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Form 990



Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

▶ Information about Form 990 and its instructions is at www.irs.gov/form990

OMB No 1545-0047

2014

Open to Public Inspection

A For the 2014 calendar year, or tax year beginning 07-01-2014 , and ending 06-30-2015

B Check if applicable ☐ Address change ☐ Name change ☐ Initial return ☐ Final return/terminated ☐ Amended return ☐ Application pending	C Name of organization MOUNTAIN STATES HEALTH ALLIANCE	D Employer identification number 62-0476282	
	Doing business as JOHNSON CITY MEDICAL CENTER		E Telephone number (423) 302-3374
	Number and street (or P O box if mail is not delivered to street address) 400 N STATE OF FRANKLIN ROAD	Room/suite	
	City or town, state or province, country, and ZIP or foreign postal code JOHNSON CITY, TN 37604		G Gross receipts \$ 733,451,692
	F Name and address of principal officer ALAN LEVINE 303 MED TECH PARKWAY STE 300 JOHNSON CITY, TN 37604		H(a) Is this a group return for subordinates? ☐ Yes ☒ No H(b) Are all subordinates included? ☐ Yes ☐ No If "No," attach a list (see instructions) H(c) Group exemption number ▶
I Tax-exempt status ☒ 501(c)(3) ☐ 501(c) () ◀(insert no) ☐ 4947(a)(1) or ☐ 527			
J Website: ▶ WWW.MOUNTAINSTATESHEALTH.COM			
K Form of organization ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶		L Year of formation 1945	M State of legal domicile TN

Part I

Summary

Activities & Governance	1	Briefly describe the organization's mission or most significant activities MOUNTAIN STATES HEALTH ALLIANCE (MSHA) IS COMMITTED TO OUR MISSION OF BRINGING LOVING CARE TO HEALTH CARE. WE EXIST TO IDENTIFY AND RESPOND TO THE HEALTHCARE NEEDS OF INDIVIDUALS AND COMMUNITIES IN THE 29-COUNTY AREA WE SERVE, HELPING THEM ATTAIN THEIR HIGHEST LEVEL OF HEALTH. MSHA DELIVERS THIS CARE THROUGH THE PHILOSOPHY OF PATIENT-CENTERED CARE, AND THE DEVELOPMENT OF COMPREHENSIVE STRATEGIC PLANNING AND IMPLEMENTATION. SEE ATTACHED NARRATIVE "PROGRAM SERVICE ACCOMPLISHMENTS".
	2	Check this box ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets
	3	Number of voting members of the governing body (Part VI, line 1a)
	4	Number of independent voting members of the governing body (Part VI, line 1b)
	5	Total number of individuals employed in calendar year 2014 (Part V, line 2a)
	6	Total number of volunteers (estimate if necessary)
	7a	Total unrelated business revenue from Part VIII, column (C), line 12
	b	Net unrelated business taxable income from Form 990-T, line 34
	8	Contributions and grants (Part VIII, line 1h)
	9	Program service revenue (Part VIII, line 2g)
Revenue	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)
	12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)
	13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)
	14	Benefits paid to or for members (Part IX, column (A), line 4)
Expenses	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)
	16a	Professional fundraising fees (Part IX, column (A), line 11e)
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶1,173,485
	17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)
	18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)
Net Assets or Fund Balances	19	Revenue less expenses. Subtract line 18 from line 12
		Beginning of Current Year
	20	Total assets (Part X, line 16)
	21	Total liabilities (Part X, line 26)
	22	Net assets or fund balances. Subtract line 21 from line 20

Part II

Signature Block

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

Sign Here	*****		2016-04-12	
	Signature of officer		Date	
Paid Preparer Use Only	LYNN KRUTAK, SENIOR VP & CFO			
	Type or print name and title			
	Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed
Firm's name ▶		Firm's EIN ▶		
Firm's address ▶		Phone no		

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

Part III

Statement of Program Service Accomplishments

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

☐ Yes ☒ No

1

Briefly describe the organization's mission

MOUNTAIN STATES HEALTH ALLIANCE (MSHA) IS COMMITTED TO OUR MISSION OF BRINGING LOVING CARE TO HEALTH CARE WE EXIST TO IDENTIFY AND RESPOND TO THE HEALTHCARE NEEDS OF INDIVIDUALS AND COMMUNITIES IN THE 29-COUNTY AREA WE SERVE, HELPING THEM ATTAIN THEIR HIGHEST LEVEL OF HEALTH MSHA DELIVERS THIS CARE THROUGH THE PHILOSOPHY OF PATIENT-CENTERED CARE, AND THE DEVELOPMENT OF COMPREHENSIVE STRATEGIC PLANNING AND IMPLEMENTATION SEE ATTACHED NARRATIVE "PROGRAM SERVICE ACCOMPLISHMENTS"

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 \$ 579,838,341 including grants of \$ 1,816,780) (Revenue \$ 695,692,282)

SEE ATTACHED DOCUMENT MSHA - PROGRAM SERVICE ACCOMPLISHMENTS FOR GUIDESTAR READERS, OUR PROGRAM SERVICE ACCOMPLISHMENTS MAY BE FOUND AT THE END

4b

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

4c

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

4d

Other program services (Describe in Schedule O)

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

4e

Total program service expenses 579,838,341

Part IV Checklist of Required Schedules

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

Part IV

Checklist of Required Schedules (continued)

21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	21	Yes	
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>	22		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	23	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	24a	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		No
25a	Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>	25a		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>	25b		No
26	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? <i>If "Yes," complete Schedule L, Part II</i>	26	Yes	
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>	27		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28a	Yes	
b	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28b	Yes	
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	28c	Yes	
29	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>	29		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>	30		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>	31		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>	32		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>	33		No
34	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	34	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>	35b	Yes	
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>	36		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>	37		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O	38	Yes	

Part V

Statements Regarding Other IRS Filings and Tax Compliance

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

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable.		
1b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable.		
1c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	Yes	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return.		
2b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions).	Yes	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	Yes	
3b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O.	Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		No
b	If "Yes," enter the name of the foreign country: See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		No
5b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		No
5c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		No
6b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		No
7b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
7c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		No
7d	If "Yes," indicate the number of Forms 8282 filed during the year.		
7e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		No
7f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		No
7g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		No
7h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		No
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
9a	Did the sponsoring organization make any taxable distributions under section 4966?		
9b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter		
10a	Initiation fees and capital contributions included on Part VIII, line 12.		
10b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities.		
11	Section 501(c)(12) organizations. Enter		
11a	Gross income from members or shareholders.		
11b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them).		
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?		
12b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.		
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
13a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O.		
13b	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.		
13c	Enter the amount of reserves on hand.		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		No
14b	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 lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.

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

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	13	
	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		
1b	Enter the number of voting members included in line 1a, above, who are independent	8	
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3	No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4	No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5	No
6	Did the organization have members or stockholders?	6	No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	No
7b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following		
8a	a The governing body?	8a	Yes
8b	b Each committee with authority to act on behalf of the governing body?	8b	Yes
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9	No

Section B. Policies

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

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

Section C. Disclosure

17	List the States with which a copy of this Form 990 is required to be filed	VA
18	Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. ☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)	
19	Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year	
20	State the name, address, and telephone number of the person who possesses the organization's books and records LYNN KRUTAK 303 MED TECH PARKWAY JOHNSON CITY, TN 37604 (423) 302-3374	

Part VII

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

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

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

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

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

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			

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			

1b	Sub-Total			
c	Total from continuation sheets to Part VII, Section A			
d	Total (add lines 1b and 1c)	8,297,714		903,288

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 21

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
SODEXO INC, PO BOX 905374 CHARLOTTE, NC 282905374	FOOD SERVICES	4,424,319
ANESTHESIA PAIN CONSULTANTS, PO BOX 3727 JOHNSON CITY, TN 376023727	ANESTHESIA SVCS	4,173,782
CROTHALL SERVICES EAST TN, 13028 COLLECTIONS CENTER DRIVE CHICAGO, IL 60693	LAUNDRY SVCS	2,787,669
WEATHERBY LOCUMS INC, PO BOX 972633 DALLAS, TX 753972633	PHYSICIAN SVCS	2,522,133
PREMIER ANESTHESIA SERVICES, PO BOX 4653 JOHNSON CITY, TN 376024653	ANESTHESIA SVCS	2,427,608

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 76

Part VIII

Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns 1a				
	b	Membership dues 1b				
	c	Fundraising events 1c				
	d	Related organizations 1d	432,538			
	e	Government grants (contributions) 1e	604,845			
	f	All other contributions, gifts, grants, and similar amounts not included above 1f	231,517			
	g	Noncash contributions included in lines 1a-1f \$				
	h	Total. Add lines 1a-1f	1,268,900			
Program Service Revenue	2a	PATIENT REVENUE	Business Code 622110	688,861,116	688,861,116	
	b	WELLNESS PROGRAMS	622110	4,847,416	4,847,416	
	c	LAB UBI REVENUE	621500	128,293		128,293
	d	RENTAL TO EXEMPT AFFILIATE	531120	13,220	13,220	
	e	P/S INCOME ISHN-MSJC	900099	-218,852	-218,852	
	f	All other program service revenue				
	g	Total. Add lines 2a-2f	693,631,193			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)	14,153,591			14,153,591
	4	Income from investment of tax-exempt bond proceeds	49,673			49,673
	5	Royalties				
	6a	Gross rents	(i) Real 434,370	(ii) Personal		
	b	Less rental expenses	265,253			
	c	Rental income or (loss)	169,117			
	d	Net rental income or (loss)	169,117		49,954	119,163
	7a	Gross amount from sales of assets other than inventory	(i) Securities 5,889,313	(ii) Other 8,761,805		
	b	Less cost or other basis and sales expenses		6,700,716		
	c	Gain or (loss)	5,889,313	2,061,089		
	d	Net gain or (loss)	7,950,402	2,061,089		5,889,313
	8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18	a			
	b	Less direct expenses	b			
	c	Net income or (loss) from fundraising events				
	9a	Gross income from gaming activities See Part IV, line 19	a			
	b	Less direct expenses	b			
	c	Net income or (loss) from gaming activities				
	10a	Gross sales of inventory, less returns and allowances	a			
	b	Less cost of goods sold	b			
	c	Net income or (loss) from sales of inventory				
		Miscellaneous Revenue	Business Code			
	11a	CAFE' SALES	722210	3,902,669		3,902,669
	b	PREMIER VENDOR INCENTIVE	900099	3,011,683		3,011,683
	c	DAY CARE	624410	1,037,639		1,037,639
	d	All other revenue		1,310,856	703,018	607,838
	e	Total. Add lines 11a-11d		9,262,847		
	12	Total revenue. See Instructions	726,485,723	695,563,989	881,265	28,771,569

Part IX

Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.		(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1	Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	1,816,780	1,816,780		
2	Grants and other assistance to domestic individuals See Part IV, line 22				
3	Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, lines 15 and 16				
4	Benefits paid to or for members				
5	Compensation of current officers, directors, trustees, and key employees	5,695,686	46,763	5,648,923	
6	Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7	Other salaries and wages	228,406,921	213,605,830	13,956,457	844,634
8	Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	10,803,715	10,232,783	530,470	40,462
9	Other employee benefits	35,998,683	35,532,397	458,288	7,998
10	Payroll taxes	17,236,975	15,573,416	1,613,741	49,818
11	Fees for services (non-employees)				
a	Management				
b	Legal	4,827,725	20,305	4,807,420	
c	Accounting	387,756	5,100	366,711	15,945
d	Lobbying	150,136	150,136		
e	Professional fundraising services See Part IV, line 17				
f	Investment management fees	981,765		981,765	
g	Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	105,617,378	97,394,017	8,218,284	5,077
12	Advertising and promotion	2,902,045	97,330	2,779,857	24,858
13	Office expenses	8,621,509	7,489,678	1,111,896	19,935
14	Information technology	16,279,219	14,557,137	1,722,082	
15	Royalties				
16	Occupancy	14,262,873	11,053,980	3,142,344	66,549
17	Travel	1,681,314	1,241,596	437,814	1,904
18	Payments of travel or entertainment expenses for any federal, state, or local public officials				
19	Conferences, conventions, and meetings				
20	Interest	42,023,955		42,023,955	
21	Payments to affiliates				
22	Depreciation, depletion, and amortization	42,026,540	21,782,580	20,239,745	4,215
23	Insurance	1,087,692	2,134	1,085,558	
24	Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a	MEDICAL SUPPLIES & DRUGS	129,100,590	129,079,049	21,541	
b	REPAIRS & MAINTENANCE	16,610,054	15,813,605	744,019	52,430
c	DUES & SUBSCRIPTIONS	3,847,285	1,599,624	2,244,315	3,346
d	TAXES- UBIT	82,655		82,655	
e	All other expenses	3,314,887	2,744,101	534,472	36,314
25	Total functional expenses. Add lines 1 through 24e	693,764,138	579,838,341	112,752,312	1,173,485
26	Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ☐ if following SOP 98-2 (ASC 958-720)				

Part X

Balance Sheet

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

				(A)		(B)
				Beginning of year		End of year
Assets	1	Cash—non-interest-bearing			1	
	2	Savings and temporary cash investments		78,251,832	2	62,262,670
	3	Pledges and grants receivable, net		99,629	3	212,728
	4	Accounts receivable, net		111,736,791	4	111,027,708
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		8,988,974	5	10,680,656
	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		29,866,592	7	24,321,103
	8	Inventories for sale or use		15,723,351	8	16,971,892
	9	Prepaid expenses and deferred charges		4,344,835	9	5,197,148
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a1,048,448,069			
	b	Less accumulated depreciation	10b548,979,568	526,552,014	10c	499,468,501
	11	Investments—publicly traded securities		261,766,810	11	312,855,173
	12	Investments—other securities See Part IV, line 11			12	
	13	Investments—program-related See Part IV, line 11		324,481,069	13	335,649,496
	14	Intangible assets		144,707,541	14	145,025,185
	15	Other assets See Part IV, line 11		96,741,552	15	92,041,920
	16	Total assets. Add lines 1 through 15 (must equal line 34)		1,603,260,990	16	1,615,714,180
Liabilities	17	Accounts payable and accrued expenses		63,659,832	17	68,353,826
	18	Grants payable			18	
	19	Deferred revenue		1,273,627	19	11,354,761
	20	Tax-exempt bond liabilities		981,126,646	20	966,918,770
	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		25,846,994	23	16,314,872
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17–24) Complete Part X of Schedule D		94,938,811	25	78,273,041
	26	Total liabilities. Add lines 17 through 25		1,166,845,910	26	1,141,215,270
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here ☒ and complete lines 27 through 29, and lines 33 and 34.					
	27	Unrestricted net assets		436,180,033	27	474,227,931
	28	Temporarily restricted net assets		235,047	28	270,979
	29	Permanently restricted net assets			29	
	Organizations that do not follow SFAS 117 (ASC 958), check here ☐ and complete lines 30 through 34.					
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		436,415,080	33	474,498,910
	34	Total liabilities and net assets/fund balances		1,603,260,990	34	1,615,714,180

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	726,485,723
2	Total expenses (must equal Part IX, column (A), line 25)	2	693,764,138
3	Revenue less expenses Subtract line 2 from line 1	3	32,721,585
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	436,415,080
5	Net unrealized gains (losses) on investments	5	-2,815,368
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	8,177,613
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	474,498,910

Part XII Financial Statements and Reporting

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

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

Additional Data

Software ID:

Software Version:

EIN: 62-0476282

Name: MOUNTAIN STATES HEALTH ALLIANCE

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) ALAN LEVINE PRESIDENT &	55 00	X		X				1,131,975	0	142,409
(1) JEFF FARROW MD DIRECTOR	4 00	X						42,800	0	0
(2) CLEM WILKES JR PAST CHAIR	7 00 0 50	X						0	0	0
(3) GARY PEACOCK DIRECTOR	6 00 2 00	X						0	0	0
(4) SANDRA BROOKS MD DIRECTOR	5 00 2 00	X						0	0	0
(5) RICK STOREY DIRECTOR	6 00	X						0	0	0
(6) THOMAS FOWLKES DIRECTOR	5 00	X						0	0	0
(7) LINDA GARCEAU DIRECTOR	6 00	X						0	0	0
(8) JOANNE GILMER SECRETARY	7 00 3 00	X						0	0	0
(9) DAVID MAY MD DIRECTOR	7 00	X						0	0	0
(10) ROBERT FEATHERS VICE CHAIR	7 00 0 50	X						0	0	0
(11) MICHAEL CHRISTIAN TREASURER	7 00	X						0	0	0
(12) BARBARA ALLEN CHAIR	9 00	X						0	0	0
(13) MARVIN EICHORN EVP/COO	47 00 8 00			X				705,370	0	42,125
(14) LYNN KRUTAK SVP/CFO	50 00			X				390,582	0	66,400
(15) DENNIS VONDERFECHT CEO (RETIRED)	55 00			X				338,334	0	4,300
(16) ANN FLEMING SVP/CONSULTA	42 50 2 50				X			549,839	0	22,858
(17) CANDACE JENNINGS SR VP TN OP	50 00				X			351,819	0	22,496
(18) MONTY MCLAURIN VP/CEO NW MK	43 00 2 00				X			351,121	0	54,334
(19) SHANE HILTON VP/TN CFO	43 50 1 50				X			348,154	0	55,626
(20) TONY BENTON VP/COO WASH	45 00				X			332,837	0	38,246
(21) LINDA WHITE VP & CEO, FW	45 00				X			267,119	0	43,807
(22) LEMMIE TAYLOR VP/CEO SE MK	45 00				X			234,615	0	46,487
(23) RHONDA MANN JCMC CNO	45 00				X			187,454	0	26,150
(24) DRU MALCOLM VP & CNO JCM	45 00				X			165,697	0	17,636

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(26) STEVE SAWYER AVP/CFO NW M	45 00				X			165,484	0	24,048
(1) MORRIS SELIGMAN MD EVP/CMO	55 00					X		583,005	0	75,184
(2) FRANK LAURO MD VP/MED DIR	45 00					X		453,473	0	44,406
(3) STEVE KILGORE PRES /CEO BR	48 00 2 00					X		419,843	0	66,506
(4) MARK WILKINSON MD VP/CMO	45 00					X		419,545	0	35,297
(5) CLAY RUNNELS MD VP/CMO WASH	45 00					X		414,248	0	35,258
(6) DALE CLAYTORE VP RESOURCE	45 00						X	238,752	0	13,581
(7) PAT NIDAY FORMER CNO W	45 00						X	205,648	0	26,134

SCHEDULE A
(Form 990 or 990EZ)

Department of the
Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization MOUNTAIN STATES HEALTH ALLIANCE	Employer identification number 62-0476282
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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		
Total						

Part II

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

Section A. Public Support						
Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support						
Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11 Total support Add lines 7 through 10						
12 Gross receipts from related activities, etc (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						▶

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

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

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

Section C. Computation of Public Support Percentage			
15 Public support percentage for 2014 (line 8, column (f) divided by line 13, column (f))	15		
16 Public support percentage from 2013 Schedule A, Part III, line 15	16		

Section D. Computation of Investment Income Percentage			
17 Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f))	17		
18 Investment income percentage from 2013 Schedule A, Part III, line 17	18		
19a 33 1/3% support tests—2014. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization ▶			
b 33 1/3% support tests—2013. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization ▶			
20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶			

Part IV Supporting Organizations

(Complete only if you checked a box on line 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
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.	1	
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).	2	
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.	3a	
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination.	3b	
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use.	3c	
4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below.	4a	
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations. . . .	4b	
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.	4c	
5a Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document).	5a	
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b	
c Substitutions only. Was the substitution the result of an event beyond the organization's control?	5c	
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (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 Part VI .	6	
7 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) .	7	
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part II of Schedule L (Form 990).	8	
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI .	9a	
b Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI .	9b	
c Did a disqualified person (as defined in line 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 Part VI .	9c	
10a 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.	10a	
b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).	10b	
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?	11a	
b A family member of a person described in (a) above?	11b	
c A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in Part VI.	11c	

Part IV

Supporting Organizations (continued)

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

	Yes	No
1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (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?		
2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).		
3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.		

