



See a Social Security Number? Say Something!  
Report Privacy Problems to <https://public.resource.org/privacy>  
Or call the IRS Identity Theft Hotline at 1-800-908-4490



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.  
▶ Information about Form 990 and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2014**  
Open to Public  
Inspection**A For the 2014 calendar year, or tax year beginning****, and ending****B** Check if applicable:

- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/terminated
- ☐ Amended return
- ☐ Application pending

**C** Name of organization**COMMUNITY HOSPITAL OF ANACONDA**

## Doing business as

Number and street (or P.O. box if mail is not delivered to street address)

**401 W PENNSYLVANIA**

Room/suite

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

**ANACONDA****MT 59711****D** Employer identification number**81-0303913****E** Telephone number**406-563-8521****G** Gross receipts **39,893,777****F** Name and address of principal officer**JOHN S. MCNEECE, CEO****401 W PENNSYLVANIA****ANACONDA****MT 59711****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)

**I** Tax-exempt status☒ 501(c)(3)☐ 501(c) ( )

(insert no)

☐ 4947(a)(1) or☐ 527**J** Website:**WWW.COMMUNITYHOSPITALOFANACONDA.ORG****H(c)** Group exemption number ▶**K** Form of organization☒ Corporation☐ Trust☐ Association☐ Other ▶**L** Year of formation **1969****M** State of legal domicile **MT****Part I Summary**

<b>Activities &amp; Governance</b>	<b>1</b> Briefly describe the organization's mission or most significant activities <b>TO PROVIDE A CARING ENVIRONMENT, RESPONDING WITH EXCELLENCE TO THE HEALTH CARE NEEDS OF THOSE WE SERVE. RESPECTING THE DIGNITY AND RECOGNIZING THE WORTH OF EACH PERSON IS THE FOUNDATION OF OUR COMMITMENT TO CARE.</b>		
	<b>2</b> Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets		
	<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	<b>11</b>
	<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	<b>7</b>
	<b>5</b> Total number of individuals employed in calendar year 2014 (Part V, line 2a)	<b>5</b>	<b>408</b>
	<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	<b>65</b>
	<b>Revenue</b>	<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>
<b>b</b> Net unrelated business taxable income from Form 990-T, line 34		<b>7b</b>	<b>-7,920</b>
<b>8</b> Contributions and grants (Part VIII, line 1h)		<b>Prior Year</b>	<b>Current Year</b>
<b>9</b> Program service revenue (Part VIII, line 2g)		<b>597,744</b>	<b>1,561,313</b>
<b>Expenses</b>	<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	<b>35,584,623</b>	<b>38,242,246</b>
	<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	<b>34,563</b>	<b>20,557</b>
	<b>12</b> Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	<b>80,884</b>	<b>69,661</b>
	<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	<b>36,297,814</b>	<b>39,893,777</b>
	<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	<b>27,973</b>	<b>29,686</b>
	<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)		<b>0</b>
	<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	<b>19,244,098</b>	<b>22,072,356</b>
	<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶		<b>0</b>
	<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	<b>16,443,960</b>	<b>17,493,076</b>
	<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	<b>35,716,031</b>	<b>39,595,118</b>
<b>Net Assets or Fund Balances</b>	<b>19</b> Revenue less expenses. Subtract line 18 from line 12	<b>581,783</b>	<b>298,659</b>
	<b>20</b> Total assets (Part X, line 16)	<b>Beginning of Current Year</b>	<b>End of Year</b>
	<b>21</b> Total liabilities (Part X, line 26)	<b>28,916,203</b>	<b>37,881,071</b>
	<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	<b>14,051,117</b>	<b>22,465,241</b>
		<b>14,865,086</b>	<b>15,415,830</b>

**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.

<b>Sign Here</b>	<b>Signature of officer</b> <i>Laura Austin</i>	<b>Date</b> <b>11-16-15</b>
	<b>Type or print name and title</b> <b>LAURA AUSTIN</b> <b>V.P. OF FINANCE</b>	
<b>Paid Preparer Use Only</b>	<b>Print/Type preparer's name</b> <b>THOMAS DINGUS</b>	<b>Preparer's signature</b> <i>Thomas Dingus</i>
	<b>Date</b> <b>11/16/15</b>	<b>Check <input type="checkbox"/> if self-employed</b>
	<b>Firm's name</b> <b>DINGUS, ZARECOR &amp; ASSOCIATES, PLLC</b>	<b>Firm's EIN</b> <b>20-0079326</b>
	<b>Firm's address</b> <b>12015 E MAIN AVE</b> <b>SPOKANE VALLEY, WA 99206-6130</b>	<b>Phone no</b> <b>509-242-0874</b>

May the IRS discuss this return with the preparer shown above? (see instructions)

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

DAA

Form **990** (2014)

SCANNED DEC 21 2015

973

**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

**TO PROVIDE A CARING ENVIRONMENT, RESPONDING WITH EXCELLENCE TO THE HEALTH CARE NEEDS OF THOSE WE SERVE. RESPECTING THE DIGNITY AND RECOGNIZING THE WORTH OF EACH PERSON IS THE FOUNDATION OF OUR COMMITMENT TO CARE.**

**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 \$ **35,419,933** including grants of\$ ) (Revenue \$ **38,176,719** )

**COMMUNITY HOSPITAL OF ANACONDA IS COMPRISED OF A 25-BED CRITICAL ACCESS HOSPITAL AND A 62-BED NURSING HOME FACILITY WHICH PROVIDES HEALTH CARE SERVICES. THE HOSPITAL PROVIDED 4,861 DAYS OF INPATIENT ACUTE CARE SERVICES, 89,230 OUTPATIENT VISITS, 8,092 EMERGENCY ROOM/CONVENIENT CARE VISITS, AND 1,288 SURGERIES. THE NURSING HOME PROVIDED 20,585 DAYS OF RESIDENT SERVICES FOR THE YEAR ENDED DECEMBER 31, 2014. THE HOSPITAL PROVIDES CARE TO PERSONS COVERED BY GOVERNMENTAL PROGRAMS AT OR BELOW COST AND TO INDIVIDUALS WHO ARE UNABLE TO PAY. THE UNREIMBURSED CHARGES OF PROVIDING CARE TO THESE PATIENTS WAS \$512,641 FOR CHARITY CARE, \$13,690,482 FOR MEDICARE, \$3,128,235 FOR MEDICAID, AND \$7,695,742 FOR OTHER THIRD PARTY PAYORS FOR THE YEAR ENDED DECEMBER 31, 2014.**

**4b** (Code ) (Expenses \$ **29,686** including grants of\$ **29,686** ) (Revenue \$ )

**COMMUNITY HOSPITAL OF ANACONDA ALSO SPONSORS NUMEROUS YOUTH GROUPS AND ACTIVITIES WITHIN ITS COMMUNITY.**

**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 ► **35,449,619**

**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	<b>X</b>	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<b>X</b>	
<b>3</b> Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I		<b>X</b>
<b>4</b> <b>Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	<b>X</b>	
<b>5</b> Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III		<b>X</b>
<b>6</b> Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I		<b>X</b>
<b>7</b> Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II		<b>X</b>
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III		<b>X</b>
<b>9</b> Did the organization report an amount in Part X, line 21, 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		<b>X</b>
<b>10</b> Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V		<b>X</b>
<b>11</b> If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	<b>X</b>	
<b>b</b> Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII		<b>X</b>
<b>c</b> Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII		<b>X</b>
<b>d</b> Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX		<b>X</b>
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	<b>X</b>	
<b>f</b> Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	<b>X</b>	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	<b>X</b>	
<b>b</b> Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional		<b>X</b>
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E		<b>X</b>
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?		<b>X</b>
<b>b</b> Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV		<b>X</b>
<b>15</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV		<b>X</b>
<b>16</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV		<b>X</b>
<b>17</b> Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)		<b>X</b>
<b>18</b> Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II		<b>X</b>
<b>19</b> Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III		<b>X</b>
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	<b>X</b>	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<b>X</b>	

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

	Yes	No
<b>21</b> 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		<b>X</b>
<b>22</b> 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		<b>X</b>
<b>23</b> 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	<b>X</b>	
<b>24a</b> 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		<b>X</b>
<b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
<b>c</b> Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
<b>25a</b> <b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I		<b>X</b>
<b>b</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		<b>X</b>
<b>26</b> Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If "Yes," complete Schedule L, Part II		<b>X</b>
<b>27</b> Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III		<b>X</b>
<b>28</b> 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)		
<b>a</b> A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV	<b>X</b>	
<b>b</b> A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV	<b>X</b>	
<b>c</b> An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV	<b>X</b>	
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M		<b>X</b>
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M		<b>X</b>
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I		<b>X</b>
<b>32</b> Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II		<b>X</b>
<b>33</b> 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		<b>X</b>
<b>34</b> Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Parts II, III, or IV, and Part V, line 1	<b>X</b>	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)?	<b>X</b>	
<b>b</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	<b>X</b>	
<b>36</b> <b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2		<b>X</b>
<b>37</b> 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		<b>X</b>
<b>38</b> Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O	<b>X</b>	

**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
<b>1a</b>	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable		
<b>1b</b>	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable		
<b>1c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	<b>X</b>	
<b>2a</b>	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		
<b>2b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	<b>X</b>	
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year?	<b>X</b>	
<b>3b</b>	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O	<b>X</b>	
<b>4a</b>	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)?		<b>X</b>
<b>4b</b>	If "Yes," enter the name of the foreign country <b>▶</b> See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)		
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		<b>X</b>
<b>5b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		<b>X</b>
<b>5c</b>	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
<b>6a</b>	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?		<b>X</b>
<b>6b</b>	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
<b>7</b>	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
<b>7a</b>	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?		<b>X</b>
<b>7b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
<b>7c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		<b>X</b>
<b>7d</b>	If "Yes," indicate the number of Forms 8282 filed during the year		
<b>7e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		<b>X</b>
<b>7f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		<b>X</b>
<b>7g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
<b>7h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
<b>9</b>	<b>Sponsoring organizations maintaining donor advised funds.</b>		
<b>9a</b>	Did the sponsoring organization make any taxable distributions under section 4966?		
<b>9b</b>	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter		
<b>10a</b>	Initiation fees and capital contributions included on Part VIII, line 12		
<b>10b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities		
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter		
<b>11a</b>	Gross income from members or shareholders		
<b>11b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)		
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?		
<b>12b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year		
<b>13</b>	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>13a</b>	Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O		
<b>13b</b>	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans		
<b>13c</b>	Enter the amount of reserves on hand		
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year?		<b>X</b>
<b>14b</b>	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O		

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

**Section A. Governing Body and Management**

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

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

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

**Section C. Disclosure**

- 17** List the states with which a copy of this Form 990 is required to be filed **▶ NONE**
- 18** Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
☐ Own website ☐ Another's website ☒ Upon request ☐ 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 AUSTIN, V.P. OF FINANCE** **401 W PENNSYLVANIA**  
**ANACONDA**

**MT 59711****406-563-8521**

**Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**Check if Schedule O contains a response or note to any line in this Part VII ☐**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees****1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.

- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."

- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.

- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.

