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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
DICKENSON COMMUNITY HOSPITAL

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
PO BOX 1440 1 HOSPITAL DRIVE

City or town, state or province, country, and ZIP or foreign postal code
CLINTWOOD, VA 24228

D Employer identification number
77-0599553

E Telephone number
(276) 926-0319

G Gross receipts $ 5,728,205

F Name and address of principal officer
MARK LEONARD
100 15TH STREET NW
NORTON, VA 24273

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/DCH

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

L Year of formation 2003

M State of legal domicile VA

Part I Summary

1 Briefly describe the organization's mission or most significant activities
DICKENSON COMMUNITY HOSPITAL IS COMMITTED TO BRINGING LOVING CARE TO HEALTH CARE WE EXIST TO IDENTIFY AND RESPOND TO THE HEALTH CARE NEEDS OF INDIVIDUALS AND COMMUNITIES IN OUR REGION AND TO ASSIST THEM IN ATTAINING THEIR HIGHEST POSSIBLE LEVEL OF HEALTH PART I, LINE I - ORGANIZATION'S ACCOMPLISHMENTS WITH A SIGNIFICANT ELDERLY POPULATION AND MOUNTAINOUS TERRAIN, TRAVEL OUTSIDE THE IMMEDIATE AREA CAN BE CHALLENGING, ESPECIALLY IN THE WINTER RURAL LIFE OFTEN INCLUDES HAZARDOUS OCCUPATIONS, WHICH IS CERTAINLY TRUE OF DICKENSON COUNTY DUE TO THE HIGH EMPLOYMENT RATES IN THE COAL MINING INDUSTRY GIVEN THESE FACTORS, RURAL HOSPITALS MUST REMAIN FLEXIBLE AND DIVERSE IN THEIR FACILITIES AND THE SERVICES THEY OFFER THE COMMUNITY MOUNTAIN STATES HEALTH ALLIANCE AND NORTON COMMUNITY HOSPITAL BELIEVE THAT SUPPORTING THE SERVICES OF DICKENSON COMMUNITY HOSPITAL (DCH) TO ASSIST RESIDENTS IN ATTAINING A HIGH LEVEL OF HEALTH CONTINUES TO BE A CORE VALUE OF OUR BUSINESS AND COMMUNITY SUPPORT DC

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

Activities & Governance

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	8
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	2
5	Total number of individuals employed in calendar year 2014 (Part V, line 2a)	**5**	0
6	Total number of volunteers (estimate if necessary)	**6**	
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	0
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	28,775	21,020
9	Program service revenue (Part VIII, line 2g)	7,641,151	5,690,502
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	14,493	84
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	12,806	16,599
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	7,697,225	5,728,205
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	34,784	0
14	Benefits paid to or for members (Part IX, column (A), line 4)		0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	3,710,705	4,075,156
16a	Professional fundraising fees (Part IX, column (A), line 11e)		0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	3,130,769	3,472,358
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	6,876,258	7,547,514
19	Revenue less expenses Subtract line 18 from line 12	820,967	-1,819,309

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	4,417,439	4,323,639
21	Total liabilities (Part X, line 26)	924,356	1,829,656
22	Net assets or fund balances Subtract line 21 from line 20	3,493,083	2,493,983

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

****** | 2016-04-26
Signature of officer | Date

KEVIN MORRISON CFO
Type or print name and title

Paid Preparer Use Only

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

1 Briefly describe the organization's mission

DICKENSON COMMUNITY HOSPITAL IS COMMITTED TO BRINGING LOVING CARE TO HEALTH CARE WE EXIST TO IDENTIFY AND RESPOND TO THE HEALTH CARE NEEDS OF INDIVIDUALS AND COMMUNITIES IN OUR REGION AND TO ASSIST THEM IN ATTAINING THEIR HIGHEST POSSIBLE LEVEL OF HEALTH PART I, LINE I - ORGANIZATION'S ACCOMPLISHMENTS WITH A SIGNIFICANT ELDERLY POPULATION AND MOUNTAINOUS TERRAIN, TRAVEL OUTSIDE THE IMMEDIATE AREA CAN BE CHALLENGING, ESPECIALLY IN THE WINTER RURAL LIFE OFTEN INCLUDES HAZARDOUS OCCUPATIONS, WHICH IS CERTAINLY TRUE OF DICKENSON COUNTY DUE TO THE HIGH EMPLOYMENT RATES IN THE COAL MINING INDUSTRY GIVEN THESE FACTORS, RURAL HOSPITALS MUST REMAIN FLEXIBLE AND DIVERSE IN THEIR FACILITIES AND THE SERVICES THEY OFFER THE COMMUNITY MOUNTAIN STATES HEALTH ALLIANCE AND NORTON COMMUNITY HOSPITAL BELIEVE THAT SUPPORTING THE SERVICES OF DICKENSON COMMUNITY HOSPITAL (DCH) TO ASSIST RESIDENTS IN ATTAINING A HIGH LEVEL OF HEALTH CONTINUES TO BE A CORE VALUE OF OUR BUSINESS AND COMMUNITY SUPPORT DC

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 $ 1,813,438 including grants of $) (Revenue $ 1,580,075)

EMERGENCY SERVICES OUR FULLY STAFFED 24-HOUR EMERGENCY DEPARTMENT IS AVAILABLE FOR PATIENTS IN A LIFE THREATENING SITUATION WE CAN PROVIDE AIR MEDICAL TRANSPORTATION TO A LARGER REGIONAL HOSPITAL FOR ANY PATIENT NEEDING A HIGHER LEVEL OF CARE THERE WERE 7,270 ED VISITS DURING FY15 THE EXPENSES REFLECT ONLY THE DIRECT EXPENSES FOR THE EMERGENCY DEPARTMENT AND DO NOT INCLUDE ANY INDIRECT EXPENSES

4b (Code) (Expenses $ 507,404 including grants of $) (Revenue $ 1,510,688)

RADIOLOGY OUR HIGHLY TRAINED TECHNICIANS CAN ADMINISTER ON-SITE PROCEDURES AND TESTING FOR CT SCANS, GENERAL RADIOLOGY (X-RAY), ULTRASOUND, AND BONE DENSITY TESTING THE HOSPITAL PERFORMED 8,181 RADIOLOGY PROCEDURES DURING FY15 THE EXPENSES REFLECT ONLY THE DIRECT EXPENSES FOR THE RADIOLOGY DEPARTMENT AND DO NOT INCLUDE ANY INDIRECT EXPENSES

4c (Code) (Expenses $ 710,870 including grants of $) (Revenue $ 1,376,205)

LABORATORY OUR EXPERIENCED STAFF OFFER COMPLETE AND COMPREHENSIVE SERVICES INCLUDING EMERGENCY & OUTPATIENT SERVICES, STAT TESTING, COMPREHENSIVE CHEMISTRY STUDIES, OCCUPATIONAL DRUG TESTING, HIGH SENSITIVE COUMADIN MONITORING, TRANSFUSION SERVICES, AND MORE WE PROVIDE LAB SERVICES 24 HOURS A DAY, 7 DAYS A WEEK DURING FY15, 63,585 LAB TESTS WERE PROCESSED THE EXPENSES REFLECT ONLY THE DIRECT EXPENSES FOR THE LABORATORY DEPARTMENT AND DO NOT INCLUDE ANY INDIRECT EXPENSES

See Additional Data

4d Other program services (Describe in Schedule O)

(Expenses $ 3,218,919 including grants of $) (Revenue $ 1,239,716)