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 <u>Activities Test</u> Answer (a) and (b) below.			
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.			
b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.			
3 <u>Parent of Supported Organizations</u> Answer (a) and (b) below.			
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI.			
b Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.			

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	Adjusted Net Income (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)	1	
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	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount 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	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (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	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

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

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2014	(iii) Distributable Amount for 2014
1 Distributable amount for 2014 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2014 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2014			
a From 2009.			
b From 2010.			
c From 2011.			
d From 2012.			
e From 2013.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2014 distributable amount			
i Carryover from 2009 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2014 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2014 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2014, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2014 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 Excess distributions carryover to 2015. Add lines 3j and 4c			
8 Breakdown of line 7			
a From 2010.			
b From 2011.			
c From 2012.			
d From 2013.			
e From 2014.			

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

Facts And Circumstances Test

Return Reference

Explanation

SCHEDULE C

(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

Political Campaign and Lobbying Activities

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

▶ **Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at**

www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

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 the organization MOUNTAIN STATES HEALTH ALLIANCE	Employer identification number 62-0476282
---	--

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-

Part II-A

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)															
b Total lobbying expenditures to influence a legislative body (direct lobbying)															
c Total lobbying expenditures (add lines 1a and 1b)															
d Other exempt purpose expenditures															
e Total exempt purpose expenditures (add lines 1c and 1d)															
f Lobbying nontaxable amount Enter the amount from the following table in both columns															
<table><tr><td>If the amount on line 1e, column (a) or (b) is:</td><td>The lobbying nontaxable amount is:</td></tr><tr><td>Not over \$500,000</td><td>20% of the amount on line 1e</td></tr><tr><td>Over \$500,000 but not over \$1,000,000</td><td>\$100,000 plus 15% of the excess over \$500,000</td></tr><tr><td>Over \$1,000,000 but not over \$1,500,000</td><td>\$175,000 plus 10% of the excess over \$1,000,000</td></tr><tr><td>Over \$1,500,000 but not over \$17,000,000</td><td>\$225,000 plus 5% of the excess over \$1,500,000</td></tr><tr><td>Over \$17,000,000</td><td>\$1,000,000</td></tr></table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000	Over \$17,000,000	\$1,000,000		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000														
Over \$17,000,000	\$1,000,000														
g Grassroots nontaxable amount (enter 25% of line 1f)															
h Subtract line 1g from line 1a If zero or less, enter -0-															
i Subtract line 1f from line 1c If zero or less, enter -0-															
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		☐ Yes ☐ No													

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

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

Part II-B

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

For each "Yes" response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?	Yes		1,129
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		253,186
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?		No	
j	Total. Add lines 1c through 1i.			254,315
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912.			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912.			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A

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

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

Part III-B

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

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

Part IV

Supplemental Information

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

Return Reference	Explanation
SCHEDULE C, PART II-B, LINE 1	THE COMMUNITY & GOVERNMENT RELATIONS VICE PRESIDENT AND/OR THE DEPARTMENT'S MANAGER OR DIRECTOR ATTENDED THE FOLLOWING LEGISLATIVE CONFERENCES - PREMIER FEDERAL AFFAIRS NETWORK MEETING - AMERICAN HOSPITAL ASSOCIATION ANNUAL MEETING - TENNESSEE HOSPITAL ASSOCIATION LEGISLATIVE ADVOCACY DAY - HOSPITAL ALLIANCE OF TENNESSEE ANNUAL MEETING - TENNESSEE PUBLIC & TEACHING HOSPITALS ASSOCIATION ANNUAL MEETING - VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION LEGISLATIVE ISSUES CONFERENCE THE COMMUNITY & GOVERNMENT RELATIONS VICE PRESIDENT AND/OR DEPARTMENTAL STAFF ALSO CONTACTED CONGRESSIONAL OFFICES CONCERNING THE FOLLOWING ISSUES - SUPPORTED PERMANENT DISPROPORTIONATE SHARE HOSPITAL FOR THE STATE OF TENNESSEE - SUPPORTED SUSTAINABLE GROWTH RATE REFORM - OPPOSED ADDITIONAL CUTS IN MEDICARE/MEDICAID - SUPPORTED REAUTHORIZATION AND FUNDING OF CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION - SUPPORTED FEDERAL FUNDING FOR TRAUMA CARE - SUPPORTED CONTINUATION OF GRADUATE MEDICAL EDUCATION FUNDING - SUPPORTED AREA WAGE INDEX REFORM - SUPPORTED STUDY OF CHRONIC CARE FOR MEDICARE RECIPIENTS - SUPPORTED CHANGES TO 2 MIDNIGHT RULE - SUPPORTED RECOVERY AUDIT CONTRACTOR REFORM - SUPPORTED MEDICARE DEPENDENT HOSPITAL AND LOW-VOLUME DESIGNATIONS THE COMMUNITY & GOVERNMENT RELATIONS VICE PRESIDENT AND/OR DEPARTMENTAL DIRECTOR RESPONDED VIA LETTER, PHONE, OR IN PERSON TO SUPPORT THE FOLLOWING TENNESSEE AND VIRGINIA LEGISLATIVE ISSUES - MEDICAID EXPANSION - TENNESSEE - CERTIFICATE OF PUBLIC ADVANTAGE - STRONG CERTIFICATE OF NEED PROGRAMS IN TENNESSEE AND VIRGINIA - CONTINUATION OF HOSPITAL ASSESSMENT FEE IN TENNESSEE - FUNDING FOR PERINATAL CENTERS IN TENNESSEE - MENTAL HEALTH FUNDING FOR INPATIENT PSYCHIATRIC CARE - TENNESSEE - STABLE MEDICAID RATES IN VIRGINIA - LESS BURDENSOME LICENSURE REQUIREMENTS FOR GRADUATES OF FOREIGN MEDICAL SCHOOLS - HELMET REQUIREMENT FOR MOTORCYCLISTS

[illegible]

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.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization MOUNTAIN STATES HEALTH ALLIANCE	Employer identification number 62-0476282
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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? ☐ Yes ☐ No	
6	Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No	

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

1

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

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

☐ Preservation of an historically important land area

☐ Protection of natural habitat

☐ Preservation of a certified historic structure

☐ Preservation of open space

2

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

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

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) Revenue 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

► \$

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

Cat No 52283D

Schedule D (Form 990) 2014

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	b (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

3a(i)

Yes

No

(ii) related organizations

3a(ii)

Yes

No

b

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

3b

Yes

No

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		48,225,494		48,225,494
b Buildings		511,933,826	179,762,710	332,171,116
c Leasehold improvements		950,676	562,176	388,500
d Equipment		487,338,073	368,654,682	118,683,391
e Other				
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				499,468,501

Schedule D (Form 990) 2014

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.

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
SCHEDULE D, PAGE 3, PART X	THE ALLIANCE IS CLASSIFIED AS AN ORGANIZATION EXEMPT FROM INCOME TAXES UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE. AS SUCH, NO PROVISION FOR INCOME TAXES HAS BEEN MADE IN THE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS FOR THE ALLIANCE AND ITS TAX-EXEMPT SUBSIDIARIES. THE ALLIANCE'S TAXABLE SUBSIDIARIES ARE DISCUSSED IN NOTE L. THE ALLIANCE HAS NO SIGNIFICANT UNCERTAIN TAX POSITIONS AT JUNE 30, 2015 AND 2014. AT JUNE 30, 2015, TAX RETURNS FOR 2011 THROUGH 2014 ARE SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE.

[illegible]

Additional Data

Software ID:

Software Version:

EIN: 62-0476282

Name: MOUNTAIN STATES HEALTH ALLIANCE

Form 990, Schedule D, Part VIII - Investments Program Related

(a) Description of investment type	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) INVESTMENT IN JMH	132,000,000	C
(2) INVESTMENT IN BRMMC	100,310,432	C
(3) INVESTMENT IN SCCH	68,400,494	C
(4) INVESTMENT IN ISHN	35,854,787	C
(5) INVESTMENT IN PREMIER	425,000	C
(6) INVESTMENT IN QRH OF JC, LLC	1,305	C
(7) INVESTMENT IN QRH OF JC, LLC	-18,302	C
(8) PREMIER RESERVE	-260,000	C
(9) INVESTMENT IN MSJC	-1,064,220	C

SCHEDULE H
(Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

► Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
► Attach to Form 990.
► Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

Part I

Financial Assistance and Certain Other Community Benefits at Cost

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

7

Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			12,019,626		12,019,626	1 730 %
b Medicaid (from Worksheet 3, column a)			110,038,412	80,207,944	29,830,468	4 300 %
c Costs of other means-tested government programs (from Worksheet 3, column b) . .						
d Total Financial Assistance and Means-Tested Government Programs .			122,058,038	80,207,944	41,850,094	6 030 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			4,952,128	838,561	4,113,567	0 590 %
f Health professions education (from Worksheet 5)			12,296,806	3,020,754	9,276,052	1 340 %
g Subsidized health services (from Worksheet 6)			20,740,601	12,558,813	8,181,788	1 180 %
h Research (from Worksheet 7)			260,074	22,625	237,449	0 030 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			1,736,609		1,736,609	0 250 %
j Total Other Benefits			39,986,218	16,440,753	23,545,465	3 390 %
k Total . Add lines 7d and 7j .			162,044,256	96,648,697	65,395,559	9 430 %

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

1

Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?

1

Yes

No

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

84,032,514

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

63,864,711

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

170,145,174

6

Enter Medicare allowable costs of care relating to payments on line 5.

6

165,836,466

7

Subtract line 6 from line 5. This is the surplus (or shortfall).

7

4,308,708

8

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

☐

Cost accounting system

☒

Cost to charge ratio

☐

Other

Section C. Collection Practices

9a

Did the organization have a written debt collection policy during the tax year?

9a

Yes

No

b

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

9b

Yes

No

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 MED'L SPEC OF JC LLC	MEDICAL SERVICES	51.000 %		49.000 %
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Section A. Hospital Facilities

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

[illegible]

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)

JOHNSON CITY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

1

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
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 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
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	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a ☒ Hospital facility's website (list url) <u>WWW.MOUNTAINSTATESHEALTH.COM</u>		
b ☐ Other website (list url) _____		
c ☒ Made a paper copy available for public inspection without charge at the hospital facility		
d ☐ Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a If "Yes" (list url) _____		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
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? \$ _____		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

JOHNSON CITY MEDICAL CENTER

	Yes	No
Financial Assistance Policy (FAP)		
13 Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a ☒ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 000000000000%</u> and FPG family income limit for eligibility for discounted care of <u>400 000000000000%</u>		
b ☐ Income level other than FPG (describe in Section C)		
c ☒ Asset level		
d ☒ Medical indigency		
e ☐ Insurance status		
f ☒ Underinsurance discount		
g ☐ Residency		
h ☐ Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	14 Yes	
15 Explained the method for applying for financial assistance?	15 Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a ☒ Described the information the hospital facility may require an individual to provide as part of his or her application		
b ☒ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c ☒ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e ☐ Other (describe in Section C)		
16 Included measures to publicize the policy within the community served by the hospital facility?	16 Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a ☒ The FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
b ☒ The FAP application form was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
c ☐ A plain language summary of the FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
d ☒ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e ☒ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f ☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g ☒ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h ☒ Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i ☐ Other (describe in Section C)		
Billing and Collections		
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a ☐ Reporting to credit agency(ies)		
b ☐ Selling an individual's debt to another party		
c ☐ Actions that require a legal or judicial process		
d ☐ Other similar actions (describe in Section C)		
e ☒ None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

JOHNSON CITY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group		Yes	No
19 Did the hospital facility or other authorized third 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		19 Yes	
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)			
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (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		21 Yes	
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)			
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		23	No
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		24	No

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)

INDIAN PATH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

2

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
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 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
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	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a ☒ Hospital facility's website (list url) <u>WWW.MOUNTAINSTATESHEALTH.COM</u>		
b ☐ Other website (list url) _____		
c ☒ Made a paper copy available for public inspection without charge at the hospital facility		
d ☐ Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a If "Yes" (list url) _____		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
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? \$ _____		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

INDIAN PATH MEDICAL CENTER

		Yes	No
Financial Assistance Policy (FAP)			
13 Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes	
a ☒ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 000000000000%</u> and FPG family income limit for eligibility for discounted care of <u>400 000000000000%</u>			
b ☐ Income level other than FPG (describe in Section C)			
c ☒ Asset level			
d ☒ Medical indigency			
e ☐ Insurance status			
f ☒ Underinsurance discount			
g ☐ Residency			
h ☐ Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance?	15	Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a ☒ Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☒ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☒ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☐ Other (describe in Section C)			
16 Included measures to publicize the policy within the community served by the hospital facility?	16	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☒ The FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>			
b ☒ The FAP application form was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>			
c ☐ A plain language summary of the FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>			
d ☒ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☒ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☒ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h ☒ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☐ Other (describe in Section C)			
Billing and Collections			
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ Actions that require a legal or judicial process			
d ☐ Other similar actions (describe in Section C)			
e ☒ None of these actions or other similar actions were permitted			

Part V

Facility Information (continued)

INDIAN PATH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group			Yes	No
19	Did the hospital facility or other authorized third 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	19	Yes	
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)			
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (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	21	Yes	
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)			
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	23		No
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	24		No

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)

FRANKLIN WOODS COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

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

3

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
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 20 15		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
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	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a ☒ Hospital facility's website (list url) WWW.MOUNTAINSTATESHEALTH.COM		
b ☐ Other website (list url)		
c ☒ Made a paper copy available for public inspection without charge at the hospital facility		
d ☐ Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 16		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a If "Yes" (list url)		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
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? \$		

Part V

Facility Information (continued)

FRANKLIN WOODS COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

	Yes	No
Financial Assistance Policy (FAP)		
13 Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a ☒ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 000000000000%</u> and FPG family income limit for eligibility for discounted care of <u>400 000000000000%</u>		
b ☐ Income level other than FPG (describe in Section C)		
c ☒ Asset level		
d ☒ Medical indigency		
e ☐ Insurance status		
f ☒ Underinsurance discount		
g ☐ Residency		
h ☐ Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	14 Yes	
15 Explained the method for applying for financial assistance?	15 Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a ☒ Described the information the hospital facility may require an individual to provide as part of his or her application		
b ☒ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c ☒ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e ☐ Other (describe in Section C)		
16 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)	16 Yes	
a ☒ The FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
b ☒ The FAP application form was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
c ☐ A plain language summary of the FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
d ☒ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e ☒ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f ☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g ☒ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h ☒ Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i ☐ Other (describe in Section C)		

Billing and Collections

17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a ☐ Reporting to credit agency(ies)		
b ☐ Selling an individual's debt to another party		
c ☐ Actions that require a legal or judicial process		
d ☐ Other similar actions (describe in Section C)		
e ☒ None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

FRANKLIN WOODS COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group		Yes	No
19 Did the hospital facility or other authorized third 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		19 Yes	
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)			
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (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		21 Yes	
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)			
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		23	No
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		24	No

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)

SYCAMORE SHOALS HOSPITAL

Name of hospital facility or letter of facility reporting group

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

4

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
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 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
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	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a ☒ Hospital facility's website (list url) <u>WWW.MOUNTAINSTATESHEALTH.COM</u>		
b ☐ Other website (list url) _____		
c ☒ Made a paper copy available for public inspection without charge at the hospital facility		
d ☐ Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a If "Yes" (list url) _____		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
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? \$ _____		

Part V

Facility Information (continued)

SYCAMORE SHOALS HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
Financial Assistance Policy (FAP)			
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes
a	☒ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 000000000000%</u> and FPG family income limit for eligibility for discounted care of <u>400 000000000000%</u>		
b	☐ Income level other than FPG (describe in Section C)		
c	☒ Asset level		
d	☒ Medical indigency		
e	☐ Insurance status		
f	☒ Underinsurance discount		
g	☐ Residency		
h	☐ Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? 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)	15	Yes
a	☒ Described the information the hospital facility may require an individual to provide as part of his or her application		
b	☒ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	☒ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	☐ Other (describe in Section C)		
16	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)	16	Yes
a	☒ The FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
b	☒ The FAP application form was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
c	☐ A plain language summary of the FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
d	☒ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	☒ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	☒ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	☒ Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	☐ Other (describe in Section C)		
Billing and Collections			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	Yes
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	☐ Reporting to credit agency(ies)		
b	☐ Selling an individual's debt to another party		
c	☐ Actions that require a legal or judicial process		
d	☐ Other similar actions (describe in Section C)		
e	☒ None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

SYCAMORE SHOALS HOSPITAL			
Name of hospital facility or letter of facility reporting group			
		Yes	No
19	Did the hospital facility or other authorized third 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)	19	Yes
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (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)	21	Yes
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	23	No
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	24	No

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)