- List all of the organization's **former** directors or trustees that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

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

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

(A) Name and Title	(B) Average hours per week (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			
(1) PETER SORINI, MD	40.00									
SURGEON/TRUSTEE	0.00	X						993,115	0	0
(2) JOHN S. MCNEECE	40.00									
CEO/TRUSTEE	0.00	X		X				397,894	0	17,717
(3) SHAWNA BAKER, MD	40.00									
PHYSICIAN/TRUSTEE	0.00	X						264,500	0	28,688
(4) BOB FRANCISCO	1.00									
CHAIR	0.00	X		X				0	0	0
(5) LEE ANN BARTOLETTI	1.00									
VICE CHAIR	0.00	X		X				0	0	0
(6) BILL FINNEGAN	1.00									
SECRETARY-TREASURER	0.00	X		X				0	0	0
(7) GENE VUCKOVICH	1.00									
TRUSTEE	0.00	X						0	0	0
(8) JACK HAFLEY	1.00									
TRUSTEE	0.00	X						0	0	0
(9) STAN BLAZ	1.00									
TRUSTEE	0.00	X						0	0	0
(10) JODI MCCARTHY	1.00									
TRUSTEE	0.00	X						0	0	0
(11) JESSE LASLOVICH	1.00									
TRUSTEE	0.00	X						0	0	0



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

(A) Name and title	(B) Average hours per week (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			
(12) <b>LAURA AUSTIN</b> <b>V.P. OF FINANCE</b>	40.00 0.00			X				229,860	0	16,497
(13) <b>PETER WENDT</b> <b>PHYSICIAN</b>	40.00 0.00					X		650,000	0	8,036
(14) <b>FREDRICK BARTOLETTI, MD</b> <b>ER PHYSICIAN</b>	40.00 0.00					X		356,385	0	23,002
(15) <b>DOUGLAS DUNHAM, MD</b> <b>ER PHYSICIAN</b>	39.00 0.00					X		342,709	0	17,717
(16) <b>REBECCA BONTADELLI</b> <b>PHYSICIAN</b>	39.00 0.00					X		341,225	0	12,206
(17) <b>GREGORZ CIEZLEWICZ</b> <b>PHYSICIAN</b>	39.00 0.00					X		328,416	0	9,681
(18)										
(19)										
<b>1b Sub-total</b>								<b>3,904,104</b>		<b>133,544</b>
<b>c Total from continuation sheets to Part VII, Section A</b>										
<b>d Total (add lines 1b and 1c)</b>								<b>3,904,104</b>		<b>133,544</b>

**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 **28**

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
<b>DR PETER SORINI</b> <b>BUTTE MT 59701</b>	<b>22 BITTERSWEET</b> <b>SURGEON SRVCS</b>	993,115
<b>DR JONATHAN PINE</b> <b>ANACONDA MT 59711</b>	<b>305 W PENN AVE</b> <b>SURGEON SRVCS</b>	674,202
<b>DR THOMAS MCMAHON</b> <b>ANACONDA MT 59711</b>	<b>401 W PENN AVE</b> <b>SURGEON SRVCS</b>	376,326
<b>MARK VANDOLAH</b> <b>ANACONDA MT 59711</b>	<b>401 W PENN AVE</b> <b>CRNA SRVCS</b>	345,593
<b>BRIAN BRADLEY</b> <b>ANACONDA MT 59711</b>	<b>401 W PENN AVE</b> <b>PAIN MGMT SRVCS</b>	345,254

**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 **8**

**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
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns	<b>1a</b>				
	<b>b</b> Membership dues	<b>1b</b>				
	<b>c</b> Fundraising events	<b>1c</b>				
	<b>d</b> Related organizations	<b>1d</b>	137,864			
	<b>e</b> Government grants (contributions)	<b>1e</b>	1,398,144			
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	25,305			
	<b>g</b> Noncash contributions included in lines 1a-1f \$					
	<b>h</b> Total. Add lines 1a-1f		1,561,313			
<b>Program Service Revenue</b>	<b>2a</b> PATIENT SERVICE REVENUE, NET	Busn. Code 624100	38,171,144	38,171,144		
	<b>b</b> PHARMACY SALES	446110	65,527		65,527	
	<b>c</b> RENTAL INCOME	621110	5,575	5,575		
	<b>d</b>					
	<b>e</b>					
	<b>f</b> All other program service revenue					
	<b>g</b> Total. Add lines 2a-2f		38,242,246			
	<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts)		20,557		
<b>4</b> Income from investment of tax-exempt bond proceeds						
<b>5</b> Royalties						
<b>6a</b> Gross rents		(i) Real (ii) Personal				
<b>b</b> Less rental exps						
<b>c</b> Rental inc or (loss)						
<b>d</b> Net rental income or (loss)						
<b>7a</b> Gross amount from sales of assets other than inventory		(i) Securities (ii) Other				
<b>b</b> Less cost or other basis & sales exps						
<b>c</b> Gain or (loss)						
<b>d</b> Net gain or (loss)						
<b>8a</b> Gross income from fundraising events (not including \$ of contributions reported on line 1c) See Part IV, line 18		<b>a</b>				
<b>b</b> Less direct expenses		<b>b</b>				
<b>c</b> Net income or (loss) from fundraising events						
<b>9a</b> Gross income from gaming activities See Part IV, line 19		<b>a</b>				
<b>b</b> Less direct expenses		<b>b</b>				
<b>c</b> Net income or (loss) from gaming activities						
<b>10a</b> Gross sales of inventory, less returns and allowances		<b>a</b>				
<b>b</b> Less cost of goods sold	<b>b</b>					
<b>c</b> Net income or (loss) from sales of inventory						
<b>Miscellaneous Revenue</b>		<b>Busn. Code</b>				
<b>11a</b> CAFETERIA REVENUE	722514	44,858			44,858	
<b>b</b> OTHER	900099	14,946			14,946	
<b>c</b> MEDICAL RECORDS & TRANSCRIPTS	900099	9,857			9,857	
<b>d</b> All other revenue						
<b>e</b> Total. Add lines 11a-11d		69,661				
<b>12</b> Total revenue. See instructions		39,893,777	38,176,719	65,527	90,218	

**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
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	29,686	29,686		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22				
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
<b>4</b> Benefits paid to or for members				
<b>5</b> Compensation of current officers, directors, trustees, and key employees	661,968		661,968	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
<b>7</b> Other salaries and wages	18,139,770	16,342,906	1,796,864	
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	441,727	398,071	43,656	
<b>9</b> Other employee benefits	1,267,657	1,120,267	147,390	
<b>10</b> Payroll taxes	1,561,234	1,359,535	201,699	
<b>11</b> Fees for services (non-employees)				
<b>a</b> Management	30,490		30,490	
<b>b</b> Legal	163,995		163,995	
<b>c</b> Accounting	57,640		57,640	
<b>d</b> Lobbying				
<b>e</b> Professional fundraising services. See Part IV, line 7				
<b>f</b> Investment management fees				
<b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	5,112,485	4,786,925	325,560	
<b>12</b> Advertising and promotion	225,206	1,329	223,877	
<b>13</b> Office expenses	2,523,364	2,308,476	214,888	
<b>14</b> Information technology	371,851	371,851		
<b>15</b> Royalties				
<b>16</b> Occupancy	1,293,736	679,866	613,870	
<b>17</b> Travel	24,850	17,983	6,867	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials				
<b>19</b> Conferences, conventions, and meetings	254,527	216,887	37,640	
<b>20</b> Interest	194,772	164,518	30,254	
<b>21</b> Payments to affiliates				
<b>22</b> Depreciation, depletion, and amortization	1,255,165	811,973	443,192	
<b>23</b> Insurance	858,183	854,146	4,037	
<b>24</b> 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.)				
<b>a</b> MEDICAL SUPPLIES & DRUGS	4,427,268	4,427,268		
<b>b</b> HOSPITAL BED TAX	325,481	325,481		
<b>c</b> DUES & SUBSCRIPTIONS	254,882	126,497	128,385	
<b>d</b> OTHER EXPENSES	59,611	7,379	52,232	
<b>e</b> All other expenses	59,570	1,098,575	-1,039,005	
<b>25</b> Total functional expenses. Add lines 1 through 24e	39,595,118	35,449,619	4,145,499	0
<b>26</b> 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 <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

**Part X Balance Sheet**Check if Schedule O contains a response or note to any line in this Part X ☐

		(A) Beginning of year		(B) End of year
<b>Assets</b>	1 Cash—non-interest bearing	1,054,724	1	2,492,658
	2 Savings and temporary cash investments	4,237,981	2	3,601,766
	3 Pledges and grants receivable, net	134,998	3	
	4 Accounts receivable, net	6,764,171	4	6,812,684
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		6	
	7 Notes and loans receivable, net	22,000	7	13,276
	8 Inventories for sale or use	641,019	8	699,163
	9 Prepaid expenses and deferred charges	303,805	9	404,779
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 33,001,735		
	b Less accumulated depreciation	10b 12,923,085	10c 11,594,073	20,078,650
	11 Investments—publicly traded securities	1,984,372	11	1,400,388
	12 Investments—other securities See Part IV, line 11	399,213	12	484,394
	13 Investments—program-related See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets See Part IV, line 11	1,779,847	15	1,893,313
16 <b>Total assets.</b> Add lines 1 through 15 (must equal line 34)	28,916,203	16	37,881,071	
<b>Liabilities</b>	17 Accounts payable and accrued expenses	3,759,104	17	3,717,533
	18 Grants payable		18	
	19 Deferred revenue	287,325	19	263,142
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability Complete Part IV of Schedule D		21	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties	9,668,695	23	17,207,641
	24 Unsecured notes and loans payable to unrelated third parties	67,372	24	52,010
	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	268,621	25	1,224,915
	26 <b>Total liabilities.</b> Add lines 17 through 25	14,051,117	26	22,465,241
	<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>		
27 Unrestricted net assets		14,865,086	27	15,415,830
28 Temporarily restricted net assets			28	
29 Permanently restricted net assets			29	
<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>				
30 Capital stock or trust principal, or current funds			30	
31 Paid-in or capital surplus, or land, building, or equipment fund			31	
32 Retained earnings, endowment, accumulated income, or other funds			32	
33 <b>Total net assets or fund balances</b>		14,865,086	33	15,415,830
34 <b>Total liabilities and net assets/fund balances</b>	28,916,203	34	37,881,071	

**Part XI Reconciliation of Net Assets**Check if Schedule O contains a response or note to any line in this Part XI ☐

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	<b>39,893,777</b>
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	<b>39,595,118</b>
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	<b>298,659</b>
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	<b>14,865,086</b>
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	<b>252,085</b>
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	<b>15,415,830</b>

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII ☐

	Yes	No
<b>1</b> Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
<b>2a</b> Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		<b>X</b>
<b>b</b> Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input checked="" type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	<b>X</b>	
<b>c</b> If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	<b>X</b>	
<b>3a</b> As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	<b>X</b>	
<b>b</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	<b>X</b>	

Form **990** (2014)

**SCHEDULE A**  
**(Form 990 or 990-EZ)**Department of the Treasury  
Internal Revenue Service**Public Charity Status and Public Support**Complete if the organization is a section 501(c)(3) organization or a section  
4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ.

▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2014**Open to Public  
Inspection

Name of the organization

**COMMUNITY HOSPITAL OF ANACONDA**

Employer identification number

**81-0303913****Part I Reason for Public Charity Status** (All organizations must complete this part ) See instructions.

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

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 ☐ A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E )
- 3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II )
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II )
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II )
- 9 ☐ An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2)**. (Complete Part III )
- 10 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4)**.
- 11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**. Check the box in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g
- 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 1–9 above or IRC section (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
(A)						
(B)						
(C)						
(D)						
(E)						
<b>Total</b>						

**Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>4</b> <b>Total.</b> Add lines 1 through 3						
<b>5</b> 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)						
<b>6</b> <b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
<b>7</b> Amounts from line 4						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>11</b> <b>Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions)					<b>12</b>	

**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**

<b>14</b> Public support percentage for 2014 (line 6, column (f) divided by line 11, column (f))	<b>14</b>	%
<b>15</b> Public support percentage from 2013 Schedule A, Part II, line 14	<b>15</b>	%
<b>16a</b> <b>33 1/3% support test—2014.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
<b>b</b> <b>33 1/3% support test—2013.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
<b>17a</b> <b>10%-facts-and-circumstances test—2014.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
<b>b</b> <b>10%-facts-and-circumstances test—2013.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
<b>18</b> <b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ► <input type="checkbox"/>		

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b> <b>Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
<b>c</b> Add lines 7a and 7b						
<b>8</b> <b>Public support</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
<b>9</b> Amounts from line 6						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b> Add lines 10a and 10b						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13</b> <b>Total support.</b> (Add lines 9, 10c, 11, and 12.)						
<b>14</b> <b>First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here <span style="float: right;">► <input type="checkbox"/></span>						

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

<b>15</b> Public support percentage for 2014 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	%
<b>16</b> Public support percentage from 2013 Schedule A, Part III, line 15	<b>16</b>	%

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

<b>17</b> Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	%
<b>18</b> Investment income percentage from 2013 Schedule A, Part III, line 17	<b>18</b>	%
<b>19a</b> <b>33 1/3% support tests—2014.</b> 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 <span style="float: right;">► <input type="checkbox"/></span>		
<b>b</b> <b>33 1/3% support tests—2013.</b> 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 <span style="float: right;">► <input type="checkbox"/></span>		
<b>20</b> <b>Private foundation.</b> If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions <span style="float: right;">► <input type="checkbox"/></span>		



**Part IV Supporting Organizations**

(Complete only if you checked a box on line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

	Yes	No
<b>1</b> Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.	<b>1</b>	
<b>2</b> 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 <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).	<b>2</b>	
<b>3a</b> Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.	<b>3a</b>	
<b>b</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 <b>Part VI</b> when and how the organization made the determination.	<b>3b</b>	
<b>c</b> Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in <b>Part VI</b> what controls the organization put in place to ensure such use.	<b>3c</b>	
<b>4a</b> Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below.	<b>4a</b>	
<b>b</b> Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.	<b>4b</b>	
<b>c</b> 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 <b>Part VI</b> 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.	<b>4c</b>	
<b>5a</b> 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 <b>Part VI</b> , 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).	<b>5a</b>	
<b>b</b> <b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	<b>5b</b>	
<b>c</b> <b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?	<b>5c</b>	
<b>6</b> Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations, (b) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in <b>Part VI</b> .	<b>6</b>	
<b>7</b> Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990).	<b>7</b>	
<b>8</b> 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).	<b>8</b>	
<b>9a</b> 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 <b>Part VI</b> .	<b>9a</b>	
<b>b</b> Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in <b>Part VI</b> .	<b>9b</b>	
<b>c</b> Did a disqualified person (as defined in line 9(a)) 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 <b>Part VI</b> .	<b>9c</b>	
<b>10a</b> Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer (b) below.	<b>10a</b>	
<b>b</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.)	<b>10b</b>	

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

	Yes	No
<b>1</b> 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 <b>Part VI</b> 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.		
<b>2</b> 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 <b>Part VI</b> how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.		

**Section C. Type II Supporting Organizations**

	Yes	No
<b>1</b> 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 <b>Part VI</b> how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).		

**Section D. All Type III Supporting Organizations**

	Yes	No
<b>1</b> Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
<b>2</b> 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 <b>Part VI</b> how the organization maintained a close and continuous working relationship with the supported organization(s).		
<b>3</b> 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 <b>Part VI</b> the role the organization's supported organizations played in this regard.		

**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
<b>a</b> 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 <b>Part VI</b> 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.		
<b>b</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 <b>Part VI</b> the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.		
<b>3 Parent of Supported Organizations. Answer (a) and (b) below.</b>		
<b>a</b> 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 <b>Part VI</b> .		
<b>b</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 <b>Part VI</b> the role played by the organization in this regard.		

**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. See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	1		
2 Recoveries of prior-year distributions	2		
3 Other gross income (see instructions)	3		
4 Add lines 1 through 3	4		
5 Depreciation and depletion	5		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7 Other expenses (see instructions)	7		
8 <b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	8		
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)			
a Average monthly value of securities	1a		
b Average monthly cash balances	1b		
c Fair market value of other non-exempt-use assets	1c		
d <b>Total</b> (add lines 1a, 1b, and 1c)	1d		
e <b>Discount</b> claimed for blockage or other factors (explain in detail in Part VI)			
2 Acquisition indebtedness applicable to non-exempt-use assets	2		
3 Subtract line 2 from line 1d	3		
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	4		
5 <b>Net value of non-exempt-use assets</b> (subtract line 4 from line 3)	5		
6 Multiply line 5 by .035	6		
7 Recoveries of prior-year distributions	7		
8 <b>Minimum Asset Amount</b> (add line 7 to line 6)	8		
Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2 Enter 85% of line 1	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3	4		
5 Income tax imposed in prior year	5		
6 <b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		
7 <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)			

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

<b>Section D - Distributions</b>		<b>Current Year</b>	
<b>1</b>	Amounts paid to supported organizations to accomplish exempt purposes		
<b>2</b>	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity		
<b>3</b>	Administrative expenses paid to accomplish exempt purposes of supported organizations		
<b>4</b>	Amounts paid to acquire exempt-use assets		
<b>5</b>	Qualified set-aside amounts (prior IRS approval required)		
<b>6</b>	Other distributions (describe in <b>Part VI</b> ) See instructions		
<b>7</b>	<b>Total annual distributions.</b> Add lines 1 through 6		
<b>8</b>	Distributions to attentive supported organizations to which the organization is responsive (provide details in <b>Part VI</b> ) See instructions		
<b>9</b>	Distributable amount for 2014 from Section C, line 6		
<b>10</b>	Line 8 amount divided by Line 9 amount		

  

<b>Section E - Distribution Allocations (see instructions)</b>		<b>(i) Excess Distributions</b>	<b>(ii) Underdistributions Pre-2014</b>	<b>(iii) Distributable Amount for 2014</b>
<b>1</b>	Distributable amount for 2014 from Section C, line 6			
<b>2</b>	Underdistributions, if any, for years prior to 2014 (reasonable cause required-see instructions)			
<b>3</b>	Excess distributions carryover, if any, to 2014			
<b>a</b>				
<b>b</b>				
<b>c</b>				
<b>d</b>				
<b>e</b>	From 2013			
<b>f</b>	Total of lines 3a through e			
<b>g</b>	Applied to underdistributions of prior years			
<b>h</b>	Applied to 2014 distributable amount			
<b>i</b>	Carryover from 2009 not applied (see instructions)			
<b>j</b>	Remainder Subtract lines 3g, 3h, and 3i from 3f			
<b>4</b>	Distributions for 2014 from Section D, line 7 \$			
<b>a</b>	Applied to underdistributions of prior years			
<b>b</b>	Applied to 2014 distributable amount			
<b>c</b>	Remainder Subtract lines 4a and 4b from 4			
<b>5</b>	Remaining underdistributions for years prior to 2014, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
<b>6</b>	Remaining underdistributions for 2014 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
<b>7</b>	<b>Excess distributions carryover to 2015.</b> Add lines 3j and 4c			
<b>8</b>	<b>Breakdown of line 7</b>			
<b>a</b>				
<b>b</b>				
<b>c</b>				
<b>d</b>	Excess from 2013			
<b>e</b>	Excess from 2014			

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

---

**SCHEDULE C**  
**(Form 990 or 990-EZ)**Department of the Treasury  
Internal Revenue Service**Political Campaign and Lobbying Activities**

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

OMB No 1545-0047

**2014****Open to Public  
Inspection**

- **Complete if the organization is described below.**      ► **Attach to Form 990 or Form 990-EZ**  
 ► **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

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

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

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

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

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax) (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 organization

**COMMUNITY HOSPITAL OF ANACONDA**

Employer identification number

**81-0303913****Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

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

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

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

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

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

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

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

Schedule C (Form 990 or 990-EZ) 2014

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

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

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

<b>Limits on Lobbying Expenditures</b> (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals
<b>1a</b> Total lobbying expenditures to influence public opinion (grass roots lobbying)			
<b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying)			
<b>c</b> Total lobbying expenditures (add lines 1a and 1b)			
<b>d</b> Other exempt purpose expenditures			
<b>e</b> Total exempt purpose expenditures (add lines 1c and 1d)			
<b>f</b> Lobbying nontaxable amount Enter the amount from the following table in both columns			
<b>If the amount on line 1e, column (a) or (b) is:</b>	<b>The lobbying nontaxable amount is:</b>		
Not over \$500,000	20% of the amount on line 1e		
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000		
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000		
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000		
Over \$17,000,000	\$1,000,000		
<b>g</b> Grassroots nontaxable amount (enter 25% of line 1f)			
<b>h</b> Subtract line 1g from line 1a If zero or less, enter -0-			
<b>i</b> Subtract line 1f from line 1c If zero or less, enter -0-			
<b>j</b> If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?			

☐ 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.)

<b>Lobbying Expenditures During 4-Year Averaging Period</b>					
Calendar year (or fiscal year beginning in)	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

Schedule C (Form 990 or 990-EZ) 2014

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

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

	(a)		(b)
	Yes	No	Amount
<b>1</b> During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
<b>a</b> Volunteers?		<b>X</b>	
<b>b</b> Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		<b>X</b>	
<b>c</b> Media advertisements?		<b>X</b>	
<b>d</b> Mailings to members, legislators, or the public?		<b>X</b>	
<b>e</b> Publications, or published or broadcast statements?		<b>X</b>	
<b>f</b> Grants to other organizations for lobbying purposes?		<b>X</b>	
<b>g</b> Direct contact with legislators, their staffs, government officials, or a legislative body?		<b>X</b>	
<b>h</b> Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		<b>X</b>	
<b>i</b> Other activities?	<b>X</b>		<b>200</b>
<b>j</b> Total. Add lines 1c through 1i.			<b>200</b>
<b>2a</b> Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		<b>X</b>	
<b>b</b> If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b> If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b> If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

**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.

**SCHEDULE C, PART II-B, LINE 1**

THE HOSPITAL DOES NOT DIRECTLY PERFORM ANY LOBBYING ACTIVITIES. THE HOSPITAL PAYS MEMBERSHIP DUES TO A STATE HOSPITAL ASSOCIATION. THE ASSOCIATION USES A PORTION OF SUCH DUES TO CARRY OUT LOBBYING ACTIVITIES.





**SCHEDULE D  
(Form 990)**Department of the Treasury  
Internal Revenue Service**Supplemental Financial Statements**▶ Complete if the organization answered "Yes" to Form 990,  
Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

▶ Attach to Form 990.

▶ Information about Schedule D (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2014**Open to Public  
Inspection

Name of the organization

Employer identification number

**COMMUNITY HOSPITAL OF ANACONDA****81-0303913****Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.**

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

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate 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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Part II Conservation Easements.**

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

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

<input type="checkbox"/> Preservation of land for public use (e.g., recreation or education)	<input type="checkbox"/> Preservation of a historically important land area
<input type="checkbox"/> Protection of natural habitat	<input type="checkbox"/> Preservation of a certified historic structure
<input type="checkbox"/> 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 Tax Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

9 In Part 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" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part 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) Revenues included in Form 990, Part VIII, line 1 ▶ \$

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

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

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

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

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

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

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

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part 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" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21

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

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

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

	Amount
1c	
1d	
1e	
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" to Form 990, Part IV, line 10.