4e **Total program service expenses** ▶ 6,250,631

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		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		No
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? *If "Yes," complete Schedule I, Parts I and II*	**21**		No
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	**22**		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	**24a**		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		
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**		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	**26**		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	**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? *If "Yes," complete Schedule L, Part IV*	**28a**		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**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? *If "Yes," complete Schedule L, Part IV*	**28c**		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	**33**		No
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	**34**	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	**35a**		No
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	**35b**		
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	1a	25		
b	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		1c	Yes	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	0		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)		2b		
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?		3a		No
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O*		3b		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		4a		No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		5a		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		5b		No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?		5c		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		6a		No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		6b		
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?		7a		No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		7b		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		7c		No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		7e		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		7f		No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		7g		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		7h		
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		8		
9a	Did the sponsoring organization make any taxable distributions under section 4966?		9a		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		9b		
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?		12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O		13a		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?		14a		No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*		14b		

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	**1a**	8		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O				
b	Enter the number of voting members included in line 1a, above, who are independent	**1b**	2		
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**		Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	**7a**		Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	**7b**		Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?	**8a**		Yes	
b	Each committee with authority to act on behalf of the governing body?	**8b**		Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	**9**			No

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

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

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

▶ KEVIN MORRISON
100 15TH STREET NW
NORTON, VA 24273 (276) 439-1011

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			
(1) ANN FLEMING MSHA CONSULT	0 50 44 50	X						0	549,839	22,858
(2) JOHN DOYLE BRMMC CFO	0 50 44 50	X						0	354,549	55,691
(3) MONTY MCLAURIN VP/CEO NW MA	0 50 44 50	X						0	351,121	54,334
(4) SHANE HILTON VP/CFO MARKE	0 50 44 50	X						0	348,154	55,626
(5) ROBERT LEONARD TREASURER	0 50 1 50	X						0	23,302	0
(6) JAMES MANICURE VICE CHAIR	0 50 1 50	X						0	17,943	0
(7) BUFORD STURGILL DIRECTOR	0 50 1 50	X						0	17,512	0
(8) DONALD BAKER CHAIR	0 50	X						0	0	0
(9) ROGER DEEL DIRECTOR	0 50	X						0	0	0
(10) VONDA BUCHANAN SECRETARY	0 50	X						0	0	0
(11) MARK LEONARD CEO	6 00 39 00			X				0	316,295	47,380
(12) KEVIN MORRISON CFO	6 00 39 00			X				0	83,936	7,626
(13) ROY DEEL MD PHYSICIAN	40 00					X		0	219,567	22,847
(14) LURTON LYLE MD PHYSICIAN	40 00					X		0	119,097	10,333

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			
(15) JOHN WRIGHT FORMER DIREC							X	0	17,775	0
(16) STEPHEN SAWYER CFO IPMC CFO/FMR	45 00						X	0	165,484	24,048

1b	**Sub-Total**			
c	**Total from continuation sheets to Part VII, Section A**			
d	**Total (add lines 1b and 1c)**		2,584,574	300,743

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 ▶

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
PSYCHIATRIC MEDICAL CARE, PO BOX 30067 KNOXVILLE, TN 379300067	MED DIRECTOR	159,158

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 ▶1

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	17,885			
	e	Government grants (contributions)	1e	3,135			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f				
	g	Noncash contributions included in lines 1a-1f $					
	h	**Total.** Add lines 1a-1f . . . . . ▶		21,020			
Program Service Revenue			Business Code				
	2a	PATIENT SERVICES	622110	5,617,222	5,617,222		
	b	WELLNESS PROGRAMS	622110	73,280	73,280		
	c						
	d						
	e						
	f	All other program service revenue					
	g	**Total.** Add lines 2a–2f . . . . . ▶		5,690,502			
	3	Investment income (including dividends, interest, and other similar amounts) . . . . . ▶		84	84		
	4	Income from investment of tax-exempt bond proceeds . . ▶					
	5	Royalties . . . . . ▶					
			(i) Real	(ii) Personal			
	6a	Gross rents					
	b	Less rental expenses					
	c	Rental income or (loss)					
	d	Net rental income or (loss) . . . . . ▶					
			(i) Securities	(ii) Other			
	7a	Gross amount from sales of assets other than inventory					
	b	Less cost or other basis and sales expenses					
	c	Gain or (loss)					
	d	Net gain or (loss) . . . . . ▶					
Other Revenue	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	HQPAF ADMINISTRATION FEE	900099	10,800	10,800		
	b	REVENUES FROM PARENT	900099	4,832	4,832		
	c	VENDING MACHINES	900099	501			501
	d	All other revenue		466	466		
	e	**Total.** Add lines 11a–11d . . . . . ▶		16,599			
	12	**Total revenue.** See Instructions . . . . . ▶		5,728,205	5,706,684		501

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				
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	47,861		47,861	
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	3,155,579	2,590,261	565,318	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	72,445	61,666	10,779	
9 Other employee benefits	588,840	500,023	88,817	
10 Payroll taxes	210,431	184,282	26,149	
11 Fees for services (non-employees)				
a Management	1,144		1,144	
b Legal	23,532		23,532	
c Accounting	1,500		1,500	
d Lobbying				
e Professional fundraising services See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	1,765,923	1,669,380	96,543	
12 Advertising and promotion	84,387		84,387	
13 Office expenses	166,666	157,207	9,459	
14 Information technology	127,157	121,338	5,819	
15 Royalties				
16 Occupancy	182,224	108,217	74,007	
17 Travel	19,949	15,778	4,171	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	2,174	2,174		
20 Interest				
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	199,019	182,288	16,731	
23 Insurance	15,102	203	14,899	
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	417,806	417,806		
b REPAIRS & MAINTENANCE	232,041	227,301	4,740	
c MANAGEMENT FEES TO PARENT	123,364		123,364	
d DUES & SUBSCRIPTIONS	40,558	3,008	37,550	
e All other expenses	69,812	9,699	60,113	
25 **Total functional expenses.** Add lines 1 through 24e	7,547,514	6,250,631	1,296,883	0
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) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing		395,418	1	1,341,045
	2	Savings and temporary cash investments			2	
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		959,898	4	1,004,630
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		84,590	8	99,718
	9	Prepaid expenses and deferred charges		53,635	9	48,559
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 4,486,987			
	b	Less accumulated depreciation	10b 2,811,423	1,776,973	10c	1,675,564
	11	Investments—publicly traded securities			11	
	12	Investments—other securities See Part IV, line 11			12	
	13	Investments—program-related See Part IV, line 11			13	
	14	Intangible assets			14	
	15	Other assets See Part IV, line 11		1,146,925	15	154,123
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		4,417,439	16	4,323,639
Liabilities	17	Accounts payable and accrued expenses		622,100	17	779,398
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability Complete Part IV of Schedule D			21	
	22	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			23	
	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		302,256	25	1,050,258
	26	**Total liabilities.** Add lines 17 through 25		924,356	26	1,829,656
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		3,483,447	27	2,479,512
	28	Temporarily restricted net assets		9,636	28	14,471
	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		3,493,083	33	2,493,983
	34	Total liabilities and net assets/fund balances		4,417,439	34	4,323,639

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	5,728,205
2	Total expenses (must equal Part IX, column (A), line 25)	2	7,547,514
3	Revenue less expenses Subtract line 2 from line 1	3	-1,819,309
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	3,493,083
5	Net unrealized gains (losses) on investments	5	
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	820,209
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	2,493,983

Part XII Financial Statements and Reporting

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

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

Additional Data

Software ID:
Software Version:
EIN: 77-0599553
Name: DICKENSON COMMUNITY HOSPITAL

Form 990, Part III - Line 4c: Program Service Accomplishments (See the Instructions)

(Code) (Expenses $ 3,218,919 including grants of $) (Revenue $ 1,239,716)