RUSSELL COUNTY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

5

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
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 20 <u>15</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
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	6a	Yes
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b	No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a	☒ Hospital facility's website (list url) <u>WWW.MOUNTAINSTATESHEALTH.COM</u>		
b	☐ Other website (list url) _____		
c	☒ Made a paper copy available for public inspection without charge at the hospital facility		
d	☐ Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a	If "Yes" (list url) _____		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
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? \$ _____		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

RUSSELL COUNTY MEDICAL CENTER

		Yes	No
Financial Assistance Policy (FAP)			
13 Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes	
a ☒ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 000000000000%</u> and FPG family income limit for eligibility for discounted care of <u>400 000000000000%</u>			
b ☐ Income level other than FPG (describe in Section C)			
c ☒ Asset level			
d ☒ Medical indigency			
e ☐ Insurance status			
f ☒ Underinsurance discount			
g ☐ Residency			
h ☐ Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 Explained the method for applying for financial assistance?	15	Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a ☒ Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☒ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☒ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☐ Other (describe in Section C)			
16 Included measures to publicize the policy within the community served by the hospital facility?	16	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☒ The FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>			
b ☒ The FAP application form was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>			
c ☐ A plain language summary of the FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>			
d ☒ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☒ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☒ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h ☒ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☐ Other (describe in Section C)			
Billing and Collections			
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ Actions that require a legal or judicial process			
d ☐ Other similar actions (describe in Section C)			
e ☒ None of these actions or other similar actions were permitted			

Part V

Facility Information (continued)

RUSSELL COUNTY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No	
19	Did the hospital facility or other authorized third 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) 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (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	19	Yes	
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)	21	Yes	
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	23		No
		24		No

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)

JOHNSON COUNTY COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

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

6

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
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 20 <u>15</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
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	6a	Yes
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b	No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a	☒ Hospital facility's website (list url) <u>WWW.MOUNTAINSTATESHEALTH.COM</u>		
b	☐ Other website (list url) _____		
c	☒ Made a paper copy available for public inspection without charge at the hospital facility		
d	☐ Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9	Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a	If "Yes" (list url) _____		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
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? \$ _____		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

JOHNSON COUNTY COMMUNITY HOSPITAL

		Yes	No
Financial Assistance Policy (FAP)			
13	Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes
a	☒ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 000000000000%</u> and FPG family income limit for eligibility for discounted care of <u>400 000000000000%</u>		
b	☐ Income level other than FPG (describe in Section C)		
c	☒ Asset level		
d	☒ Medical indigency		
e	☐ Insurance status		
f	☒ Underinsurance discount		
g	☐ Residency		
h	☐ Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance?	15	Yes
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a	☒ Described the information the hospital facility may require an individual to provide as part of his or her application		
b	☒ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	☒ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	☐ Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility?	16	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a	☒ The FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
b	☒ The FAP application form was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
c	☐ A plain language summary of the FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
d	☒ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	☒ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	☒ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	☒ Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	☐ Other (describe in Section C)		
Billing and Collections			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	Yes
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	☐ Reporting to credit agency(ies)		
b	☐ Selling an individual's debt to another party		
c	☐ Actions that require a legal or judicial process		
d	☐ Other similar actions (describe in Section C)		
e	☒ None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

JOHNSON COUNTY COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
19	Did the hospital facility or other authorized third 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)	19 Yes	
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (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)	21 Yes	
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	23	No
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	24	No

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)

UNICOI COUNTY MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

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

7

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3	Yes
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 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
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	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	No
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	7	Yes
a ☒ Hospital facility's website (list url) <u>WWW.MOUNTAINSTATESHEALTH.COM</u>		
b ☐ Other website (list url) _____		
c ☒ Made a paper copy available for public inspection without charge at the hospital facility		
d ☐ Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	No
a If "Yes" (list url) _____		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	Yes
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
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? \$ _____		

Part V

Facility Information (continued)

Name of hospital facility or letter of facility reporting group

UNICOI COUNTY MEMORIAL HOSPITAL

		Yes	No
Financial Assistance Policy (FAP)			
13	Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13	Yes
a	☒ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200 000000000000%</u> and FPG family income limit for eligibility for discounted care of <u>400 000000000000%</u>		
b	☐ Income level other than FPG (describe in Section C)		
c	☒ Asset level		
d	☒ Medical indigency		
e	☐ Insurance status		
f	☒ Underinsurance discount		
g	☐ Residency		
h	☐ Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance?	15	Yes
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)		
a	☒ Described the information the hospital facility may require an individual to provide as part of his or her application		
b	☒ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	☒ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	☐ Other (describe in Section C)		
16	Included measures to publicize the policy within the community served by the hospital facility?	16	Yes
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a	☒ The FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
b	☒ The FAP application form was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
c	☐ A plain language summary of the FAP was widely available on a website (list url) <u>WWWMOUNTAINSTATESHEALTHCOM</u>		
d	☒ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	☒ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	☐ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	☒ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
h	☒ Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	☐ Other (describe in Section C)		
Billing and Collections			
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	Yes
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	☐ Reporting to credit agency(ies)		
b	☐ Selling an individual's debt to another party		
c	☐ Actions that require a legal or judicial process		
d	☐ Other similar actions (describe in Section C)		
e	☒ None of these actions or other similar actions were permitted		

Part V

Facility Information (continued)

UNICOI COUNTY MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
19	Did the hospital facility or other authorized third 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	19	Yes
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)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (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	21	Yes
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)		
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	23	No
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	24	No

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.

Form and Line Reference	Explanation
See Additional Data Table	

Part V

Facility Information *(continued)*

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

How many non-hospital health care facilities did the organization operate during the tax year? **10**

Name and address		Type of Facility (describe)
1	JCMC AMBULATORY SURGERY CENTER 400 N STATE OF FRANKLIN ROAD JOHNSON CITY, TN 37604	LICENSED AMBULATORY SURGERY CENTER
2	MOUNTAIN STATES IMAGING CENTER 301 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604	LICENSED OUTPATIENT DIAGNOSTIC CENTER
3	INDIAN PATH TRANSITIONAL CARE 2000 BROOKSIDE DRIVE KINGSPORT, TN 37660	LICENSED SKILLED NURSING FACILITY
4	MEDICAL CNTR HOME CARE-JOHNSON CITY 101 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604	LICENSED HOME HEALTH AGENCY
5	MEDICAL CNTR HOME CARE-KINGSPORT 2020 BROOKSIDE DRIVE 28 KINGSPORT, TN 37660	LICENSED HOME HEALTH AGENCY
6	RUSSELL CO MEDICAL CNTR HOME HLTH 116 FLANNAGAN AVENUE LEBANON, VA 24266	LICENSED HOME HEALTH AGENCY
7	MEDICAL CENTER HOSPICE 101 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604	LICENSED HOSPICE AGENCY
8	JOHNSON COUNTY HOME HEALTH 1987 SOUTH SHADY STREET MOUNTAIN CITY, TN 37683	LICENSED HOME HEALTH AGENCY
9	RUSSELL COUNTY MEDICAL CNTR HOSPICE 116 FLANNAGAN AVENUE LABANON, VA 24266	LICENSED HOSPICE AGENCY
10	UNICOI COUNTY LONG TERM CARE 100 GREENWAY CIRCLE UNICOI, TN 37650	LICENSED LONG TERM CARE FACILITY

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

Form and Line Reference	Explanation
PART I, LINE 6A - RELATED ORGANIZATION INFORMATION	MSHA'S COMMUNITY BENEFIT REPORT WAS COMPLETED IN FY15

Form and Line Reference	Explanation
PART I, LINE 7 - COSTING METHODOLOGY EXPLANATION	THE COST TO CHARGE RATIO (WORKSHEET 2 "RATIO OF PATIENT CARE COST TO CHARGES") WAS USED TO CALCULATE LINE 7A FINANCIAL ASSISTANCE (CHARITY CARE) COST OUR COST ACCOUNTING SYSTEM WAS USED TO DETERMINE LOSSES FROM MEDICAID AND TENNCARE REPORTED ON LINE 7B, WITH THE EXCEPTION OF HOME HEALTH, A SMALL PHYSICIAN CLINIC AND UCMH - WE USED THE COST TO CHARGE RATIO FOR THEIR DATA BECAUSE THESE ARE SMALLER DIVISIONS NOT AVAILABLE IN OUR COST ACCOUNTING SOFTWARE LINE 7E COMMUNITY HEALTH IMPROVEMENT INCLUDES COSTS THAT ARE TAKEN DIRECTLY FROM DEPARTMENTAL OPERATING REPORTS, WITH NO ADDITIONAL OVERHEAD INCLUDED IN THE COST LINE 7F HEALTH PROFESSIONS EDUCATION IS COMPRISED OF INTERNSHIPS (PRIMARILY INTERNAL MEDICINE RESIDENTS, NURSING, PHARMACY, AND THERAPY STUDENTS) WITH SCHOOLS AND UNIVERSITIES, ALLOWING THEIR HEALTH PROFESSION STUDENTS TO GET HANDS-ON TRAINING MEDICAL RESIDENT COSTS ARE TAKEN FROM JCMC AND IPMC MEDICARE COST REPORTS (NET OF ASSOCIATED REIMBURSEMENT) OUR ORGANIZATIONAL DEVELOPMENT DEPARTMENT KEEPS DETAILED RECORDS ON HOURS SPENT ON THE OTHER TYPES OF STUDENTS' ACTIVITIES, THE NUMBER OF STUDENTS THAT ROTATE THROUGH OUR HOSPITALS, ETC INFORMATION IS MAINTAINED FOR EACH HOSPITAL UNIT THAT PARTICIPATES WE ONLY INCLUDE LABOR COSTS AND WE ONLY ASSUME A PERCENTAGE OF OUR TEAM MEMBERS' TIME DEVOTED TO THESE STUDENTS FOR LINE 7G SUBSIDIZED HEALTH CARE SERVICES, WE USE OUR COST ACCOUNTING SYSTEM BECAUSE WE HAVE ESTABLISHED, STANDARD COSTING REPORTS FOR THESE SERVICES WE ARE CAREFUL TO ENSURE NO DOUBLE COUNTING OF COST (FOR EXAMPLE, WE DO NOT INCLUDE CHARITY AND TENNCARE/MEDICAID ALREADY REPORTED ON LINES 7A AND 7B) AND, PURSUANT TO IRS INSTRUCTIONS, WE DO NOT INCLUDE BAD DEBT LOSSES ALTHOUGH WE HAVE MANY SERVICE LINES WITHIN OUR HOSPITALS THAT LOSE MONEY, WE DO NOT REPORT SERVICES THAT HOSPITALS ARE REQUIRED BY STATE LICENSURE TO PROVIDE WE ALSO INCLUDE A PHYSICIAN SPECIALTY CLINIC OPERATED BY JCCH, A FEDERALLY DESIGNATED CRITICAL ACCESS HOSPITAL THIS CONTINUES TO BA A VALUABLE RESOURCE TO THE RESIDENTS OF THE AREA BY AIDING WITH TRANSPORTATION ISSUES (OTHER PHYSICIAN OFFICES ARE MORE THAN AN HOUR AWAY), RESOLVING ACCESS LIMITATIONS FOR SPECIALTY SERVICES, AND PROVIDING RELIEF TO THE SPECIAL HEALTH PROBLEMS OF A LARGELY ELDERLY POPULATION THE CLINIC INCURRED A LOSS OF 54,215 DURING FY15 LINE 7H RESEARCH IS REPORTED USING THE RESEARCH DEPARTMENT'S ACTUAL EXPENSES AND NO OVERHEAD PROVISION IS ADDED LINE 7I CASH AND IN-KIND CONTRIBUTIONS INCLUDES CASH DISBURSEMENTS AND IN-KIND DONATIONS OF MEDICATIONS TO LOCAL NON-PROFIT RESCUE SQUADS AND FIRE DEPARTMENTS IN-KIND DONATIONS OF MEDICATIONS ARE BASED ON OUR ACTUAL COST FOR THESE ITEMS

Form and Line Reference	Explanation
PART II - COMMUNITY BUILDING ACTIVITIES	MSHA LEADERS SUPPORT AND ENCOURAGE ALL TEAM MEMBERS TO VOLUNTEER TIME, MONEY AND SKILLS TO COMMUNITY SERVICE PROJECTS AND CHARITABLE ORGANIZATIONS. SENIOR LEADERS AND BOARD MEMBERS SET A POSITIVE EXAMPLE FOR MSHA TEAM MEMBERS, SERVING VOLUNTARILY ON COMMITTEES AND MANAGING BOARDS OF LOCAL SERVICE AND NON-PROFIT ORGANIZATIONS. SOME ALSO SERVE AS MEMBERS AND CONSULTANTS ON PROFESSIONAL COMMITTEES AND TASK FORCES THAT AFFECT REGIONAL DEVELOPMENT IN HEALTHCARE AND EDUCATION. MSHA, IN COLLABORATION WITH AREA HEALTH AGENCIES AND PROVIDERS, MAY OFFER ASSISTANCE WITH COORDINATION, ADVOCACY, PROVIDE SPACE, OR CONTRIBUTE SUPPLIES TO SUPPORT GROUPS FOR THEIR PROGRAM ACTIVITIES THAT SERVE TO ASSIST SPECIAL POPULATIONS WITHIN OUR AREA. MSHA INCURRED EXPENSES OF ALMOST 1.6 MILLION ON PHYSICIAN RECRUITMENT TO REPLACE PHYSICIANS RETIRING OR LEAVING OUR SERVICE AREAS, INCLUDING RECRUITMENT TO GOVERNMENT DESIGNATED UNDERSERVED COMMUNITIES. WITHOUT MSHA'S DEDICATION TO RURAL HEALTH, THERE WOULD NOT BE AN ADEQUATE NUMBER OF PHYSICIANS TO SERVE THIS PATIENT POPULATION. MSHA PROVIDED NUMEROUS CONTRIBUTIONS TO CHARITABLE ORGANIZATIONS THAT SERVE TO ASSIST SPECIAL POPULATIONS WITHIN OUR AREA. MOST OF THESE ORGANIZATIONS WORK TO IMPROVE THE LIVES OF COMMUNITY MEMBERS THAT HAVE LIMITED, OR NO, FINANCIAL RESOURCES. SOME OF THESE INCLUDE FEEDING THE POOR, HEALTH AND DENTAL CARE, HOMES FOR CHILDREN, IMPROVING ACCESS TO HEALTH CARE, AND ACTIVITIES FOR AT-RISK CHILDREN. WE MADE MANY DONATIONS SPECIFIC TO CHILDREN, SUCH AS AFTER SCHOOL ACTIVITIES, HEALTH IMPROVEMENT SERVICES AND MENTORING PROGRAMS. OTHER DONATIONS ARE MADE TO BROADER-BASED ORGANIZATIONS SUCH AS AMERICAN CANCER SOCIETY AND AMERICAN HEART ASSOCIATION. MSHA PROVIDES FUNDING TO AREA UNIVERSITIES AND COLLEGES IN SUPPORT OF HEALTH PROFESSIONAL EDUCATION.

Form and Line Reference	Explanation
PART III, LINE 2 - BAD DEBT EXPENSE METHODOLOGY	SELF-PAY BALANCES INCLUDE ACCOUNTS AFTER PAYMENTS AND CONTRACTUAL ADJUSTMENTS (DISCOUNTS) HAVE BEEN POSTED FROM ALL THIRD-PARTY PAYERS- GENERALLY LEAVING THE PATIENT RESPONSIBLE FOR ANY REMAINING DEDUCTIBLE AND/OR CO-PAYMENT OTHER SELF-PAY ACCOUNTS ARE FROM PATIENTS WITH NO INSURANCE OR OTHER THIRD-PARTY COVERAGE ALL PATIENTS WITH NO FORM OF THIRD- PARTY PAYER COVERAGE RECEIVE A 66% CALCULATED DISCOUNT, AS REQUIRED BY TENNESSEE LAW THE EXCEPTION IS OUR CRITICAL ACCESS HOSPITAL, JOHNSON COUNTY COMMUNITY HOSPITAL, WHICH PROVIDES THE UNINSURED WITH A 50% CALCULATED DISCOUNT JCCH'S CALCULATED DISCOUNT, AS DETERMINED BY TENNESSEE LAW, IS LOWER DUE TO THE SMALL HOSPITAL'S LOWER COST STRUCTURE MSHA APPLIES TENNESSEE LAW TO OUR VIRGINIA HOSPITALS' PATIENT ACCOUNTS AS WELL AFTER THE NORMAL COLLECTION PROCESS HAS INDICATED AN ACCOUNT IS UNCOLLECTIBLE, MSHA WRITES THE ACCOUNT OFF TO BAD DEBT THE HOSPITAL'S OVERALL SELF-PAY ACCOUNTS RECEIVABLE BALANCE IS EVALUATED ON AN ONGOING BASIS TO GATHER HISTORICAL INFORMATION TO APPLY TO THE CURRENT BALANCE IN OTHER WORDS, THE HOSPITAL EVALUATES PAST COLLECTION HISTORY ON ACCOUNTS WRITTEN OFF TO BAD DEBT AND APPLIES THE HISTORICAL UNPAID RATE TO THE CURRENT SELF-PAY ACCOUNTS RECEIVABLE BALANCE

Form and Line Reference	Explanation
PART III, LINE 3 BAD DEBT EXPENSE, PATIENTS ELIGIBLE FOR ASSISTANCE	MSHA'S PATIENT FINANCIAL SERVICES MANAGEMENT ESTIMATES THAT 76% OF BAD DEBT EXPENSE IS ASSUMED ATTRIBUTABLE TO PATIENTS LIKELY ELIGIBLE FOR FINANCIAL ASSISTANCE. WE BASE THIS PERCENTAGE ON THE COMPOSITION OF BAD DEBTS ATTRIBUTABLE TO PATIENT ACCOUNTS WITH NO FORM OF INSURANCE OR THIRD-PARTY COVERAGE, WHICH REPRESENTS THE MAJORITY OF BAD BEBT ACCOUNTS. WE ALSO ESTIMATE A MUCH SMALLER PERCENTAGE OF LIKELY CHARITY-ELIGIBLE ACCOUNTS TO ACCOUNTS WITH BALANCES AFTER INSURANCE/THIRD-PARTY COVERAGE HAS PAID (E.G. REMAINING DEDUCTIBLE AND CO-PAYMENT BALANCES). IT IS IMPLAUSIBLE TO DETERMINE WITH EXACTITUDE THE AMOUNT OF MSHA'S BAD DEBT ASSOCIATED WITH THOSE PATIENTS WHO MAY HAVE MET THE CRITERIA SET FORTH IN OUR FINANCIAL ASSISTANCE POLICY WITHOUT HAVING A COMPLETED FINANCIAL ASSESSMENT. WE ARE UNABLE TO DETERMINE OUR PATIENTS' FINANCIAL CIRCUMSTANCES UNLESS A COMPLETED FINANCIAL ASSISTANCE FORM IS VOLUNTARILY PROVIDED TO US. WE CAN ASSERT THAT MORE THAN 97% OF OUR PATIENTS WHO HAVE PROVIDED COMPLETED FINANCIAL ASSISTANCE FORMS HAVE BEEN APPROVED FOR AT LEAST PARTIAL FINANCIAL ASSISTANCE. WE HAVE MANY INSTANCES OF PATIENTS WITH LARGE ACCOUNT BALANCES AND NO HEALTH INSURANCE COVERAGE THAT WE ARE SURE WOULD QUALIFY FOR CHARITY CARE. ALTHOUGH HOSPITAL TEAM MEMBERS ENCOURAGE THESE INDIVIDUALS TO COMPLETE OUR FINANCIAL ASSISTANCE APPLICATION, MANY WILL NOT DO SO. EVEN WHEN WE TELL PATIENTS THAT WE FEEL CONFIDENT THEY WILL QUALIFY FOR FINANCIAL ASSISTANCE, MANY STILL REFUSE TO COMPLETE OUR FINANCIAL ASSISTANCE APPLICATION. OUR TEAM MEMBERS VOLUNTEER TO ASSIST PATIENTS WITH COMPLETION OF THE APPLICATION SO IT IS FRUSTRATING TO WRITE OFF AN ACCOUNT TO BAD DEBT MERELY BECAUSE THE PATIENT WILL NOT PROVIDE THE REQUIRED INFORMATION TO CONFIRM ELIGIBILITY.

