CANCER, HEART DISEASE, AND DIABETES, MENTAL ILLNESS AND MENTAL HEALTH . . DON HEALTH PRIORITIES (OPTIONAL): BUILT ENVIRONMENT, EDUCATION, SOCIAL ENVIRONMENT. . HEALTH ISSUES: CANCER-BREAST, CHRONIC DISEASE-ALZHEIMER'S DISEASE, CHRONIC DISEASE-CARDIAC DISEASE, CHRONIC DISEASE-DIABETES, HEALTH BEHAVIORS/MENTAL HEALTH-BEREAVEMENT, HEALTH BEH AVIORS/MENTAL HEALTH-DEPRESSION, HEALTH BEHAVIORS/MENTAL HEALTH-MENTAL HEALTH, HEALTH BEHA VIORS/MENTAL HEALTH-STRESS MANAGEMENT, MATERNAL/CHILD HEALTH-CHILD CARE, MATERNAL/CHILD HE ALTH-FAMILY PLANNING, MATERNAL/CHILD HEALTH-PARENTING SKILLS, MATERNAL/CHILD HEALTH-REPROD UCTIVE AND MATERNAL HEALTH, OTHER-SENIOR HEALTH CHALLENGES/CARE COORDINATION,. . TARGET PO PULATION: REGIONS SERVED: BARNSTABLE, ENVIRONMENTS SERVED: ALL GENDER: ALL - AGE GROUP: AL L - RACE/ETHNICITY: ALL LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STATUS: NOT SPECIFIED . GOAL DESCRIPTION WORK WITH COMMUNITY STAKEHOLDERS AND PROVIDERS TO DETERMINE NEEDS FOR S UPPORT GROUPS AND MENTAL HEALTH WELLNESS SERVICES AND IMPLEMENT SERVICES IN A WAY THAT MAK ES THEM ACCESSIBLE TO THE ENTIRE COMMUNITY. TIMEFRAME: YEAR 1 OF 3. GOAL STATUS SUPPORT GR OUPS WERE IMPLEMENTED BASED ON FINDINGS FROM THE CHNA. GROUPS WERE ABLE TO PIVOT TO CONTIN UE TO OFFER SERVICES DESPITE THE COVID-19 CRISIS. PARTNER NAME, DESCRIPTION AND WEB ADDRES S VISITING NURSE ASSOCIATION OF CAPE COD - VNA -HTTPS://WWW.CAPECODHEALTH.ORG/ABOUT/VNA/ P ROGRAM DESCRIPTION - CAPE COD HEALTHCARE OFFERS A VARIETY OF SUPPORT GROUPS AND OTHER RESO URCES FOR MENTAL HEALTH AND WE