DURING FY15, DCH BEGAN OFFERING PHYSICAL THERAPY (PT) SERVICES ON A 3-DAYS PER WEEK BASIS WITHIN DICKENSON COUNTY, THERE HAS HISTORICALLY BEEN ONLY ONE PHYSICAL THERAPY PROVIDER AND THEREFORE ONLY ONE OPTION FOR PT PATIENTS THIS ONE OPTION ALSO OPERATES A GYM WITHIN HIS PRACTICE AND SOME ELDERLY OR INJURED PATIENTS FOUND IT SOMEWHAT INTIMIDATING TO RECEIVE THERAPY IN THAT ENVIRONMENT DCH INITIATED PHYSICAL THERAPY SERVICES IN JANUARY 2015 AND WITHIN WEEKS GREW OUR PATIENT VOLUME TO THE MAXIMUM OUR CAPACITY WOULD ALLOW DURING FY15, DCH'S WOUND CARE PROGRAM HAS INCREASED MORE THAN 5-FOLD FROM LAST YEAR IT BEGAN AS AN OUTGROWTH FROM NORTON COMMUNITY HOSPITAL IN AN EFFORT TO REACH PATIENTS THAT COULD NOT ACCESS CARE WOUND CARE PATIENTS OFTEN HAVE MULTIPLE HEALTH ISSUES AND MANY TIMES TRAVEL IS VERY DIFFICULT FOR THEM THESE HARDSHIPS OFTEN CAUSED PATIENTS THE INABILITY TO ACCESS NECESSARY CARE PATIENTS SERVED AT DCH INCLUDE THOSE WITH DIABETIC ULCERS, VENOUS STASIS ULCERS, ARTERIAL ULCERS, NON-HEALING TRAUMATIC AND SURGICAL WOUNDS AND OTHER CHRONIC WOUND CONDITIONS DUE TO THE INITIAL SUCCESS OF DCH'S SENIOR LIFE SOLUTIONS PROGRAM, DCH BEGAN PERFORMING DUE DILIGENCE ON THE NEED FOR INPATIENT GERIATRIC BEHAVIORAL HEALTH SERVICES WE FOUND THAT WHILE THERE WERE A HANDFUL OF PSYCHIATRIC SERVICES LOCATED WITHIN THE SOUTHWEST VIRGINIA AREA, NONE WERE DEDICATED SPECIFICALLY TO THE GERIATRIC POPULATION WE RECEIVED A CERTIFICATE OF PUBLIC NEED FROM THE STATE IN JANUARY 2015 DCH BEGAN CONSTRUCTION IN APRIL 2015, AND BEGAN WORKING TOWARDS COMPLETION OF ALL REQUIRED STATE AND FEDERAL SURVEYS DICKENSON COMMUNITY HOSPITAL'S SENIOR LIFE SOLUTIONS (SLS) PROGRAM CONTINUES SERVING THE BEHAVIORAL, EMOTIONAL, AND MENTAL HEALTH NEEDS OF INDIVIDUALS AGES 65 AND OVER SLS, AN INTENSIVE OUTPATIENT PSYCHIATRIC PROGRAM (IOP), PROVIDES GROUP, INDIVIDUAL AND FAMILY PSYCHOTHERAPY TREATMENT AT A MORE INTENSIVE RATE THAN TRADITIONAL OUTPATIENT THERAPY THE SLS DESIGN PROVIDES A BRIDGE BETWEEN TRADITIONAL OUTPATIENT SERVICES AND PSYCHIATRIC INPATIENT HOSPITALIZATION A TYPICAL PATIENT WILL RECEIVE NINE HOURS OF GROUP PSYCHOTHERAPY PER WEEK, WHICH IS DIVIDED INTO THREE ONE-HOUR SESSIONS A DAY, AT THREE DAYS PER WEEK SLS IMPLEMENTED AN ADDITIONAL ONE- HOUR GROUP SERVICE NAMED THE TRANSITION GROUP THIS ALLOWS PATIENTS THAT ARE SHOWING PROGRESS THROUGH SYMPTOM REDUCTION TO DECREASE TREATMENT HOURS IN A MANNER THAT MAINTAINS THEIR STABILITY DCH IS LOCATED IN A RURAL AREA AND THE SLS PROVIDES WARRANTED SERVICES TO A GROWING SENIOR POPULATION WHICH WAS PREVIOUSLY UNDERSERVED DURING FY15, DCH'S UNREIMBURSED COST FOR OUTPATIENT PSYCH SERVICES, INCLUDING THE SENIOR LIFE SOLUTIONS PROGRAM, WAS 517,244 DCH HAS PARTNERED WITH THE COMPANY ADVANCED PATIENT ADVOCACY TO WORK WITH SELF-PAYING PATIENTS WHO HAVE LIMITED FINANCIAL RESOURCES DURING FY15, REPRESENTATIVES WERE AVAILABLE TO DCH PATIENTS AND WERE ABLE TO DETERMINE GOVERNMENTAL MEDICAL ASSISTANCE(MEDICAID OR TENNCARE) ELIGIBILITY, AND TO HELP WITH THE APPLICATION PROCESS AND FOLLOW-UP ONCE A PERSON IS APPROVED FOR MEDICAID (OR TENNCARE) THROUGH THE PROGRAM OFFERED THROUGH DCH, THEY RETAIN COVERAGE FOR FUTURE MEDICAL CARE ADVANCED PATIENT ADVOCACY IS COMPENSATED BY DCH DCH'S COST FOR THIS PROGRAM WAS 6,609

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

▶ **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
DICKENSON COMMUNITY HOSPITAL

Employer identification number
77-0599553

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? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization 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 III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
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.*	1		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in* ***Part VI*** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.*	2		

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

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)

			Yes	No
2	Activities Test **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.*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	2b		
3	Parent of Supported Organizations **Answer (a) and (b) below.**			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in Part VI.*	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in Part VI the role played by the organization in this regard.*	3b		

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

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov 20, 1970 **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

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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	Employer identification number
DICKENSON COMMUNITY HOSPITAL	77-0599553

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

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

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

4-Year Averaging Period Under section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the 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) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?	Yes		272
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?		No	
j	Total. Add lines 1c through 1i			272
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 IV	DCH HAD LOBBYING EXPENSES OF 272 WHICH REPRESENTS THE PORTION OF VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION DUES ATTRIBUTABLE TO DIRECT LOBBYING

Part IV Supplemental Information *(continued)*

Return Reference	Explanation

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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
DICKENSON COMMUNITY HOSPITAL

Employer identification number
77-0599553

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	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

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

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

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

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

(i) 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 ▶ $ _____

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

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

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

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

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

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

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

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

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

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

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

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

Part VI Land, Buildings, and Equipment. Complete if the organization answered 'Yes' to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings		636,632	181,107	455,525
c Leasehold improvements		557,291	444,030	113,261
d Equipment		3,293,064	2,186,286	1,106,778
e Other				
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				1,675,564

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
Other		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 12)* ▶		

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

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
Total. *(Column (b) must equal Form 990, Part X, col (B) line 13)* ▶		

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

(a) Description	(b) Book value
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* . . . . . ▶	

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

1 (a) Description of liability	(b) Book value
Federal income taxes	
PENSION BENEFIT LIABILITIES	657,800
DUE TO THIRD PARTIES	348,058
PROF LIABILITY RESERVE	43,650
OTHER	750
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	1,050,258

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

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

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 "

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493117008316

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
DICKENSON COMMUNITY HOSPITAL

Employer identification number
77-0599553

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			58,428		58,428	0 770 %
b Medicaid (from Worksheet 3, column a)			1,462,576	693,774	768,802	10 190 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			1,521,004	693,774	827,230	10 960 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			6,609		6,609	0 090 %
f Health professions education (from Worksheet 5)			53,874		53,874	0 710 %
g Subsidized health services (from Worksheet 6)			930,060	153,921	776,139	10 280 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits			990,543	153,921	836,622	11 080 %
k **Total.** Add lines 7d and 7j			2,511,547	847,695	1,663,852	22 050 %