Form and Line Reference	Explanation
BAD DEBT EXPENSE FOOTNOTE TO FINANCIAL STATEMENTS	THE TEXT OF MSHA'S FINANCIAL STATEMENTS THAT DESCRIBES BAD DEBT EXPENSE APPEARS ON PAGE 13 IN OUR MOST RECENT AUDITED FINANCIAL STATEMENTS (ATTACHED)

Form and Line Reference	Explanation
PART III, LINE 8 - MEDICARE EXPLANATION	MEDICARE ALLOWABLE COSTS ARE REPORTED USING MSHA'S FILED MEDICARE COST REPORT (C/R) THE C/R USES A COST TO CHARGE RATIO BASED ON A STEP-DOWN ALLOCATION METHODOLOGY IN CARING FOR THE PATIENT, THERE ARE SEVERAL SERVICES THAT ARE CONSIDERED NON-ALLOWABLE SUCH AS TRANSPORTATION OF A PATIENT AND COMFORT ITEMS TO INCLUDE A TELEVISION AND A TELEPHONE THE RECRUITMENT OF PHYSICIANS ARE NON-ALLOWED COSTS BY THE MEDICARE PROGRAM EVEN THOUGH PHYSICIANS ARE RECRUITED BASED ON DOCUMENTED COMMUNITY NEED MEDICARE LOSSES, INCLUDING SOME NON-ALLOWABLE COSTS SUCH AS THOSE NOTED ABOVE, SHOULD BE COUNTED AS A COMMUNITY BENEFIT AS THIS IS THE COST OF CARE FOR SERVING THE AGING POPULATION WHILE WE AGREE THAT COSTS SUCH AS MARKETING TO ATTRACT PATIENTS AND LOBBYING ARE REASONABLE TO EXCLUDE, IT DOES NOT SEEM REASONABLE TO EXCLUDE RECRUITMENT OF PHYSICIANS AND BASIC ITEMS SUCH AS TELEVISIONS IN PATIENT ROOMS AS A NOT-FOR-PROFIT ORGANIZATION, WE EXIST TO IDENTIFY AND RESPOND TO THE HEALTH CARE NEEDS OF THE COMMUNITY AND THE INDIVIDUAL WHILE MAINTAINING A HIGH LEVEL OF HEALTH CARE SERVICES WITHOUT LOSSES SINCE LOSSES DO OCCUR THROUGH THE CMS SYSTEM OF REIMBURSEMENT, THESE LOSSES ARE A COST OF DOING BUSINESS FOR OUR COMMUNITY AND SHOULD BE CONSIDERED A COMMUNITY BENEFIT AS A PARTICIPATING PROVIDER IN THE MEDICARE PROGRAM, HOSPITALS ARE REQUIRED TO PROVIDE THE FULL REGIMEN OF CARE FOR THE MEDICARE POPULATION THERE ARE A NUMBER OF CARE REGIMENS THAT ARE COMPENSATED BY THE MEDICARE PROGRAM AT LEVELS BELOW COST THEREFORE, IT IS ONLY LOGICAL TO ALLOW HOSPITALS TO REPORT THESE UNCOMPENSATED SERVICES AS A COMMUNITY BENEFIT BY MAKING THIS CHANGE, NON-PROFIT PROVIDERS WILL BE ENCOURAGED TO SUSTAIN IMPORTANT CARE DELIVERY MODELS FOR OUR AGING POPULATION IN SPITE OF THE FACT IT IS SOMETIMES ECONOMICALLY INJURIOUS PART III, LINE 9B COLLECTION PRACTICES EXPLANATION MSHA HAS ESTABLISHED A STRONG COMMITMENT TO MEET THE MEDICAL NEEDS OF THE COMMUNITIES WE SERVE ALL REQUESTS FOR FINANCIAL ASSISTANCE ARE EVALUATED USING ESTABLISHED GENERAL GUIDELINES, WHILE ALLOWING FOR UNIQUE FINANCIAL CIRCUMSTANCES MSHA RECOGNIZES ITS OBLIGATION TO PROVIDE QUALITY HEALTH CARE TO THOSE WHO ARE UNABLE TO PAY FINANCIAL ASSISTANCE ELIGIBILITY ENCOMPASSES A VARIETY OF PATIENTS, SUCH AS THOSE WITH MEDICAID ELIGIBILITY AFTER THE DATE OF SERVICE, PATIENTS THAT ARE DECEASED WITH NO ESTATE, MEDICAID ELIGIBLE ENCOUNTERS WHERE BENEFITS HAVE BEEN EXHAUSTED, ETC MSHA CHARITY GUIDELINES ARE BASED ON THE NATIONAL POVERTY GUIDELINES HOWEVER, FINANCIAL ASSISTANCE IS NOT BASED SOLELY ON INCOME UNIQUE FINANCIAL CIRCUMSTANCES ARE CONSIDERED, WHICH CAN CHANGE THE CATEGORY OF ELIGIBILITY IN ADDITION, CHARITY DETERMINATION MAY BE RETROACTIVE FOR ALL DATES OF SERVICE WHEN A PATIENT REQUESTS FINANCIAL ASSISTANCE OR WHEN AN APPLICATION HAS BEEN RECEIVED, THE PATIENT ACCOUNT IS PLACED IN A HOLD STATUS TO PREVENT FURTHER COLLECTION ACTIVITIES UNTIL FINANCIAL ASSISTANCE ELIGIBILITY IS DETERMINED

Form and Line Reference	Explanation
PART VI, LINE 2 - NEEDS ASSESSMENT	MSHA INCLUDED AMERICA'S HEALTH RANKINGS (AHR) IN ITS ASSESSMENT IN ORDER TO BETTER DEFINE THE HEALTH CARE NEEDS OF THE COMMUNITIES IT SERVES. TENNESSEE RANKED 43RD AND VIRGINIA RANKED 21ST. HOWEVER, IT SHOULD BE NOTED THAT SOUTHWEST VIRGINIA (WHERE SOME OF MSHA FACILITIES ARE LOCATED) CLOSELY RESEMBLES THE HEALTH RANKINGS FOR TENNESSEE. AMERICA'S HEALTH RANKINGS ARE BASED ON A SERIES OF MEASURES INCLUDING SEVERAL HEALTH OUTCOMES AND HEALTH FACTORS. A SURVEY WAS GIVEN TO 106 INDIVIDUALS REPRESENTING THE TEN COUNTIES IN WHICH MSHA OWNS A FACILITY. THESE INDIVIDUALS INCLUDED PHYSICIANS, PUBLIC HEALTH LEADERS, NON-PROFIT DIRECTORS, SCHOOL NURSES AND OFFICIALS, AND BUSINESS LEADERS. A SURVEY WAS GIVEN TO EACH INDIVIDUAL SEEKING FEEDBACK REGARDING AVAILABLE RESOURCES IN EACH AREA, THE PERCEIVED HEALTH STATUS, HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT. THE MAJORITY OF RESPONSES SUGGESTED FOCUSING ON EDUCATION IN ORDER TO PROMOTE HEALTHY HABITS AND INCREASED ACCESS TO RESOURCES. OTHER RESPONSES INCLUDED: MAKE PHYSICAL EDUCATION A REQUIREMENT AS PART OF SCHOOL CURRICULUM, IMPROVE NATURAL TRAILS AND WALKWAYS, INCREASE COMMUNITY SUPPORT FOR SMOKE-FREE AREAS, PARTNER WITH LOCAL FARMER'S MARKETS, SHARE HEALTH INFORMATION BETWEEN PHARMACIES, NETWORK WITH SMALL BUSINESSES AND NON-PROFITS IN ORDER TO AVOID DUPLICATING RESOURCES, AND PROVIDE EARLY SCREENINGS FOR THE UNINSURED OR UNDERINSURED. OVERALL, THE COMMUNITY MEMBERS GAVE MSHA'S CORE SERVICE AREA A HEALTH STATUS RANKING OF 4.55 OUT OF 10 (1 BEING THE LOWEST, 10 BEING THE HIGHEST). RANKINGS BY FACILITY: -JCMC AND FWCH WERE GIVEN A HEALTH STATUS RANKING OF 5.3 -IPMC WAS GIVEN A HEALTH STATUS RANKING OF 3.6 -SSH WAS GIVEN A HEALTH STATUS RANKING OF 4.7 -JCCH WAS GIVEN A HEALTH STATUS RANKING OF 5.14 - UCMH WAS GIVEN A HEALTH STATUS RANKING OF 4.9 -RCMC WAS GIVEN A HEALTH STATUS RANKING OF 5.0. AMONG THE 106 PARTICIPANTS, THE AREAS OF OBESITY, CANCER, HEART DISEASE, SMOKING, SUBSTANCE/PRESCRIPTION DRUG ABUSE, AND DIABETES WERE THE TOP HEALTH PRIORITIES IN OUR REGION. AHR REPORTS THAT VIRGINIA AND TENNESSEE BOTH SAW AN INCREASE IN DIABETES AND OBESITY WITHIN THE PAST TEN YEARS. TENNESSEE RANKS 44TH FOR BOTH CARDIOVASCULAR DEATHS AND CANCER DEATHS (47TH FOR SMOKING) AND 48TH FOR DIABETES. VIRGINIA RANKS 25TH FOR CARDIOVASCULAR DEATHS, 23RD FOR CANCER DEATHS (31ST FOR SMOKING) AND 21ST FOR DIABETES. COUNTY HEALTH RANKINGS FOR COUNTIES INCLUDED IN THE MSHA SERVICE AREA: THE PERCENTAGE OF CHILDREN LIVING IN POVERTY: JOHNSON COUNTY 38%, CARTER COUNTY 34%, UNICOI COUNTY 29%, AND RUSSELL COUNTY 26%. PERCENTAGE OF PHYSICAL INACTIVITY: UNICOI COUNTY 37%, RUSSELL COUNTY 36%, JOHNSON COUNTY 34%, AND CARTER COUNTY 32%. PERCENTAGE OF ADULT OBESITY: RUSSELL COUNTY 35%, JOHNSON COUNTY 31%, UNICOI COUNTY 30%, AND CARTER COUNTY 29%. PERCENTAGE OF ADULT SMOKING: CARTER COUNTY 31%, JOHNSON COUNTY 28%, RUSSELL COUNTY 25%, AND UNICOI COUNTY 23%.

Form and Line Reference	Explanation
PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE	MSHA PROVIDES COMMUNICATION OF FINANCIAL ASSISTANCE ON ITS WEBSITE AND ON POSTERS LOCATED IN PROMINENT AREAS OF OUR HOSPITALS SUCH AS ADMITTING AND EMERGENCY DEPARTMENTS. PRINTED EDUCATIONAL MATERIALS INCLUDING FINANCIAL ASSISTANCE CONTACT INFORMATION ARE ALSO PROVIDED IN EACH PATIENT'S REGISTRATION PAPERWORK. POSTERS AND REFERENCE MATERIALS ARE WRITTEN IN BOTH ENGLISH AND SPANISH. ADMITTING STAFF ARE TRAINED TO EDUCATE PATIENTS ON OUR FINANCIAL ASSISTANCE POLICY. MSHA ALSO HAS FINANCIAL COUNSELORS TO PROVIDE FURTHER INFORMATION AND ASSISTANCE TO PATIENTS REGARDING OUR FINANCIAL ASSISTANCE POLICY. THESE COUNSELORS HELP UNINSURED PATIENTS DETERMINE SOURCES OF PAYMENT FOR MEDICAL BILLS AND HELP PATIENTS DETERMINE ELIGIBILITY FOR PROGRAMS SUCH AS TENNNCARE/MEDICAID. MSHA PARTNERED WITH THE COMPANIES FIRSTSOURCE SOLUTIONS USA AND ADVANCED PATIENT ADVOCACY TO WORK WITH SELF-PAYING PATIENTS WHO HAVE LIMITED FINANCIAL RESOURCES. REPRESENTATIVES WERE AVAILABLE AT MSHA TO ASSIST PATIENTS. THE REPRESENTATIVES WERE ABLE TO DETERMINE GOVERNMENTAL MEDICAL ASSISTANCE (TENNCARE OR MEDICAID) ELIGIBILITY, AND TO HELP WITH THE APPLICATION PROCESS AND FOLLOW-UP. ONCE A PERSON IS APPROVED FOR TENNCARE OR MEDICAID THROUGH THE PROGRAM OFFERED THROUGH MSHA, THEY RETAIN COVERAGE FOR FUTURE MEDICAL CARE. 7,851 PATIENTS WERE APPROVED FOR GOVERNMENTAL ASSISTANCE DURING THE YEAR. FIRSTSOURCE AND ADVANCED PATIENT ADVOCACY ARE COMPENSATED BY MSHA. DURING FY15, OUR COST FOR THIS PROGRAM WAS 701,226.

Form and Line Reference	Explanation
PART VI, LINE 4 - COMMUNITY INFORMATION	MSHA SERVES THE HEALTHCARE NEEDS OF 29 APPALACHIAN COUNTIES IN TENNESSEE, SOUTHWEST VIRGINIA, KENTUCKY AND NORTH CAROLINA SOME OF THE COUNTIES MSHA SERVES ARE FEDERALLY DESIGNATED MEDICALLY UNDERSERVED AREAS MSHA OPERATES 2 CRITICAL ACCESS HOSPITALS DICKENSON COMMUNITY HOSPITAL IN VIRGINIA, AND JOHNSON COUNTY COMMUNITY HOSPITAL IN TENNESSEE THE HEALTH STATUS OF THE POPULATION IN MSHA'S SERVICE AREA IS GENERALLY POOR THE SERVICE AREA EXTENDS TO SOME OF THE POOREST RURAL COUNTIES IN THE REGION WITH A POVERTY RATE OF ALMOST 30% SOME OF THE MOST WELL-OFF COUNTIES IN MSHA'S SERVICE AREA STILL HAVE A MEDIAN HOUSEHOLD INCOME LOWER THAN STATE AND NATIONAL AVERAGES RURAL SERVICE AREA COUNTIES SHARE COMMON CHALLENGES OF 1 HIGH RATES OF UNINSURED 2 HIGH PREVALENCE OF OBESITY 3 HIGH PREVALENCE OF DIABETES 4 HIGH PREVALENCE OF CANCER 5 HIGH PREVALENCE OF POOR CARDIAC HEALTH

Form and Line Reference	Explanation
PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH	MSHA IS DEDICATED TO OPERATING EFFICIENTLY SO THAT WASTE IS MINIMIZED MSHA'S LEADERSHIP REMAINS MINDFUL OF MANAGING THE ALLIANCE'S LIMITED RESOURCES SO THAT ADEQUATE FACILITIES AND EQUIPMENT ARE AVAILABLE FOR THE CARE OF OUR PATIENTS VARIOUS CHECKS AND BALANCES ARE ESTABLISHED TO ENSURE THAT EXPENDITURES FOR OPERATING EXPENSES AND CAPITAL COSTS ARE REASONABLE AND NECESSARY SURPLUS FUNDS ARE INVESTED INTO IMPROVING TREATMENT OPTIONS FOR OUR PATIENTS THROUGH NEW TECHNOLOGIES, RECRUITING PHYSICIANS AND TRAINED STAFF IN SHORTAGE AREAS, AND IMPROVING OUR FACILITIES THE MAJORITY OF MSHA'S GOVERNING BODY IS COMPRISED OF PERSONS WHO RESIDE IN THE ORGANIZATION'S PRIMARY SERVICE AREA PHYSICIANS THAT REQUEST PRIVILEGES WHO ARE QUALIFIED AND CREDENTIALLED ARE EXTENDED PRIVILEGES BY MSHA

Form and Line Reference	Explanation
PART VI, LINE 6 - AFFILIATED HEALTH CARE SYSTEM	MSHA PROVIDES CARE TO PEOPLE IN 29 COUNTIES IN TENNESSEE, VIRGINIA, KENTUCKY AND NORTH CAROLINA. EACH HOSPITAL IS FULLY ACCREDITED BY THE JOINT COMMISSION, WITH THE EXCEPTION OF JCCH. JCCH RECEIVES CERTIFICATION THROUGH THE STATE OF TENNESSEE SINCE IT IS A CRITICAL ACCESS HOSPITAL. MSHA, BASED IN JOHNSON CITY, TENNESSEE IS INTEGRATED BOTH VERTICALLY AND HORIZONTALLY AND IS THE LARGEST REGIONAL HEALTHCARE SYSTEM WITH 13 HOSPITALS. NINE FACILITIES ARE WHOLLY-OWNED FACILITIES: 8 FACILITIES IN TENNESSEE AND 1 IN VIRGINIA. IN ADDITION TO THE WHOLLY-OWNED HOSPITALS REPORTED WITHIN THIS FORM 990, MSHA ALSO HAS MAJORITY OWNERSHIP IN 4 HOSPITALS IN SOUTHWEST VIRGINIA. IN ADDITION TO OUR ACUTE CARE HOSPITALS, OUR SYSTEM INCLUDES SUCH SERVICES AS PRIMARY/SPECIALTY PHYSICIAN PRACTICES, URGENT CARE CENTERS, EMERGENCY DEPARTMENTS, OCCUPATIONAL MEDICINE, REHABILITATION, OUTREACH LABORATORY, MENTAL HEALTH, NEONATAL INTENSIVE CARE, A NACHRI-AFFILIATED CHILDREN'S HOSPITAL, RENAL DIALYSIS, ST. JUDE'S ONCOLOGY, INPATIENT/OUTPATIENT SURGERY, SKILLED NURSING, LONG-TERM CARE, HOME HEALTH, AIR AMBULANCE TRANSPORT AND MORE. WITH THESE ADDITIONAL FACILITIES AND SERVICES, MSHA EXTENDS A HIGHLY EFFECTIVE HEALTH CARE DELIVERY SYSTEM. SINCE OUR SYSTEM IS BOTH HORIZONTALLY AND VERTICALLY INTEGRATED, PATIENTS CAN BE EFFICIENTLY MOVED ALONG AN INTEGRATED, COMPREHENSIVE CONTINUUM OF CARE AS THEIR HEALTH STATUS DICTATES. OUR FLAGSHIP FACILITY, JOHNSON CITY MEDICAL CENTER IS AT THE CORE OF OUR SYSTEM OFFERING FULL-SERVICE TERTIARY CARE. IN ADDITION TO OUR HOSPITALS, MSHA IS THE SOLE MEMBER OF BLUE RIDGE MEDICAL MANAGEMENT CORPORATION (BRMMC). MSHA EXTENDS AN INTEGRATED HEALTHCARE DELIVERY SYSTEM THROUGH BRMMC TO INCLUDE MULTIPLE PRIMARY AND SPECIALTY CARE PATIENT ACCESS CENTERS AND NUMEROUS OUTPATIENT CARE SITES, INCLUDING URGENT CARE CENTERS, OCCUPATIONAL MEDICINE SERVICES, SAME DAY SURGERY CENTERS AND REHABILITATION. MSHA COUNTY-SPECIFIC OPERATIONS ARE GOVERNED BY A COMMUNITY BOARD OF DIRECTORS. COUNTY BOARDS REPORT TO A SYSTEM LEVEL BOARD OF DIRECTORS. ALL BOARDS ARE PRIMARILY COMPOSED OF LOCAL COMMUNITY RESIDENTS.