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

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

- a Board designated or quasi-endowment ☐ %  
 b Permanent endowment ☐ %  
 c Temporarily restricted endowment ☐ %  
 The percentages in lines 2a, 2b, and 2c should equal 100%

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

- (i) unrelated organizations  
 (ii) related organizations

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

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

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

**Part VI Land, Buildings, and Equipment.**

Complete if the organization answered "Yes" to 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		809,274		809,274
b Buildings		6,450,729	4,013,506	2,437,223
c Leasehold improvements				
d Equipment		12,928,809	8,496,356	4,432,453
e Other		12,812,923	413,223	12,399,700
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				20,078,650

**Part VII Investments—Other Securities.**

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

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

**Part VIII Investments—Program Related.**

Complete if the organization answered "Yes" to 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)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 13.) ►		

**Part IX Other Assets.**

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

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 15.) ►	

**Part X Other Liabilities.**

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) <b>ESTIMATED THIRD PARTY SETTLEMENT</b>	<b>1,224,915</b>
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col (B) line 25.) ►	<b>1,224,915</b>

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" to Form 990, Part IV, line 12a

<b>1</b>	Total revenue, gains, and other support per audited financial statements	<b>1</b>	<b>40,145,862</b>
<b>2</b>	Amounts included on line 1 but not on Form 990, Part VIII, line 12		
<b>a</b>	Net unrealized gains (losses) on investments	<b>2a</b>	<b>252,085</b>
<b>b</b>	Donated services and use of facilities	<b>2b</b>	
<b>c</b>	Recoveries of prior year grants	<b>2c</b>	
<b>d</b>	Other (Describe in Part XIII )	<b>2d</b>	
<b>e</b>	Add lines 2a through 2d	<b>2e</b>	<b>252,085</b>
<b>3</b>	Subtract line 2e from line 1	<b>3</b>	<b>39,893,777</b>
<b>4</b>	Amounts included on Form 990, Part VIII, line 12, but not on line 1		
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b	<b>4a</b>	
<b>b</b>	Other (Describe in Part XIII )	<b>4b</b>	
<b>c</b>	Add lines 4a and 4b	<b>4c</b>	
<b>5</b>	Total revenue Add lines 3 and 4c. (This must equal Form 990, Part I, line 12 )	<b>5</b>	<b>39,893,777</b>

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

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

<b>1</b>	Total expenses and losses per audited financial statements	<b>1</b>	<b>39,595,118</b>
<b>2</b>	Amounts included on line 1 but not on Form 990, Part IX, line 25		
<b>a</b>	Donated services and use of facilities	<b>2a</b>	
<b>b</b>	Prior year adjustments	<b>2b</b>	
<b>c</b>	Other losses	<b>2c</b>	
<b>d</b>	Other (Describe in Part XIII )	<b>2d</b>	
<b>e</b>	Add lines 2a through 2d	<b>2e</b>	
<b>3</b>	Subtract line 2e from line 1	<b>3</b>	<b>39,595,118</b>
<b>4</b>	Amounts included on Form 990, Part IX, line 25, but not on line 1		
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b	<b>4a</b>	
<b>b</b>	Other (Describe in Part XIII )	<b>4b</b>	
<b>c</b>	Add lines 4a and 4b	<b>4c</b>	
<b>5</b>	Total expenses Add lines 3 and 4c. (This must equal Form 990, Part I, line 18 )	<b>5</b>	<b>39,595,118</b>

**Part XIII Supplemental Information.**

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

**PART X - FIN 48 FOOTNOTE**

THE HOSPITAL IS A NOT-FOR-PROFIT CORPORATION AND IS EXEMPT FROM FEDERAL INCOME TAXES UNDER SECTION 501(C) (3) OF THE INTERNAL REVENUE CODE. ACCORDINGLY, NO PROVISION FOR INCOME TAX IS NECESSARY. THE HOSPITAL EVALUATES UNCERTAIN TAX POSITIONS WHEREBY THE EFFECT OF THE UNCERTAINTY WOULD BE RECORDED IF THE OUTCOME WERE CONSIDERED PROBABLE AND REASONABLY ESTIMABLE. AS OF DECEMBER 31, 2014 AND 2013, THE HOSPITAL HAS NO UNCERTAIN TAX POSITIONS REQUIRING ACCRUAL.



**SCHEDULE H  
(Form 990)**Department of the Treasury  
Internal Revenue Service

Name of the organization

**Hospitals**

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.

▶ Attach to Form 990.

▶ Information about Schedule H (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2014**Open to Public  
Inspection**COMMUNITY HOSPITAL OF ANACONDA**

Employer identification number

**81-0303913****Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<b>X</b>	
<b>b</b> If "Yes," was it a written policy?	<b>X</b>	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) 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 <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>130</u> %	<b>X</b>	
<b>b</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 <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>220</u> %	<b>X</b>	
<b>c</b> 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		
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<b>X</b>	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<b>X</b>	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		<b>X</b>
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<b>X</b>	
<b>b</b> If "Yes," did the organization make it available to the public?	<b>X</b>	

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

**7 Financial Assistance and Certain Other Community Benefits at Cost**

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1)			<b>266,573</b>		<b>266,573</b>	<b>0.67</b>
<b>b</b> Medicaid (from Worksheet 3, column a)			<b>3,227,972</b>	<b>3,227,972</b>		
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)						
<b>d</b> Total Financial Assistance and Means-Tested Government Programs			<b>3,494,545</b>	<b>3,227,972</b>	<b>266,573</b>	<b>0.67</b>
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			<b>300,470</b>		<b>300,470</b>	<b>0.76</b>
<b>f</b> Health professions education (from Worksheet 5)			<b>1,833</b>		<b>1,833</b>	
<b>g</b> Subsidized health services (from Worksheet 6)			<b>16,047,073</b>	<b>12,227,758</b>	<b>3,819,315</b>	<b>9.65</b>
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)			<b>10,068</b>		<b>10,068</b>	<b>0.03</b>
<b>j</b> Total. Other Benefits			<b>16,359,444</b>	<b>12,227,758</b>	<b>4,131,686</b>	<b>10.43</b>
<b>k</b> Total. Add lines 7d and 7j			<b>19,853,989</b>	<b>15,455,730</b>	<b>4,398,259</b>	<b>11.11</b>

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

DAA

Schedule H (Form 990) 2014

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

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

**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?	<b>X</b>	
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	962,463
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	
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	11,250,739
6 Enter Medicare allowable costs of care relating to payments on line 5	6	11,328,764
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-78,025
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other		

**Section C. Collection Practices**

9a Did the organization have a written debt collection policy during the tax year?	9a	<b>X</b>
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	<b>X</b>

**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 N/A				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				





**Part V Facility Information (continued)****Section B. Facility Policies and Practices**

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

Name of hospital facility or letter of facility reporting group **COMMUNITY HOSPITAL OF ANACONDA**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): **1****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?
- 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
- 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  
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 ☒ Information gaps that limit the hospital facility's ability to assess the community's health needs
- j ☐ Other (describe in Section C)
- 4 Indicate the tax year the hospital facility last conducted a CHNA: **13**
- 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
- 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C
- 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
- 7 Did the hospital facility make its CHNA report widely available to the public?  
If "Yes," indicate how the CHNA report was made widely available (check all that apply)
- a ☒ Hospital facility's website (list url) **WWW.COMMUNITYHOSPITALOFANACONDA.ORG**
- 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
- 9 Indicate the tax year the hospital facility last adopted an implementation strategy: **13**
- 10 Is the hospital facility's most recently adopted implementation strategy posted on a website?
- a If "Yes," (list url) **WWW.COMMUNITYHOSPITALOFANACONDA.ORG**
- b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?
- 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed
- 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
- b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?
- c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

	Yes	No
1		<input checked="" type="checkbox"/>
2		<input checked="" type="checkbox"/>
3	<input checked="" type="checkbox"/>	
5	<input checked="" type="checkbox"/>	
6a		<input checked="" type="checkbox"/>
6b		<input checked="" type="checkbox"/>
7	<input checked="" type="checkbox"/>	
8	<input checked="" type="checkbox"/>	
10	<input checked="" type="checkbox"/>	
10b		
12a		<input checked="" type="checkbox"/>
12b		

**Part V Facility Information (continued)****Financial Assistance Policy (FAP)**Name of hospital facility or letter of facility reporting group **COMMUNITY HOSPITAL OF ANACONDA**

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that		
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b> <input checked="" type="checkbox"/>	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care <u>at 30</u> % and FPG family income limit for eligibility for discounted care of <u>220</u> %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input type="checkbox"/> Medical indigency		
e <input type="checkbox"/> Insurance status		
f <input type="checkbox"/> Underinsurance status		
g <input type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients?	<b>14</b> <input checked="" type="checkbox"/>	
<b>15</b> Explained the method for applying for financial assistance? 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)	<b>15</b> <input checked="" type="checkbox"/>	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
<b>16</b> Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b> <input checked="" type="checkbox"/>	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url). <u>WWW.COMMUNITYHOSPITALOFANACONDA.ORG</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url). <u>WWW.COMMUNITYHOSPITALOFANACONDA.ORG</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url). <u>WWW.COMMUNITYHOSPITALOFANACONDA.ORG</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input type="checkbox"/> Other (describe in Section C)		
<b>Billing and Collections</b>		
<b>17</b> 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 non-payment?	<b>17</b> <input checked="" type="checkbox"/>	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Actions that require a legal or judicial process		
d <input type="checkbox"/> Other similar actions (describe in Section C)		
e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

**Part V Facility Information** (continued)Name of hospital facility or letter of facility reporting group **COMMUNITY HOSPITAL OF ANACONDA**

- 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?

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 ☐ Actions that require a legal or judicial process  
 d ☐ Other similar actions (describe in Section C)

	Yes	No
<b>19</b>		<b>X</b>

- 20** Indicate which efforts the hospital facility or other authorized party made before initializing any of the actions listed (whether or not checked) in line 19 (check all that apply)

- a ☒ Notified individuals of the financial assistance policy on admission  
 b ☒ Notified individuals of the financial assistance policy prior to discharge  
 c ☒ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills  
 d ☒ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy  
 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?

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)

	Yes	No
<b>21</b>	<b>X</b>	

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

- 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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged  
 b ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged  
 c ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged  
 d ☐ Other (describe in Section C)

- 23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?

If "Yes," explain in Section C

- 24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?

If "Yes," explain in Section C

	Yes	No
<b>23</b>		<b>X</b>
<b>24</b>		<b>X</b>

**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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

**FACILITY 1, COMMUNITY HOSPITAL OF ANACONDA - PART V, LINE 5**

IN CONDUCTING ITS MOST RECENT CHNA, THE HOSPITAL TOOK INTO ACCOUNT PERSONS INPUT WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE HOSPITAL BY ENSURING THE ZIP CODES WITH THE LARGEST NUMBER OF ADMISSIONS WERE INCLUDED IN THE SURVEY SAMPLE.

THE PROCESS INCLUDED A RANDOM, WRITTEN SURVEY MAILED TO 800 RESIDENTS OF ANACONDA-DEER LODGE COUNTY HOUSEHOLDS FOLLOWED BY THREE FOCUS GROUPS. IN ADDITION, A STEERING COMMITTEE OF VARIOUS COMMUNITY MEMBERS WAS FORMED TO ASSIST IN THE DEVELOPMENT OF THE SURVEY INSTRUMENT AND TO PROVIDE A FORUM TO DISCUSS THE COMMUNITY'S ISSUES WITH RESPECT TO HEALTHCARE.

**FACILITY 1, COMMUNITY HOSPITAL OF ANACONDA - PART V, LINE 11**

THE HOSPITAL WAS NOT ABLE TO ADDRESS ALL HEALTH NEEDS IDENTIFIED IN ITS MOST RECENTLY CONDUCTED CHNA DUE TO NOT CURRENTLY HAVING THE STAFF OR FINANCIAL RESOURCES TO DEVOTE TO THE NEED. THE NEEDS IDENTIFIED BUT NOT ADDRESSED INCLUDE ONCOLOGY SERVICES FOR CANCER PATIENTS, ADDITIONAL SPECIALTY SERVICES SUCH AS DERMATOLOGY, EAR/NOSE/THROAT, AND CARDIAC REHABILITATION, AND REDUCING THE CHARGES OF HEALTH CARE SERVICES TO ITS PATIENTS.

**How many non-hospital health care facilities did the organization operate during the tax year?**<sup>2</sup>

Schedule H (Form 990) 2014

**Part VI Supplemental Information**

Provide the following information

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

**PART I, LINE 7G - SUBSIDIZED HEALTH SERVICES EXPLANATION**

THE HOSPITAL HAS INCLUDED COSTS ASSOCIATED WITH PHYSICIAN CLINICS AS SUBSIDIZED HEALTH SERVICES IN PART I, LINE 7G IN THE AMOUNT OF \$7,039,154 IN COLUMN C AND \$3,838,832 IN COLUMN D.