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15?	1	Yes	
2	Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount 2 1,517,248			
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 1,092,418			
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	2,776,955
6	Enter Medicare allowable costs of care relating to payments on line 5	6	2,120,765
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	656,190
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used		

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

Part V Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
How many hospital facilities did the organization operate during the tax year? 1

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)

	Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
	See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group DICKENSON COMMUNITY HOSPITAL

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	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☐ 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?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☑ Hospital facility's website (list url) WWW MOUNTAINSTATESHEALTH COM/DCH			
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)*

DICKENSON COMMUNITY 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?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000% and FPG family income limit for eligibility for discounted care of 400 000000000000%			
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) WWWMOUNTAINSTATESHEALTHCOM			
b	☑ The FAP application form was widely available on a website (list url) WWWMOUNTAINSTATESHEALTHCOM			
c	☐ A plain language summary of the FAP was widely available on a website (list url) WWWMOUNTAINSTATESHEALTHCOM			
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)*

DICKENSON 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?	**19**	Yes	
	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			
Policy Relating to Emergency Medical Care				
21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	**21**	Yes	
	If "No," indicate why			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ Other (describe in Section C)			
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?	**23**		No
	If "Yes," explain in Section C			
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?	**24**		No
	If "Yes," explain in Section C			

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 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? _____

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

Part VI Supplemental Information

Provide the following information

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

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

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

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

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

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

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

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

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 COST OUR COST ACCOUNTING SYSTEM PROVIDED MEDICAID/TENNCARE LOSSES REPORTED ON LINE 7B, WITH THE EXCEPTION OF OUR PHYSICIAN CLINIC WE USED COST TO CHARGE RATIO FOR OUR PHYSICIAN CLINIC BECAUSE ITS DATA IS NOT AVAILABLE IN OUR COST ACCOUNTING SYSTEM 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 NURSING AND PHARMACY STUDENTS) WITH SCHOOLS AND UNIVERSITIES, ALLOWING THEIR HEALTH PROFESSION STUDENTS TO GET HANDS-ON TRAINING AT A HOSPITAL AS PART OF THEIR EDUCATION AND TRAINING OUR ORGANIZATIONAL DEVELOPMENT DEPARTMENT KEEPS DETAILED RECORDS OF HOURS SPENT ON THESE STUDENT ACTIVITIES, THE NUMBER OF STUDENTS THAT ROTATE THROUGH OUR HOSPITAL, 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 SERVICES, WE USE OUR COST ACCOUNTING SYSTEM, EXCEPT FOR THE 227,660 SUBSIDY OF OUR OWNED AND OPERATED CLINIC LOCATED IN A RURAL, LOW INCOME AREA WE ARE CAREFUL TO ENSURE NO DOUBLE COUNTING OF COST (FOR EXAMPLE, WE DO NOT INCLUDE CHARITY AND 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 HOSPITAL THAT LOSE MONEY, WE DO NOT REPORT SERVICES THAT HOSPITALS ARE REQUIRED BY STATE LICENSURE TO PROVIDE FOR THE SERVICE LINES WE DO REPORT, SUCH AS OUTPATIENT PSYCH, WE USED OUR COST ACCOUNTING SYSTEM SINCE THESE SERVICES HAVE ESTABLISHED, STANDARD FINANCIAL REPORTS

Form and Line Reference	Explanation
PART II - COMMUNITY BUILDING ACTIVITIES	DCH LEADERS SUPPORT AND ENCOURAGE ALL TEAM MEMBERS TO VOLUNTEER THEIR TIME, MONEY AND SKILLS TO COMMUNITY SERVICE PROJECTS AND CHARITABLE ORGANIZATIONS SENIOR LEADERS AND BOARD MEMBERS SET A POSITIVE EXAMPLE FOR 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

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 50% CALCULATED DISCOUNT, AS REQUIRED BY TENNESSEE LAW MSHA APPLIES TENNESSEE LAW TO OUR VIRGINIA HOSPITALS' PATIENT ACCOUNTS AFTER THE NORMAL COLLECTION PROCESS HAS INDICATED AN ACCOUNT IS UNCOLLECTIBLE, DCH 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	DCH'S PATIENT FINANCIAL SERVICES MANAGEMENT ESTIMATE THAT 72% 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 PEOPLE WITH NO FORM OF INSURANCE OR OTHER THIRD-PARTY COVERAGE, WHICH REPRESENTS THE MAJORITY OF BAD BEBT ACCOUNTS WE ALSO ESTIMATE A MUCH SMALLER PERCENTAGE OF LIKELY CHARITY-ELIGIBLE ACCOUNTS TO PEOPLE WITH BALANCES AFTER INSURANCE/THIRD-PARTY COVERAGE HAS PAID (E G DEDUCTIBLES AND CO-PAYMENT BALANCES) IT IS IMPLAUSIBLE TO DETERMINE WITH EXACTITUDE THE AMOUNT OF DCH'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 THESE INDIVIDUALS ARE TOLD WE FEEL SURE THEY DO QUALIFY FOR FULL OR PARTIAL ASSISTANCE, THEY STILL REFUSE TO COMPLETE OUR FINANCIAL ASSISTANCE APPLICATION

Form and Line Reference	Explanation
BAD DEBT EXPENSE FOOTNOTE TO FINANCIAL STATEMENTS	THE TEXT TO 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 DCH'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, COMFORT ITEMS TO INCLUDE A TELEVISION AND A TELEPHONE THE RECRUITMENT OF PHYSICIANS AND PHYSICIAN GUARANTEES ARE NON-ALLOWED COSTS BY THE MEDICARE PROGRAM EVEN THOUGH PHYSICIANS ARE RECRUITED BASED ON DOCUMENTED COMMUNITY NEED ALSO, A PORTION OF THE BAD DEBT ASSOCIATED WITH THE CARE OF THE PATIENT IS NOT AN ALLOWED COST BY MEDICARE 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, DCH IS REQUIRED TO PROVIDE THE FULL REGIMEN OF CARE FOR OUR MEDICARE POPULATION THERE ARE A NUMBER OF CARE REGIMENS THAT ARE COMPENSATED BY THE MEDICARE PROGRAM AT LEVELS BELOW OUR 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 DCH 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 DCH RECOGNIZES ITS OBLIGATION TO PROVIDE QUALITY HEALTHCARE 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 OUR 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 ELGIBILITY 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 VIRGINIA RANKED 21ST AND TENNESSEE RANKED 43RD HOWEVER, IT SHOULD BE NOTED THAT SOUTHWEST VIRGINIA (WHERE DCH IS 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) DCH WAS GIVEN A HEALTH STATUS RANKING OF 3 8 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 VIRGINIA RANKS 25TH FOR CARDIOVASCULAR DEATHS, 23RD FOR CANCER DEATHS (31ST FOR SMOKING) AND 21ST FOR DIABETES THE ROBERT WOOD JOHNSON FOUNDATION REPORTS 32% OF DICKENSON COUNTY'S CITIZENS SMOKE COMPARED TO 18% IN THE STATE OF VIRGINIA AND, 29% OF OUR COUNTY'S ADULTS ARE CONSIDERED OBESE AND 30% ARE PHYSICALLY INACTIVE DICKENSON COUNTY'S HEALTH RANKING IS 130 OUT OF 133 STATEWIDE (1 BEING THE BEST AND 133 BEING THE WORST)