Form and Line Reference	Explanation
PART VI, LINE 7 - STATE FILING OF COMMUNITY BENEFIT REPORT	TENNESSEE, VIRGINIA

Additional Data

Software ID:
Software Version:
EIN: 62-0476282
Name: MOUNTAIN STATES HEALTH ALLIANCE

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

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

Form and Line Reference	Explanation
FACILITY 1, JOHNSON CITY MEDICAL CENTER - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES (INCLUDING ALL OF THE HOSPITALS INCLUDED IN THIS 990) LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NON-PROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO JCMC, THE GROUP CONSISTED OF REPRESENTATIVES FROM THE WASHINGTON COUNTY HEALTH DEPARTMENT, FRONTIER HEALTH, ETSU COLLEGE OF NURSING, ETSU JOHNSON CITY COMMUNITY HEALTH CENTER, ETSU COLLEGE OF PUBLIC HEALTH, WASHINGTON COUNTY COMMISSION, NORTHEAST TENNESSEE REGIONAL HEALTH DEPARTMENT, WASHINGTON COUNTY/JOHNSON CITY EMERGENCY MEDICAL SERVICES, UNITED WAY, PROJECT ACCESS, CHAMBER OF COMMERCE, FAMILIES FREE, CITY OF JOHNSON CITY, AND CENTER ON AGING AND HEALTH EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS THE WASHINGTON COUNTY COMMUNITY BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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

Form and Line Reference	Explanation
FACILITY 1, JOHNSON CITY MEDICAL CENTER - PART V, LINE 6A	EACH HOSPITAL WITHIN THE MSHA SYSTEM COMPLETED A CHNA FOR THOSE HOSPITALS THAT ARE LOCATED IN THE SAME COUNTY, ONLY ONE COMMUNITY GROUP WAS SURVEYED FOR INSTANCE, JOHNSON CITY MEDICAL CENTER (INCLUDES NISWONGER CHILDREN'S HOSPITAL AND WOODRIDGE HOSPITAL) AND FRANKLIN WOODS COMMUNITY HOSPITAL ARE ALL LOCATED IN WASHINGTON COUNTY, TENNESSEE JCMC'S CHNA WAS CONDUCTED WITH ALL MSHA HOSPITALS TO INCLUDE FRANKLIN WOODS COMMUNITY HOSPITAL, INDIAN PATH MEDICAL CENTER, SYCAMORE SHOALS HOSPITAL, JOHNSON COUNTY COMMUNITY HOSPITAL, UNICOI COUNTY MEMORIAL HOSPITAL, RUSSELL COUNTY MEDICAL CENTER, SMYTH COUNTY COMMUNITY HOSPITAL, JOHNSTON MEMORIAL HOSPITAL, NORTON COMMUNITY HOSPITAL AND DICKENSON COMMUNITY HOSPITAL

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

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

Form and Line Reference	Explanation
FACILITY 1, JOHNSON CITY MEDICAL CENTER - PART V, LINE 11	MSHA PUBLISHED ITS COMMUNITY HEALTH NEEDS ASSESSMENT ON JUNE 29, 2015 THE DATA INCLUDED WAS COLLECTED OVER THE COURSE OF 2014 AND 2015 AN IMPLEMENTATION PLAN WAS CREATED FOR EACH HOSPITAL, AND EACH HOSPITAL'S COMMUNITY BOARD APPROVED THE IMPLEMENTATION PLAN DURING THE MONTHS OF NOVEMBER AND DECEMBER 2015 MSHA ANNUALLY TRACKS PROGRESS OF IMPLEMENTATION STRATEGIES FOR EACH HOSPITAL DUE TO LACK OF RESOURCES, SOME OF MSHA'S FACILITIES WERE UNABLE TO ADDRESS ISSUES THAT WERE IDENTIFIED

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

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

Form and Line Reference	Explanation
FACILITY 1, JOHNSON CITY MEDICAL CENTER - PART V, LINE 22D	UNINSURED PATIENTS RECEIVE A 66% DISCOUNT, AND, BASED ON OTHER FACTORS SUCH AS INCOME OR MEDICAL INDIGENCY, MAY QUALIFY FOR AN ADDITIONAL DISCOUNT ALLOWABLE AMOUNTS FOR INSURED PATIENTS ARE BASED ON THE NEGOTIATED RATE WITH COMMERCIAL INSURANCE OR MEDICARE

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

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

Form and Line Reference	Explanation
FACILITY 2, INDIAN PATH MEDICAL CENTER - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES (INCLUDING ALL OF THE HOSPITALS INCLUDED IN THIS 990) LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NON-PROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO IPMC, THE GROUP CONSISTED OF REPRESENTATIVES FROM HEALTHY KINGSFORT, KINGSFORT CITY SCHOOLS, UNITED WAY OF GREATER KINGSFORT, SULLIVAN COUNTY HEALTH DEPARTMENT, IPMC HEALTH RESOURCE CENTER, SULLIVAN COUNTY DEPARTMENT OF EDUCATION, KINGSFORT CHAMBER OF COMMERCE, AND KINGSFORT BOARD OF MAYOR AND ALDERMAN EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS IPMC'S SULLIVAN COUNTY COMMUNITY BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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

Form and Line Reference	Explanation
FACILITY 2, INDIAN PATH MEDICAL CENTER - PART V, LINE 6A	EACH HOSPITAL WITHIN THE MSHA SYSTEM COMPLETED A CHNA FOR THOSE HOSPITALS THAT ARE LOCATED IN THE SAME COUNTY, ONLY ONE COMMUNITY GROUP WAS SURVEYED FOR INSTANCE, JOHNSON CITY MEDICAL CENTER (INCLUDES NISWONGER CHILDREN'S HOSPITAL AND WOODRIDGE HOSPITAL) AND FRANKLIN WOODS COMMUNITY HOSPITAL ARE ALL LOCATED IN WASHINGTON COUNTY, TENNESSEE IPMC'S CHNA WAS CONDUCTED WITH ALL MSHA HOSPITALS TO INCLUDE FRANKLIN WOODS COMMUNITY HOSPITAL, JOHNSON CITY MEDICAL CENTER, SYCAMORE SHOALS HOSPITAL, JOHNSON COUNTY COMMUNITY HOSPITAL, UNICOI COUNTY MEMORIAL HOSPITAL, RUSSELL COUNTY MEDICAL CENTER, SMYTH COUNTY COMMUNITY HOSPITAL, JOHNSTON MEMORIAL HOSPITAL, NORTON COMMUNITY HOSPITAL AND DICKENSON COMMUNITY HOSPITAL

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

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

Form and Line Reference	Explanation
FACILITY 2, INDIAN PATH MEDICAL CENTER - PART V, LINE 11	MSHA PUBLISHED ITS COMMUNITY HEALTH NEEDS ASSESSMENT ON JUNE 29, 2015 THE DATA INCLUDED WAS COLLECTED OVER THE COURSE OF 2014 AND 2015 AN IMPLEMENTATION PLAN WAS CREATED FOR EACH HOSPITAL, AND EACH HOSPITAL'S COMMUNITY BOARD APPROVED THE IMPLEMENTATION PLAN DURING THE MONTHS OF NOVEMBER AND DECEMBER 2015 MSHA ANNUALLY TRACKS PROGRESS OF IMPLEMENTATION STRATEGIES FOR EACH HOSPITAL DUE TO LACK OF RESOURCES, SOME OF MSHA'S FACILITIES WERE UNABLE TO ADDRESS ISSUES THAT WERE IDENTIFIED

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Form and Line Reference	Explanation
FACILITY 2, INDIAN PATH MEDICAL CENTER - PART V, LINE 22D	UNINSURED PATIENTS RECEIVE A 66% DISCOUNT, AND, BASED ON OTHER FACTORS SUCH AS INCOME OR MEDICAL INDIGENCY, MAY QUALIFY FOR AN ADDITIONAL DISCOUNT ALLOWABLE AMOUNTS FOR INSURED PATIENTS ARE BASED ON THE NEGOTIATED RATE WITH COMMERCIAL INSURANCE OR MEDICARE

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

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

Form and Line Reference	Explanation
FACILITY 3, FRANKLIN WOODS COMMUNITY HOSPITAL - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES (INCLUDING ALL OF THE HOSPITALS INCLUDED IN THIS 990) LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NON-PROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO FWCH, THE GROUP CONSISTED OF REPRESENTATIVES FROM THE WASHINGTON COUNTY HEALTH DEPARTMENT, FRONTIER HEALTH, ETSU COLLEGE OF NURSING, ETSU JOHNSON CITY COMMUNITY HEALTH CENTER, ETSU COLLEGE OF PUBLIC HEALTH, WASHINGTON COUNTY COMMISSION, NORTHEAST TENNESSEE REGIONAL HEALTH DEPARTMENT, WASHINGTON COUNTY/JOHNSON CITY EMERGENCY MEDICAL SERVICES, UNITED WAY, PROJECT ACCESS, CHAMBER OF COMMERCE, FAMILIES FREE, CITY OF JOHNSON CITY, AND CENTER ON AGING AND HEALTH EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS THE WASHINGTON COUNTY COMMUNITY BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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

Form and Line Reference	Explanation
FACILITY 3, FRANKLIN WOODS COMMUNITY HOSPITAL - PART V, LINE 6A	EACH HOSPITAL WITHIN THE MSHA SYSTEM COMPLETED A CHNA FOR THOSE HOSPITALS THAT ARE LOCATED IN THE SAME COUNTY, ONLY ONE COMMUNITY GROUP WAS SURVEYED FOR INSTANCE, JOHNSON CITY MEDICAL CENTER (INCLUDES NISWONGER CHILDREN'S HOSPITAL AND WOODRIDGE HOSPITAL) AND FRANKLIN WOODS COMMUNITY HOSPITAL ARE ALL LOCATED IN WASHINGTON COUNTY, TENNESSEE FWCH'S CHNA WAS CONDUCTED WITH ALL MSHA HOSPITALS TO INCLUDE JOHNSON CITY MEDICAL CENTER, INDIAN PATH MEDICAL CENTER, SYCAMORE SHOALS HOSPITAL, JOHNSON COUNTY COMMUNITY HOSPITAL, UNICOI COUNTY MEMORIAL HOSPITAL, RUSSELL COUNTY MEDICAL CENTER, SMYTH COUNTY COMMUNITY HOSPITAL, JOHNSTON MEMORIAL HOSPITAL, NORTON COMMUNITY HOSPITAL AND DICKENSON COMMUNITY HOSPITAL

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

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

Form and Line Reference	Explanation
FACILITY 3, FRANKLIN WOODS COMMUNITY HOSPITAL - PART V, LINE 11	MSHA PUBLISHED ITS COMMUNITY HEALTH NEEDS ASSESSMENT ON JUNE 29, 2015 THE DATA INCLUDED WAS COLLECTED OVER THE COURSE OF 2014 AND 2015 AN IMPLEMENTATION PLAN WAS CREATED FOR EACH HOSPITAL, AND EACH HOSPITAL'S COMMUNITY BOARD APPROVED THE IMPLEMENTATION PLAN DURING THE MONTHS OF NOVEMBER AND DECEMBER 2015 MSHA ANNUALLY TRACKS PROGRESS OF IMPLEMENTATION STRATEGIES FOR EACH HOSPITAL DUE TO LACK OF RESOURCES, SOME OF MSHA'S FACILITIES WERE UNABLE TO ADDRESS ISSUES THAT WERE IDENTIFIED

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Form and Line Reference	Explanation
FACILITY 3, FRANKLIN WOODS COMMUNITY HOSPITAL - PART V, LINE 22D	UNINSURED PATIENTS RECEIVE A 66% DISCOUNT, AND, BASED ON OTHER FACTORS SUCH AS INCOME OR MEDICAL INDIGENCY, MAY QUALIFY FOR AN ADDITIONAL DISCOUNT ALLOWABLE AMOUNTS FOR INSURED PATIENTS ARE BASED ON THE NEGOTIATED RATE WITH COMMERCIAL INSURANCE OR MEDICARE

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

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Form and Line Reference	Explanation
FACILITY 4, SYCAMORE SHOALS HOSPITAL - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES (INCLUDING ALL OF THE HOSPITALS INCLUDED IN THIS 990) LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NON-PROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO SSH, THE GROUP CONSISTED OF REPRESENTATIVES FROM ELIZABETHTON CITY SCHOOLS, CARTER COUNTY SCHOOLS, UNITED HEALTHCARE, UT-CARTER COUNTY EXTENSION, CENTER ON AGING AND HEALTH, CARTER COUNTY GOVERNOR'S OFFICE, COORDINATED SCHOOL HEALTH, BABE BREASTFEEDING COALITION, PROJECT ACCESS AND CARTER COUNTY HEALTH DEPARTMENT EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS SSH'S CARTER COUNTY COMMUNITY BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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

Form and Line Reference	Explanation
FACILITY 4, SYCAMORE SHOALS HOSPITAL - PART V, LINE 6A	EACH HOSPITAL WITHIN THE MSHA SYSTEM COMPLETED A CHNA FOR THOSE HOSPITALS THAT ARE LOCATED IN THE SAME COUNTY, ONLY ONE COMMUNITY GROUP WAS SURVEYED FOR INSTANCE, JOHNSON CITY MEDICAL CENTER (INCLUDES NISWONGER CHILDREN'S HOSPITAL AND WOODRIDGE HOSPITAL) AND FRANKLIN WOODS COMMUNITY HOSPITAL ARE ALL LOCATED IN WASHINGTON COUNTY, TENNESSEE SSH'S CHNA WAS CONDUCTED WITH ALL MSHA HOSPITALS TO INCLUDE FRANKLIN WOODS COMMUNITY HOSPITAL, INDIAN PATH MEDICAL CENTER, JOHNSON CITY MEDICAL CENTER, JOHNSON COUNTY COMMUNITY HOSPITAL, UNICOI COUNTY MEMORIAL HOSPITAL, RUSSELL COUNTY MEDICAL CENTER, SMYTH COUNTY COMMUNITY HOSPITAL, JOHNSTON MEMORIAL HOSPITAL, NORTON COMMUNITY HOSPITAL AND DICKENSON COMMUNITY HOSPITAL

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

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Form and Line Reference	Explanation
FACILITY 4, SYCAMORE SHOALS HOSPITAL - PART V, LINE 11	MSHA PUBLISHED ITS COMMUNITY HEALTH NEEDS ASSESSMENT ON JUNE 29, 2015 THE DATA INCLUDED WAS COLLECTED OVER THE COURSE OF 2014 AND 2015 AN IMPLEMENTATION PLAN WAS CREATED FOR EACH HOSPITAL, AND EACH HOSPITAL'S COMMUNITY BOARD APPROVED THE IMPLEMENTATION PLAN DURING THE MONTHS OF NOVEMBER AND DECEMBER 2015 MSHA ANNUALLY TRACKS PROGRESS OF IMPLEMENTATION STRATEGIES FOR EACH HOSPITAL DUE TO LACK OF RESOURCES, SOME OF MSHA'S FACILITIES WERE UNABLE TO ADDRESS ISSUES THAT WERE IDENTIFIED

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Form and Line Reference	Explanation
FACILITY 4, SYCAMORE SHOALS HOSPITAL - PART V, LINE 22D	UNINSURED PATIENTS RECEIVE A 66% DISCOUNT, AND, BASED ON OTHER FACTORS SUCH AS INCOME OR MEDICAL INDIGENCY, MAY QUALIFY FOR AN ADDITIONAL DISCOUNT ALLOWABLE AMOUNTS FOR INSURED PATIENTS ARE BASED ON THE NEGOTIATED RATE WITH COMMERCIAL INSURANCE OR MEDICARE