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GOAL DESCRIPTION	LLNESS IN OUR COMMUNITY. THESE INCLUDE HELPLINES FOR BEHAVIORAL HEALTH AND BREASTFEEDING H ELP, VARIOUS SUPPORT GROUPS FOR NEW PARENTS, SUPPORT GROUPS FOR VARIOUS DISEASES AND PHYSI CAL CONDITIONS, AND BEREAVEMENT SUPPORT GROUPS. THESE SERVICES NOT ONLY PROVIDE A SOCIAL S UPPORT SYSTEM THAT ENCOURAGES SHARING SIMILAR EXPERIENCES WITH THE GROUP, BUT ALSO ACTS AS A PLACE TO MEET PATIENTS WHERE THEY ARE AND REFER THEM TO ANY COMMUNITY SERVICES THEY MAY NEED. CONGESTIVE HEART FAILURE CLINIC . PROGRAM TYPE: DIRECT CLINICAL SERVICES. . PROGRAM IS PART OF A GRANT OR FUNDING PROVIDED TO AN OUTSIDE ORGANIZATION: NO . PROGRAM HASHTAGS: COMMUNITY EDUCATION, PREVENTION,. . EOHHS FOCUS ISSUE(S) (OPTIONAL): CHRONIC DISEASE WITH FOCUS ON CANCER, HEART DISEASE, AND DIABETES. . DON HEALTH PRIORITIES (OPTIONAL): BUILT E NVIRONMENT, EDUCATION. . HEALTH ISSUES: CHRONIC DISEASE-CARDIAC DISEASE,. . TARGET POPULAT ION: REGIONS SERVED: BARNSTABLE, ENVIRONMENTS SERVED: ALL GENDER: ALL - AGE GROUP: ADULTS, ELDERLY, - RACE/ETHNICITY: ALL, HYANNIS LANGUAGE: ALL - ADDITIONAL TARGET POPULATION STAT US: NOT SPECIFIED. GOAL DESCRIPTION PROVIDE THE NECESSARY MATERIALS FOR THIS DEPARTMENT TO BE COMPLIANT WITH THE PROPER PROCEDURES AND DISPOSAL OF SHARPS TO PATIENTS IN THE CONGEST IVE HEART FAILURE CLINIC. TIMEFRAME: YEAR 1 OF 3. GOAL STATUS ONGOING. GOAL DESCRIPTION KE EP HEART FAILURE PATIENTS OUT OF THE HOSPITAL. TIMEFRAME: YEAR 1 OF 3. GOAL STATUS ONGOING . GOAL DESCRIPTION MODIFY PATIENTS' RISK FACTORS FOR HEART FAILURE SYMPTOMS AND CHANGE THE COURSE OF THEIR DISEASE. TIMEFRAME: YEAR 1 OF 3. GOAL STATUS ONGOING. PARTNER NAME, DESCR IPTION AND WEB ADDRESS CAPE COD HEALTHCARE HEART FAILURE CLINIC - HTTPS://WWW.CAPECODHEALT H.ORG/MEDICAL-SERVICES/HEART-VASCULAR-CARE/CARDIOL OGY/HEART-FAILURE-CLINIC/ PROGRAM DESCR IPTION - CAPE COD HEALTHCARE HELPS THOSE DIAGNOSED WITH HEART FAILURE STAY ACTIVE AND AVOI D HOSPITALIZATION THROUGH THE HEART FAILURE CLINIC. THE COMMUNITY-BASED HEART FAILURE CLIN IC AT THE CARDIOVASCULAR CENTER IN HYANNIS, UNDER THE DIRECTION OF CARDIOLOGIST ELISSA THO MPSON, MD, IS A RESOURCE DESIGNED TO EDUCATE AND HELP PATIENTS MAINTAIN THE BEST POSSIBLE QUALITY OF LIFE AND MANAGE THEIR SYMPTOMS. THE HEART FAILURE CLINIC PROVIDES ACCESS TO A M ULTIDISCIPLINARY TEAM THAT INCLUDES A CARDIOLOGIST, NURSE PRACTITIONER, NUTRITIONIST, VISI TING NURSE AND PHARMACIST TO TREAT AND EDUCATE PATIENTS. ONCE REFERRED TO THE CLINIC BY TH EIR PRIMARY CARE PHYSICIAN, CARDIOLOGIST OR OTHER SPECIALIST, PATIENTS ARE OFFERED SAME-DA Y OR NEXT-DAY APPOINTMENTS, AS WELL AS SCHEDULED VISITS, TO MANAGE THE SYMPTOMS OF HEART F AILURE. THE CLINIC WORKS WITH PATIENTS AS WELL AS FAMILIES AND TEACHES THEM HOW TO LIVE WI TH THEIR ILLNESS. PATIENTS HAVE ONE-STOP ACCESS TO THE MULTIDISCIPLINARY TEAM. COMMUNITY B ENEFITS ALSO PROVIDED FUNDING FOR SHARPS COMPLIANCE TRAINING AND MATERIALS TO CAPE COD HEA LTHCARE'S CONGESTIVE HEART FAILURE CLINIC. CONTACT INFORMATION JENNIFER CUMMINGS 32 MAIN S T. HYANNIS, MA 02601 PHONE: 50

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Return Reference	Explanation
GOAL DESCRIPTION	8-862-7849

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Return Reference	Explanation
FUNCTIONAL EXPENSE NOTE	FORM 990, PART I AND PART IX FUNDRAISING IS CONDUCTED ON BEHALF OF CAPE COD HEALTHCARE, INC. BY CAPE COD HEALTHCARE FOUNDATION, INC. CERTAIN OFFICERS ARE COMPENSATED BY CAPE COD HEATHCARE, INC. FUNDS RAISED ARE REPORTED AT CAPE COD HEALTHCARE, INC. AND AFFILIATES.

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FORM 990, PART I, LINE 6	CAPE COD HEALTHCARE, INC.'S VOLUNTEERS INCLUDE ITS TRUSTEES.

