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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

2016

Open to Public Inspection

A For the 2016 calendar year, or tax year beginning 07-01-2016 , and ending 06-30-2017

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

C Name of organization
MOUNTAIN STATES HEALTH ALLIANCE

Doing business as
JOHNSON CITY MEDICAL CENTER

Number and street (or P O box if mail is not delivered to street address) | Room/suite
1106 W MARKET STREET

City or town, state or province, country, and ZIP or foreign postal code
JOHNSON CITY, TN 37604

D Employer identification number
62-0476282

E Telephone number
(423) 302-3374

G Gross receipts $ 741,879,865

F Name and address of principal officer
ALAN LEVINE
303 MED TECH PARKWAY STE 300
JOHNSON CITY, TN 37604

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

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

H(c) Group exemption number ▶

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

J Website: ▶ WWW BALLADHEALTH ORG

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

L Year of formation 1945

M State of legal domicile TN

Part I Summary

1 Briefly describe the organization's mission or most significant activities
MOUNTAIN STATES HEALTH ALLIANCE (MSHA) 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

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

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	12
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	8
5	Total number of individuals employed in calendar year 2016 (Part V, line 2a)	**5**	8,150
6	Total number of volunteers (estimate if necessary)	**6**	1,655
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	1,608,039
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	431,511

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	3,520,559	2,851,553
9	Program service revenue (Part VIII, line 2g)	708,190,056	716,841,391
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	19,402,926	15,838,583
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,616,520	5,414,293
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	736,730,061	740,945,820
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	843,424	1,009,333
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)	299,232,233	295,310,931
16a	Professional fundraising fees (Part IX, column (A), line 11e)		0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶1,072,066		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	411,468,902	409,686,609
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	711,544,559	706,006,873
19	Revenue less expenses Subtract line 18 from line 12	25,185,502	34,938,947

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	1,547,756,754	1,581,000,029
21	Total liabilities (Part X, line 26)	1,060,941,339	1,045,335,789
22	Net assets or fund balances Subtract line 21 from line 20	486,815,415	535,664,240

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

****** 2018-05-10
Signature of officer Date

LYNN KRUTAK EVP/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

MOUNTAIN STATES HEALTH ALLIANCE (MSHA) 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

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 $ 584,813,275 including grants of $ 1,009,333) (Revenue $ 716,877,555)

See Additional Data

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

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

4d Other program services (Describe in Schedule O)

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

4e **Total program service expenses** ▶ 584,813,275

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c	Yes	
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d		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

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

			Yes	No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	**20a**	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	**20b**	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	**21**	Yes	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	**22**		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a*	**24a**	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**	Yes	
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		No
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Did the organization report any amount on Part X, line 5, 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**	Yes	
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *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**	Yes	
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**	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	**35b**	Yes	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

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

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . .	**1a**	598		
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**	8,150		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	**2b**		Yes	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .	**3a**		Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .	**3b**		Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .	**4a**			No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .	**5a**			No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	**5b**			No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	**5c**			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .	**6a**			No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	**6b**			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	**7a**			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	12		
	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	8		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2			No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3			No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			No
6	Did the organization have members or stockholders?	6			No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a			No
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			No
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	Yes	
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b	Yes	
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	Yes	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	Yes	
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	Yes	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	Yes	

Section C. Disclosure

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

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

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

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records ▶LYNN KRUTAK 303 MED TECH PARKWAY JOHNSON CITY, TN 37604 (423) 302-3374

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

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

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								7,440,877		1,009,270

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 ▶ 227

			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
CERNER HEALTH SERVICES INC, C/O US BANK PO BOX 959167 ST LOUIS, MO 631959167	IT MAINT CONTR	7,899,513
TEKLINKS INC, 201 SUMMIT PARKWAY BIRMINGHAM, AL 35209	MAINT CONTR	5,071,418
ANESTHESIA PAIN CONSULTANTS, PO BOX 3727 JOHNSON CITY, TN 376023727	ANESTHESIA SVCS	4,426,325
VIGILANCE ANESTHESIA SOLUTIONS, LOCKBOX005293 PO BOX 645293 CINCINNATI, OH 452645293	ANESTHESIA SVCS	2,913,335
ADVISORY BOARD COMPANY, 2445 M STREET NW WASHINGTON, DC 20037	DATA, BUS SOF	2,837,150

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 ▶ 128

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	1,419,297			
	e Government grants (contributions)	1e	973,792			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	458,464			
	g Noncash contributions included in lines 1a-1f $					
	h Total. Add lines 1a-1f		2,851,553			
Program Service Revenue		Business Code				
	2a PATIENT REVENUE	622110	710,269,692	710,269,692		
	b WELLNESS PROGRAMS	622110	6,830,634	6,830,634		
	c LAB UBI REVENUE	621500	822,761		822,761	
	d P/S INCOME ISHN & MSJC	900099	-1,081,696	-1,081,696		
	e					
	f All other program service revenue					
	g Total. Add lines 2a-2f		716,841,391			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		13,648,360			13,648,360
	4 Income from investment of tax-exempt bond proceeds		17,184			17,184
	5 Royalties					
		(i) Real	(ii) Personal			
	6a Gross rents	972,523				
	b Less rental expenses	564,277				
	c Rental income or (loss)	408,246				
	d Net rental income or (loss)		408,246		294,701	113,545
		(i) Securities	(ii) Other			
	7a Gross amount from sales of assets other than inventory	2,136,875	405,932			
	b Less cost or other basis and sales expenses		369,768			
	c Gain or (loss)	2,136,875	36,164			
	d Net gain or (loss)		2,173,039	36,164		2,136,875
	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 VENDOR SETTLEMENT	900099	2,827,297			2,827,297
	b DAY CARE	624410	1,059,860			1,059,860
	c DIETARY,SECURITY,ENGIN , ETC	900099	452,364			452,364
	d All other revenue		666,526		490,577	175,949
	e Total. Add lines 11a-11d		5,006,047			
	12 Total revenue. See Instructions		740,945,820	716,054,794	1,608,039	20,431,434

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) Fundraisingexpenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	1,009,333	1,009,333		
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, line 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	5,496,716	5,500	5,491,216	
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	230,806,748	215,682,901	14,387,378	736,469
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	11,277,556	10,724,866	516,069	36,621
9 Other employee benefits	30,710,369	30,628,112	74,064	8,193
10 Payroll taxes	17,019,542	15,413,562	1,564,825	41,155
11 Fees for services (non-employees)				
a Management				
b Legal	4,545,194	150	4,545,044	
c Accounting	565,474	4,752	540,722	20,000
d Lobbying	197,125	197,125		
e Professional fundraising services See Part IV, line 17				
f Investment management fees	900,819		900,819	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	123,183,294	107,245,378	15,919,784	18,132
12 Advertising and promotion	4,985,789	236,467	4,743,120	6,202
13 Office expenses	7,223,052	6,122,577	1,082,925	17,550
14 Information technology	16,789,917	14,886,668	1,903,249	
15 Royalties				
16 Occupancy	13,850,786	10,557,958	3,222,932	69,896
17 Travel	1,987,383	1,404,342	570,689	12,352
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	37,573,001		37,573,001	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	41,496,661	20,913,202	20,582,178	1,281
23 Insurance	1,053,244	104,265	948,979	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a MEDICAL SUPPLIES & DRUGS	129,871,320	129,871,320		
b REPAIRS & MAINTENANCE	16,738,405	16,049,516	621,989	66,900
c DUES & SUBSCRIPTIONS	4,443,772	1,651,431	2,791,025	1,316
d TAXES - UBIT	146,714		146,714	
e All other expenses	4,134,659	2,103,850	1,994,810	35,999
25 **Total functional expenses.** Add lines 1 through 24e	706,006,873	584,813,275	120,121,532	1,072,066
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing	42,140,274	1	62,507,823
	2	Savings and temporary cash investments	3,714,306	2	6,331,382
	3	Pledges and grants receivable, net	305,041	3	308,342
	4	Accounts receivable, net	105,638,499	4	103,319,561
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L	11,094,226	5	11,535,908
	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	19,370,927	7	19,597,279
	8	Inventories for sale or use	17,330,502	8	17,983,101
	9	Prepaid expenses and deferred charges	6,448,512	9	7,401,767
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a: 1,095,130,708			
	b	Less accumulated depreciation — 10b: 605,932,989	489,793,500	10c	489,197,719
	11	Investments—publicly traded securities	296,888,356	11	320,692,082
	12	Investments—other securities See Part IV, line 11		12	
	13	Investments—program-related See Part IV, line 11	337,772,493	13	338,744,993
	14	Intangible assets	145,025,185	14	145,025,185
	15	Other assets See Part IV, line 11	72,234,933	15	58,354,887
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	1,547,756,754	16	1,581,000,029
Liabilities	17	Accounts payable and accrued expenses	115,088,906	17	125,337,834
	18	Grants payable		18	
	19	Deferred revenue	7,666,818	19	6,511,099
	20	Tax-exempt bond liabilities	904,388,726	20	877,932,035
	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	12,140,000	23	8,190,000
	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	21,656,889	25	27,364,821
	26	**Total liabilities.** Add lines 17 through 25	1,060,941,339	26	1,045,335,789
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	486,418,331	27	535,395,968
	28	Temporarily restricted net assets	397,084	28	268,272
	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	486,815,415	33	535,664,240
	34	Total liabilities and net assets/fund balances	1,547,756,754	34	1,581,000,029