**PART I, LINE 7 - COSTING METHODOLOGY EXPLANATION**

THE HOSPITAL APPLIES THE RATIO OF PATIENT CARE COST-TO-CHARGES FOR FIGURES REPORTED IN THE TABLE (TOTAL OPERATING EXPENSES LESS NON-PATIENT CARE ACTIVITIES, MEDICAID PROVIDER TAXES, TOTAL COMMUNITY BENEFIT, AND TOTAL COMMUNITY BUILDING EXPENSES).

**PART II - COMMUNITY BUILDING ACTIVITIES**

CHA IS A LEADING SUPPORTER OF SOCIAL SERVICE PROGRAMS THAT BENEFIT LOCAL RESIDENTS. HOSPITAL EMPLOYEES ARE ENCOURAGED TO VOLUNTEER IN THE COMMUNITY. EMPLOYEES VOLUNTEER AT THE LOCAL FOOD BANK AND VOLUNTEER THEIR TIME TO TEACHING BASIC LIFE SUPPORT COURSES AT LOCAL BUSINESSES. THE HOSPITAL SUPPORTS THE LOCAL SCHOOL'S MOUTH-RINSE AND HEALTHY SNACK PROGRAMS AND OFFERS FINANCIAL SUPPORT TO AFTER SCHOOL AND SUMMER PROGRAMS

**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

**FOR AT RISK YOUTH.**

SINCE 2012, CHA HAS GIVEN AN ANNUAL \$1,000 CONTRIBUTION TO THE BOYS AND GIRLS CLUB OF ANACONDA. THE BOYS & GIRLS CLUBS OF AMERICA IS AN ORGANIZATION THAT PROMOTES POSITIVE YOUTH DEVELOPMENT IN STUDENTS BY PROVIDING A SAFE PLACE WITH CARING ADULTS AND FUN ACTIVITIES WHERE YOUTH CAN SPEND THEIR FREE TIME. THE LOCAL CLUB PROVIDES TUTORING ASSISTANCE, EDUCATIONAL ENHANCEMENT ACTIVITIES, AND SUMMER PROGRAMS TARGETED FOR AT RISK YOUTH.

CHA IS ALSO COMMITTED TO SPONSORING LOCAL FUN RUNS AND EVENTS SUCH AS THE ANNUAL ECHO LAKE TRAILS ASSOCIATION RACE, ST. PATRICK'S DAY RACE, THE ANACONDA BICYCLE FEST, AND THE BUTTE 100 BIKE RACE. THE ST. PATRICK'S DAY RACE IS ORGANIZED BY THE LOCAL ANCIENT ORDER OF HIBERNIANS AND INCLUDES BOTH A THREE AND SIX MILE RACE AND A WHEELCHAIR DIVISION, WITH CLOSE TO 1,000 PARTICIPANTS. THE BUTTE 100 OFFERS 25, 50 AND 100 MILE EVENTS WHILE THE ANACONDA BICYCLE FESTIVAL IS A TWO-DAY WEEKEND OF BICYCLE EVENTS THAT RAISES FUNDS FOR THE UPKEEP AND RESTORATION OF



**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

ANACONDA'S WASHOE PARK. ALL EVENTS ARE DEDICATED TO RAISING AWARENESS  
AND PROMOTING HEALTHY LIFESTYLES.

IN THE FALL OF 2014, COMMUNITY HOSPITAL OF ANACONDA HOSTED ITS TENTH  
ANNUAL HEALTH, FITNESS AND WELLNESS FAIR. PARTICIPANTS WERE OFFERED A  
SPECTRUM OF LAB WORK FOR \$50, WHICH INCLUDED A TSH, LIPID PANEL, GLUCOSE  
AND CBC. FOR AN ADDITIONAL \$25, PARTICIPANTS COULD HAVE HEMOGLOBIN A-1C  
AND/OR PSA. ALL SERVICES THAT WOULD NORMALLY COST IN EXCESS OF \$300!  
PARTICIPANTS RECEIVED INFORMATION ON HOW TO INTERPRET THEIR LAB RESULTS  
AS WELL AS FREE BLOOD PRESSURE SCREENINGS, FREE BLOOD GLUCOSE TESTING,  
OXYGEN SATURATION SCREENINGS AND COMPLIMENTARY HEALTH PROMOTION ITEMS.  
CHA OFFERS THE FAIR ANNUALLY TO ENSURE THE COMMUNITY KNOWS THEIR NUMBERS  
AND RISKS AND AS A RESULT, FOCUSES ON PREVENTION AND INTERVENTION.

IN 2014, CHA PROVIDED SCHOLARSHIPS TO TWO ANACONDA HIGH SCHOOL STUDENTS  
PURSUING HIGHER EDUCATION IN THE HEALTHCARE ARENA. CHA ALSO PROVIDED  
FUNDING FOR THE MEDSTART SUMMER CAMP WHICH IS A WEEK-LONG CAMP DESIGNED  
TO ENCOURAGE CURRENT SOPHOMORE AND JUNIOR HIGH SCHOOL STUDENTS TO PURSUE

**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

THEIR INTEREST IN A VARIETY OF HEALTHCARE CAREERS. THE CAMP FOCUSES ON ACCEPTING STUDENTS WHO COME FROM DISADVANTAGED BACKGROUNDS, LOW-INCOME FAMILIES, RURAL AREAS, MINORITIES, OR WILL BE FIRST IN THEIR FAMILY TO ATTEND COLLEGE. THE AIM OF MEDSTART IS TO PROVIDE STUDENTS WHO MAY NOT OTHERWISE HAVE THE OPPORTUNITY A CHANCE TO FURTHER EXPLORE HEALTHCARE CAREERS, LEARN ABOUT COLLEGE LIFE, AND REALIZE IT IS POSSIBLE TO PURSUE HIGHER EDUCATION.

IN ADDITION, CHA PROVIDED A SCHOLARSHIP FOR A PHARMACY STUDENT AT THE UNIVERSITY OF MONTANA. CHA ALSO HOSTED SEVERAL NURSING, MID-LEVEL STUDENTS AS WELL AS HIGH SCHOOL STUDENTS LOOKING FOR SHADOWING OPPORTUNITIES. IN 2014, CHA BECAME A SITE FOR THE FAMILY MEDICINE RESIDENCY OF WESTERN MONTANA PROGRAM.

IN 2014, CHA OFFERED TWO FIVE WEEK FREE PRE-NATAL CLASSES WHICH COVERED A VARIETY OF TOPICS INCLUDING THE IMPORTANCE OF PRE-NATAL CARE AND FETAL DEVELOPMENT, PREPARING FOR DELIVERY, POSTPARTUM ADJUSTMENTS AND NEWBORN CARE. IN MAY OF 2014, WE PROVIDED OVER 150 FREE SPORTS PHYSICALS TO

**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

**LOCAL HIGH SCHOOL AND MIDDLE SCHOOL ATHLETES. THE PHYSICALS INCLUDED A COMPLIMENTARY ECHOCARDIOGRAM AND BAR-B-QUE! PARTNERSHIPS CONTINUED WITH THE LOCAL METCALF SENIOR CENTER, OFFERING "SIT AND BE FIT" CLASSES AS WELL AS A DEMENTIA SUPPORT GROUP.**

**CHA ALSO SUPPORTS LOCAL ARTS AND ENTERTAINMENT INCLUDING SHAKESPEARE IN THE PARK, ALIVE AFTER FIVE AND ART IN THE PARK.**

**IN 2014, CHA SPONSORED THE FOLLOWING PROGRAMS:**

**\*BOYS AND GIRLS CLUB OF ANACONDA**

**\*AHS CLASS OF 2014 CHEMICAL FREE GRADUATION PARTY**

**\*ANACONDA ANCIENT ORDER OF HIBERNIANS ST. PATRICK'S DAY RUN**

**\*SPECIAL OLYMPICS OF ANACONDA AND MONTANA**

**\*COPPER VILLAGE MUSEUM AND ART CENTER**

**\*UNITED VETERANS OF ANACONDA**

**\*UNITED WAY ANACONDA**

**\*ANACONDA RELAY FOR LIFE**

**\*WAYNE ESTES BASKETBALL TOURNAMENT**

**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

**\*ANACONDA SHAKESPEARE IN THE PARK****\*COPPER VILLAGE MUSEUM AND ART CENTER****\*ANACONDA A'S BASEBALL****\*ANACONDA LITTLE LEAGUE****\*DEMENTIA SUPPORT GROUP****\*SIT & BE FIT PROGRAM****\*ANACONDA FOOD BANK****\*ANACONDA PUBLIC SCHOOLS****\*SCHOOL MOUTH RINSE PROGRAM****\*FOOD FOR BLOOD DRIVES****\*WORK SHADOWING FOR HIGH SCHOOL STUDENTS****\*FREE SPORTS PHYSICALS FOR ATHLETES****\*ANACONDA BICYCLE FESTIVAL****\*FREE PRE-NATAL CLASSES****\*MEDICAL TRAINING FOR VOLUNTEER EMS GROUPS****\*JOB CORPS PICNIC****\*AHS BOOSTER CLUB SPONSORSHIP****\*CHA HEALTH FAIR**

**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

**\*PINTLER SUICIDE AWARENESS & PREVENTION PROGRAM****\*SCHOLARSHIPS FOR AHS GRADUATES****\*NEWSPAPERS IN EDUCATION****\*MARCH OF DIMES****\*COMMUNITY INTERVENTION****\*KIWANIS****\*UM PHARMACY SCHOLARSHIP****\*MT MED START CAMP****\*ANACONDA ROTARY CARING IS SHARING PROGRAM****\*TRI COUNTY FAIR****PART III, LINE 2 - BAD DEBT EXPENSE METHODOLOGY**

**THE HOSPITAL USED THE COST TO CHARGE RATIO OF PATIENT CARE TO DETERMINE  
THE COST OF BAD DEBT EXPENSE.**

**PART III, LINE 3 - BAD DEBT EXPENSE, PATIENTS ELIGIBLE FOR ASSISTANCE**

**THE HOSPITAL DID NOT TRACK THE AMOUNT OF BAD DEBT EXPENSE THAT COULD  
REASONABLY BE ATTRIBUTABLE TO PATIENTS WHO LIKELY WOULD QUALIFY FOR**

**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

**FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S CHARITY CARE POLICY BUT FOR WHOM SUFFICIENT INFORMATION WAS NOT OBTAINED TO MAKE DETERMINATION OF THEIR ELIGIBILITY DURING THE YEAR.**

**PART III, LINE 4 - BAD DEBT EXPENSE FOOTNOTE TO FINANCIAL STATEMENTS**  
**THE PATIENT ACCOUNTS RECEIVABLE FOOTNOTE OF THE AUDITED FINANCIAL STATEMENTS IS FOUND IN FOOTNOTE #4 ON PAGE 12 OF THE AUDITED FINANCIAL STATEMENTS. THE PROVISION FOR BAD DEBTS IS INCLUDED IN THE FIRST PARAGRAPH OF FOOTNOTE #4 ON PAGE 12 OF THE AUDITED FINANCIAL STATEMENTS.**

**PART III, LINE 8 - MEDICARE EXPLANATION**  
**ANY MEDICARE ALLOWABLE COSTS OF PATIENT CARE SHORTFALLS ARE NOT COUNTED AS COMMUNITY BENEFIT. THESE ALLOWABLE COSTS ARE OBTAINED FROM THE MEDICARE COST REPORT FOR THE YEAR.**

**PART III, LINE 9B - COLLECTION PRACTICES EXPLANATION**  
**IF A PATIENT CANNOT PAY THE ENTIRE BILL WITHIN THE**  
**TIMELINE SPECIFIED IN THE BILLING/COLLECTION POLICY, AN**

**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

INTERVIEW WITH THE PATIENT IS CONDUCTED. WE SCREEN THE PATIENT TO DETERMINE THEIR FINANCIAL STATUS. IF THEY ARE TRUE SELF PAY WITHOUT INSURANCE, WE MAKE A REFERRAL TO THE MASH PROGRAM TO SEE IF THEY QUALIFY FOR ANY GOVERNMENT PROGRAMS SUCH AS MEDICAID, MEDICARE, SSI, ETC. IF THEY HAVE BEEN SCREENED AND DO NOT QUALIFY FOR ANY PROGRAMS, WE DETERMINE IF THEY ARE ELIGIBLE FOR OUR FINANCIAL ASSISTANCE PROGRAM. PART OF THE FINANCIAL ASSISTANCE PROGRAM IS A REDUCED PAYMENT PLAN THAT CAN BE APPROVED EVEN IF THE PATIENT DOES NOT QUALIFY FOR FULL FINANCIAL ASSISTANCE. IF THE PATIENT HAS INSURANCE, THE SAME PROCEDURE IS COMPLETED WITHOUT THE PATIENT BEING SCREENED BY THE MASH PROGRAM.