Form and Line Reference	Explanation
PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE	DCH PROVIDES COMMUNICATION OF FINANCIAL ASSISTANCE ON OUR WEBSITE AND ON POSTERS LOCATED IN PROMINENT AREAS OF THE HOSPITAL SUCH AS ADMITTING AND THE EMERGENCY DEPARTMENT 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 THESE COUNSELORS HELP UNINSURED PATIENTS DETERMINE SOURCES OF PAYMENT FOR MEDICAL BILLS AND HELP PATIENTS DETERMINE ELIGIBILITY FOR PROGRAMS SUCH AS MEDICAID/TENNCARE DCH PARTNERED WITH THE COMPANY ADVANCED PATIENT ADVOCACY TO WORK WITH SELF-PAYING PATIENTS WHO HAVE LIMITED FINANCIAL RESOURCES REPRESENTATIVES WERE AVAILABLE AT DCH TO ASSIST PATIENTS THE REPRESENTATIVES WERE ABLE TO DETERMINE GOVERNMENTAL MEDICAL ASSISTANCE (MEDICAID OR TENNCARE) ELIGIBILITY, AND TO HELP WITH THE APPLICATION PROCESS AND FOLLOW-UP ONCE A PERSON IS APPROVED FOR MEDICAID OR TENNCARE THROUGH THE PROGRAM OFFERED THROUGH DCH, THEY RETAIN COVERAGE FOR FUTURE MEDICAL CARE ADVANCED PATIENT ADVOCACY IS COMPENSATED BY DCH DURING FY15, OUR COST FOR THIS PROGRAM WAS 6,609

Form and Line Reference	Explanation
PART VI, LINE 4 - COMMUNITY INFORMATION	DCH IS LOCATED IN CLINTWOOD, DICKENSON COUNTY, WHICH IS IN RURAL SOUTHWEST VIRGINIA SOUTHWEST VIRGINIA (SWVA) IS LOCATED WITHIN THE APPALACHIAN MOUNTAINS, SPECIFICALLY THE BLUE RIDGE MOUNTAIN REGION SWVA IS CONSIDERED RURAL AND MUCH DIFFERENT THAN THE REST OF THE STATE SWVA HAS BEEN AND REMAINS A MAJOR COAL MINING REGION AND HAS A HIGH RATE OF INDIVIDUALS WHO ARE UNINSURED ACCORDING TO U S CENSUS BUREAU ESTIMATES, THE TOWN OF CLINTWOOD HAS A POPULATION OF 1,414, WHILE DICKENSON COUNTY'S POPULATION IS 15,903 THE LATEST CENSUS BUREAU DATA ESTIMATES THE MEDIAN AGE OF RESIDENTS OF DICKENSON COUNTY IS 43 5 WHICH IS OLDER THAN THE MEDIAN AGE OF 37 6 IN VIRGINIA THE BUREAU ESTIMATES DICKENSON COUNTY MEDIAN HOUSEHOLD INCOME AT 33,106 COMPARED TO 64,792 FOR THE STATE OF VIRGINIA 27% OF DICKENSON COUNTY'S CHILDREN LIVE IN POVERTY COMPARED TO 16% STATEWIDE DICKENSON COUNTY'S HEALTH OUTCOMES RANK 130 OUT OF 133 IN THE STATE

Form and Line Reference	Explanation
PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH	DCH PROVIDES LOCAL ACCESS TO DIAGNOSTIC SERVICES TO THE RESIDENTS OF THE AREA, WHO OTHERWISE WOULD HAVE TO DRIVE 45 MINUTES FOR HEALTHCARE SERVICES, THIS CONTINUES TO BE A VALUABLE RESOURCE TO THE RESIDENTS OF THE AREA BY AIDING WITH TRANSPORTATION ISSUES RESOLVING ACCESS LIMITATIONS FOR SPECIALTY SERVICES, AND PROVIDING RELIEF TO THE SPECIAL HEALTH PROBLEMS OF OUR AREA DCH OPERATES AND SUBSIDIZES A PRIMARY CARE CLINIC POOR MENTAL HEALTH DAYS ARE WHEN A PERSON INDICATES THEIR ACTIVITIES ARE LIMITED DUE TO MENTAL HEALTH DIFFICULTIES THIS IS A GENERAL INDICATION OF THE POPULATION'S ABILITY TO FUNCTION ON A DAY-TO-DAY BASIS WHEN THE CHNA WAS CONDUCTED THE STATE OF VIRGINA REPORTED 3 1 DAYS COMPARED TO DICKENSON COUNTY'S 6 4 DAYS (MORE THAN DOUBLE) ALSO, THERE IS ONLY 1 MENTAL HEALTH PROVIDER FOR EVERY 5,230 RESIDENTS COMPARED TO 1 FOR EVERY 521 FOR THE STATE OF VIRGINIA DCH HAS IMPLEMENTED PROGRAMS TO PROVIDE SERVICES TO HELP REDUCE THIS CONCERN FOR DICKENSON COUNTY THE PSYCH SERVICES DCH PROVIDED DURING FY15 RESULTED IN A LOSS OF 517,244 DCH IS DEDICATED TO OPERATING EFFICIENTLY SO THAT WASTE IS MINIMIZED DCH'S LEADERSHIP REMAINS MINDFUL OF MANAGING THE HOSPITAL'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 IN MOST YEARS, DCH DOES NOT ENJOY NET OPERATING SURPLUSES AND RELIES ON SUBSIDIZATION FROM NORTON COMMUNITY HOSPITAL THE MAJORITY OF DCH'S GOVERNING BODY IS COMPRISED OF PERSONS WHO RESIDE IN THE ORGANIZATION'S PRIMARY SERVICE AREA ONLY TWO DIRECTORS, SHANE HILTON AND MONTY MCLAURIN, EMPLOYEES OF MSHA, LIVE OUTSIDE THE AREA MANY OF OUR BOARD MEMBERS ARE DEEMED NON-INDEPENDENT, PER IRS FORM 990 INSTRUCTIONS TWO EMPLOYEES OF MSHA ARE DCH DIRECTORS, THREE HAD REPORTABLE INCOME EXCEEDING 10,000 FOR HEALTH INSURANCE PAID BY NCH (DCH'S SOLE MEMBER), AND, ONE DIRECTOR HAD A FAMILY MEMBER EMPLOYED BY DCH (IN A NON-MANAGERIAL POSITION) PHYSICIANS THAT REQUEST PRIVILEGES WHO ARE QUALIFIED AND CREDENTIALED ARE EXTENDED PRIVILEGES BY DCH

Form and Line Reference	Explanation
PART VI, LINE 6 - AFFILIATED HEALTH CARE SYSTEM	DCH IS LICENSED FOR 25-BEDS BUT OPERATES AS A 1-BED CRITICAL ACCESS HOSPITAL UNDER THE DIRECTION OF AN 8-MEMBER BOARD OF DIRECTORS PRIMARILY COMPRISED OF LOCAL COMMUNITY RESIDENTS DCH IS OWNED BY NORTON COMMUNITY HOSPITAL (NCH) DCH HAS A LOAN AGREEMENT WITH NCH THAT PROVIDES FOR NCH TO ASSIST IN SUBSIDIZING DCH'S OPERATING EXPENSES NCH IS MAJORITY OWNED BY MOUNTAIN STATES HEALTH ALLIANCE (MSHA) BASED IN JOHNSON CITY, TENNESSEE MSHA IS INTEGRATED BOTH VERTICALLY AND HORIZONTALLY AND IS THE LARGEST REGIONAL HEALTHCARE SYSTEM WITH 13 HOSPITALS MSHA PROVIDES CARE TO PEOPLE IN 29 COUNTIES IN TENNESSEE, VIRGINIA, KENTUCKY, AND NORTH CAROLINA DCH SERVES AS THE COUNTY'S PRIMARY HEALTH SERVICE PROVIDER PATIENTS BENEFIT FROM DCH'S AFFILIATION WITH A HEALTHCARE SYSTEM WHERE THEY CAN BE EFFICIENTLY MOVED ALONG AN INTEGRATED, COMPREHENSIVE CONTINUUM OF CARE AS THEIR HEALTH STATUS DICTATES IF NEED BE, PATIENTS CAN BE MOVED TO THE SYSTEM'S FLAGSHIP FACILITY, JOHNSON CITY MEDICAL CENTER, WHICH IS A TERTIARY CARE FACILITY PROVIDING ADVANCED TREATMENT OPTIONS DCH OPERATES A 24-HOUR EMERGENCY DEPARTMENT TO TREAT PATIENTS IN LIFE THREATENING SITUATIONS FOR ANY PATIENT WHO NEEDS A HIGHER LEVEL OF CARE THAN DCH CAN PROVIDE, AIR MEDICAL TRANSPORTATION IS AVAILABLE THROUGH WINGS AIR RESCUE WINGS III IS BASED IN JENKINS, KENTUCKY AND CAN QUICKLY RESPOND AND HAVE ANY PATIENT TRANSPORTED TO NORTON COMMUNITY HOSPITAL (7 MINUTES), JOHNSON CITY MEDICAL CENTER (20 MINUTES) AND OTHER REGIONAL HOSPITALS WHEN MINUTES COUNT