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	740,945,820
2	Total expenses (must equal Part IX, column (A), line 25)	2	706,006,873
3	Revenue less expenses Subtract line 2 from line 1	3	34,938,947
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	486,815,415
5	Net unrealized gains (losses) on investments	5	18,346,411
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	-4,436,533
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	535,664,240

Part XII Financial Statements and Reporting

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

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

Additional Data

Software ID:

Software Version:

EIN: 62-0476282

Name: MOUNTAIN STATES HEALTH ALLIANCE

Form 990 (2016)

Form 990, Part III, Line 4a:

SEE ATTACHED DOCUMENT MSHA - PROGRAM SERVICE ACCOMPLISHMENTS

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ALAN LEVINE PRESIDENT &	53 00 2 00	X		X				965,545	0	174,357
SANDRA BROOKS MD DIRECTOR	1 90	X						5,250	0	0
CLEM WILKES JR PAST CHAIR	3 80	X						0	0	0
GARY PEACOCK DIRECTOR	3 80 3 70	X						0	0	0
RICK STOREY DIRECTOR	1 90	X						0	0	0
LINDA GARCEAU DIRECTOR	1 90	X						0	0	0
JOANNE GILMER SECRETARY	2 40 4 80	X		X				0	0	0
DAVID MAY MD DIRECTOR	3 80	X						0	0	0
ROBERT FEATHERS VICE CHAIR	3 80	X		X				0	0	0
MICHAEL CHRISTIAN TREASURER	1 90	X		X				0	0	0

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
BARBARA ALLEN CHAIR	1 90	X		X				0	0	0
DAVID MOULTON MD DIRECTOR	1 90	X						0	0	0
MARVIN EICHORN EVP/COO	46 60 8 40			X				590,395	0	39,746
LYNN KRUTAK EVP/CFO	49 80 0 20			X				478,664	0	86,942
MONTY MCLAURIN VP/CEO NW MK	35 50 9 50				X			565,441	0	54,906
DAWN TRIMBLE VP/CEO WASH	45 00				X			476,727	0	60,388
SHANE HILTON VP/CFO-MKT O	41 00 4 00				X			339,387	0	58,849
TONY BENTON VP/COO WASH	45 00				X			300,372	0	37,609
RICHARD BOONE VP/CFO WASH	45 00				X			286,063	0	26,773
LINDA WHITE VP & CEO, FW	45 00				X			270,885	0	49,216

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
LEMMIE TAYLOR VP/CEO SE MK	45 00				X			211,551	0	48,728
STEVE SAWYER AVP/CFO NW M	36 00 9 00				X			189,714	0	30,666
MORGAN MAY JCMC CNO	45 00				X			152,336	0	27,937
MORRIS SELIGMAN MD EVP & CMO	52 50 2 50					X		535,274	0	88,641
ANTHONY KECK SVP/CHIEF DE	54 70 0 30					X		359,808	0	65,473
CLAY RUNNELS MD VP HOSP PRG	44 00 1 00					X		356,888	0	36,998
MARK WILKINSON MD VP/CMO	45 00					X		353,558	0	37,203
PAUL MERRYWELL CIO	45 00					X		323,333	0	44,200
CANDACE JENNINGS SR VP TN OP							X	265,626	0	0
DALE CLAYTORE FMR KEY EMP	45 00						X	235,494	0	13,673

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
PAT NIDAY FMR KEY EMP	45 00						X	178,566	0	26,965

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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

2016

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

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

The organization is not a private foundation because it is (For lines 1 through 12, check only one box)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ))

3 ☑ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170 (b)(1)(A)(iv).** (Complete Part II)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)

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

_____

10 ☐ An organization that normally receives (1) more than 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)

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

12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g

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

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

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

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

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

f Enter the number of supported organizations _____

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

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

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, 8, or 9 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)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")						
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)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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 2016 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2015 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2016.** 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—2015.** 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—2016.** 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—2015.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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 2016 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2015 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2016** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2015** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2016.** 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—2015.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

			Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *If "No," describe in* ***Part VI*** *how the supported organization(s) effectively operated, supervised, or controlled the organization's activities If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year*	1		
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, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?	1		
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)

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

Section D - Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	
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 2016 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-2016**	**(iii) Distributable Amount for 2016**
1 Distributable amount for 2016 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2016 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2016			
a			
b			
c From 2013.			
d From 2014.			
e From 2015.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2016 distributable amount			
i Carryover from 2011 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2016 from Section D, line 7 $			
a Applied to underdistributions of prior years			
b Applied to 2016 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2016, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 **Excess distributions carryover to 2017.** Add lines 3j and 4c			
8 Breakdown of line 7			
a			
b Excess from 2013.			
c Excess from 2014.			
d Excess from 2015.			
e Excess from 2016.			

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

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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

2016

Open to Public Inspection

If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then
- Section 501(c)(3) organizations Complete Parts I-A and B Do not complete Part I-C
- Section 501(c) (other than section 501(c)(3)) organizations Complete Parts I-A and C below Do not complete Part I-B
- Section 527 organizations Complete Part I-A only

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then
- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then
- Section 501(c)(4), (5), or (6) organizations Complete Part III

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

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

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

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

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

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

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

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

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	**(a)** Filing organization's totals	**(b)** Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount Enter the amount from the following table in both columns		
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)** 2013	**(b)** 2014	**(c)** 2015	**(d)** 2016	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?	Yes		103,781
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		472,020
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?		No	
j	Total Add lines 1c through 1i			575,801
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
SCHEDULE C, PART II-B, LINE 1	MSHA'S COMMUNITY & GOVERNMENT RELATIONS VICE PRESIDENT AND/OR THE DEPARTMENT'S MANAGER OR DIRECTOR ATTENDED THE FOLLOWING LEGISLATIVE CONFERENCES PREMIER FEDERAL AFFAIRS NETWORK MEETING AMERICA'S ESSENTIAL HOSPITALS ANNUAL MEETING AMERICAN HOSPITAL ASSOCIATION ANNUAL MEETING TENNESSEE HOSPITAL ASSOCIATION LEGISLATIVE ADVOCACY DAY TENNESSEE PUBLIC & TEACHING HOSPITALS ASSOCIATION ANNUAL MEETING VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION LEGISLATIVE ISSUES CONFERENCE THE COMMUNITY & GOVERNMENT RELATIONS VICE PRESIDENT AND/OR DEPARTMENTAL STAFF ALSO CONTACTED CONGRESSIONAL OFFICES CONCERNING THE FOLLOWING ISSUES OPPOSED ADDITIONAL CUTS IN MEDICARE/MEDICAID SUPPORTED REAUTHORIZATION AND FUNDING OF CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION SUPPORTED CONTINUATION OF GRADUATE MEDICAL EDUCATION FUNDING SUPPORTED AREA WAGE INDEX REFORM SUPPORTED MEDICARE DEPENDENT HOSPITAL AND LOW-VOLUME DESIGNATIONS SUPPORTED CHILDREN'S HEALTH INSURANCE PROGRAM FUNDING OPPOSED CUTS TO 340B PROGRAM THE COMMUNITY & GOVERNMENT RELATIONS VICE PRESIDENT AND/OR DEPARTMENTAL DIRECTOR RESPONDED VIA LETTER, PHONE, OR IN PERSON TO SUPPORT THE FOLLOWING TENNESSEE AND VIRGINIA LEGISLATIVE ISSUES CERTIFICATE OF NEED(TN)/CERTIFICATE OF PUBLIC NEED(VA)REFORM CONTINUATION OF HOSPITAL ASSESSMENT FEE IN TENNESSEE FUNDING FOR PERINATAL CENTERS IN TENNESSEE MENTAL HEALTH FUNDING FOR INPATIENT PSYCHIATRIC CARE-TENNESSEE ADEQUATE MEDICAID FUNDING IN VIRGINIA AND TENNESSEE HELMET REQUIREMENT FOR MOTORCYCLISTS CONTINUATION OF MAINTENANCE OF CERTIFICATE REQUIREMENTS FOR PHYSICIAN PRIVILEGES