ANOTHER PROVISION IN THE CREDIT AND COLLECTIONS POLICY ALLOWS THE PATIENT ACCOUNT REPRESENTATIVE TO APPROVE A LESSER PAYMENT ARRANGEMENT IF THE ARRANGEMENT IS IN THE BEST INTEREST OF THE HOSPITAL AND THE PATIENT. AN EXAMPLE

**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

OF THIS WOULD BE IF A PATIENT IS IN A TEMPORARY SITUATION  
 THAT PREVENTS MEETING A HIGHER PAYMENT, WE WILL APPROVE  
 THE LOWER PAYMENT PLAN WITH A DATE TO REEVALUATE WHEN THAT  
 SITUATION IS RESOLVED. CHA WORKS WITH PATIENTS TO  
 ACCOMMODATE THEIR FINANCIAL SITUATION. THE FACT THAT THEY  
 CANNOT MEET THE GUIDELINES UNDER THE FINANCIAL POLICY,  
 DOES NOT MEAN THAT THEY ARE SENT DIRECTLY TO COLLECTIONS.  
 PARTIAL OR FULL PAYMENT MAY BE REQUIRED PRIOR TO SERVICE  
 IN SOME SITUATIONS. ALL NON-EMERGENT PATIENTS REQUIRING A  
 SURGICAL PROCEDURE THAT DO NOT HAVE INSURANCE COVERAGE  
 MUST MEET WITH A PATIENT ACCOUNT REPRESENTATIVE PRIOR TO  
 HAVING THE SERVICE PROVIDED. WE INTERVIEW THE PATIENT TO  
 DETERMINE THEIR FINANCIAL STATUS. BASED ON THE PROCEDURE  
 BEING PERFORMED AND THE FINANCIAL STATUS OF THE PATIENT, A  
 PARTIAL OR FULL PAYMENT MAY BE REQUIRED. IF THE PATIENT  
 IS UNABLE TO MAKE THE PARTIAL OR FULL PAYMENT, A REFERRAL  
 IS MADE WITH THE MASH PROGRAM TO DETERMINE IF THE PATIENT  
 QUALIFIES FOR ANY GOVERNMENT PROGRAMS. ONCE SCREENED BY



**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

**MASH, FOR ANY PATIENT THAT DOES NOT QUALIFY FOR ANY**

**GOVERNMENT PROGRAM, AN APPLICATION FOR FINANCIAL**

**ASSISTANCE IS OFFERED PRIOR TO THE SERVICE BEING**

**PERFORMED. BASED ON THE RESULTS OF THE FINANCIAL**

**ASSISTANCE APPLICATION, THE BALANCE OF THE ACCOUNT AND THE**

**PATIENT'S ABILITY TO PAY ARE EVALUATED. IF THE PATIENT**

**HAS THE ABILITY TO PAY, A PARTIAL OR FULL PAYMENT IS**

**REQUIRED. IF THE PATIENT DOES NOT HAVE THE ABILITY TO**

**PAY, THE ACCOUNT IS RELIEVED UNDER THE PATIENT FINANCIAL**

**ASSISTANCE PROGRAM.**

**PART VI, LINE 2 - NEEDS ASSESSMENT**

**IN AUGUST 2012, CHA BEGAN THE PROCESS OF CONDUCTING ANOTHER HEALTH CARE**

**SERVICES SURVEY AS PART OF THE COMMUNITY HEALTH SERVICES DEVELOPMENT**

**PROGRAM. A STEERING COMMITTEE COMPRISED OF A DIVERSE GROUP OF COMMUNITY**

**MEMBERS WAS FORMED TO DISCUSS THEIR PERCEPTION OF HEALTH ISSUES IN THE**

**COMMUNITY, PROVIDE INPUT INTO THE DEVELOPMENT OF A SURVEY INSTRUMENT AND**

**TO REVIEW THE RESULTS OF THE SURVEY AND FOCUS GROUPS.**

**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

IN OCTOBER 2012, 800 SURVEYS WERE SENT TO A RANDOM LIST OF 800 RESIDENTS  
 SELECTED FROM PRIME NET DATA SOURCE. 234 SURVEYS WERE RETURNED, FOR A  
 32% RESPONSE RATE. THE SURVEY WAS BASED ON THE DESIGN USED EXTENSIVELY  
 IN ALASKA, IDAHO, WASHINGTON, WYOMING AND MONTANA. THE SURVEY WAS  
 DESIGNED TO PROVIDE EACH FACILITY WITH INFORMATION FROM LOCAL RESIDENTS  
 REGARDING:

\*DEMOGRAPHICS OF RESPONDENTS;

\*HOSPITALS, PRIMARY CARE PROVIDERS AND SPECIALISTS USED, AND REASON FOR  
 SELECTION;

\*LOCAL HEALTH CARE PROVIDER USAGE;

\*SERVICES PROVIDED LOCALLY; AND

\*PERCEPTION AND SATISFACTION OF LOCAL HEALTH CARE.

IN ADDITION, THREE FOCUS GROUPS WERE HELD TO IDENTIFY THE MOTIVES USED BY  
 LOCALS WHEN SELECTING HEALTH CARE PROVIDERS AND DISCOVER THE REASONS WHY  
 PEOPLE MAY LEAVE THE ANACONDA AREA TO SEEK HEALTH CARE SERVICES. A KEY  
 INFORMANT INTERVIEW WAS ALSO HELD WITH THE ANACONDA DEER LODGE PUBLIC

**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

**HEALTH DEPARTMENT TO IDENTIFY LOCAL HEALTH CARE ISSUES.**

**AN IMPLEMENTATION PLANNING TEAM WAS THEN FORMED, COMPRISED OF STAFF LEADERS FROM COMMUNITY HOSPITAL OF ANACONDA TO SYSTEMATICALLY RESPOND TO ALL ISSUES IDENTIFIED IN THE SURVEYS, FOCUS GROUPS AND KEY INFORMANT INTERVIEWS, WITH CONSIDERATION GIVEN TO CHA'S PARAMETERS AND LIMITATIONS.**

**THE PRIORITIZED HEALTH NEEDS AS DETERMINED THROUGH THE ASSESSMENT PROCESS AND WHICH THE FACILITY WILL BE ADDRESSING RELATES TO THE FOLLOWING:**

- 1. ACCESS TO AFFORDABLE HEALTH CARE SERVICES AND QUALITY OF CARE**
- 2. SENIOR SERVICES**
- 3. ALCOHOL AND DRUG ABUSE**
- 4. MENTAL HEALTH**
- 5. HEALTHY BEHAVIORS AND LIFESTYLES**

**IN ADDRESSING THE AFOREMENTIONED ISSUES, COMMUNITY HOSPITAL OF ANACONDA SEEKS TO:**

**A) IMPROVE ACCESS TO HEALTH CARE SERVICES;**

**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

**B) ENHANCE THE HEALTH OF THE COMMUNITY ;****C) ADVANCE MEDICAL OR HEALTH KNOWLEDGE ; AND/OR****D) RELIEVE OR REDUCE THE BURDEN OF GOVERNMENT OR OTHER COMMUNITY EFFORTS**

**THE FOLLOWING GOALS WERE DEVELOPED TO ADDRESS THE PRIORITIZED HEALTH NEEDS :**

**\*GOAL 1: EXPAND COMMUNITY HOSPITAL OF ANACONDA'S ROLE IN IMPROVING ACCESS TO LOCAL HEALTH CARE SERVICES FOR COMMUNITY MEMBERS**

**\*GOAL 2: PROVIDE MORE SERVICES TARGETED TOWARD THE GROWING SENIOR POPULATION**

**\*GOAL 3: INCREASE UTILIZATION OF RESOURCES FOR ALCOHOL/SUBSTANCE ABUSE AND MENTAL HEALTH.**

**\*GOAL 4: PROMOTE HEALTHY LIVING IN DEER LODGE COUNTY.**

**ACTIVITIES AND STRATEGIES WERE DEVELOPED FOR EACH GOAL WITH A CORRESPONDING IMPLEMENTATION GRID.**

**COMMUNITY HOSPITAL OF ANACONDA (CHA) DISSEMINATED THE COMMUNITY HEALTH**

**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

**NEEDS ASSESSMENT (CHNA) AND IMPLEMENTATION PLAN BY POSTING BOTH DOCUMENTS CONSPICUOUSLY ON CHA'S WEBSITE (WWW.COMMUNITYHOSPITALOFANACONDA.ORG) AS WELL AS HAVING COPIES AVAILABLE AT THE FACILITY SHOULD COMMUNITY MEMBERS REQUEST TO VIEW THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) OR THE IMPLEMENTATION PLANNING DOCUMENTS.**

**THE STEERING COMMITTEE, WHICH WAS FORMED SPECIFICALLY AS A RESULT OF THE CHNA PROCESS IN ORDER TO INTRODUCE THE COMMUNITY TO THE ASSESSMENT PROCESS, WAS INFORMED OF THE IMPLEMENTATION PLAN TO SEE THE VALUE OF THEIR INPUT AND TIME IN THE CHNA PROCESS, AS WELL AS HOW COMMUNITY HOSPITAL OF ANACONDA IS UTILIZING THEIR INPUT. THE STEERING COMMITTEE, AS WELL AS THE BOARD OF DIRECTORS, WILL BE ENCOURAGED TO ACT AS ADVOCATES IN DEER LODGE COUNTY AS THE FACILITY SEEKS TO ADDRESS THE HEALTH CARE NEEDS OF THEIR COMMUNITY.**

**CHA BOARD MEMBERS APPROVED AND ADOPTED THE PLAN ON NOVEMBER 27, 2013. BOARD MEMBERS ARE ENCOURAGED TO FAMILIARIZE THEMSELVES WITH THE CHNA REPORT AND IMPLEMENTATION PLAN SO THEY CAN PUBLICALLY PROMOTE THE**

**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

**FACILITY'S PLAN TO INFLUENCE THE COMMUNITY IN A BENEFICIAL MANNER.****TO DATE, CHA HAS MADE THE FOLLOWING PROGRESS TOWARDS THE OUTLINED GOALS:****GOAL 1: EXPAND COMMUNITY HOSPITAL OF ANACONDA'S ROLE IN IMPROVING ACCESS TO LOCAL HEALTH CARE SERVICES FOR COMMUNITY MEMBERS:**

**\*PINTLER FAMILY MEDICINE EAST WAS REOPENED, WITH THREE PHYSICIANS AND A MID-LEVEL, EXPANDING ACCESS TO PRIMARY CARE.**

**\*IN 2014, CHA COMMENCED DISCUSSIONS WITH THE STATE OF MONTANA TO OFFER A NEW EMPLOYEE STATE HEALTH CLINIC. THIS CLINIC REPRESENTS A NEW MODEL OF PARTNERING WITH A LOCAL HOSPITAL IN A WAY THAT BENEFITS BOTH STATE EMPLOYEES AND MAIN STREET MONTANA. THE BUTTE/ANACONDA AREA HAS A LARGE NUMBER OF STATE EMPLOYEES THAT WILL TAKE ADVANTAGE OF THIS CLINIC. THE CLINIC OPENED IN MARCH 2015.**

**\*IN 2014, CHA LAUNCHED AN INFORMATION CAMPAIGN TO RAISE AWARENESS OF NEW AND EXISTING SERVICES, UTILIZING NEWS PRINT, RADIO, DIRECT MAIL, THE CHA WEBSITE AND FACEBOOK.**

**\*AS NEW PROVIDERS ARE ADDED, CHA HAS IMPLEMENTED INTERNAL AND EXTERNAL**

**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

CAMPAIGNS TO INTRODUCE THE PROVIDER AND IMPROVE ACCESS TO CARE.