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Form and Line Reference	Explanation
FACILITY 5, RUSSELL COUNTY MEDICAL CENTER - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES (INCLUDING ALL OF THE HOSPITALS INCLUDED IN THIS 990) LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NON-PROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO RCMC, THE GROUP CONSISTED OF REPRESENTATIVES FROM THE CUMBERLAND PLATEAU HEALTH DISTRICT, VIRGINIA DEPARTMENT OF HEALTH, DANTE EMERGENCY MEDICAL SERVICES, TOWN OF LEBANON, RUSSELL COUNTY DEPARTMENT OF SOCIAL SERVICES, AND RUSSELL COUNTY YMCA EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS RUSSELL COUNTY MEDICAL CENTER'S BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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Form and Line Reference	Explanation
FACILITY 5, RUSSELL COUNTY MEDICAL CENTER - PART V, LINE 6A	EACH HOSPITAL WITHIN THE MSHA SYSTEM COMPLETED A CHNA FOR THOSE HOSPITALS THAT ARE LOCATED IN THE SAME COUNTY, ONLY ONE COMMUNITY GROUP WAS SURVEYED FOR INSTANCE, JOHNSON CITY MEDICAL CENTER (INCLUDES NISWONGER CHILDREN'S HOSPITAL AND WOODRIDGE HOSPITAL) AND FRANKLIN WOODS COMMUNITY HOSPITAL ARE ALL LOCATED IN WASHINGTON COUNTY, TENNESSEE RCMC'S CHNA WAS CONDUCTED WITH ALL MSHA HOSPITALS TO INCLUDE FRANKLIN WOODS COMMUNITY HOSPITAL, INDIAN PATH MEDICAL CENTER, SYCAMORE SHOALS HOSPITAL, JOHNSON COUNTY COMMUNITY HOSPITAL, UNICOI COUNTY MEMORIAL HOSPITAL, JOHNSON CITY MEDICAL CENTER, SMYTH COUNTY COMMUNITY HOSPITAL, JOHNSTON MEMORIAL HOSPITAL, NORTON COMMUNITY HOSPITAL AND DICKENSON COMMUNITY HOSPITAL

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Form and Line Reference	Explanation
FACILITY 5, RUSSELL COUNTY MEDICAL CENTER - PART V, LINE 11	MSHA PUBLISHED ITS COMMUNITY HEALTH NEEDS ASSESSMENT ON JUNE 29, 2015 THE DATA INCLUDED WAS COLLECTED OVER THE COURSE OF 2014 AND 2015 AN IMPLEMENTATION PLAN WAS CREATED FOR EACH HOSPITAL, AND EACH HOSPITAL'S COMMUNITY BOARD APPROVED THE IMPLEMENTATION PLAN DURING THE MONTHS OF NOVEMBER AND DECEMBER 2015 MSHA ANNUALLY TRACKS PROGRESS OF IMPLEMENTATION STRATEGIES FOR EACH HOSPITAL DUE TO LACK OF RESOURCES, SOME OF MSHA'S FACILITIES WERE UNABLE TO ADDRESS ISSUES THAT WERE IDENTIFIED

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Form and Line Reference	Explanation
FACILITY 5, RUSSELL COUNTY MEDICAL CENTER - PART V, LINE 22D	UNINSURED PATIENTS RECEIVE A 66% DISCOUNT, AND, BASED ON OTHER FACTORS SUCH AS INCOME OR MEDICAL INDIGENCY, MAY QUALIFY FOR AN ADDITIONAL DISCOUNT ALLOWABLE AMOUNTS FOR INSURED PATIENTS ARE BASED ON THE NEGOTIATED RATE WITH COMMERCIAL INSURANCE OR MEDICARE

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

Form and Line Reference	Explanation
FACILITY 6, JOHNSON COUNTY COMMUNITY HOSPITAL - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES (INCLUDING ALL OF THE HOSPITALS INCLUDED IN THIS 990) LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NON-PROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO JCCH, THE GROUP CONSISTED OF REPRESENTATIVES FROM JOHNSON COUNTY COMMUNITY HOSPITAL, JOHNSON COUNTY HEALTH DEPARTMENT, JOHNSON COUNTY RESCUE AND EMERGENCY MEDICAL SERVICES, ETSU COLLEGE OF NURSING AT MOUNTAIN CITY EXTENDED HOURS, AND JOHNSON COUNTY SCHOOLS EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS JOHNSON COUNTY COMMUNITY HOSPITAL'S BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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

Form and Line Reference	Explanation
FACILITY 6, JOHNSON COUNTY COMMUNITY HOSPITAL - PART V, LINE 6A	EACH HOSPITAL WITHIN THE MSHA SYSTEM COMPLETED A CHNA FOR THOSE HOSPITALS THAT ARE LOCATED IN THE SAME COUNTY, ONLY ONE COMMUNITY GROUP WAS SURVEYED FOR INSTANCE, JOHNSON CITY MEDICAL CENTER (INCLUDES NISWONGER CHILDREN'S HOSPITAL AND WOODRIDGE HOSPITAL) AND FRANKLIN WOODS COMMUNITY HOSPITAL ARE ALL LOCATED IN WASHINGTON COUNTY, TENNESSEE JCCH'S CHNA WAS CONDUCTED WITH ALL MSHA HOSPITALS TO INCLUDE FRANKLIN WOODS COMMUNITY HOSPITAL, INDIAN PATH MEDICAL CENTER, SYCAMORE SHOALS HOSPITAL, JOHNSON CITY MEDICAL CENTER, UNICOI COUNTY MEMORIAL HOSPITAL, RUSSELL COUNTY MEDICAL CENTER, SMYTH COUNTY COMMUNITY HOSPITAL, JOHNSTON MEMORIAL HOSPITAL, NORTON COMMUNITY HOSPITAL AND DICKENSON COMMUNITY HOSPITAL

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

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

Form and Line Reference	Explanation
FACILITY 6, JOHNSON COUNTY COMMUNITY HOSPITAL - PART V, LINE 11	MSHA PUBLISHED ITS COMMUNITY HEALTH NEEDS ASSESSMENT ON JUNE 29, 2015 THE DATA INCLUDED WAS COLLECTED OVER THE COURSE OF 2014 AND 2015 AN IMPLEMENTATION PLAN WAS CREATED FOR EACH HOSPITAL, AND EACH HOSPITAL'S COMMUNITY BOARD APPROVED THE IMPLEMENTATION PLAN DURING THE MONTHS OF NOVEMBER AND DECEMBER 2015 MSHA ANNUALLY TRACKS PROGRESS OF IMPLEMENTATION STRATEGIES FOR EACH HOSPITAL DUE TO LACK OF RESOURCES, SOME OF MSHA'S FACILITIES WERE UNABLE TO ADDRESS ISSUES THAT WERE IDENTIFIED

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

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

Form and Line Reference	Explanation
FACILITY 6, JOHNSON COUNTY COMMUNITY HOSPITAL - PART V, LINE 22D	UNINSURED PATIENTS RECEIVE A 50% DISCOUNT, AND, BASED ON OTHER FACTORS SUCH AS INCOME OR MEDICAL INDIGENCY, MAY QUALIFY FOR AN ADDITIONAL DISCOUNT ALLOWABLE AMOUNTS FOR INSURED PATIENTS ARE BASED ON THE NEGOTIATED RATE WITH COMMERCIAL INSURANCE OR MEDICARE

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

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

Form and Line Reference	Explanation
FACILITY 7, UNICOI COUNTY MEMORIAL HOSPITAL - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES (INCLUDING ALL OF THE HOSPITALS INCLUDED IN THIS 990) LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NON-PROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO UCMH, THE GROUP CONSISTED OF REPRESENTATIVES FROM THE UNICOI COUNTY CHAMBER OF COMMERCE, BANK OF TENNESSEE, UNICOI COUNTY FAMILY YMCA, KEESECKER/STEEL RAILS, CENTER ON AGING AND HEALTH, UETHDA HEAD START, TELEMONT HEAD START, AND UNICOI COUNTY HEALTH DEPARTMENT EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS THE UNICOI COUNTY COMMUNITY BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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

Form and Line Reference	Explanation
FACILITY 7, UNICOI COUNTY MEMORIAL HOSPITAL - PART V, LINE 6A	EACH HOSPITAL WITHIN THE MSHA SYSTEM COMPLETED A CHNA FOR THOSE HOSPITALS THAT ARE LOCATED IN THE SAME COUNTY, ONLY ONE COMMUNITY GROUP WAS SURVEYED FOR INSTANCE, JOHNSON CITY MEDICAL CENTER (INCLUDES NISWONGER CHILDREN'S HOSPITAL AND WOODRIDGE HOSPITAL) AND FRANKLIN WOODS COMMUNITY HOSPITAL ARE ALL LOCATED IN WASHINGTON COUNTY, TENNESSEE UCMH'S CHNA WAS CONDUCTED WITH ALL MSHA HOSPITALS TO INCLUDE FRANKLIN WOODS COMMUNITY HOSPITAL, INDIAN PATH MEDICAL CENTER, SYCAMORE SHOALS HOSPITAL, JOHNSON COUNTY COMMUNITY HOSPITAL, JOHNSON CITY MEDICAL CENTER, RUSSELL COUNTY MEDICAL CENTER, SMYTH COUNTY COMMUNITY HOSPITAL, JOHNSTON MEMORIAL HOSPITAL, NORTON COMMUNITY HOSPITAL AND DICKENSON COMMUNITY HOSPITAL

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

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

Form and Line Reference	Explanation
FACILITY 7, UNICOI COUNTY MEMORIAL HOSPITAL - PART V, LINE 11	MSHA PUBLISHED ITS COMMUNITY HEALTH NEEDS ASSESSMENT ON JUNE 29, 2015 THE DATA INCLUDED WAS COLLECTED OVER THE COURSE OF 2014 AND 2015 AN IMPLEMENTATION PLAN WAS CREATED FOR EACH HOSPITAL, AND EACH HOSPITAL'S COMMUNITY BOARD APPROVED THE IMPLEMENTATION PLAN DURING THE MONTHS OF NOVEMBER AND DECEMBER 2015 MSHA ANNUALLY TRACKS PROGRESS OF IMPLEMENTATION STRATEGIES FOR EACH HOSPITAL DUE TO LACK OF RESOURCES, SOME OF MSHA'S FACILITIES WERE UNABLE TO ADDRESS ISSUES THAT WERE IDENTIFIED

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

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

Form and Line Reference	Explanation
FACILITY 7, UNICOI COUNTY MEMORIAL HOSPITAL - PART V, LINE 22D	UNINSURED PATIENTS RECEIVE A 66% DISCOUNT, AND, BASED ON OTHER FACTORS SUCH AS INCOME OR MEDICAL INDIGENCY, MAY QUALIFY FOR AN ADDITIONAL DISCOUNT ALLOWABLE AMOUNTS FOR INSURED PATIENTS ARE BASED ON THE NEGOTIATED RATE WITH COMMERCIAL INSURANCE OR MEDICARE

Schedule I
(Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public
Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

Part I General Information on Grants and Assistance

1

Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?

☒ Yes ☐ No

2

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

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
See Additional Data Table							

2

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

19

3

Enter total number of other organizations listed in the line 1 table

Part III

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

(a)Type of grant or assistance	(b)Number of recipients	(c)Amount of cash grant	(d)Amount of non-cash assistance	(e)Method of valuation (book, FMV, appraisal, other)	(f)Description of non-cash assistance

Part IV

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

Return Reference	Explanation
SCHEDULE I, PAGE 1, PART I, LINE 2	MOST DONATION REQUESTS ARE MADE THROUGH AN APPLICATION PROCESS WHERE THE APPLICANT DESCRIBES HOW THE MONEY WILL BE USED, HOW IT BENEFITS THE COMMUNITY, HOW OUR DONATION WILL CORRELATE WITH HEALTH NEEDS IDENTIFIED BY OUR COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA), AND THE AGREEMENT THAT THE DONEE WILL PROVIDE FOLLOW-UP OF HOW OUR DONATION WAS USED (WHO BENEFITED, ETC) NOT ALL OF OUR DONATIONS ARE RESTRICTED TO OUR CHNA, BUT MANY ARE MSHA'S SOCIAL RESPONSIBILITY COMMITTEE REVIEWS MOST DONATION REQUESTS TO DETERMINE WHICH REQUESTS MSHA WILL FUND THERE ARE MANY FACTORS THAT ARE CONSIDERED DURING THE REVIEW PROCESS BY THE COMMITTEE, SUCH AS OUR BUDGET CONSTRAINTS, IF THE APPLICANT HAS ALREADY RECEIVED A DONATION FROM A MSHA FACILITY, HOW THE REQUESTING ORGANIZATION FITS WITH OUR CHNA, ETC MSHA ADHERED TO THE FOLLOWING CRITERIA FOR OUR CONTRIBUTIONS TO ORGANIZATIONS IN THE REGION HEALTHCARE THE ORGANIZATION ENHANCED OR IMPROVED ACCESS FOR THE UNINSURED OR UNDERINSURED POPULATION OR SUPPORTED A PROGRAM TO IMPROVE THE HEALTH OF OUR RESIDENTS EDUCATION THE ORGANIZATION PROVIDED A PROGRAM TO IMPROVE EDUCATION OF THE RESIDENTS IN OUR REGION ALL THE WAY TO COLLEGE AGE STUDENTS (SUCH AS A NURSING PROGRAM) LARGE DONATIONS WERE MADE DURING THE YEAR TO SUPPORT HEALTH PROFESSIONS PROGRAMS AT LOCAL UNIVERSITIES AND COLLEGES FOR EXAMPLE, A PHARMACY PROGRAM, A NURSING PROGRAM, AND A NEW PHYSICIAN ASSISTANT PROGRAM QUALITY OF LIFE THE ORGANIZATION SUPPORTED PROGRAMS TO ENHANCE THE QUALITY OF LIFE, WHICH IS IMPORTANT IN THE RECRUITMENT EFFORTS OF BUSINESSES IN THE REGION AS WE WORK TO ATTRACT AND RETAIN THE BEST TALENT

Additional Data

Software ID:
Software Version:
EIN: 62-0476282
Name: MOUNTAIN STATES HEALTH ALLIANCE

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

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN CANCER SOCIETY250 WILLIAMS STREET NW SUITE 400 ATLANTA,GA 30303	13-1788491	501C3	26,000				PROGRAM SUPPORT
AMERICAN HEART ASSOCIATION208 SUNSET DRIVE JOHNSON CITY,TN 37604	13-5613797	501C3	41,250				MULTI-EVENT SPONSOR
APPALACHIAN MOUNTAIN PROJECT ACCESS809 SOUTH ROAN STREET SUITE 4 JOHNSON CITY,TN 37601	26-2102040	501C3	336,846				HEALTH ACCESS

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

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BARTER THEATRE PO BOX 867 ABINGDON, VA 24212	54-6000120	501C3	18,800				CONTRIBUTION
CASA OF NE TENNESSEE PO BOX 1021 JOHNSON CITY, TN 37605	45-0515257	501C3	12,500				PROGRAM SUPPORT
CITY OF JOHNSON CITY 601 E MAIN ST JOHNSON CITY, TN 37601	62-6000320	501C3	26,250				NATURE TRAIL, ETC

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

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV , appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CROSSROADS MEDICAL MISSIONPO BOX 16852 BRISTOL,VA 24209	54-2038877	501C3	10,000				PROGRAM SUPPORT
CRUMLEY HOUSE BRAIN INJURY REHAB300 URBANA ROAD LESTONE,TN 37681	58-1988511	501C3	5,000	83		PRINTING	PROGRAM SUPPORT
EAST TENN STATE UNIV FNDTNPO BOX 70721 JOHNSON CITY,TN 37614	23-7092731	501C3	14,600				CLINIC & MED SCHOOL

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

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
EAST TENNESSEE STATE UNIVERSITYPO BOX 70732JOHNSON CITY,TN 37614	62-6021046	501C3	721,547				NURSING & PHARMACY
FRIENDS IN NEED HEALTH CENTER1105 W STONE DRIVEKINGSPORT,TN 37660	62-1541637	501C3	15,000				DENTAL CARE
GOV'S FNDTN FOR HEALTH & WELLNESSPO BOX 198198NASHVILLE,TN 37219	45-3635908	501C3	25,000				HEALTH INITIATIVE

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

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
HANDS ON REGIONAL MUSEUM315 EAST MAIN STREET JOHNSON CITY, TN 37601	62-1282542	501C3	7,500				HEALTH EXHIBIT
KINGSPORT CHAMBER FOUNDATION151 EAST MAIN STREET KINGSPORT, TN 37660	58-1453565	501C3	20,000				HEALTHY KPT PRGRM
LEBANON LIFESAVING CREW INCP O BOX 516 60 S CHURCH ST LEBANON, VA 24266	54-1382140	501C3		7,129		MED SUPPLIES	DRUG REFILLS

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

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MARCH OF DIMESPO BOX 799 2700 S ROAN ST 430 JOHNSON CITY,TN 37605	13-1846366	501C3	10,000				MARCH FOR BABIES
MILLIGAN COLLEGEPO BOX 189 MILLIGAN COLLEGE,TN 37682	62-0535755	501C3	432,948				HEALTH PROF PROGRAM
SUSAN KOMEN BREAST CANCER FOUNDPO BOX 5835 KINGSPORT,TN 37663	84-1689067	501C3	10,000				PROGRAM SUPPORT

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

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV , appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
WOUNDED WARRIORS PROJECT INC4899 BELFORT RD 300 JACKSONVILLE,FL 32256	20-2370934	501C3	10,000				CONTRIBUTION

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

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

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number

62-0476282

Part I

Questions Regarding Compensation

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

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

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

Note. The sum of columns (B)(i)-(iii) 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				
See Additional Data Table							