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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

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

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

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

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

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

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

		Held at the End of the Year
a	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 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, handling of violations, and enforcing conservation easements during the year ▶ _____

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

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

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

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

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

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

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

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

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

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

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

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

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

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

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

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

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

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

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

	(a)Current year	(b)Prior year	(c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance					
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 on lines 2a, 2b, and 2c should equal 100%

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

	Yes	No
(i) unrelated organizations . . . . . 3a(i)		
(ii) related organizations . . . . . 3a(ii)		
b If "Yes" on 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' on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b)Cost or other basis (other)	(c)Accumulated depreciation	(d)Book value
1a Land		38,870,089		38,870,089
b Buildings		529,182,757	205,684,796	323,497,961
c Leasehold improvements		956,142	633,357	322,785
d Equipment		517,890,492	394,635,647	123,254,845
e Other		8,231,228	4,979,189	3,252,039
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* ▶				489,197,719

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

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

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

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) INVESTMENT IN JMH	132,000,000	C
(2) INVESTMENT IN BRMMC	100,310,432	C
(3) INVESTMENT IN SCCH	70,400,494	C
(4) INVESTMENT IN ISHN	37,015,787	C
(5) INVESTMENT IN PREMIER	342,500	C
(6) PREMIER RESERVE	-260,000	C
(7) INVESTMENT IN MSJC	-1,064,220	C
(7)		
(8)		
(9)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 13)* ▶	338,744,993	

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

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

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
OTHER LONG-TERM LIABILITIES	11,588,467
EST FAIR VALUE OF INT RATE SWAP	9,709,747
DUE TO THIRD-PARTY PAYERS	6,066,607
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	27,364,821

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

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

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

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

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

Supplemental Information

Return Reference	Explanation
SCHEDULE D, PAGE 3, PART X	"THE ALLIANCE IS CLASSIFIED AS AN ORGANIZATION EXEMPT FROM FEDERAL INCOME TAXES UNDER SECT ION 501(C)(3) OF THE INTERNAL REVENUE CODE AS SUCH, NO PROVISION FOR FEDERAL 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, 2017 AND 2016 AT JUNE 30, 2017, TAX RETURNS FOR 2014 THROUGH 2016 ARE SUBJECT TO EXAMINATION BY THE INTERNAL RE VENUE SERVICE "

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year			
	☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for *free* care	3a	Yes	
	☐ 100% ☐ 150% ☑ 200% ☐ Other _____ %			
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	3b	Yes	
	☐ 200% ☐ 250% ☐ 300% ☐ 350% ☑ 400% ☐ Other _____ %			
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
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	Yes	
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		No
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)			9,824,800		9,824,800	1 390 %
b Medicaid (from Worksheet 3, column a)			115,828,087	96,481,376	19,346,711	2 740 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			125,652,887	96,481,376	29,171,511	4 130 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			4,529,816	567,196	3,962,620	0 560 %
f Health professions education (from Worksheet 5)			16,252,131	2,852,171	13,399,960	1 900 %
g Subsidized health services (from Worksheet 6)			9,247,927	6,788,764	2,459,163	0 350 %
h Research (from Worksheet 7)			284,321	150,694	133,627	0 020 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			833,180		833,180	0 120 %
j **Total.** Other Benefits			31,147,375	10,358,825	20,788,550	2 940 %
k **Total.** Add lines 7d and 7j			156,800,262	106,840,201	49,960,061	7 080 %

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			6,600		6,600	
2 Economic development			1,364		1,364	
3 Community support			24,460		24,460	
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			32,424		32,424	

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	80,550,331		
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	59,915,727		
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	153,896,142
6	Enter Medicare allowable costs of care relating to payments on line 5	6	147,298,493
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	6,597,649
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 MED'L SPEC OF JC LLC	MEDICAL SERVICES	51 000 %		49 000 %
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? **7**

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 JOHNSON CITY MEDICAL CENTER

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	☐ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA 20 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	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b		No
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☑ Hospital facility's website (list url) WWW BALLADHEALTH ORG			
b	☐ Other website (list url)			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	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" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

JOHNSON CITY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 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 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☑ The FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
b ☑ The FAP application form was widely available on a website (list url) WWW BALLADHEALTH ORG			
c ☑ A plain language summary of the FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

JOHNSON CITY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

JOHNSON CITY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section 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 INDIAN PATH MEDICAL CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 2

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☐ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 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	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	**6b**		No
7 Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) WWW BALLADHEALTH ORG			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	**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
If "Yes" (list url) **a**			
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" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

INDIAN PATH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 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 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☑ The FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
b ☑ The FAP application form was widely available on a website (list url) WWW BALLADHEALTH ORG			
c ☑ A plain language summary of the FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

INDIAN PATH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

INDIAN PATH MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section 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 FRANKLIN WOODS COMMUNITY HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 3

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☐ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA 20 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	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b		No
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a	☑ Hospital facility's website (list url) WWW BALLADHEALTH ORG			
b	☐ Other website (list url)			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	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" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

FRANKLIN WOODS COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 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 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☑ The FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
b ☑ The FAP application form was widely available on a website (list url) WWW BALLADHEALTH ORG			
c ☑ A plain language summary of the FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

FRANKLIN WOODS COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

FRANKLIN WOODS COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section 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 SYCAMORE SHOALS HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 4

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☐ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 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	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	**6b**		No
7 Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) WWW BALLADHEALTH ORG			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	**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
If "Yes" (list url) **a**			
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" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

SYCAMORE SHOALS HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 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 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☑ The FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
b ☑ The FAP application form was widely available on a website (list url) WWW BALLADHEALTH ORG			
c ☑ A plain language summary of the FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

SYCAMORE SHOALS HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

SYCAMORE SHOALS HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section 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 RUSSELL COUNTY MEDICAL CENTER

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 5

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☐ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 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	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	6b		No
7 Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) WWW BALLADHEALTH ORG			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	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
If "Yes" (list url)			
a			
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" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

RUSSELL COUNTY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 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 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☑ The FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
b ☑ The FAP application form was widely available on a website (list url) WWW BALLADHEALTH ORG			
c ☑ A plain language summary of the FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

RUSSELL COUNTY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

RUSSELL COUNTY MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section 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 JOHNSON COUNTY COMMUNITY HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 6

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply)			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☐ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA 20 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 BALLADHEALTH ORG			
b	☐ Other website (list url)			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	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" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

JOHNSON COUNTY COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 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 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☑ The FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
b ☑ The FAP application form was widely available on a website (list url) WWW BALLADHEALTH ORG			
c ☑ A plain language summary of the FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

JOHNSON COUNTY COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

JOHNSON COUNTY COMMUNITY HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Part V Facility Information *(continued)*

Section 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 UNICOI COUNTY MEMORIAL HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 7

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☐ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 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	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	**6b**		No
7 Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) WWW BALLADHEALTH ORG			
b ☐ Other website (list url)			
c ☑ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	**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
If "Yes" (list url) **a**			
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" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

UNICOI COUNTY MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 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	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
b	☑ The FAP application form was widely available on a website (list url) WWW BALLADHEALTH ORG			
c	☑ A plain language summary of the FAP was widely available on a website (list url) WWW BALLADHEALTH ORG			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☐ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

UNICOI COUNTY MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

UNICOI COUNTY MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

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

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

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

Form and Line Reference	Explanation
See Add'l Data	

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

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

How many non-hospital health care facilities did the organization operate during the tax year? **11**