SPECIALISTS IN THE AREAS OF ENDOCRINOLOGY, UROLOGY, PULMONOLOGY/CRITICAL CARE, AND PEDIATRICS HAVE JOINED CHA SINCE THE NEEDS ASSESSMENT WAS COMPLETED.

\*AN INSURANCE COUNSELOR/MARKET PLACE SPECIALIST IS AVAILABLE TO ASSIST COMMUNITY MEMBERS IN NAVIGATING THE INSURANCE MARKETPLACE AND ENROLLING FOR INSURANCE.

\*SOYRING CONSULTANTS WAS ENGAGED TO EVALUATE PROCESSES IN THE CHA CLINICS.

\*HCAHP SCORES ARE PART OF OUR MONTHLY QUALITY IMPROVEMENT DISCUSSION.

\*CHA PRIDE AND MORALE BOOSTING STRATEGIES ARE ONGOING SUCH AS BBQS, HOLIDAY PARTIES AND CHA APPAREL.

GOAL 2: PROVIDE MORE SERVICES TARGETED TOWARD THE GROWING SENIOR POPULATION:

\*THE DEVELOPMENT OF A MASTER FACILITY PLAN FOR THE NURSING HOME AND EVALUATION OF STRATEGIES FOR HOME HEALTH AND HOSPICE ARE ONGOING.

\*CHA CONTINUES TO ENGAGE IN THE COMMUNITY, PARTNERING WITH ANACONDA PUBLIC SCHOOLS, AND THE METCALF SENIOR CENTER.

**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

---

**GOAL 3: INCREASE UTILIZATION OF RESOURCES FOR ALCOHOL/SUBSTANCE ABUSE AND MENTAL HEALTH:**

---

**\*CHA CONTINUES TO ASSESS OUR RESPONSIBILITIES REGARDING ALCOHOL AND SUBSTANCE ABUSE IN OUR COMMUNITY AND CONTINUES TO SUPPORT ANACONDA COMMUNITY INTERVENTION WITH PROGRAMS/ACTIVITIES TO EDUCATE YOUTH AND DETER UNDERAGE DRINKING.**

**\*CHA CONTINUES TO PARTNER WITH MONTANA STATE HOSPITAL FOR ADDICTIVE AND MENTAL DISORDERS.**

**\*THE CHA SPONSORED COMMUNITY DEMENTIA SUPPORT GROUP IS ONGOING.**

**\*TRAINING OPPORTUNITIES ARE CONSTANTLY BEING ASSESSED.**

---

**GOAL 4: PROMOTE HEALTHY LIVING IN DEER LODGE COUNTY:**

---

**\*CHA CONTINUES TO OFFER PRE-NATAL CLASSES TWICE PER YEAR.**

**\*THE ANNUAL HEALTH FAIR IS IN ITS ELEVENTH YEAR.**

**\*THE CHA DIABETES PREVENTION PROGRAM HOLDS THREE HEALTHY LIFESTYLE CLASSES ANNUALLY.**

**\*GRANTS HAVE BEEN OBTAINED TO EXPAND WELLNESS PROGRAMS ON FALL PREVENTION,**

Schedule H (Form 990) 2014



**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

**STRENGTH TRAINING, ETC.****PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE****IN COMPLIANCE WITH THE COLLECTION POLICIES OF CHA, AN ANNUAL REVIEW IS PERFORMED OF ALL CREDIT/COLLECTION AND FINANCIAL ASSISTANCE POLICIES.****ONCE REVIEWED AND REVISED, THE INFORMATION IS DISTRIBUTED TO THE COMMUNITY IN A VARIETY OF WAYS. THE FACILITY PUBLISHED A BROCHURE THAT IS PLACED IN PUBLIC AREAS OF ALL THE CHA FACILITIES, AS WELL AS INCLUDED IN ALL FORMAL ADMISSION PACKETS TO PATIENTS. THE PATIENT ACCOUNT REPRESENTATIVES HAND OUT THE INFORMATION DURING PATIENT CONSULTS AS WELL. THE INFORMATION IS ALSO AVAILABLE ON THE CHA WEBSITE.****ANNUALLY, THE PATIENT ACCOUNTS LEADER DISTRIBUTES THE NEW INFORMATION TO LOCAL AGENCIES THAT ASSIST LOW INCOME POPULATIONS. DISCUSSIONS OCCUR WITH THE AGENCIES REGARDING THE FINANCIAL ASSISTANCE PROGRAMS AND CHA'S ABILITY TO ASSIST PATIENTS WITH THE BURDEN OF APPLYING FOR GOVERNMENT PROGRAMS SUCH AS DISABILITY, ETC.**

**Part VI Supplemental Information**

Provide the following information

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

**PART VI, LINE 4 - COMMUNITY INFORMATION**

ANACONDA-DEER LODGE COUNTY (ADLC) COVERS 737 SQUARE MILES OF SOUTHWESTERN MONTANA, WITH 12.6 PERSONS PER SQUARE MILE, MAKING IT A RURAL COUNTY WITH RURAL URBAN CONTINUUM CODE OF 7 (RUCC 1 = MOST URBAN, 10= MOST RURAL).

ANACONDA DEER LODGE COUNTY IS A DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREA (HPSA, ID#1309993042). THE 2010 POPULATION WAS 9,298 COMPARED TO A 2000 POPULATION OF 9,417, REPRESENTING A POPULATION LOSS OF 1.3% SINCE 2000. THE MAJOR COMMUNITY IN ANACONDA-DEER LODGE COUNTY IS ANACONDA, WITH A MEDIAN AGE OF 46 YEARS. 21.2% OF THE PEOPLE IN THE COUNTY LIVE BELOW THE POVERTY LINE, WITH AN AVERAGE UNEMPLOYMENT RATE OF 7.8%, COMPARED TO THE STATE RATE OF 6.8%.

COMMUNITY HOSPITAL OF ANACONDA (CHA) HAS BEEN SERVING THE HEALTHCARE NEEDS OF ANACONDA-DEER LODGE COUNTY (ADLC) SINCE 1889. THE HOSPITAL IS A PRIVATELY OWNED, NON-PROFIT, TWENTY-FIVE BED CRITICAL ACCESS FACILITY BUILT IN 1981. CHA OFFERS A FULL CONTINUUM OF CARE INCLUDING INPATIENT HOSPITAL SERVICES, OUTPATIENT SERVICES, FOUR AMBULATORY CARE CLINICS INCLUDING INTERNAL/FAMILY MEDICINE, SURGICAL, PEDIATRICS AND CONVENIENT

**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

CARE, A LONG-TERM CARE FACILITY, AND HOSPICE/HOME HEALTH SERVICES. CHA  
EMPLOYS CLOSE TO 400 INDIVIDUALS, WITH AN ANNUAL PAYROLL IN EXCESS OF \$20  
MILLION.

PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH

COMMUNITY HOSPITAL OF ANACONDA'S BOARD OF TRUSTEES IS COMPRISED OF  
COMMUNITY MEMBERS REPRESENTING MULTIPLE FACETS OF OUR COMMUNITY FROM THE  
FINANCIAL SECTOR TO SMALL BUSINESS OWNERS TO RETIREES AND SCHOOL DISTRICT  
EMPLOYEES. THIS VOLUNTEER BOARD HAS DEDICATED THEIR TIME TO ENSURING  
THEY UNDERSTAND THE HEALTH AND WELFARE NEEDS OF OUR COMMUNITY.

MEDICAL STAFF PRIVILEGES AT CHA ARE OPEN TO ALL MEDICAL PROVIDERS WITH  
ACTIVE LICENSURE. WHILE WE HAVE INSTITUTED AN ARDUOUS CREDENTIALING  
PROCESS TO ENSURE PRACTITIONERS OF THE HIGHEST CALIBER ARE PRIVILEGED,  
WE ENCOURAGE PRACTITIONERS FROM NUMEROUS SPECIALTIES TO MEET THE EVER  
EXPANDING HEALTHCARE NEEDS OF THE COMMUNITY.

AS A NON-PROFIT CORPORATION, WE DO NOT HAVE SHAREHOLDERS. THEREFORE,

**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

SURPLUS FUNDS ARE REINVESTED INTO OUR FACILITIES, EQUIPMENT AND EMPLOYEE  
EDUCATION. THE ABSENCE OF SHAREHOLDERS ELIMINATES THE POTENTIAL FOR  
CONFLICTS OF INTEREST RELATED TO ATTAINING INFLATED PROFIT MARGINS AND  
ALLOWS COMMUNITY HOSPITAL OF ANACONDA TO FOCUS ON WHAT IS IMPORTANT;  
MEETING THE HEALTH AND WELFARE NEEDS OF OUR COMMUNITY.

PART VI, LINE 6 - AFFILIATED HEALTH CARE SYSTEM

N/A.

PART VI, LINE 7 - STATE FILING OF COMMUNITY BENEFIT REPORT

MONTANA

**SCHEDULE J**  
**(Form 990)**Department of the Treasury  
Internal Revenue Service

Name of the organization

**Compensation Information**For certain Officers, Directors, Trustees, Key Employees, and Highest  
Compensated Employees

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

▶ Attach to Form 990.

▶ Information about Schedule J (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2014**Open to Public  
Inspection**COMMUNITY HOSPITAL OF ANACONDA**Employer identification number  
**81-0303913****Part I Questions Regarding Compensation****1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items

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

**b** If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain**2** Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?**3** Indicate which, if any, of the following the filing organization uses to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III

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

**4** During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization**a** Receive a severance payment or change-of-control payment?**b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?**c** Participate in, or receive payment from, an equity-based compensation arrangement?

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

**Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5–9.****5** For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of**a** The organization?**b** Any related organization?