Part III Supplemental Information

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

Return Reference	Explanation
SCHEDULE J, PAGE 1, PART I, LINE 1A	BOARD MEMBERS AND TEAM MEMBERS OF MSHA ARE NOT PERMITTED TO TRAVEL FIRST- CLASS WITH THE EXCEPTION OF MSHA'S CEO AS SANCTIONED BY MSHA'S BOARD OF DIRECTORS, MSHA'S CEO IS PERMITTED TO TRAVEL FIRST-CLASS WHEN THE FLIGHT'S DURATION IS GREATER THAN TWO HOURS DUE TO THE LENGTH OF SUCH FLIGHTS, THE BOARD BELIEVES IT IS IN THE BEST INTEREST OF MSHA FOR THE CEO TO TRAVEL FIRST-CLASS CHARTER TRAVEL IS LIMITED TO MSHA BUSINESS TRIPS THAT INCLUDE NUMEROUS TRAVELERS AND WHICH CAN BE JUSTIFIED BASED UPON FINANCIAL AND/OR ESSENTIAL TIME SAVINGS CHARTER FLIGHTS MUST BE APPROVED BY THE CEO PRIOR TO BOOKING THE FLIGHT
SCHEDULE J, PAGE 1, PART I, LINE 4	ALAN LEVINE 0 120,750 0 LYNN KRUTAK 0 24,856 0 MONTY MCLAURIN 0 13,992 0 SHANE HILTON 0 14,760 0 LINDA WHITE 0 10,880 0 LEMMIE TAYLOR 0 9,848 0 MORRIS SELIGMAN, M D 0 43,960 0 STEVE KILGORE 0 24,472 0
SCHEDULE J, PART III	THE FOLLOWING EXECUTIVES LISTED IN SCHEDULE J, PART II PARTICIPATED IN A 457(F) RETIREMENT PLAN PROVIDED BY MOUNTAIN STATES HEALTH ALLIANCE (MSHA) ALAN LEVINE, LYNN KRUTAK, MONTY MCLAURIN, SHANE HILTON, LINDA WHITE, LEMMIE TAYLOR, MORRIS SELIGMAN, AND STEVE KILGORE THE 457(F)PLAN IS A NONQUALIFIED TAX-DEFERRED COMPENSATION PLAN AVAILABLE TO A SELECT GROUP OF KEY EXECUTIVES FOR THE INTENT OF SUPPORTING RETENTION AND TO OFFER A COMPETITIVE TOTAL RETIREMENT PROGRAM ACCOUNT BALANCES HAVE A "SUBSTANTIAL RISK OF FORFEITURE" IN ADDITION TO CREDITOR RISK, SUBSTANTIAL RISK OF FORFEITURE IS CREATED THROUGH DEFAULT RISK IF THE PARTICIPANT'S EMPLOYMENT WITH MSHA IS TERMINATED PRIOR TO AGE 65 HOWEVER, THE 457(F) PLAN CONTAINS A NON-COMPETE PROVISION THAT PROVIDES THE ACCOUNT BALANCE TO BE PAID IN A LUMP SUM AFTER THE EXECUTIVE SATISFIES THE TWO-YEAR NON-COMPETE PERIOD THIS PROVISION APPLIES TO EMPLOYER CONTRIBUTIONS IF THE EXECUTIVE HAS PROVIDED ELIGIBLE SERVICE FOR SIX OR MORE YEARS (ELIGIBLE SERVICE IS OFFICER SERVICE THAT PERMITTED THE EXECUTIVE TO PARTICIPATE IN THE PLAN) THE EXECUTIVE WILL RECEIVE THE ENTIRE ACCOUNT BALANCE IF HE/SHE BECOMES DISABLED, DIES OR IF THE EXECUTIVE TERMINATES FOR "GOOD REASON- OR IS INVOLUNTARILY TERMINATED WITHOUT "GOOD CAUSE" WITHIN A 24-MONTH PERIOD AFTER A CHANGE-OF-CONTROL OCCURS DISTRIBUTIONS FROM THIS PLAN ARE SUBJECT TO FEDERAL, STATE, AND LOCAL TAXES ON THE ENTIRE ACCOUNT BALANCE UPON DISTRIBUTION

Additional Data

Software ID:

Software Version:

EIN: 62-0476282

Name: MOUNTAIN STATES HEALTH ALLIANCE

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
ALAN LEVINE, PRESIDENT & CEO	(i) (ii)	763,535	250,724	117,716	120,750	43,318	1,274,384	
MARVIN EICHORN, EVP/COO	(i) (ii)	513,864	140,426	51,080	18,788	46,674	747,495	
LYNN KRUTAK, SVP/CFO	(i) (ii)	329,541	57,373	3,668	48,125	18,275	456,982	
DENNIS VONDERFECHT, CEO (RETIRED FY14)	(i) (ii)	32,486	149,231	156,617		8,600	342,634	
ANN FLEMING, SVP/CONSULTANT	(i) (ii)	319,105	108,007	122,727	10,125	12,733	572,697	39,222
CANDACE JENNINGS, SR VP TN OPERATIONS	(i) (ii)	268,263		83,556	5,421	17,075	374,315	
MONTY MCLAURIN, VP/CEO NW MKT	(i) (ii)	268,960	61,819	20,342	29,617	24,717	405,455	
SHANE HILTON, VP/TN CFO	(i) (ii)	287,587	51,843	8,724	32,472	23,154	403,780	
TONY BENTON, VP/COO WASH CO MKT	(i) (ii)	273,318	54,994	4,525	16,463	21,783	371,083	
LINDA WHITE, VP & CEO, FWCH/WR	(i) (ii)	212,669	48,277	6,173	23,936	19,871	310,926	
LEMMIE TAYLOR, VP/CEO SE MKT	(i) (ii)	190,518	41,701	2,396	25,604	20,883	281,102	
RHONDA MANN, JCMC CNO	(i) (ii)	157,558	14,837	15,059	11,133	15,017	213,604	
DRU MALCOLM, VP & CNO JCMC/WR	(i) (ii)	152,064	6,550	7,083	12,247	5,389	183,333	
STEVE SAWYER, AVP/CFO NW MKT	(i) (ii)	150,118	6,550	8,816	6,418	17,630	189,532	
MORRIS SELIGMAN MD, EVP/CMO	(i) (ii)	435,096	123,037	24,872	56,066	19,118	658,189	
FRANK LAURO MD, VP/MED DIR CARDIO	(i) (ii)	366,216	80,526	6,731	19,873	24,533	497,879	
STEVE KILGORE, PRES /CEO BRMMC	(i) (ii)	331,273	71,259	17,311	44,102	22,404	486,349	
MARK WILKINSON MD, VP/CMO	(i) (ii)	336,139	79,140	4,266	11,203	24,094	454,842	
CLAY RUNNELS MD, VP/CMO WASH CO	(i) (ii)	342,450	68,903	2,895	11,338	23,920	449,506	
DALE CLAYTORE, VP RESOURCE MGMT	(i) (ii)	186,696	42,215	9,841	11,202	4,758	252,333	

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
	(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
PAT NIDAY, FORMER CNO WASH CO	(i)	155,750					
	(ii)		29,901	19,997	8,012	18,122	231,782

Schedule K
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

Part I

Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	HLTH & EDU FACIL BD 2011A&B&C&D OF THE CITY OF JOHNSON CITY TN	62-1464028	478271JS9	10-19-2011	195,840,000	CONSTRUCTION & EQUIP		X		X		X
B	HLTH & EDU FACIL BD 2010A&B	62-1464028	478271JH3	04-29-2010	205,877,528	PARTIAL REFUNDING		X		X		X
C	HLTH & EDU FACIL BD 2009A&B&C	62-1464028	478271HT9	03-31-2009	124,301,533	CONSTRUCTION & EQUIP		X		X		X
D	HLTH & EDU FACIL BD 2006A	62-1464028	478271GX1	02-14-2006	178,614,171	CONSTRUCTION & EQUIP		X		X		X

Part II

Proceeds

		A		B		C		D	
1	Amount of bonds retired	121,045,000		32,185,000		7,610,000		6,010,000	
2	Amount of bonds legally defeased								
3	Total proceeds of issue	195,841,616		206,153,675		125,817,329		185,446,812	
4	Gross proceeds in reserve funds								
5	Capitalized interest from proceeds								
6	Proceeds in refunding escrows								
7	Issuance costs from proceeds	2,353,905		3,474,644		2,481,706		2,383,533	
8	Credit enhancement from proceeds								
9	Working capital expenditures from proceeds								
10	Capital expenditures from proceeds	158,517,509				100,727,095		101,295,664	
11	Other spent proceeds	34,166,505		202,679,030		20,428,687		65,532,086	
12	Other unspent proceeds					2,179,840		16,235,529	
13	Year of substantial completion	2014					2011		
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X		X			X	X	
15	Were the bonds issued as part of an advance refunding issue?		X		X		X	X	
16	Has the final allocation of proceeds been made?	X		X		X		X	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III

Private Business Use

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

Part III

Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?	X		X		X		X	
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X		X		X	
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government								
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government								
6	Total of lines 4 and 5								
7	Does the bond issue meet the private security or payment test?		X		X		X		X
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?	X		X			X	X	
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	0 020 %		0 020 %				0 130 %	
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?		X		X				X
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X		X		X	

Part IV

Arbitrage

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

Part IV

Arbitrage (Continued)

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

Part V

Procedures To Undertake Corrective Action

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

Part VI

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

Return Reference	Explanation
SCHEDULE K - PURPOSE OF ISSUE DESCRIPTION	HLTH & EDU FACIL BD 2011A&B&C&D (PAGE 1 - LINE A) CONSTRUCT AND EQUIP HOSPITAL FACILITIES,INCLUDING REFINANCING TAXABLE DEBT RELATING THERETO, REFUND BONDS ISSUED 12/01/2001, REFINANCING LOANS AND EQUIPMENT LEASES HLTH & EDU FACIL BD 2010A&B (PAGE 1 - LINE B) PARTIAL REFUNDING OF BONDS ISSUED 12/14/2007 (2007A) AND (2007C) AND 2/20/2008 (2008A) HLTH & EDU FACIL BD 2009A&B&C (PAGE 1 - LINE C) CONSTRUCT AND EQUIP HOSPITAL FACILITIES,INCLUDING REFINANCING OF TAXABLE INDEBTEDNESS RELATING THERETO HLTH & EDU FACIL BD 2006A (PAGE 1 - LINE D) CONSTRUCT AND EQUIP HOSPITAL FACILITIES,INCLUDING REFINANCING TAXABLE DEBT RELATING THERETO, AND COST OF INTEREST RATE HEDGE, REFUND BONDS ISSUED 3/28/01, 7/01/03, 7/08/04, 11/23/04, 9/7/05 AND 11/23/05 HLTH & EDU FACIL BD 2012A&B&C (PAGE 2 - LINE A) CONSTRUCT AND EQUIP SURGERY CENTER AT JCMC, CONSTRUCT AND EQUIP HOSPITAL FACILITIES, INCLUDING REFINANCING OF INDEBTEDNESS RELATING THERETO HLTH & EDU FACIL BD 2013A&C&D&E (PAGE 2 - LINE B) CONSTRUCT & EQUIP HOSPITAL FACILITIES, INCLUDING REFINANCING OF INDEBTEDNESS RELATING THERETO, REFUND BONDS ISSUED 2/20/08, 10/19/11 & 9/18/12

Return Reference	Explanation
SCHEDULE K - DATE REBATE COMPUTATION PERFORMED	HLTH & EDU FACIL BD 2010A&B 02/25/15 HLTH & EDU FACIL BD 2009A&B&C 03/21/14 HLTH & EDU FACIL BD 2006A 02/17/11

Return Reference	Explanation
SCHEDULE K - ADDITIONAL INFORMATION	HLTH & EDU FACIL BD 2011A&B&C&D SCHEDULE K PART VI 1 COMMENT ON SCHEDULE K, PART I, MOUNTAIN STATES HEALTH ALLIANCE OWNS AND/OR OPERATES HOSPITALS IN A NUMBER OF DIFFERENT LOCATIONS BOTH IN TENNESSEE AND IN VIRGINIA AS A RESULT, MOUNTAIN STATES HEALTH ALLIANCE MUST UTILIZE CONDUIT GOVERNMENTAL BOND ISSUERS IN A NUMBER OF JURISDICTIONS IN ORDER TO FINANCE IMPROVEMENTS TO ITS HOSPITAL FACILITIES IN 2009, 2010, 2011, 2012 AND 2013, MOUNTAIN STATES HEALTH ALLIANCE WAS THE CONDUIT BORROWER OF TAX-EXEMPT BONDS ISSUED BY MULTIPLE ISSUERS IN TENNESSEE AND VIRGINIA FOR FEDERAL TAX PURPOSES, EVEN THOUGH DIFFERENT GOVERNMENT ISSUERS WERE INVOLVED, THESE MULTIPLE ISSUES IN EACH YEAR WERE REQUIRED TO BE TREATED, AND WERE TREATED, AS A SINGLE "ISSUE" BECAUSE THEY MET THE SINGLE "ISSUE" TEST UNDER THE APPLICABLE FEDERAL TAX REGULATIONS THEREFORE, MULTIPLE ISSUERS ARE LISTED BECAUSE THE BONDS THAT WERE ISSUED WERE PART OF A SINGLE "ISSUE" FOR FEDERAL TAX PURPOSES 2 COMMENT ON SCHEDULE K, PART II, LINE 3 FOR EACH THE LISTED BOND ISSUES DOES NOT MATCH THE APPLICABLE ISSUE PRICE FOR EACH SUCH BOND ISSUE BECAUSE OF INTEREST EARNINGS EARNED ON THE PROCEEDS OF EACH SERIES OF BONDS 3 COMMENT ON SCHEDULE K, PART II, LINE 9 THROUGH 11 THE INSTRUCTIONS ARE UNCLEAR AS TO WHETHER AMOUNTS USED TO REFINANCE SHORT-TERM TAXABLE LOANS INCURRED TO TEMPORARILY FINANCE ELIGIBLE COSTS SHOULD BE SHOWN AS CAPITAL EXPENDITURES AND WORKING CAPITAL (LINES 9 AND 10) OR AS OTHER SPENT PROCEEDS (LINE 11) BASED UPON A REVIEW OF OTHER 990 FILINGS, IT APPEARS THAT MOST REPORTING ENTITIES HAVE LISTED THE APPLICATION OF PROCEEDS FOR SUCH PURPOSE UNDER OTHER SPENT PROCEEDS (LINE 11) THIS FILING TAKES THAT APPROACH 4 COMMENT ON SCHEDULE K, PART II, LINE 12 IT IS UNCLEAR UNDER THE INSTRUCTIONS WHETHER TRANSFERRED PROCEEDS SHOULD BE TREATED AS OTHER UNSPENT PROCEEDS FOR REPORTING PURPOSES ON LINE 12 AS AN ABUNDANCE OF CAUTION, TRANSFERRED PROCEEDS HAVE BEEN INCLUDED ON LINE 12 FOR THE 2013 AND 2012 BONDS TO THE EXTENT APPLICABLE ALSO, DURING ITS 2013 FISCAL YEAR, MOUNTAIN STATES HEALTH ALLIANCE WAS ABLE TO REMOVE THE REQUIREMENT THAT CERTAIN DEBT SERVICE RESERVE FUNDS BE MAINTAINED AS A RESULT, MOUNTAIN STATES HEALTH ALLIANCE WAS ABLE TO TRANSFER PROCEEDS FROM DEBT SERVICE RESERVE FUNDS FOR CERTAIN ISSUES TO BOND SINKING FUNDS FOR THOSE ISSUES TO PAY PRINCIPAL ON THE ISSUE AND TO REDUCE THE AMOUNT OF TAX-EXEMPT BONDS OUTSTANDING IN THE MARKET AS A RESULT, UNSPENT PROCEEDS WERE INCREASED FOR CERTAIN ISSUES WHILE SUCH FUNDS ARE HELD IN THE BOND SINKING FUNDS, AND THE AMOUNTS PREVIOUSLY HELD IN DEBT SERVICE RESERVE FUNDS FOR SUCH ISSUES WERE REDUCED MOUNTAIN STATES HEALTH ALLIANCE IS USING SUCH PROCEEDS TO PAY PRINCIPAL AS QUICKLY ON THOSE ISSUES AS THE BOND DOCUMENTS PERMIT 5 COMMENT ON SCHEDULE K, PART III, LINE 8C A VERY SMALL AMOUNT OF EQUIPMENT THAT WAS FINANCED OR REFINANCED WITH THE PROCEEDS OF THE 2013, 2011, 2009, AND 2006A BONDS WERE DISPOSED OF DURING THE FISCAL YEAR NO REMEDIAL ACTION WAS TAKEN PURSUANT TO SECTIONS 1.141-12 AND 1.145-2 OF THE TREASURY REGULATIONS BECAUSE THE DISPOSITION OF SUCH EQUIPMENT DID NOT RESULT IN THE PRIVATE BUSINESS USE TEST THRESHOLD BEING EXCEEDED THEREFORE, SUCH REGULATIONS WERE INAPPLICABLE HOWEVER, AS A PRECAUTION, MOUNTAIN STATES HEALTH ALLIANCE ALLOCATED FROM THE PROCEEDS OF THE SALE OF THE FINANCED EQUIPMENT AND OTHER EQUIPMENT, AN AMOUNT EQUAL TO THE DEPRECIATED BOOK VALUE OF SUCH FINANCED EQUIPMENT TO NEW EQUIPMENT ACQUIRED DURING THE FISCAL YEAR BY MOUNTAIN STATES HEALTH ALLIANCE 6 COMMENT ON SCHEDULE K, PART IV, LINE 1 PRIOR TO JUNE 30, 2015, THE REPORTING DATE OF THE 990, THE ONLY ARBITRAGE REBATE CALCULATIONS THAT WERE REQUIRED RELATED TO THE BONDS FOR THE SERIES 2006, 2009 AND 2010 BONDS MOUNTAIN STATES HEALTH ALLIANCE RETAINED A REBATE CALCULATION AGENT TO CALCULATE WHETHER ANY ARBITRAGE REBATE WAS DUE WITH RESPECT TO THOSE BONDS, AND THERE WAS NEGATIVE ARBITRAGE REBATE LIABILITY IN A SIGNIFICANT AMOUNT THEREFORE, NO FORM 8038-T WAS REQUIRED TO BE FILED WITH RESPECT TO THOSE BOND ISSUES 7 COMMENT ON SCHEDULE K, PART IV, LINE 6 THE 2013 AND 2012 BOND ISSUES HAVE TRANSFERRED PROCEEDS OF PRIOR BOND ISSUES THAT FINANCED SIGNIFICANT CAPITAL IMPROVEMENTS TO HOSPITAL FACILITIES OR PROCEEDS THAT ARE TO BE USED FOR SUCH PURPOSES THERE HAVE BEEN UNEXPECTED DELAYS IN THE CONSTRUCTION AND EQUIPPING OF CERTAIN OF THESE HOSPITAL FACILITIES, AND THEREFORE NOT ALL OF SUCH PROCEEDS WERE SPENT WITHIN THE THREE-YEAR TEMPORARY PERIOD RELATIVE TO CONSTRUCTION PROJECTS HOWEVER, MOUNTAIN STATES HEALTH ALLIANCE HAS YIELD RESTRICTED THESE PROCEEDS AFTER THE END OF THE APPLICABLE TEMPORARY PERIOD AND/OR WILL BE MAKING A YIELD REDUCTION PAYMENT WITH RESPECT TO THOSE PROCEEDS, IF REQUIRED ALSO, THE PROCEEDS HELD IN THE BOND SINKING FUNDS AS DESCRIBED IN COMMENT 4 ABOVE ARE NO LONGER ELIGIBLE FOR ANY TEMPORARY PERIOD AND WILL BE INVESTED AT A RESTRICTED YIELD OR WILL BE SUBJECT TO A YIELD REDUCTION PAYMENT

Schedule L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered
"Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c,
or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at
www.irs.gov/form990.