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

Part VI Supplemental Information

Provide the following information

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

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

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

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

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

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

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

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Form and Line Reference	Explanation
PART I, LINE 3C - OTHER INCOME BASED CRITERIA FOR FREE OR DISCOUNTED CARE	FINANCIAL ASSISTANCE APPROVAL CAN APPLY TO AN ASSORTMENT OF PATIENTS SUCH AS THOSE WHO HAVE EXHAUSTED THEIR TENNCARE/MEDICAID BENEFITS, THOSE WHO QUALIFIED FOR TENNCARE/MEDICAID AFTER THE DATE OF SERVICE, DECEASED PATIENTS WITH NO ESTATE OR ASSETS, UNINSURED PATIENTS, AND UNDERINSURED PATIENTS MSHA CHARITY QUALIFICATION IS BASED ON FEDERAL POVERTY GUIDELINES BUT ALSO USES ASSET VALUES TO DETERMINE FINANCIAL ASSISTANCE ELIGIBILITY CHARITY APPROVAL COVERS ALL DATES OF SERVICE FOR THE PATIENT WHEN THEY ARE APPROVED AND THERE IS NO LIMITATION OR CAP ON THE AMOUNT OF CHARITY THAT THEY CAN RECEIVE MSHA ALWAYS ATTEMPTS TO FULFILL ITS OBLIGATION TO PROVIDE FINANCIAL ASSISTANCE TO THOSE PATIENTS WITHOUT THE ABILITY TO PAY THE MAJORITY OF MSHA HOSPITALS ARE LOCATED IN TENNESSEE AND PURSUANT TO TENNESSEE LAW ALL PATIENTS WITHOUT THIRD-PARTY PAYER COVERAGE RECEIVE A DISCOUNT OF 70%, WITH THE EXCEPTION OF CRITICAL ACCESS HOSPITAL, JOHNSON COUNTY COMMUNITY HOSPITAL (JCCH) JCCH PROVIDES UNINSURED PATIENTS A 58% DISCOUNT BOTH THE 70% AND THE 58% DISCOUNTS ARE CALCULATED ACCORDING TO TENNESSEE LAW AND THE DISCOUNTS ARE UPDATED ANNUALLY MSHA EXTENDS THESE UNINSURED DISCOUNTS TO OUR VIRGINIA HOSPITALS AS WELL

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7 - COSTING METHODOLOGY EXPLANATION	THE COST TO CHARGE RATIO (WORKSHEET 2 "RATIO OF PATIENT CARE COST TO CHARGES") WAS USED TO CALCULATE LINE 7A FINANCIAL ASSISTANCE (CHARITY CARE) COST OUR COST ACCOUNTING SYSTEM WAS USED TO DETERMINE LOSSES FROM TENNCARE AND MEDICAID REPORTED ON LINE 7B, WITH THE EXCEPTION OF HOME HEALTH, A SMALL PHYSICIAN CLINIC AND UCMH - WE USED THE COST TO CHARGE RATIO FOR THEIR DATA BECAUSE THESE ARE SMALLER DIVISIONS NOT AVAILABLE IN OUR COST ACCOUNTING SOFTWARE LINE 7E COMMUNITY HEALTH IMPROVEMENT INCLUDES COSTS THAT ARE TAKEN DIRECTLY FROM DEPARTMENTAL OPERATING REPORTS OR EXPENSES SPECIFIC TO A COMMUNITY HEALTH EVENT, WITH NO ADDITIONAL OVERHEAD INCLUDED IN THE COST LINE 7F HEALTH PROFESSIONS EDUCATION IS COMPRISED OF INTERNSHIPS (PRIMARILY INTERNAL MEDICINE RESIDENTS, NURSING, PHARMACY, AND THERAPY STUDENTS) WITH SCHOOLS AND UNIVERSITIES, ALLOWING THEIR HEALTH PROFESSION STUDENTS TO GET HANDS-ON TRAINING MEDICAL RESIDENT, PHARMACY AND PASTORAL CARE COSTS AND REIMBURSEMENTS ARE TAKEN FROM JCMC AND IPMC MEDICARE COST REPORTS FWCH'S CERTIFIED NURSE ASSISTANT PROGRAM COST AND REIMBURSEMENT COMES FROM ITS MEDICARE COST REPORT OUR ORGANIZATIONAL DEVELOPMENT DEPARTMENT KEEPS DETAILED RECORDS OF HOURS SPENT ON THE OTHER TYPES OF STUDENTS' ACTIVITIES, THE NUMBER OF STUDENTS THAT ROTATE THROUGH OUR HOSPITALS, ETC INFORMATION IS MAINTAINED FOR EACH HOSPITAL UNIT THAT PARTICIPATES WE ONLY INCLUDE LABOR RELATED COSTS AND WE ONLY ASSUME A PERCENTAGE OF OUR TEAM MEMBERS' TIME ARE DEVOTED TO THESE STUDENTS FOR LINE 7G SUBSIDIZED HEALTH CARE SERVICES, WE USE OUR COST ACCOUNTING SYSTEM BECAUSE WE HAVE ESTABLISHED, STANDARD COSTING REPORTS FOR THESE SERVICES THERE ARE TWO EXCEPTIONS WHERE WE DO NOT USE OUR COST ACCOUNTING SYSTEM WE HAVE A SMALL CLINIC INSIDE JCCH, A FEDERALLY DESIGNATED CRITICAL ACCESS HOSPITAL JCCH SUBSIDIZES THE CLINIC AND WE USE THE CLINIC'S DEPARTMENTAL OPERATING REPORT TO COMPUTE THE CLINIC'S COMMUNITY BENEFIT (21,516) THE OTHER EXCEPTION RELATES TO CLINICAL SERVICES WE PROVIDE TO LOCAL NONPROFITS (16,816) FOR THESE, WE APPLIED THE 990 COMPUTED COST TO CHARGE RATIO FOR MANY YEARS, MSHA HAS PROVIDED FREE CLINICAL SERVICES TO ORGANIZATIONS THAT WORK WITH HOMELESS OR LOW INCOME INDIVIDUALS WE ARE CAREFUL TO ENSURE NO DOUBLE COUNTING OF COST (FOR EXAMPLE, WE DO NOT INCLUDE CHARITY AND TENNCARE/MEDICAID ALREADY REPORTED ON LINES 7A AND 7B) AND, PURSUANT TO IRS INSTRUCTIONS, WE DO NOT INCLUDE BAD DEBT LOSSES ALTHOUGH WE HAVE MANY SERVICE LINES WITHIN OUR HOSPITALS THAT LOSE MONEY, WE DO NOT REPORT SERVICES THAT HOSPITALS ARE REQUIRED BY STATE LICENSURE TO PROVIDE LINE 7H RESEARCH IS REPORTED USING THE RESEARCH DEPARTMENT'S ACTUAL EXPENSES AND NO OVERHEAD PROVISION IS INCLUDED LINE 7I CASH AND IN-KIND CONTRIBUTIONS INCLUDE CASH DISBURSEMENTS AND IN-KIND DONATIONS OF MEDICATIONS TO LOCAL NONPROFIT RESCUE SQUADS AND FIRE DEPARTMENTS IN-KIND DONATIONS OF MEDICATIONS ARE BASED ON OUR ACTUAL COST FOR THESE ITEMS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II - COMMUNITY BUILDING ACTIVITIES	MSHA LEADERS SUPPORT AND ENCOURAGE ALL TEAM MEMBERS TO VOLUNTEER TIME, MONEY AND SKILLS TO COMMUNITY SERVICE PROJECTS AND CHARITABLE ORGANIZATIONS SENIOR LEADERS AND BOARD MEMBERS SET A POSITIVE EXAMPLE FOR MSHA TEAM MEMBERS, SERVING VOLUNTARILY ON COMMITTEES AND BOARDS OF LOCAL SERVICE AND NONPROFIT ORGANIZATIONS SOME ALSO SERVE AS MEMBERS AND CONSULTANTS ON PROFESSIONAL COMMITTEES AND TASK FORCES THAT AFFECT REGIONAL DEVELOPMENT IN HEALTHCARE AND EDUCATION WE DO NOT CAPTURE COSTS ASSOCIATED WITH TEAM MEMBERS THAT SERVE ON OTHER NONPROFIT BOARDS OR PROVIDE SERVICES TO OTHER NONPROFITS COMMUNITY BUILDING REPORTED ON THIS RETURN INCLUDES CHARITABLE CONTRIBUTIONS TO NONPROFITS DIRECTED TO PROVIDING ASSISTANCE TO HOMELESS AND LOW INCOME FAMILIES, A SCHOOL FOR AT-RISK CHILDREN, AN ECONOMIC DEVELOPMENT PROJECT, AND OTHER SERVICES SPECIFIC TO CHILDREN MSHA, IN COLLABORATION WITH AREA HEALTH AGENCIES AND PROVIDERS, MAY OFFER ASSISTANCE WITH COORDINATION, ADVOCACY, PROVIDE SPACE, OR CONTRIBUTE SUPPLIES TO SUPPORT GROUPS FOR THEIR PROGRAM ACTIVITIES THAT SERVE TO ASSIST SPECIAL POPULATIONS WITHIN OUR AREA MOST OF THESE ORGANIZATIONS WORK TO IMPROVE THE LIVES OF COMMUNITY MEMBERS THAT HAVE LIMITED, OR NO, FINANCIAL RESOURCES