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FORM 990, PART VI, LINE 2	TRUSTEES AND OFFICERS SIT ON THE BOARDS OF THE FOLLOWING: CAPE HEALTH INSURANCE COMPANY: MICHAEL K LAUF MICHAEL L CONNORS MICHAEL G JONES BRUCE JOHNSTON THE MEMBERS OF CAPE COD HEALTHCARE, INC.'S BOARD ALSO SIT ON THE BOARD OF CAPE COD MEDICAL OFFICE BUILDING, INC., A FOR-PROFIT RELATED ORGANIZATION.

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Return Reference	Explanation
FORM 990, PART VI, LINES 6 & 7 (A)	THE ORGANIZATION HAS MEMBERS/INCORPORATORS WHO ELECT THE ORGANIZATION'S TRUSTEES.

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FORM 990, PART VI, LINE 7(B)	THE DECISIONS OF THE GOVERNING BODY THAT NEED APPROVAL BY ITS MEMBERS/INCORPORATORS INCLUDE APPROVAL OF CHANGES MADE TO THE CORPORATION'S BYLAWS AND APPROVAL WHEN THERE IS A DIVESTING OF ONE OF THE MAJOR AFFILIATES OF THE ORGANIZATION.

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FORM 990, PART VI, LINE 11B	THE ORGANIZATION'S FORM 990 IS REVIEWED AT SEVERAL LEVELS. THE ORGANIZATION ENGAGES A PUBLIC ACCOUNTING FIRM TO ASSIST IN THE PREPARATION AND REVIEW OF ITS FORM 990 AND WHO SIGNS AS PAID PREPARER. SENIOR MANAGEMENT OF THE ORGANIZATION IS RESPONSIBLE FOR THE TIMELY PREPARATION OF FORM 990. THE COMPLETED FORM 990 IS PROVIDED TO THE FINANCE COMMITTEE AND THE ENTIRE BOARD IN ADVANCE OF THE FILING DEADLINE.

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FORM 990, PART VI, LINE 12	THE ORGANIZATION MAINTAINS A CONFLICT OF INTEREST POLICY AND REGULARLY AND CONSISTENTLY MONITORS AND ENFORCES COMPLIANCE WITH THIS POLICY. ON AN ANNUAL BASIS, EACH TRUSTEE, OFFICER AND EMPLOYEE AT THE SENIOR MANAGEMENT LEVEL COMPLETES A CONFLICT OF INTEREST DISCLOSURE FORM. THE FORMS ARE REVIEWED BY CAPE COD HEALTHCARE, INC.'S ("CCHC") DIRECTOR OF CLINICAL AND RESEARCH COMPLIANCE WHO PREPARES A SUMMARY FOR CCHC'S COMPLIANCE OFFICER. ANY MATERIAL INTERESTS SO DISCLOSED ARE PRESENTED TO THE CORPORATION'S GOVERNANCE COMMITTEE FOR REVIEW AND RESOLUTION. ALL DISCLOSURE STATEMENTS SUBMITTED BY EMPLOYEES WILL BE REVIEWED BY HUMAN RESOURCES AND/OR CCHC'S DIRECTOR OF CLINICAL AND RESEARCH COMPLIANCE. FOR ANY DISCLOSURE THAT IS CONSIDERED SUBSTANTIVE THE EMPLOYEE'S AREA MANAGER WILL BE CONSULTED TO DETERMINE IF THE SITUATION IS GENERALLY ACCEPTABLE, REQUIRES FURTHER EXAMINATION AND POSSIBLE ACTION OR IS GENERALLY NOT ACCEPTABLE. ANY ACTION PLAN CREATED TO MANAGE A CONFLICT OF INTEREST WILL BE MONITORED BY THE EMPLOYEE'S AREA MANAGER OR SUPERVISOR.

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Return Reference	Explanation
FORM 990, PART VI, LINE 15	THE ANNUAL PROCESS FOR DETERMINING COMPENSATION OF THE ORGANIZATION'S CEO, OFFICERS, EXECUTIVES AND KEY EMPLOYEES INCLUDE THE FOLLOWING: CEO - COMPENSATION WILL BE DETERMINED BY THE COMPENSATION COMMITTEE OF THE BOARD OF TRUSTEES, AND WILL INCLUDE CONSIDERATION OF RELEVANT MARKET DATA FURNISHED BY A DISINTERESTED COMPENSATION CONSULTANT, AND A REVIEW OF JOB PERFORMANCE. OFFICERS, EXECUTIVES AND KEY EMPLOYEES - OFFICER, EXECUTIVE AND KEY EMPLOYEE COMPENSATION WILL BE DETERMINED BY THE CEO AND WILL INCLUDE CONSIDERATION OF RECENT RELEVANT MARKET DATA FURNISHED BY A DISINTERESTED COMPENSATION CONSULTANT, AND A REVIEW OF JOB PERFORMANCE. THE CEO'S DETERMINATION OF SUCH COMPENSATION WILL BE SUBJECT TO THE APPROVAL OF THE COMPENSATION COMMITTEE OF THE BOARD OF TRUSTEES. THE PROCESS AND CONCLUSIONS ARE DOCUMENTED IN THE MEETING MINUTES.