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

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

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

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

Part II

Loans to and/or From Interested Persons.
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(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) DENNIS VONDERFECHT		SPLIT LIFE INSUR LOAN,INCL PR YRS		X	7,205,125	8,295,295		No	Yes		Yes	
(2) MARVIN EICHORN		SPLIT DOLLAR LIFE INSURANCE LOAN		X	700,000	1,410,710		No	Yes		Yes	
(3) MARVIN EICHORN		SPLIT DOLLAR LIFE INSURANCE LOAN		X	183,364	374,136		No	Yes		Yes	
(4) MARVIN EICHORN		SPLIT DOLLAR LIFE INSURANCE LOAN		X	304,332	304,332		No	Yes		Yes	
(5) MARVIN EICHORN		SPLIT LIFE INSUR LOAN,INCL PR YRS		X	296,183	296,183		No	Yes		Yes	
Total ▶ \$						10,680,656						

Part III

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

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) WORKSPACE INTERIORS INC	VENDOR	422,524	SEE PART V		No
(2) MATTHEW MARTIN	FAMILY MEMBER	26,019	SEE PART V		No
(3) CLEM WILKES III	FAMILY MEMBER	130,195	SEE PART V		No
(4) PAULA CLAYTORE	FAMILY MEMBER	278,296	SEE PART V		No
(5) SCOTT PETERS	FAMILY MEMBER	28,841	SEE PART V		No

Part V Supplemental Information

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

Return Reference	Explanation
SCHEDULE L, PART V	(1) ROBERT FEATHERS, VICE CHAIR OF THE MSHA BOARD OF DIRECTORS, IS OWNER OF WORKSPACE INTERIORS, INC WHICH PROVIDES COMMERCIAL FURNISHINGS AND DESIGN SERVICES TO MSHA. TRANSACTIONS ARE CONDUCTED AT ARMS-LENGTH. (2) JOANNE GILMER, SECRETARY OF THE MSHA BOARD OF DIRECTORS, IS A FAMILY MEMBER OF MATTHEW MARTIN, AN EMPLOYEE OF MSHA. (3) CLEM WILKES, JR., PAST CHAIR OF THE MSHA BOARD OF DIRECTORS, IS A FAMILY MEMBER OF CLEM WILKES III, AN EMPLOYEE OF MSHA. (4) DALE CLAYTORE, FORMER KEY EMPLOYEE OF MSHA, IS A FAMILY MEMBER OF PAULA CLAYTORE, AN EMPLOYEE OF MSHA. (5) LEMMIE TAYLOR, KEY EMPLOYEE OF MSHA, IS A FAMILY MEMBER OF SCOTT PETERS, AN EMPLOYEE OF MSHA.

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.**

OMB No 1545-0047

2014

**Open to Public
Inspection**

Name of the organization MOUNTAIN STATES HEALTH ALLIANCE	Employer identification number 62-0476282
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Return Reference	Explanation
FORM 990, PAGE 1, ITEM C	NISWONGER CHILDREN'S HOSPITAL, FRANKLIN WOODS COMMUNITY HOSPITAL, INDIAN PATH MEDICAL CENTER, SYCAMORE SHOALS HOSPITAL, WOODRIDGE HOSPITAL FOR BEHAVIORAL HEALTH SERVICES, JOHNSON COUNTY COMMUNITY HOSPITAL, RUSSELL COUNTY MEDICAL CENTER, UNICOI COUNTY MEMORIAL HOSPITAL

Return Reference	Explanation
FORM 990 - ORGANIZATION'S MISSION	MOUNTAIN STATES HEALTH ALLIANCE (MSHA) IS COMMITTED TO OUR MISSION OF BRINGING LOVING CARE TO HEALTH CARE. WE EXIST TO IDENTIFY AND RESPOND TO THE HEALTHCARE NEEDS OF INDIVIDUALS AND COMMUNITIES IN THE 29-COUNTY AREA WE SERVE, HELPING THEM ATTAIN THEIR HIGHEST LEVEL OF HEALTH. MSHA DELIVERS THIS CARE THROUGH THE PHILOSOPHY OF PATIENT-CENTERED CARE, AND THE DEVELOPMENT OF COMPREHENSIVE STRATEGIC PLANNING AND IMPLEMENTATION. SEE ATTACHED NARRATIVE "PROGRAM SERVICE ACCOMPLISHMENTS"

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 11B	THE CFO/SENIOR VP REVIEWED THE FORM 990 WITH THE BOARD OF DIRECTORS PRIOR TO FILING AND THE RETURN WAS MADE AVAILABLE TO EACH BOARD MEMBER IN AN ELECTRONIC FORMAT PRIOR TO THE REVIEW

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 12C	ANNUALLY , THE CORPORATE AUDIT AND COMPLIANCE DEPARTMENT OF MSHA FORWARDS THE CONFLICT OF INTEREST POLICY AND DISCLOSURE FORM TO ALL MSHA MANAGEMENT TEAM MEMBERS AND BOARD MEMBERS EMPLOYEES AND BOARD MEMBERS MUST NOTE ANY CONFLICTS OR ATTEST THEY HAVE "NONE", AND RETURN THE FORM TO THE AUDIT AND COMPLIANCE DEPARTMENT ANY NOTED DISCLOSURES ARE FORWARDED TO THE APPROPRIATE MANAGEMENT OR BOARD PERSONNEL TO EVALUATE AND UTILIZE WHEN A TRANSACTION INVOLVING A CONFLICTED PERSON ARISES ADDITIONALLY , PERSONNEL WHO HAVE A CONFLICT ARISE BETWEEN THE ANNUAL DISTRIBUTION OF THE POLICY AND FORMS ARE REQUIRED TO DISCLOSE THE CONFLICT AND WOULD BE DISCIPLINED IN ANY INSTANCE WHERE THEY HAVE NOT DISCLOSED AND ENGAGED IN A CONFLICTED TRANSACTION

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15A	THE MSHA BOARD OF DIRECTORS APPROVES THE TOTAL COMPENSATION OF MSHA'S PRESIDENT/CEO, INCLUDING ANY INCENTIVE COMPENSATION PROGRAM PAY OUTS. MSHA'S INCENTIVE PLAN IS BASED ON TARGETED ACHIEVEMENT METRICS SET IN ADVANCE OF THE PAY YEAR. ESTABLISHED METRICS INCLUDE COMMUNICATION WITH PATIENTS, PATIENT EVIDENCE-BASED CARE SCORES AND PATIENT SAFETY, VALUE- BASED PURCHASING, ETC. THESE SAME METRICS ARE USED FOR ALL EMPLOYEES WITHIN MSHA, WITH A SMALL NUMBER OF EXCEPTIONS FOR OUR COMPANIES THAT DO NOT PROVIDE DIRECT PATIENT CARE. THE EXECUTIVE COMMITTEE OF MSHA'S BOARD OF DIRECTORS IS THE DESIGNATED COMPENSATION COMMITTEE FOR MSHA. MSHA USES AN INDEPENDENT OUTSIDE COMPENSATION CONSULTING FIRM AND THIS FIRM USES INDUSTRY DATA TO ASSIST IN DETERMINING REASONABLE COMPENSATION FOR OUR CEO AND OTHER EXECUTIVES. THERE IS A WRITTEN EMPLOYMENT AGREEMENT BETWEEN MSHA AND ITS CEO. ALL MSHA EXECUTIVE PAY IS EVALUATED ON AN ANNUAL OR NEAR ANNUAL BASIS.

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15B	SIMILAR TO THE CEO'S COMPENSATION, THE CFO RECEIVES COMPENSATION AND BENEFITS THAT COMPLY WITH MSHA'S SALARY POLICY HER PAY IS SET AT A MARKET PERCENTILE SPECIFIC TO HER POSITION

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 19	GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE MADE AVAILABLE UPON REQUEST TO APPROPRIATE PARTIES REQUESTING THEM. FINANCIAL STATEMENTS ARE MADE AVAILABLE UPON REQUEST TO APPROPRIATE PARTIES REQUESTING THEM, AND THEY ARE MADE AVAILABLE TO THOSE PARTIES WHO OWN INDEBTEDNESS OF THE COMPANY ON A QUARTERLY BASIS. FORM 990, PART VII, OFFICERS, KEY EMPLOYEES, & HIGHEST PAID COMPENSATION: STEVE KILGORE, REPORTABLE AS A HIGHEST COMPENSATED EMPLOYEE, IS PAID BY MSHA AND HIS SALARY AND BENEFITS ARE FULLY REIMBURSED TO MSHA BY BRMMC. CERTAIN EXECUTIVES OF THE ORGANIZATION, SUCH AS THE HEALTH SYSTEM'S CEO, SVP/CFO, EVP/COO, ETC., PROVIDE SERVICES TO SOME OR ALL OF THE ORGANIZATIONS RELATED TO MSHA.

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	PHYSICIAN FEES 33,899,403 0 0 DIETARY SERVICES 7,665,258 0 0 CONSULTING SERVICES 0 4,179,386 0 ENVIRONMENTAL SERVICES 4,464,795 0 0 LAUNDRY SERVICES 2,773,289 0 0 COLLECTION SERVICES 3,354,117 0 0 PHARMACY 1,880,859 0 0 LABORATORY SERVICES 3,095,892 0 0 CONTRACT LABOR 2,123,325 0 0 PATIENT RESOURCE SERVICES 748,304 0 0 TRANSCRIPTION SERVICES 1,614,515 0 0 PHYSICIAN LOAN FORGIVENESS 716,579 0 0 SURGERY 353,600 0 0 EMERGENCY 140,239 0 0 NUC MED /RADIOLOGY/MRI 225,747 0 0 ENGINEERING SERVICES 0 1,525,958 0 OTHER FEES 34,338,095 2,512,940 5,077

Return Reference	Explanation
FORM 990, PART XI, LINE 9	PARTNERSHIP CHARITABLE CONTRIBUTION NOT ON BOOKS 2,590 PARTNERSHIP ORDINARY LOSS NOT ON BOOKS 92,628 ADJUST ACQUISITION INVESTMENT-UMCH 10,790 TEMPORARILY RESTRICTED GRANTS 35,932 CUMULATIVE EFFECT OF CHANGE IN ACCTG PRINCIPLE 317,644 CHANGE IN FAIR VALUE OF DERIVATIVES 7,718,029 TOTAL TO FORM 990, PART XI, LINE 9 8,177,613

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2014

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

Part I

Identification of Disregarded Entities

Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

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

Part II

Identification of Related Tax-Exempt Organizations

Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
See Additional Data Table							

Part III

Identification of Related Organizations Taxable as a Partnership

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end- of-year assets	(h) Disproprtionate allocations?		(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) INTEGRATED SOLUTIONS HEALTH NETWORK 509 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604 62-1711997	INVESTMENT	TN	MSHA	EXCLUDED	-86,761	14,318,070		No			No	99 890 %
(2) EMMAUS COMMUNITY HEALTHCARE LLC 6070 HWY 11E PINEY FLATS, TN 37686 20-0577483	MED SERV	TN	NA					No			No	
(3) MEDICAL SPECIALISTS OF JC LLC 2528 WESLEY STREET SUITE 2 JOHNSON CITY, TN 37601 27-2199037	MED SERV	TN	MSHA	EXCLUDED	-157,730	-11,783		No			No	51 000 %
(4) EAST TN AMBULATORY SURGERY CNTR 701 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604 62-1787537	MED SERV	TN	NA					No			No	

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
See Additional Data Table									

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)

Yes

No

1a Yes

1b Yes

1c Yes

1d Yes

1e

1f

1g Yes

1h

1i

1j Yes

1k Yes

1l Yes

1m Yes

1n

1o Yes

1p Yes

1q Yes

1r Yes

1s Yes

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
See Additional Data Table			

Schedule R (Form 990) 2014

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	

Part VII **Supplemental Information**

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

Return Reference	Explanation
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Additional Data

Software ID:

Software Version:

EIN: 62-0476282

Name: MOUNTAIN STATES HEALTH ALLIANCE

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(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? YesNo
(1) DICKENSON COMMUNITY HOSPITAL ONE HOSPITAL DRIVE CLINTWOOD, VA 24228 77-0599553	HOSPITAL	VA	501C3	3	NCH	No
(1) MOUNTAIN STATES FOUNDATION 2335 KNOB CREEK ROAD STE 101 JOHNSON CITY, TN 37604 58-1418862	FUNDRAISER	TN	501C3	11A	MSHA	No
(2) MSHA AUXILIARY 400 N STATE OF FRANKLIN ROAD JOHNSON CITY, TN 37604 58-1418345	SUPPORT	TN	501C3	11A	MSHA	No
(3) SMYTH COUNTY COMMUNITY HOSPITAL 245 MEDICAL PARK DRIVE MARION, VA 24354 54-0794913	HOSPITAL	VA	501C3	3	MSHA	No
(4) NORTON COMMUNITY HOSPITAL 100 15TH STREET NW NORTON, VA 24273 54-0566029	HOSPITAL	VA	501C3	3	NA	No
(5) JOHNSTON MEMORIAL HOSPITAL 16000 JOHNSTON MEMORIAL DRIVE ABINGDON, VA 24211 54-0544705	HOSPITAL	VA	501C3	3	NA	No
(6) ABINGDON PHYSICIAN PARTNERS 16000 JOHNSTON MEMORIAL DRIVE ABINGDON, VA 24211 20-5485346	MED SERV	VA	501C3	11A	JMH	No
(7) APPALACHIAN EMERGENCY PHYSICIANS 1021 W OAKLAND AVENUE STE 207 JOHNSON CITY, TN 37604 80-0592504	MED SERV	VA	501C3	11A	NA	No

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

(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							
BLUE RIDGE MEDICAL MANAGEMENT CORP 1021 W OAKLAND AVENUE STE 207 JOHNSON CITY, TN 37604 62-1490616	MED SERV	TN	MSHA	C CORP	119,370,052	228,517,067	100 000 %	No
MEDISERVE MEDICAL EQUIPMENT 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1212286	DME	TN	BRMMC	C CORP	4,008,809	4,671,094	100 000 %	No
MOUNTAIN STATES PROPERTIES 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1845895	PROP MGMT	TN	BRMMC	C CORP	13,981,453	147,505,563	100 000 %	No
MOUNTAIN STATES PHYSICIAN GROUP 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1700412	MED SERV	TN	BRMMC	C CORP	66,186,365	7,659,924	100 000 %	No
COMMUNITY HOME CARE INC 1460 PARK AVENUE NORTON, VA 24273 54-1453810	DME	VA	NCH	C CORP	353,069	538,579	50 100 %	No
SOUTHWEST COMMUNITY HEALTH SERV PO BOX 880 MARION, VA 24354 54-1460695	MED SERV	VA	SCCH	C CORP	197		80 000 %	No
WILSON PHARMACY INC PO BOX 5289 JOHNSON CITY, TN 37604 62-0329587	PHARMACY	TN	BRMMC	C CORP	4,253,522	5,521,875	100 000 %	No
CRESTPOINT HEALTH INSURANCE COMPANY 509 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604 62-0381170	INSURANCE	TN	ISHN	C CORP	23,249,905	13,651,783	99 830 %	No

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
MSHA AUXILIARY	C	82,748	
MSHA AUXILIARY	P	85,863	
MSHA AUXILIARY	Q	1,151,233	
BLUE RIDGE MEDICAL MANAGMENT CORP	A	149,979	
BLUE RIDGE MEDICAL MANAGMENT CORP	G	4,392,033	
BLUE RIDGE MEDICAL MANAGMENT CORP	L	6,136,116	
BLUE RIDGE MEDICAL MANAGEMENT CORP	M	35,160,355	
BLUE RIDGE MEDICAL MANAGEMENT CORP	O	543,798	
BLUE RIDGE MEDICAL MANAGEMENT CORP	P	68,312	
BLUE RIDGE MEDICAL MANAGEMENT CORP	Q	28,710,238	
BLUE RIDGE MEDICAL MANAGMENT CORP	S	6,498,719	
HEALTHPLUS	J	53,370	
HEALTHPLUS	L	86,008	
HEALTHPLUS	M	291,320	
HEALTHPLUS	O	189,279	
HEALTHPLUS	P	98,284	
HEALTHPLUS	Q	16,973,900	
HEALTHPLUS	R	140,295	
MEDISERVE	K	167,860	
MEDISERVE	L	71,328	
MEDISERVE	Q	3,182,570	
MOUNTAIN STATES PROPERTIES	G	1,362,238	
MOUNTAIN STATES PROPERTIES	K	2,576,614	
MOUNTAIN STATES PROPERTIES	L	496,039	
MOUNTAIN STATES PROPERTIES	M	261,908	

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
MOUNTAIN STATES PROPERTIES	O	497,165	
MOUNTAIN STATES PROPERTIES	Q	5,638,833	
MOUNTAIN STATES PROPERTIES	R	63,481	
MOUNTAIN STATES FOUNDATION	C	348,706	
NORTON COMMUNITY HOSPITAL	D	21,095,386	
NORTON COMMUNITY HOSPITAL	L	5,489,324	
NORTON COMMUNITY HOSPITAL	O	190,493	
NORTON COMMUNITY HOSPITAL	P	501,546	
NORTON COMMUNITY HOSPITAL	Q	27,309,250	
NORTON COMMUNITY HOSPITAL	R	217,629	
DICKENSON COMMUNITY HOSPITAL	L	797,476	
ISHN	B	10,274,850	
ISHN	J	205,671	
ISHN	L	232,298	
ISHN	M	3,186,946	
ISHN	Q	7,752,487	
SMYTH COUNTY COMMUNITY HOSPITAL	D	15,965,896	
SMYTH COUNTY COMMUNITY HOSPITAL	L	4,334,405	
SMYTH COUNTY COMMUNITY HOSPITAL	Q	61,084	
JOHNSTON MEMORIAL HOSPITAL	L	10,802,688	
JOHNSTON MEMORIAL HOSPITAL	O	263,704	
JOHNSTON MEMORIAL HOSPITAL	R	106,338	
APP	L	140,618	