990 Schedule H, Supplemental Information

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 UNINSURED PATIENTS RECEIVE A 70% UNINSURED DISCOUNT, WITH THE EXCEPTION OF JCCH, OUR CRITICAL ACCESS HOSPITAL JCCH PATIENTS RECEIVE AN UNINSURED DISCOUNT OF 58% BASED ON HISTORICAL DATA, MOST SELF-PAY PATIENTS WILL QUALIFY FOR CHARITY CARE IF THEY PROVIDE THE FINANCIAL INFORMATION WE NEED TO DEEM THEM ELIGIBLE AFTER THE NORMAL COLLECTION PROCESS HAS INDICATED AN ACCOUNT IS UNCOLLECTIBLE, MSHA WRITES THE ACCOUNT OFF TO BAD DEBT THE HOSPITAL'S OVERALL SELF-PAY ACCOUNTS RECEIVABLE BALANCE IS EVALUATED ON AN ONGOING BASIS TO GATHER HISTORICAL INFORMATION TO APPLY TO THE CURRENT RECEIVABLE BALANCE ANOTHER CONSIDERATION WHEN ESTIMATING BAD DEBT EXPENSE IS UNUSUAL CIRCUMSTANCES (SUCH AS LOCAL, REGIONAL OR NATIONAL ECONOMIC CONDITIONS) WHICH AFFECT THE COLLECTABILITY OF RECEIVABLES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 3 BAD DEBT EXPENSE, PATIENTS ELIGIBLE FOR ASSISTANCE	OUR REIMBURSEMENT DEPARTMENT ESTIMATES THAT 70% OF BAD DEBT EXPENSE AT MSHA IS ASSUMED ATTRIBUTABLE TO PATIENTS LIKELY ELIGIBLE FOR FINANCIAL ASSISTANCE, EITHER A FULL OR PARTIAL WRITE-OFF OF CHARGES THIS ESTIMATE IS BASED 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 DEBT 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 MSHA'S BAD DEBT ASSOCIATED WITH THOSE PATIENTS WHO MAY HAVE MET THE CRITERIA SET FORTH IN OUR FINANCIAL ASSISTANCE POLICY WITHOUT HAVING A COMPLETED FINANCIAL ASSESSMENT WE ARE UNABLE TO DETERMINE OUR PATIENTS' FINANCIAL CIRCUMSTANCES UNLESS A COMPLETED FINANCIAL ASSISTANCE FORM IS VOLUNTARILY PROVIDED TO US WE CAN ASSERT THAT 84 6% OF COMPLETED FINANCIAL ASSISTANCE APPLICATIONS PROCESSED DURING FY17 RECEIVED A FULL DISCOUNT (COMPLETE WRITE-OFF) AN ADDITIONAL 11 2% RECEIVED A PARTIAL DISCOUNT, RESULTING IN AN OVERALL APPROVAL RATE OF 95 8% FOR COMPLETED APPLICATIONS DURING FY17, ONLY 4 2% OF COMPLETED FINANCIAL ASSISTANCE APPLICATIONS WERE DENIED UNFORTUNATELY, MANY PATIENTS EITHER DO NOT SUBMIT AN APPLICATION FOR FINANCIAL ASSISTANCE OR DO NOT PROVIDE A COMPLETE APPLICATION INCOMPLETE APPLICATIONS ARE RETURNED TO PATIENTS ALONG WITH A NOTICE OF MISSING INFORMATION THE NOTICE ALSO PROVIDES A CONTACT PHONE NUMBER PATIENTS MAY CALL FOR ASSISTANCE IN COMPLETING THE APPLICATION ALL SELF-PAY PATIENTS RECEIVE FOLLOW UP CALLS EVERY 7 DAYS FROM A COMPANY MSHA PAYS TO PROCESS CHARITY CARE APPLICATIONS FOR UNINSURED PATIENTS AND TO OFFER PATIENTS ENROLLMENT ASSISTANCE IN TENNCARE/MEDICAID OUR FINANCIAL COUNSELORS FOLLOW UP WITH PATIENTS THAT HAVE A BALANCE AFTER INSURANCE HAS PAID WE HAVE MANY INSTANCES OF PATIENTS WITH LARGE ACCOUNT BALANCES AND NO HEALTH INSURANCE COVERAGE THAT WE ARE SURE WOULD QUALIFY FOR FINANCIAL ASSISTANCE ALTHOUGH PATIENTS ARE ENCOURAGED TO APPLY FOR ASSISTANCE, MANY WILL NOT DO SO MSHA WOULD PREFER FOR PATIENTS TO SUBMIT COMPLETED FINANCIAL ASSISTANCE APPLICATIONS GIVEN HISTORICAL DATA CLEARLY INDICATES THAT MOST UNINSURED PATIENTS WILL QUALIFY FOR FINANCIAL ASSISTANCE UNDER OUR PROGRAM WITHOUT A COMPLETED APPLICATION, WE HAVE NO CHOICE OTHER THAN TO REPORT AN UNPAID ACCOUNT AS BAD DEBT INSTEAD OF CHARITY CARE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
BAD DEBT EXPENSE FOOTNOTE TO FINANCIAL STATEMENTS	THE TEXT OF MSHA'S FINANCIAL STATEMENTS THAT DESCRIBES BAD DEBT EXPENSE APPEARS ON PAGES 13 AND 14 IN OUR MOST RECENT AUDITED FINANCIAL STATEMENTS (ATTACHED)

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Form and Line Reference	Explanation
PART III, LINE 8 - MEDICARE EXPLANATION	MEDICARE ALLOWABLE COSTS ARE REPORTED USING MSHA'S FILED MEDICARE COST REPORTS (C/R) THE C/R USES A COST TO CHARGE RATIO BASED ON A STEP-DOWN ALLOCATION METHODOLOGY IN CARING FOR THE PATIENT, THERE ARE SEVERAL SERVICES THAT ARE CONSIDERED NON-ALLOWABLE SUCH AS TRANSPORTATION OF A PATIENT AND COMFORT ITEMS TO INCLUDE A TELEVISION AND A TELEPHONE THE RECRUITMENT OF PHYSICIANS ARE NON-ALLOWED COSTS BY THE MEDICARE PROGRAM EVEN THOUGH PHYSICIANS ARE RECRUITED BASED ON DOCUMENTED COMMUNITY NEED 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 ALTHOUGH MSHA DID NOT SUSTAIN A MEDICARE LOSS THIS YEAR, WE STRONGLY FEEL HOSPITALS THAT DO SUSTAIN OVERALL MEDICARE LOSSES SHOULD BE ALLOWED TO REPORT LOSSES IN PART I AS A COMMUNITY BENEFIT, SIMILAR TO GOVERNMENTAL PROGRAMS SUCH AS MEDICAID AS A PARTICIPATING PROVIDER IN THE MEDICARE PROGRAM, HOSPITALS ARE REQUIRED TO PROVIDE THE FULL REGIMEN OF CARE FOR THE MEDICARE POPULATION THERE ARE A NUMBER OF CARE REGIMENS THAT ARE COMPENSATED BY THE MEDICARE PROGRAM AT LEVELS BELOW COST THEREFORE, IT IS ONLY LOGICAL TO ALLOW HOSPITALS TO REPORT THESE UNCOMPENSATED SERVICES AS A COMMUNITY BENEFIT BY MAKING THIS CHANGE, NON-PROFIT PROVIDERS WILL BE ENCOURAGED TO SUSTAIN IMPORTANT CARE DELIVERY MODELS FOR OUR AGING POPULATION IN SPITE OF THE FACT IT IS SOMETIMES ECONOMICALLY INJURIOUS PART III, LINE 9B COLLECTION PRACTICES EXPLANATION MSHA HAS ESTABLISHED A STRONG COMMITMENT TO MEET THE MEDICAL NEEDS OF THE COMMUNITIES WE SERVE ALL REQUESTS FOR FINANCIAL ASSISTANCE ARE EVALUATED USING ESTABLISHED GENERAL GUIDELINES, WHILE ALLOWING FOR UNIQUE FINANCIAL CIRCUMSTANCES - FOR EXAMPLE, MEDICALLY INDIGENT PATIENTS WITH CATASTROPHIC MEDICAL COSTS THAT WOULD THREATEN THE PATIENT'S HOUSEHOLD FINANCIAL VIABILITY MSHA RECOGNIZES ITS OBLIGATION TO PROVIDE QUALITY HEALTH CARE TO THOSE WHO ARE UNABLE TO PAY MSHA CHARITY GUIDELINES ARE BASED ON NATIONAL POVERTY GUIDELINES HOWEVER, FINANCIAL ASSISTANCE IS NOT BASED SOLELY ON INCOME UNIQUE FINANCIAL CIRCUMSTANCES ARE CONSIDERED, WHICH CAN CHANGE THE CATEGORY OF ELIGIBILITY IN ADDITION, CHARITY DETERMINATION MAY BE RETROACTIVE FOR ALL DATES OF SERVICE WHEN A PATIENT REQUESTS FINANCIAL ASSISTANCE OR WHEN AN APPLICATION HAS BEEN RECEIVED, THE PATIENT ACCOUNT IS PLACED IN A HOLD STATUS TO PREVENT FURTHER COLLECTION ACTIVITIES UNTIL FINANCIAL ASSISTANCE ELIGIBILITY IS DETERMINED ALL MSHA HOSPITALS ADHERE TO IRS REGULATORY GUIDELINES SET FORTH IN 501(R) A COPY OF OUR CREDIT AND COLLECTION POLICY MAY BE FOUND ONLINE OR OBTAINED IN PRINT VERSION FREE OF CHARGE