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

Additional Data

Software ID:
Software Version:
EIN: 77-0599553
Name: 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, DICKENSON COMMUNITY HOSPITAL - PART V, LINE 5	
FACILITY 1, DICKENSON COMMUNITY HOSPITAL - PART V, LINE 6A	EACH HOSPITAL WITHIN THE MSHA SYSTEM COMPLETED A CHNA DCH'S CHNA WAS CONDUCTED WITH ALL M SHA HOSPITALS TO INCLUDE JOHNSON CITY MEDICAL CENTER (INCLUDES NISWONGER CHILDREN'S HOSPI TAL AND WOODRIDGE HOSPITAL), FRANKLIN WOODS COMMUNITY HOSPITAL, INDIAN PATH MEDICAL CENTER , SYCAMORE SHOALS HOSPITAL, JOHNSON COUNTY COMMUNITY HOSPITAL, UNICOI COUNTY MEMORIAL HOSP ITAL, RUSSELL COUNTY MEDICAL CENTER, SMYTH COUNTY COMMUNITY HOSPITAL, JOHNSTON MEMORIAL HO SPITAL AND NORTON COMMUNITY HOSPITAL
FACILITY 1, DICKENSON COMMUNITY HOSPITAL - PART V, LINE 11	MSHA PUBLISHED ITS COMMUNITY HEALTH NEEDS ASSESSMENT ON JUNE 29, 2015 THE DATA INCLUDED W AS COLLECTED OVER THE COURSE OF 2014 AND 2015 AN IMPLEMENTATION PLAN WAS CREATED FOR EACH HOSPITAL, AND EACH HOSPITAL'S BOARD APPROVED THE IMPLEMENTATION PLAN DURING THE MONTHS OF NOVEMBER AND DECEMBER 2015 MSHA ANNUALLY TRACKS PROGRESS OF IMPLEMENTATION STRATEGIES FO R EACH HOSPITAL DUE TO LACK OF RESOURCES, SOME OF MSHA FACILITIES WERE UNABLE TO ADDRESS ISSUES THAT WERE IDENTIFIED
FACILITY 1, DICKENSON COMMUNITY HOSPITAL - PART V, LINE 22D	UNINSURED PATIENTS RECEIVE A 50% DISCOUNT, AND, BASED ON OTHER FACTORS SUCH AS INCOME OR M EDICAL INDIGENCY, MAY QUALIFY FOR AN ADDITIONAL DISCOUNT ALLOWABLE AMOUNTS FOR INSURED PA TIENTS ARE BASED ON THE NEGOTIATED RATE WITH COMMERCIAL INSURANCE OR MEDICARE

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

▶ **Complete if the organization answered "Yes" 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
DICKENSON COMMUNITY HOSPITAL

Employer identification number
77-0599553

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax idemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e g , maid, chauffeur, chef)		
b	If any of the boxes 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	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	**2**		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III			
	☐ Compensation committee	☐ Written employment contract		
	☑ Independent compensation consultant	☑ Compensation survey or study		
	☐ Form 990 of other organizations	☐ Approval by the board or compensation committee		
4	During the year, did any person listed 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?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed 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?	**5b**		No
	If "Yes," to line 5a or 5b, describe in Part III			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," to line 6a or 6b, describe in Part III			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		No
8	Were any amounts reported in Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" 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				
1 ANN FLEMING, MSHA CONSULTANT	(i)							
	(ii)	319,105	108,007	122,727	10,125	12,733	572,697	39,222
2 JOHN DOYLE, BRMMC CFO	(i)							
	(ii)	287,522	58,179	8,848	32,472	23,219	410,240	
3 MONTY MCLAURIN, VP/CEO NW MARKET	(i)							
	(ii)	268,960	61,819	20,342	29,617	24,717	405,455	
4 SHANE HILTON, VP/CFO MARKET OPER	(i)					1		
	(ii)	287,587	51,843	8,724	32,472	23,204	403,780	
5 MARK LEONARD, CEO	(i)							
	(ii)	239,328	61,237	15,730	22,220	25,160	363,675	
6 ROY DEEL MD, PHYSICIAN	(i)							
	(ii)	194,578	9,714	15,275	6,729	16,118	242,414	
7 JOHN WRIGHT, FORMER DIRECTOR	(i)							
	(ii)			17,775			17,775	
8 STEPHEN SAWYER CFO, IPMC CFO/FMR DCH CFO	(i)							
	(ii)	150,118	6,550	8,816	6,418	17,630	189,532	

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 4	JOHN DOYLE 0 14,760 0 MONTY MCLAURIN 0 13,992 0 SHANE HILTON 0 14,760 0 MARK LEONARD 0 12,451 0
SCHEDULE J, PART III	PART I, LINE 4B MARK LEONARD, SHANE HILTON, MONTY MCLAURIN, AND JOHN DOYLE PARTICIPATED IN A 457(F)RETIREMENT PLAN PROVIDED BY MOUNTAIN STATES HEALTH ALLIANCE (MSHA) 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

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

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

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

▶ **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
DICKENSON COMMUNITY HOSPITAL

Employer identification number
77-0599553

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? To	From	**(e)** Original principal amount	**(f)** Balance due	**(g)** In default? Yes	No	**(h)** Approved by board or committee? Yes	No	**(i)** Written agreement? Yes	No

Total ▶ $			

Part III Grants or Assistance Benefiting Interested Persons.