If "Yes" to line 5a or 5b, describe in Part III

**6** For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of**a** The organization?**b** Any related organization?

If "Yes" to line 6a or 6b, describe in Part III

**7** For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III**8** Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III**9** If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

Yes No

1b

2

4a

4b

4c

5a

5b

6a

6b

7

8

9

X

X

X

X

X

X

X

X

X

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

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

(A) Name 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 in prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
<b>PETER SORINI, MD</b>	(i) 993,115	0	0	0	0	993,115	0
<b>1 SURGEON/TRUSTEE</b>	(ii) 0	0	0	0	0	0	0
<b>JOHN S. MCNEECE</b>	(i) 397,894	0	0	8,036	9,681	415,611	0
<b>2 CEO/TRUSTEE</b>	(ii) 0	0	0	0	0	0	0
<b>SHAWNA BAKER, MD</b>	(i) 264,500	0	0	8,036	20,652	293,188	0
<b>3 PHYSICIAN/TRUSTEE</b>	(ii) 0	0	0	0	0	0	0
<b>LAURA AUSTIN</b>	(i) 229,860	0	0	7,366	9,131	246,357	0
<b>4 V.P. OF FINANCE</b>	(ii) 0	0	0	0	0	0	0
<b>PETER WENDT</b>	(i) 650,000	0	0	8,036	0	658,036	0
<b>5 PHYSICIAN</b>	(ii) 0	0	0	0	0	0	0
<b>FREDRICK BARTOLETTI, MD</b>	(i) 356,385	0	0	8,036	14,966	379,387	0
<b>6 ER PHYSICIAN</b>	(ii) 0	0	0	0	0	0	0
<b>DOUGLAS DUNHAM, MD</b>	(i) 342,709	0	0	8,036	9,681	360,426	0
<b>7 ER PHYSICIAN</b>	(ii) 0	0	0	0	0	0	0
<b>REBECCA BONTADELLI</b>	(i) 341,225	0	0	2,525	9,681	353,431	0
<b>8 PHYSICIAN</b>	(ii) 0	0	0	0	0	0	0
<b>GREGORZ CIEZLEWICZ</b>	(i) 328,416	0	0	0	9,681	338,097	0
<b>9 PHYSICIAN</b>	(ii) 0	0	0	0	0	0	0
	(i) 0	0	0	0	0	0	0
	(ii) 0	0	0	0	0	0	0
	(i) 0	0	0	0	0	0	0
	(ii) 0	0	0	0	0	0	0
	(i) 0	0	0	0	0	0	0
	(ii) 0	0	0	0	0	0	0
	(i) 0	0	0	0	0	0	0
	(ii) 0	0	0	0	0	0	0
	(i) 0	0	0	0	0	0	0
	(ii) 0	0	0	0	0	0	0
	(i) 0	0	0	0	0	0	0
	(ii) 0	0	0	0	0	0	0
	(i) 0	0	0	0	0	0	0
	(ii) 0	0	0	0	0	0	0

**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

**SCHEDULE L**  
**(Form 990 or 990-EZ)**Department of the Treasury  
Internal Revenue Service

Name of the organization

**Transactions With Interested Persons**

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

▶ Attach to Form 990 or Form 990-EZ.

▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2014**Open To Public  
Inspection

COMMUNITY HOSPITAL OF ANACONDA

Employer identification number

81-0303913

**Part I Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and 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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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 org?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												
<b>Total</b>							▶ \$					

**Part III Grants or Assistance Benefiting Interested Persons.**  
Complete if the organization answered "Yes" on Form 990, Part IV, line 27

(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
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				





**SCHEDULE O**  
**(Form 990 or 990-EZ)**Department of the Treasury  
Internal Revenue Service**Supplemental Information to Form 990 or 990-EZ**Complete to provide information for responses to specific questions on  
Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

**2014****Open to Public  
Inspection**

Name of the organization

**COMMUNITY HOSPITAL OF ANACONDA**

Employer identification number

**81-0303913****FORM 990, PART VI, LINE 2 - RELATED PARTY INFORMATION AMONG OFFICERS****LEE ANN BARTOLETTI****FREDRICK BARTOLETTI, MD****TRUSTEE****ER PHYSICIAN****FAMILY RELATIONSHIP****FORM 990, PART VI, LINE 6 - CLASSES OF MEMBERS OR STOCKHOLDERS**

WHEN THE HOSPITAL WAS FORMED IN 1969, SOME COMMUNITY MEMBERS PURCHASED THE HOSPITAL FROM SISTERS OF CHARITY. AS THESE ORIGINAL MEMBERS DECEASE, THEIR MEMBERSHIP IS LOST. AN ANNUAL MEETING IS SCHEDULED IN SEPTEMBER OF EACH YEAR WITH A PUBLIC NOTICE POSTED IN THE LOCAL PAPER. THE REMAINING ORIGINAL MEMBERS MAY ATTEND THE MEETING; HOWEVER, THEY ARE NOT ACTIVE MEMBERS AND DO NOT HAVE VOTING RIGHTS.

**FORM 990, PART VI, LINE 11B - ORGANIZATION'S PROCESS TO REVIEW FORM 990**

A COPY OF THE 990 IS PROVIDED TO THE V.P. OF FINANCE, WHO REVIEWS THE FORM, SCHEDULES, AND RELATED ATTACHMENTS. THE FINANCE COMMITTEE IS DESIGNATED BY THE BOARD OF TRUSTEES TO ASSUME RESPONSIBILITY FOR OVERSIGHT OF THE 990 AND IS ALSO PART OF THE REVIEW PROCESS. ANY COMMENTS OR QUESTIONS ARE ADDRESSED WITH THE PREPARER AND A FINAL APPROVAL IS GIVEN TO THE PREPARER BEFORE FINALIZING. ONCE MANAGEMENT IS SATISFIED WITH THE 990, THE V.P. OF FINANCE SIGNS OFF ON THE FORM 8879-EO BEFORE THE RETURN IS E-FILED BY THE PREPARER.

**FORM 990, PART VI, LINE 12C - ENFORCEMENT OF CONFLICTS POLICY**

ARTICLE II OF THE BYLAWS STATES THAT, AT A MINIMUM, EACH MEMBER OF THE

Name of the organization

Employer identification number

COMMUNITY HOSPITAL OF ANACONDA

81-0303913

BOARD WILL EXECUTE THE CONFLICT OF INTEREST FORM AT THE COMMENCEMENT OF THE TERM OR IN THE EVENT OF ANY CHANGE THAT MAY DEVELOP. THE CONFLICT OF INTEREST GUIDELINES ARE MONITORED BY THE CHA CORPORATE COMPLIANCE OFFICER. THE COMPLIANCE OFFICER ATTENDS NEW EMPLOYEE ORIENTATION AND PRESENTS THE POLICY AS PART OF THE OVERALL CORPORATE LEGAL COMPLIANCE PROGRAM. EACH EMPLOYEE IS PRESENTED WITH A CONFLICT OF INTEREST STATEMENT. ALL POTENTIAL CONFLICTS ARE DISCLOSED. IF ANY POTENTIAL CONFLICTS ARE IDENTIFIED, THE COMPLIANCE OFFICER WILL MEET WITH THE EMPLOYEE'S SUPERVISOR AND ADMINISTRATION TO DETERMINE IF A CONFLICT EXISTS. ON AN ANNUAL BASIS, ALL EMPLOYEES AND THE BOARD OF DIRECTORS ARE REQUIRED TO READ AND SIGN THE CONFLICT OF INTEREST STATEMENT. THE CORPORATE COMPLIANCE OFFICER TRACKS THE RECEIPT AND COMPLETION OF THE CONFLICT OF INTEREST STATEMENTS. THE PROCESS IS A PART OF THE ANNUAL EMPLOYEE REQUIREMENTS MANDATED FOR CONTINUED EMPLOYMENT.

FORM 990, PART VI, LINE 15A - COMPENSATION PROCESS FOR TOP OFFICIAL THE SOURCES UTILIZED BY CHA IN REGARD TO FAIR MARKET VALUE IN SALARIES ARE AN EXECUTIVE COMPENSATION SURVEY, PUBLISHED BY CRITICAL DATA, INC., AND THE MONTANA HOSPITAL ASSOCIATION (MHA) ANNUAL SALARY SURVEY. THESE SURVEYS ARE UTILIZED FOR SETTING THE SALARY LEVELS OF EMPLOYEES AT CHA. THE MHA SURVEY ITEMIZES ALL HOSPITALS AS A GROUP, CAH HOSPITALS, AND HOSPITALS BY REGION. CHALLENGES EXIST WHEN CHA JOB DESCRIPTIONS ARE UNIQUE AND, THEREFORE, MAY NOT BE LISTED AS A JOB CATEGORY IN THE MHA SURVEY. IN REGARD TO SETTING THE SALARY LEVELS OF PHYSICIANS, CHA UTILIZES THE MGMA PHYSICIAN COMPENSATION AND PRODUCTION SURVEY. THIS SURVEY ITEMIZES SALARIES AND PRODUCTIVITY BY PHYSICIAN SPECIALTY, YEARS IN PRACTICE, GEOGRAPHIC REGION, AND OTHER CATEGORIES.

Name of the organization

Employer identification number

COMMUNITY HOSPITAL OF ANACONDA

81-0303913

CHA STRIVES TO PAY MARKET LEVEL SALARIES TO ALL EMPLOYEES OF THE ORGANIZATION. IT IS OUR GOAL TO RECRUIT AND RETAIN TOP TALENT IN EVERY VENUE, WHILE CONTROLLING SALARY AND BENEFIT COSTS WITHIN ESTABLISHED TARGETS.

IN 2010, 2012, AND 2014, CHA HIRED AN INDEPENDENT CONSULTANT TO EVALUATE THE SALARY LEVELS OF THE SENIOR MANAGEMENT. THIS SALARY SURVEY REVIEWED SALARIES FOR HOSPITALS IN CHA'S REVENUE RANGE IN OUR REGION, AS WELL AS SALARY LEVELS ACROSS THE COUNTRY. ALL JOBS REVIEWED WERE WELL WITHIN THE PUBLISHED RANGES, AS DETERMINED BY CRITICAL DATA, INC.

FORM 990, PART VI, LINE 15B - COMPENSATION PROCESS FOR OFFICERS  
SEE FORM 990, PART VI, LINE 15A.

FORM 990, PART VI, LINE 19 - GOVERNING DOCUMENTS DISCLOSURE EXPLANATION  
COMMUNITY HOSPITAL OF ANACONDA MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST. THE FINANCIAL STATEMENTS ARE ALSO INCLUDED IN THE COMMUNITY BENEFIT REPORT.

FORM 990, PART IX, LINE 11G - OTHER FEES FOR SERVICES  
DESCRIPTION

PROGRAM SERVICE

MGT &amp; GENERAL

FUNDRAISING

\$ 4,786,925

\$ 325,560

\$ 0

**SCHEDULE R**  
**(Form 990)**Department of the Treasury  
Internal Revenue Service

Name of the organization

**Related Organizations and Unrelated Partnerships**

- Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.  
 ► Attach to Form 990.  
 ► Information about Schedule R (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No. 1545-0047

**2014****Open to Public  
Inspection**Employer identification number  
**81-0303913****COMMUNITY HOSPITAL OF ANACONDA****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
(1)						
(2)						
(3)						
(4)						
(5)						

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

	(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?
							Yes No
(1)	<b>CHANHA FOUNDATION</b> <b>PO BOX 1245</b> <b>ANACONDA MT 59711</b> <b>81-0504127</b>	<b>SUPPORT</b>	<b>MT</b>	<b>501C3</b>	<b>11B</b>	<b>COMMUNITY</b>	<b>X</b>
(2)							
(3)							
(4)							
(5)							

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

DAA

Schedule R (Form 990) 2014

**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) Dispro- portionate alloc.?		(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	
(1)												
(2)												
(3)												
(4)												

**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	No
(1)									
(2)									
(3)									
(4)									

**Part V Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36**Note.** Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule**1** During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?**a** Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity**b** Gift, grant, or capital contribution to related organization(s)**c** Gift, grant, or capital contribution from related organization(s)**d** Loans or loan guarantees to or for related organization(s)**e** Loans or loan guarantees by related organization(s)**f** Dividends from related organization(s)**g** Sale of assets to related organization(s)**h** Purchase of assets from related organization(s)**i** Exchange of assets with related organization(s)**j** Lease of facilities, equipment, or other assets to related organization(s)**k** Lease of facilities, equipment, or other assets from related organization(s)**l** Performance of services or membership or fundraising solicitations for related organization(s)**m** Performance of services or membership or fundraising solicitations by related organization(s)**n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)**o** Sharing of paid employees with related organization(s)**p** Reimbursement paid to related organization(s) for expenses**q** Reimbursement paid by related organization(s) for expenses**r** Other transfer of cash or property to related organization(s)**s** Other transfer of cash or property from related organization(s)**2** If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	CHANHA FOUNDATION	C	133,364	ACTUAL
(2)				
(3)				
(4)				
(5)				
(6)				

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) 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) Disproportionate allocations?		(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													



**Part VII Supplemental Information**

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