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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 IN 2017, TENNESSEE MOVED FROM 44TH TO 45TH, WHILE VIRGINIA'S OVERALL HEALTH RANKING REMAINED 19TH HOWEVER, IT SHOULD BE NOTED THAT SOUTHWEST VIRGINIA (WHERE SOME OF MSHA FACILITIES ARE LOCATED) CLOSELY RESEMBLES THE HEALTH RANKINGS FOR TENNESSEE AMERICA'S HEALTH RANKINGS ARE BASED ON A SERIES OF MEASURES INCLUDING SEVERAL HEALTH OUTCOMES AND HEALTH FACTORS A SURVEY WAS GIVEN TO 106 INDIVIDUALS REPRESENTING THE TEN COUNTIES IN WHICH MSHA OWNS A FACILITY THESE INDIVIDUALS INCLUDED PHYSICIANS, PUBLIC HEALTH LEADERS, NONPROFIT 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 NONPROFITS IN ORDER TO AVOID DUPLICATING RESOURCES, AND PROVIDE EARLY SCREENINGS FOR THE UNINSURED OR UNDERINSURED OVERALL, THE COMMUNITY MEMBERS GAVE MSHA'S CORE SERVICE AREA A HEALTH STATUS RANKING OF 4 55 OUT OF 10 (1 BEING THE LOWEST, 10 BEING THE HIGHEST) RANKINGS BY FACILITY -JCMC AND FWCH WERE GIVEN A HEALTH STATUS RANKING OF 5 3 -IPMC WAS GIVEN A HEALTH STATUS RANKING OF 3 6 -SSH WAS GIVEN A HEALTH STATUS RANKING OF 4 7 -JCCH WAS GIVEN A HEALTH STATUS RANKING OF 5 14 -UCMH WAS GIVEN A HEALTH STATUS RANKING OF 4 9 -RCMC WAS GIVEN A HEALTH STATUS RANKING OF 5 0 AMONG THE 106 PARTICIPANTS, THE AREAS OF OBESITY, CANCER, HEART DISEASE, SMOKING, SUBSTANCE/PRESCRIPTION DRUG ABUSE, AND DIABETES WERE THE TOP HEALTH PRIORITIES IN OUR REGION ACCORDING TO THE MOST RECENT AHR REPORTS, TENNESSEE AND VIRGINIA BOTH SAW AN INCREASE IN DIABETES AND OBESITY WITHIN THE PAST TEN YEARS TENNESSEE RANKS 45TH FOR CARDIOVASCULAR DEATHS, 44TH FOR DIABETES AND CANCER DEATHS (43RD FOR SMOKING) VIRGINIA RANKS 25TH FOR CARDIOVASCULAR DEATHS, 24TH FOR CANCER DEATHS AND 23RD FOR DIABETES

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Form and Line Reference	Explanation
PART VI, LINE 3 - PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE	MOUNTAIN STATES HEALTH ALLIANCE COMMUNICATES WITH AND EDUCATES OUR PATIENTS THROUGH VARIOUS AVENUES FOR GOVERNMENTAL ASSISTANCE PROGRAMS AND HOSPITAL FINANCIAL ASSISTANCE EDUCATION IS PROVIDED TO PATIENTS THROUGH SIGNAGE AND FINANCIAL ASSISTANCE BROCHURES AT ALL HOSPITAL AND AMBULATORY ADMISSION LOCATIONS FINANCIAL ASSISTANCE APPLICATIONS AND PLAIN LANGUAGE SUMMARIES ARE PROVIDED TO PATIENTS SHOULD THEY REQUEST ONE DURING THEIR PRE- REGISTRATION, REGISTRATION OR FINANCIAL COUNSELING PROCESS OUR GOVERNMENTAL PROGRAM ELIGIBILITY REPRESENTATIVES ASSIST PATIENTS IN SECURING ELIGIBILITY FOR TENNCARE/MEDICAID, FEDERAL DISABILITY AND OTHER GOVERNMENTAL ASSISTANCE PROGRAMS ADDITIONALLY, IF A PATIENT OR COMMUNITY RESIDENT EXPRESSES AN INTEREST IN THE ACA-HEALTHCARE EXCHANGE, OUR REPRESENTATIVES HAVE THE QUALIFICATIONS AND EXPERIENCE TO ASSIST THEM THROUGH THE ENTIRE PROCESS FINANCIAL COUNSELORS OFFER FINANCIAL ASSISTANCE APPLICATIONS TO PATIENTS WHO DO NOT QUALIFY FOR GOVERNMENTAL ASSISTANCE PROGRAMS AND ARE UNABLE TO PAY FOR THE COST OF THEIR HEALTHCARE FINANCIAL ASSISTANCE APPLICATIONS ARE AVAILABLE ON OUR WEBSITE TO INCLUDE THE FINANCIAL ASSISTANCE APPLICATION, POLICY AND PLAIN LANGUAGE SUMMARY IN BOTH ENGLISH AND SPANISH ALL PATIENT STATEMENTS HAVE VERBIAGE DISCUSSING FINANCIAL ASSISTANCE ALONG WITH THE CONTACT INFORMATION OUR LAST LETTER TO THE PATIENT DISPLAYS THE PLAIN LANGUAGE SUMMARY IN ALL ORAL CORRESPONDENCES WITH THE PATIENT, IF IT IS IDENTIFIED THEY CANNOT MEET THE PAYMENT REQUIREMENTS ON THEIR ACCOUNT, FINANCIAL ASSISTANCE IS DISCUSSED AS AN OPTION