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Return Reference	Explanation
FORM 990, PART VI, LINE 19	THE ORGANIZATION MAKES ITS BYLAWS, FINANCIAL STATEMENTS AND CONFLICT OF INTEREST POLICY AVAILABLE TO THE PUBLIC UPON REQUEST. THE ORGANIZATION'S FINANCIAL STATEMENTS ARE ALSO ATTACHED TO THE ANNUALLY FILED FORM PC, A PUBLICLY DISCLOSED TAX-EXEMPT ORGANIZATION FILING FOR THE STATE OF MASSACHUSETTS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VII, COLUMN (B)	THE INDIVIDUALS REPORTED AS RECEIVING COMPENSATION FROM A RELATED ORGANIZATION IN COLUMNS (E) AND (F) IN PART VII ARE EMPLOYEES AT CAPE COD HEALTHCARE, INC., A TAX-EXEMPT RELATED ORGANIZATION. FORM 990, PART VII, SECTION A THE FULL TITLE FOR BRUCE JOHNSTON IS TRUSTEE/TREASURER (UNTIL 5/20) AND TRUSTEE/CHAIR (AS OF 5/20) THE FULL TITLE FOR SHERYL DECILIO IS VICE PRESIDENT OF PATIENT FINANCIAL SERVICES & REVENUE CYCLE (AS OF 1/19) THE FULL TITLE FOR MICHAEL G. JONES, ESQ IS CLERK (UNTIL 5/20) AND SR VP & CHIEF LEGAL OFFICER THE FULL TITLE FOR ROBERT TALERMAN IS TRUSTEE (UNTIL 5/20), CLERK (AS OF 5/20) THE FULL TITLE FOR RAMANI AYER IS TRUSTEE (UNTIL 5/20), VICE CHAIR & TREASURER (AS OF 5/20)

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VII, SECTION B	WITH THE EXCEPTION OF REPORTING FOR VISITING NURSE ASSOCIATION OF CAPE COD, INC, CAPE COD HEALTHCARE, INC. PAYS INDEPENDENT CONTRACTORS ON BEHALF OF ITS AFFILIATES WHO FILE AS PART OF A GROUP FORM 990 AS CAPE COD HEALTHCARE, INC. AND AFFILIATES.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CHANGE IN VALUE SPLIT INTEREST AGREEMENT $ 85,752 CHANGE IN PERPETUAL TRUSTS $ 428,194 TRANSFERS TO/FROM AFFILIATES $ (50,329) NET ASSETS RELEASED FROM RESTRICTIONS $ (122,347) OTHER $ (14,581) ---------- OTHER CHANGES IN NET ASSETS $ 326,689 ==========

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
CAPE COD HEALTHCARE INC & AFFILIATES

Employer identification number
90-0054984

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
(1)CAPE COD HEALTHCARE INC 297 NORTH STREET BLDG 3 HYANNIS, MA 02601 22-2600704	PARENT CORP	MA	501(c) (3)	10	NA	Yes	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) CAPE AND ISLAND ENDOSCOPY CENTER 700 ATTUCKS LANE HYANNIS, MA 02601	ENDOSCOPY CENTER	MA	NA									

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1)CAPE HEALTH INSURANCE COMPANY PO BOX 1051GT GRAND CAYMAN CJ 98-1230418	INSURANCE	CJ	CAPE COD HLTHCR	C CORP	0	0			No
(2)CAPE COD MEDICAL OFFICE BUILDING INC 27 PARK STREET HYANNIS, MA 02601 04-2423073	RENTAL SRVCE	MA	NA	C CORP	0	15,000	100.000 %		No
(3)POOLED INCOME FUNDS (2)	SUPPORT	MA	NA						No
(4)CHARITABLE REMAINDER TRUSTS (20)	SUPPORT	MA	NA						No

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)CAPE HEALTH INSURANCE COMPANY	R	6,520,553	FMV

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate 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	

Part VII Supplemental Information

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

Return Reference	Explanation