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

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) ROY R DEEL	FAMILY MEMBER	234,999	EMPLOYMENT		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 (A) NAME OF PERSON ROY R DEEL 1 (B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION FAMILY MEMBER OF ROGER DEEL, DCH BOARD MEMBER 1 (D) DESCRIPTION OF TRANSACTION ROGER DEEL, DCH BOARD MEMBER, IS A FAMILY MEMBER OF ROY DEEL, AN EMPLOYEE OF DICKENSON COMMUNITY HOSPITAL

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SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ 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
DICKENSON COMMUNITY HOSPITAL

Employer identification number
77-0599553

Return Reference	Explanation
FORM 990 - ORGANIZATION'S MISSION	DICKENSON COMMUNITY HOSPITAL IS COMMITTED TO BRINGING LOVING CARE TO HEALTH CARE. WE EXIST TO IDENTIFY AND RESPOND TO THE HEALTH CARE NEEDS OF INDIVIDUALS AND COMMUNITIES IN OUR REGION AND TO ASSIST THEM IN ATTAINING THEIR HIGHEST POSSIBLE LEVEL OF HEALTH. PART I, LINE I - ORGANIZATION'S ACCOMPLISHMENTS. WITH A SIGNIFICANT ELDERLY POPULATION AND MOUNTAINOUS TERRAIN, TRAVEL OUTSIDE THE IMMEDIATE AREA CAN BE CHALLENGING, ESPECIALLY IN THE WINTER. RURAL LIFE OFTEN INCLUDES HAZARDOUS OCCUPATIONS, WHICH IS CERTAINLY TRUE OF DICKENSON COUNTY DUE TO THE HIGH EMPLOYMENT RATES IN THE COAL MINING INDUSTRY. GIVEN THESE FACTORS, RURAL HOSPITALS MUST REMAIN FLEXIBLE AND DIVERSE IN THEIR FACILITIES AND THE SERVICES THEY OFFER THE COMMUNITY. MOUNTAIN STATES HEALTH ALLIANCE AND NORTON COMMUNITY HOSPITAL BELIEVE THAT SUPPORTING THE SERVICES OF DICKENSON COMMUNITY HOSPITAL (DCH) TO ASSIST RESIDENTS IN ATTAINING A HIGH LEVEL OF HEALTH CONTINUES TO BE A CORE VALUE OF OUR BUSINESS AND COMMUNITY SUPPORT. DCH IS A FEDERALLY DESIGNATED CRITICAL ACCESS HOSPITAL. THIS FACILITY IS LOCATED IN ONE OF THE POOREST REGIONS OF VIRGINIA. IN ADDITION TO EMERGENCY, OUTPATIENT, AND RADIOLOGY SERVICES, THE HOSPITAL PROVIDES PULMONARY FUNCTION TESTING, CARDIAC ULTRASOUND AND CT SCANNING SERVICES. DCH PROVIDES LOCAL ACCESS FOR DIAGNOSTIC SERVICES TO THE RESIDENTS OF THE AREA, WHO OTHERWISE WOULD HAVE TO DRIVE 45 MINUTES FOR HEALTHCARE SERVICES. DCH IS THE ONLY HOSPITAL IN DICKENSON COUNTY, VA. PREVIOUSLY, HOSPITAL ADMISSIONS REQUIRED PATIENTS TO BE TRANSFERRED TO ANOTHER FACILITY OUTSIDE THE COUNTY WHICH CREATED AN INCONVENIENCE TO THE PATIENT AS WELL AS THEIR FAMILY. AND, THERE ARE ADDITIONAL COSTS INCURRED WHEN A PATIENT IS ADMITTED TO A FACILITY OUTSIDE THEIR HOME COUNTY. BY KEEPING PATIENTS AT DCH, THE PATIENT IS CLOSER TO HOME AND FAMILY SO TIME AND MONEY ARE SAVED BY THE PATIENT AND HIS/HER FAMILY

Return Reference	Explanation
FORM 990, PAGE 2, PART III, LINE 4D	DURING FY15, DCH BEGAN OFFERING PHYSICAL THERAPY (PT) SERVICES ON A 3-DAYS PER WEEK BASIS WITHIN DICKENSON COUNTY, THERE HAS HISTORICALLY BEEN ONLY ONE PHYSICAL THERAPY PROVIDER AND THEREFORE ONLY ONE OPTION FOR PT PATIENTS THIS ONE OPTION ALSO OPERATES A GYM WITHIN HIS PRACTICE AND SOME ELDERLY OR INJURED PATIENTS FOUND IT SOMEWHAT INTIMIDATING TO RECEIVE THERAPY IN THAT ENVIRONMENT DCH INITIATED PHYSICAL THERAPY SERVICES IN JANUARY 2015 AND WITHIN WEEKS GREW OUR PATIENT VOLUME TO THE MAXIMUM OUR CAPACITY WOULD ALLOW DURING FY15, DCH'S WOUND CARE PROGRAM HAS INCREASED MORE THAN 5-FOLD FROM LAST YEAR IT BEGAN AS AN OUTGROWTH FROM NORTON COMMUNITY HOSPITAL IN AN EFFORT TO REACH PATIENTS THAT COULD NOT ACCESS CARE WOUND CARE PATIENTS OFTEN HAVE MULTIPLE HEALTH ISSUES AND MANY TIMES TRAVEL IS VERY DIFFICULT FOR THEM THESE HARDSHIPS OFTEN CAUSED PATIENTS THE INABILITY TO ACCESS NECESSARY CARE PATIENTS SERVED AT DCH INCLUDE THOSE WITH DIABETIC ULCERS, VENOUS STASIS ULCERS, ARTERIAL ULCERS, NON-HEALING TRAUMATIC AND SURGICAL WOUNDS AND OTHER CHRONIC WOUND CONDITIONS DUE TO THE INITIAL SUCCESS OF DCH'S SENIOR LIFE SOLUTIONS PROGRAM, DCH BEGAN PERFORMING DUE DILIGENCE ON THE NEED FOR INPATIENT GERIATRIC BEHAVIORAL HEALTH SERVICES WE FOUND THAT WHILE THERE WERE A HANDFUL OF PSYCHIATRIC SERVICES LOCATED WITHIN THE SOUTHWEST VIRGINIA AREA, NONE WERE DEDICATED SPECIFICALLY TO THE GERIATRIC POPULATION WE RECEIVED A CERTIFICATE OF PUBLIC NEED FROM THE STATE IN JANUARY 2015 DCH BEGAN CONSTRUCTION IN APRIL 2015, AND BEGAN WORKING TOWARDS COMPLETION OF ALL REQUIRED STATE AND FEDERAL SURVEYS DICKENSON COMMUNITY HOSPITAL'S SENIOR LIFE SOLUTIONS (SLS) PROGRAM CONTINUES SERVING THE BEHAVIORAL, EMOTIONAL, AND MENTAL HEALTH NEEDS OF INDIVIDUALS AGES 65 AND OVER SLS, AN INTENSIVE OUTPATIENT PSYCHIATRIC PROGRAM (IOP), PROVIDES GROUP, INDIVIDUAL AND FAMILY PSYCHOTHERAPY TREATMENT AT A MORE INTENSIVE RATE THAN TRADITIONAL OUTPATIENT THERAPY THE SLS DESIGN PROVIDES A BRIDGE BETWEEN TRADITIONAL OUTPATIENT SERVICES AND PSYCHIATRIC INPATIENT HOSPITALIZATION A TYPICAL PATIENT WILL RECEIVE NINE HOURS OF GROUP PSYCHOTHERAPY PER WEEK, WHICH IS DIVIDED INTO THREE ONE-HOUR SESSIONS A DAY, AT THREE DAYS PER WEEK SLS IMPLEMENTED AN ADDITIONAL ONE- HOUR GROUP SERVICE NAMED THE TRANSITION GROUP THIS ALLOWS PATIENTS THAT ARE SHOWING PROGRESS THROUGH SYMPTOM REDUCTION TO DECREASE TREATMENT HOURS IN A MANNER THAT MAINTAINS THEIR STABILITY DCH IS LOCATED IN A RURAL AREA AND THE SLS PROVIDES WARRANTED SERVICES TO A GROWING SENIOR POPULATION WHICH WAS PREVIOUSLY UNDERSERVED DURING FY15, DCH'S UNREIMBURSED COST FOR OUTPATIENT PSYCH SERVICES, INCLUDING THE SENIOR LIFE SOLUTIONS PROGRAM, WAS 517,244 DCH HAS PARTNERED WITH THE COMPANY ADVANCED PATIENT ADVOCACY TO WORK WITH SELF-PAYING PATIENTS WHO HAVE LIMITED FINANCIAL RESOURCES DURING FY15, REPRESENTATIVES WERE AVAILABLE TO DCH PATIENTS AND WERE ABLE TO DETERMINE GOVERNMENTAL MEDICAL ASSISTANCE(MEDICAID OR TENNCARE) ELIGIBILITY, AND TO HELP WITH THE APPLICATION PROCESS AND FOLLOW-UP ONCE A PERSON IS APPROVED FOR MEDICAID (OR TENNCARE) THROUGH THE PROGRAM OFFERED THROUGH DCH, THEY RETAIN COVERAGE FOR FUTURE MEDICAL CARE ADVANCED PATIENT ADVOCACY IS COMPENSATED BY DCH DCH'S COST FOR THIS PROGRAM WAS 6,609