Form and Line Reference	Explanation
PART VI, LINE 4 - COMMUNITY INFORMATION	MSHA SERVES THE HEALTHCARE NEEDS OF 29 APPALACHIAN COUNTIES IN TENNESSEE, SOUTHWEST VIRGIN IA, KENTUCKY, AND NORTH CAROLINA SOME OF THE COUNTIES MSHA SERVES ARE FEDERALLY DESIGNATE D AS MEDICALLY UNDERSERVED AREAS MSHA'S LARGEST HOSPITAL, JOHNSON CITY MEDICAL CENTER, IS A TERTIARY REFERRAL CENTER AND LEVEL ONE TRAUMA CENTER JCMC'S INPATIENT POPULATION AT AN Y TIME WILL HISTORICALLY DRAW NEARLY 50% OF ITS PATIENTS FROM MEDICALLY UNDERSERVED AREAS SYCAMORE SHOALS HOSPITAL DRAWS A SIGNIFICANT NUMBER OF PATIENTS FROM JOHNSON AND CARTER C OUNTIES, BOTH OF WHICH ARE LISTED ON THE TENNESSEE HEALTH DEPARTMENT'S WEBSITE AS MEDICALL Y UNDERSERVED AREAS UNICOI COUNTY MEMORIAL HOSPITAL IS LISTED AS A WHOLE-COUNTY MEDICALLY UNDERSERVED AREA ON THE TENNESSEE HEALTH DEPARTMENT'S WEBSITE RUSSELL COUNTY MEDICAL CEN TER IS DESIGNATED BY THE STATE OF VIRGINIA AS A WHOLE-COUNTY HEALTH PROFESSIONAL SHORTAGE AREA MSHA OPERATES 2 CRITICAL ACCESS HOSPITALS JOHNSON COUNTY COMMUNITY HOSPITAL (JCCH) IN TENNESSEE AND MAJORITY-OWNED DICKENSON COUNTY COMMUNITY HOSPITAL IN VIRGINIA MANY RURA L RESIDENTS MUST TRAVEL A GREATER DISTANCE TO ACCESS DIFFERENT POINTS OF THE HEALTH CARE D ELIVERY SYSTEM, HOWEVER, DUE TO GEOGRAPHIC DISTANCE, SOMETIMES EXTREME WEATHER CONDITIONS, LACK OF PUBLIC TRANSPORTATION AND CHALLENGING ROADS, RURAL RESIDENTS MAY BE LIMITED, AND IN SOME INSTANCES, EVEN PROHIBITED FROM ACCESSING HEALTH CARE SERVICES MORE THAN 50% OF V EHICLE CRASH-RELATED FATALITIES OCCUR IN RURAL AREAS, EVEN THOUGH LESS THAN ONE-THIRD OF M ILES TRAVELED IN A VEHICLE OCCUR THERE AND, THERE IS AN ADDITIONAL 22% RISK OF INJURY-REL ATED DEATHS IN RURAL COMMUNITIES SOME OF THE COUNTIES IN MSHA'S SERVICE AREA HAVE A MUCH HIGHER RISK RUSSELL COUNTY (69%), JOHNSON COUNTY (29%), AND UNICOI COUNTY (26%) AND, WHI LE OUR AREA HAS GENERALLY UNFAVORABLE HEALTH STATISTICS, THERE ARE FAR FEWER PRIMARY CARE PHYSICIANS PER RESIDENT IN SOME OF OUR COUNTIES THAN THE STATE'S AVERAGE FOR EXAMPLE, IN CARTER COUNTY, OUR RATIO OF POPULATION TO PRIMARY CARE PHYSICIANS IS 72% HIGHER THAN THE S TATE'S AVERAGE AND UNICOI'S RATIO IS 63% HIGHER BOTH OF THESE COUNTIES ARE MORE THAN DOUB LE THE RATIO OF U S TOP PERFORMERS ACCORDING TO THE ROBERT WOOD JOHNSON FOUNDATION'S COUN TY HEALTH RANKINGS RECRUITING PHYSICIANS TO RURAL AREAS IS OFTEN CHALLENGING DUE TO A MYR IAD OF FACTORS, SUCH AS GEOGRAPHY, ECONOMICS, CULTURE AND EDUCATION GEOGRAPHICALLY, RURAL COMMUNITIES ARE OFTEN FAR REMOVED FROM SUBURBAN AND URBAN CENTERS THAT PROVIDE ACCESS TO EDUCATIONAL, CULTURAL AND ECONOMIC OPPORTUNITIES THESE LIMITATIONS INFLUENCE THE RELOCATI ON DECISION OF THE PHYSICIAN CANDIDATE AND HIS/HER SPOUSE/CHILDREN TO LOCATE TO A RURAL AR EA A NUMBER OF FACTORS CONTRIBUTE TO A UNIQUE AND CHALLENGING ENVIRONMENT THAT INFLUENCE THE OVERALL HEALTH STANDING FOR COUNTIES INCLUDED IN THE MSHA SERVICE AREA OBESITY INCREA SES THE RISK FOR MANY HEALTH CONDITIONS SUCH AS CORONARY HEART DISEASE, TYPE 2 DIABETES, H YPERTENSION, STROKE, CANCER, SLEEP APNEA AND RESPIRATORY PROBLEMS, AND OSTEOARTHRITIS EVI DENCE INDICATES PHYSICAL ACTIVITY, INDEPENDENT OF ITS EFFECT ON WEIGHT, HAS SUBSTANTIAL BE NEFITS FOR HEALTH RELATIVE TO OBESITY AND PHYSICAL ACTIVITY LEVELS, MANY OF OUR COUNTIES HAVE HIGH LEVELS OF OBESITY COMBINED WITH HIGH LEVELS OF PHYSICAL INACTIVITY THE PERCENTA GES OF ADULT OBESITY JOHNSON COUNTY 37%, UNICOI COUNTY 33%, CARTER COUNTY 32%, AND RUSSEL L COUNTY 29% THE STATEWIDE RATES ARE 32% IN TENNESSEE AND 27% IN VIRGINIA THE PERCENTAGE S OF PHYSICAL INACTIVITY CARTER COUNTY 34%, SULLIVAN COUNTY 33%, UNICOI COUNTY 32%, JOHNS ON COUNTY 31%, AND RUSSELL COUNTY 27% THE STATEWIDE RATES ARE 30% IN TENNESSEE AND 21% IN VIRGINIA THE HEALTH STATUS OF THE POPULATION IN MSHA'S SERVICE AREA IS GENERALLY POOR O UR SERVICE AREA EXTENDS TO SOME OF THE POOREST RURAL COUNTIES IN THE REGION WITH A POVERTY RATE OF ALMOST 30% IN SOME AREAS (ALL PEOPLE IN POVERTY) THE CENSUS BUREAU ESTIMATES COU NTY MEDIAN HOUSEHOLD INCOMES ARE JOHNSON COUNTY - 30,180, CARTER COUNTY - 33,177, AND UNI COI COUNTY - 35,390 COMPARED TO 46,574 IN THE STATE OF TENNESSEE SOME OF THE MOST WELL-OF F COUNTIES IN MSHA'S SERVICE AREA STILL HAVE A MEDIAN HOUSEHOLD INCOME LOWER THAN STATE AN D NATIONAL AVERAGES WASHINGTON COUNTY'S MEDIAN HOUSEHOLD INCOME IS 44,444 AND SULLIVAN CO UNTY'S IS 40,983 CHILDREN IN POVERTY IN SOME AREAS EXCEEDS 30% FOR EXAMPLE, THE PERCENTA GE OF CHILDREN LIVING IN POVERTY IN JOHNSON COUNTY IS 34%, CARTER COUNTY IS 33%, UNICOI CO UNTY IS 28%, AND RUSSELL COUNTY IS 28% THE LATEST CENSUS BUREAU DATA ESTIMATES THE MEDIAN AGE OF RESIDENTS OF UNICOI COUNTY IS 45 6, JOHNSON COUNTY IS 44 8, AND CARTER COUNTY IS 4 4, ALL SIGNIFICANTLY OLDER THAN THE MEDIAN AGE OF 38 5 IN TENNESSEE ALL OF OUR COMMUNITIE S HAVE A LARGE ELDERLY POPULATION, FAR EXCEEDING THAT OF THE COUNTRY PERSONS 65 YEARS AND OLDER IN THE COUNTIES OUR HOSPITALS ARE LOCATED IN RANGE FROM 16 9% TO 22 1% COMPARED TO 14 9% FOR THE U S MUCH OF OUR SERVICE AREA IS RUR

Form and Line Reference	Explanation
PART VI, LINE 4 - COMMUNITY INFORMATION	AL RURAL SERVICE AREA COUNTIES SHARE COMMON CHALLENGES OF 1 HIGH RATES OF UNINSURED 2 HIGH PREVALENCE OF OBESITY 3 HIGH PREVALENCE OF DIABETES 4 HIGH PREVALENCE OF CANCER 5 HIGH PREVALENCE OF POOR CARDIAC HEALTH 6 A HIGH RATE OF INJURIES