Return Reference	Explanation
FORM 990, PART V	LINE 2A W-2 EMPLOYEES DICKENSON COMMUNITY HOSPITAL (DCH) TEAM MEMBERS ARE PAID BY NORTON COMMUNITY HOSPITAL, SOLE MEMBER OF DCH, EXCEPT FOR THE CEO AND CFO WHO ARE PAID BY MOUNTAIN STATES HEALTH ALLIANCE. THE CEO AND CFO SALARY AND BENEFIT COSTS ARE ALLOCATED BETWEEN NCH AND DCH. NORTON COMMUNITY HOSPITAL BILLS DCH FOR ITS SHARE OF SALARY AND BENEFITS AND THE EXPENSE IS RECORDED ON DCH'S BOOKS

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 6	THE CORPORATION IS ORGANIZED AS A VIRGINIA NON-STOCK, NON-PROFIT CORPORATION DICKENSON COMMUNITY HOSPITAL IS A 100% OWNED SUBSIDARY OF NORTON COMMUNITY HOSPITAL, INC

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 7A	THE BOARD OF DIRECTORS OF NORTON COMMUNITY HOSPITAL ANNUALLY ELECT MEMBERS TO THE BOARD OF DIRECTORS FOR DICKENSON COMMUNITY HOSPITAL A REQUIREMENT OF AT LEAST (1) MEMBER IS TO BE FROM DICKENSON COUNTY INDUSTRIAL DEVELOPMENT AUTHORITY NORTON COMMUNITY HOSPITAL IS THE SOLE OWNER OF DICKENSON COMMUNITY HOSPITAL

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 7B	CERTAIN DECISIONS OF THE BOARD ARE, PURSUANT TO CHARTER AND VIRGINIA STATUTE, SUBJECT TO APPROVAL OF THE MEMBERS THESE DECISIONS INCLUDE DISSOLUTION OF THE CORPORATION, MERGER OF THE CORPORATION, NON-ORDINARY COURSE OF BUSINESS SALE OF ASSETS, ETC NO ORDINARY DAY-TO-DAY DECISIONS ARE SUBJECT TO MEMBER APPROVAL

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 11B	THE CFO REVIEWED THE FORM 990 WITH THE BOARD OF DIRECTORS PRIOR TO FILING THE RETURN WITH THE IRS 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, INCLUDING THOSE AT DCH 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 COMPENSATION OF DCH'S CEO IS INITIALLY DETERMINED BY MOUNTAIN STATES HEALTH ALLIANCE'S HUMAN RESOURCE DEPARTMENT BASED ON MARKET DATA OF COMPARABLE POSITIONS IN SIMILAR SETTINGS EXECUTIVE SALARIES ARE EVALUATED ON AN ANNUAL OR NEAR-ANNUAL BASIS MSHA OFFERS AN INCENTIVE PLAN TO EXECUTIVES 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 COMPANIES THAT DO NOT PROVIDE DIRECT PATIENT CARE MSHA USES AN OUTSIDE AND INDEPENDENT COMPENSATION CONSULTING FIRM TO ESTABLISH REASONABLE COMPENSATION

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15B	COMPENSATION FOR DCH'S CFO IS ESTABLISHED THE SAME WAY AS THE CEO'S, DESCRIBED ABOVE (LINE 15A)

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 19	GOVERNING DOCUMENTS AND OUR 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

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	PHYSICIAN FEES 1,574,972 0 0 HEALTH INFO & LAB TESTS 37,208 0 0 LINEN & ENVIRONMENTAL SERV 0 57,224 0 ENGINEERING 0 24,118 0 VARIOUS FEES 57,200 15,201 0

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CHANGE IN TEMP RESTRICTED CONTRIBUTIONS & GRANTS 4,835 ELIMINATION OF INTERCOMPANY REC/PAY -2,633 PENSION LIABILITY ADJUSTMENT 818,007 TOTAL TO FORM 990, PART XI, LINE 9 820,209

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ 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
DICKENSON COMMUNITY HOSPITAL

Employer identification number
77-0599553

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
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) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) INTEGRATED SOLUTIONS HEALTH NETWORK 509 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604 62-1711997	INVESTMENT	TN	NA					No			No	
(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	NA					No			No	
(4) EAST TN AMBULATORY SURGERY CENTER 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	(i) 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.

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

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

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

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

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

Part VII Supplemental Information

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

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 77-0599553
Name: DICKENSON COMMUNITY HOSPITAL

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? Yes	(g) No
(1) NORTON COMMUNITY HOSPITAL 100 15TH STREET NW NORTON, VA 24273 54-0566029	HOSPITAL	VA	501C3	3	NA		No
(1) MOUNTAIN STATES HEALTH ALLIANCE 400 N STATE OF FRANKLIN ROAD JOHNSON CITY, TN 37604 62-0476282	HOSP SYS	TN	501C3	3	NA		No
(2) SMYTH COUNTY COMMUNITY HOSPITAL 245 MEDICAL PARK DRIVE MARION, VA 24354 54-0794913	HOSPITAL	VA	501C3	3	MSHA		No
(3) JOHNSTON MEMORIAL HOSPITAL 16000 JOHNSTON MEMORIAL DRIVE ABINGDON, VA 24211 54-0544705	HOSPITAL	VA	501C3	3	NA		No
(4) ABINGDON PHYSICIAN PARTNERS 16000 JOHNSTON MEMORIAL DRIVE ABINGDON, VA 24211 20-5485346	MED SERV	VA	501C3	11A	JMH		No
(5) MOUNTAIN STATES FOUNDATION 2335 KNOB CREEK ROAD STE 101 JOHNSON CITY, TN 37604 58-1418862	FUNDRAISER	TN	501C3	11A	MSHA		No
(6) MOUNTAIN STATES HEALTH ALLIANCE AUX 400 N STATE OF FRANKLIN ROAD JOHNSON CITY, TN 37604 58-1418345	SUPP ORG	TN	501C3	11A	MSHA		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**							
COMMUNITY HOME CARE INC 1460 PARK AVENUE NORTON, VA 24273 54-1453810	DME	VA	NA	C CORP				No
SOUTHWEST COMMUNITY HEALTH SERV PO BOX 880 MARION, VA 24354 54-1460695	MED SERV	VA	NA	C CORP				No
BLUE RIDGE MEDICAL MANAGEMENT CORP 1021 W OAKLAND AVENUE STE 207 JOHNSON CITY, TN 37604 62-1490616	MED SERV	TN	NA	C CORP				No
MEDISERVE 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1212286	DME	TN	NA	C CORP				No
MOUNTAIN STATES PROPERTIES 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1845895	PROP MGMT	TN	NA	C CORP				No
MOUNTAIN STATES PHYSICIANS GRP INC 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1700412	HEALTHCARE	TN	NA	C CORP				No
WILSON PHARMACY INC PO BOX 5289 JOHNSON CITY, TN 37602 62-0329587	PHARMACY	TN	NA	C CORP				No
CRESTPOINT HEALTH INSURANCE CO INC 509 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604 62-0381170	INSURANCE	TN	NA	C CORP				No