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Form and Line Reference	Explanation
PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH	MSHA IS DEDICATED TO OPERATING EFFICIENTLY SO THAT WASTE IS MINIMIZED MSHA'S LEADERSHIP REMAINS MINDFUL OF MANAGING THE ALLIANCE'S LIMITED RESOURCES SO THAT ADEQUATE FACILITIES AND EQUIPMENT ARE AVAILABLE FOR THE CARE OF OUR PATIENTS SURPLUS FUNDS ARE INVESTED INTO IMPROVING TREATMENT OPTIONS FOR OUR PATIENTS THROUGH NEW TECHNOLOGIES, RECRUITING PHYSICIANS AND TRAINED STAFF IN SHORTAGE AREAS, AND IMPROVING OUR FACILITIES VARIOUS CHECKS AND BALANCES ARE ESTABLISHED TO ENSURE THAT EXPENDITURES FOR OPERATING EXPENSES AND CAPITAL COSTS ARE REASONABLE AND NECESSARY MSHA HAS SEVERAL HOSPITALS WITH MEDICARE-APPROVED HEALTH PROFESSION EDUCATION PROGRAMS IN ADDITION, OUR HOSPITALS SERVE AS TRAINING SITES FOR MANY TYPES OF HEALTH PROFESSIONS NURSING, PHARMACY, PSYCHOLOGY, LAB, RESPIRATORY THERAPY, EMT, PUBLIC HEALTH, ETC STUDENTS FROM NUMEROUS COLLEGES, UNIVERSITIES, AND PROGRAMS RECEIVE TRAINING AND EXPERIENCE IN OUR HOSPITALS WE DEVOTE RESOURCES TO HEALTH CONFERENCES FOR LOCAL HEALTH PROFESSIONALS, OPERATE TWO HEALTH RESOURCE CENTERS LOCATED IN SHOPPING MALLS, PROVIDE FOR MEDIA COVERAGE TO EDUCATE OUR RESIDENTS ON HEALTH ISSUES, OFFER EVENTS TO THE PUBLIC THAT COMBINE FUN ACTIVITIES WITH HEALTH EDUCATION, AND MANY OTHER PROGRAMS FOCUSED ON IMPROVING THE HEALTH OF OUR RESIDENTS WHILE WE OPERATE HOSPITALS IN PREDOMINANTLY LOW-INCOME, RURAL AREAS, WE CONTINUE TO OFFER SERVICES THAT OPERATE AT A LOSS TO MSHA BECAUSE RESIDENTS WOULD OTHERWISE NEED TO LEAVE THEIR HOME TOWN OR COUNTY TO RECEIVE NEEDED CARE THE MAJORITY OF MSHA'S GOVERNING BODY IS COMPRISED OF PERSONS WHO RESIDE IN THE ORGANIZATION'S PRIMARY SERVICE AREAS PHYSICIANS THAT REQUEST PRIVILEGES WHO ARE QUALIFIED AND CREDENTIALED ARE EXTENDED PRIVILEGES BY MSHA

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Form and Line Reference	Explanation
PART VI, LINE 6 - AFFILIATED HEALTH CARE SYSTEM	MSHA PROVIDES CARE TO PEOPLE IN 29 COUNTIES IN TENNESSEE, VIRGINIA, KENTUCKY AND NORTH CAROLINA EACH HOSPITAL IS FULLY ACCREDITED BY THE JOINT COMMISSION, WITH THE EXCEPTION OF JCCH JCCH RECEIVES CERTIFICATION THROUGH THE STATE OF TENNESSEE SINCE IT IS A CRITICAL ACCESS HOSPITAL MSHA, BASED IN JOHNSON CITY, TENNESSEE IS THE LARGEST REGIONAL HEALTHCARE SYSTEM WITH 13 HOSPITALS NINE FACILITIES ARE WHOLLY-OWNED FACILITIES 8 FACILITIES IN TENNESSEE AND 1 IN VIRGINIA IN ADDITION TO THE WHOLLY-OWNED HOSPITALS REPORTED WITHIN THIS FORM 990, MSHA ALSO HAS MAJORITY OWNERSHIP IN 4 HOSPITALS IN SOUTHWEST VIRGINIA MSHA HOSPITALS WORK CLOSELY WITH ONE ANOTHER TO SHARE EXPERTISE AND RESOURCES FOR EXAMPLE, JMH ASSISTED RUSSELL COUNTY MEDICAL CENTER (RCMC) AND SMYTH COUNTY COMMUNITY HOSPITAL (SCCH) TO ESTABLISH OUTPATIENT ONCOLOGY SERVICES AT BOTH FACILITIES THE EXPERIENCED CLINICAL TEAM AT JMH PROVIDED VALUABLE INSIGHT THAT SAVED SCCH AND RCMC TIME, MONEY, AND MISTAKES THERE ARE MANY OTHER EXAMPLES OF SHARED EXPERTISE AND SERVICES BETWEEN MSHA FACILITIES - LABORATORY, CARDIAC SERVICES, ADMINISTRATIVE, ETC IN ADDITION TO OUR ACUTE CARE HOSPITALS, OUR SYSTEM INCLUDES SUCH SERVICES AS PRIMARY/SPECIALTY PHYSICIAN PRACTICES, EMERGENCY DEPARTMENTS, OCCUPATIONAL MEDICINE, REHABILITATION, OUTREACH LABORATORY, MENTAL HEALTH, NEONATAL INTENSIVE CARE, A NACHRI-AFFILIATED CHILDREN'S HOSPITAL, RENAL DIALYSIS, ST JUDE'S ONCOLOGY, INPATIENT/OUTPATIENT SURGERY, SKILLED NURSING, LONG- TERM CARE, HOME HEALTH, AND MORE WITH THESE ADDITIONAL FACILITIES AND SERVICES, MSHA EXTENDS A HIGHLY EFFECTIVE HEALTH CARE DELIVERY SYSTEM SINCE OUR SYSTEM IS BOTH HORIZONTALLY AND VERTICALLY INTEGRATED, PATIENTS CAN BE EFFICIENTLY MOVED ALONG AN INTEGRATED, COMPREHENSIVE CONTINUUM OF CARE AS THEIR HEALTH STATUS DICTATES OUR FLAGSHIP FACILITY, JOHNSON CITY MEDICAL CENTER IS AT THE CORE OF OUR SYSTEM OFFERING FULL-SERVICE TERTIARY CARE IN ADDITION TO OUR HOSPITALS, MSHA IS THE SOLE MEMBER OF BLUE RIDGE MEDICAL MANAGEMENT CORPORATION (BRMMC) MSHA EXTENDS AN INTEGRATED HEALTHCARE DELIVERY SYSTEM THROUGH BRMMC TO INCLUDE MULTIPLE PRIMARY AND SPECIALTY CARE PATIENT ACCESS CENTERS AND NUMEROUS OUTPATIENT CARE SITES, INCLUDING URGENT CARE CENTERS, OCCUPATIONAL MEDICINE SERVICES, AND A SAME DAY SURGERY CENTER MSHA IS A 99 9% SHAREHOLDER OF INTEGRATED SOLUTIONS HEALTH NETWORK, LLC (ISHN) ISHN OPERATES ANEWCARE COLLABORATIVE, THE REGION'S FIRST ACCOUNTABLE CARE ORGANIZATION, BRINGING TOGETHER COMMUNITY HEALTH CARE PROVIDERS TO PROVIDE BETTER OUTCOMES AND IMPROVED PATIENT SATISFACTION AT A LOWER COST MSHA COUNTY-SPECIFIC OPERATIONS ARE GOVERNED BY A COMMUNITY BOARD OF DIRECTORS COUNTY BOARDS REPORT TO A SYSTEM LEVEL BOARD OF DIRECTORS ALL BOARDS ARE PRIMARILY COMPOSED OF LOCAL COMMUNITY RESIDENTS

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

Additional Data

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

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **7** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	JOHNSON CITY MEDICAL CENTER 400 N STATE OF FRANKLIN ROAD JOHNSON CITY, TN 37604 00000121	X	X	X	X		X	X		MENTAL HEALTH	
2	INDIAN PATH MEDICAL CENTER 2000 BROOKSIDE DRIVE KINGSPORT, TN 37660 00000134	X	X		X			X			
3	FRANKLIN WOODS COMMUNITY HOSPITAL 300 MED TECH PARKWAY JOHNSON CITY, TN 37604 00000123	X	X		X			X			
4	SYCAMORE SHOALS HOSPITAL 1501 W ELK AVENUE ELIZABETHTON, TN 37643 00000012	X	X					X			
5	RUSSELL COUNTY MEDICAL CENTER 58 CARROLL STREET LEBANON, VA 24266 H 1892	X	X					X			

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **7** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
6	JOHNSON COUNTY COMMUNITY HOSPITAL 16901 S SHADY STREET MOUNTAIN CITY, TN 37683 00000039	X				X		X			
7	UNICOI COUNTY MEMORIAL HOSPITAL 100 GREENWAY CIRCLE ERWIN, TN 37650 00000119	X	X					X			

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

Form and Line Reference	Explanation
FACILITY 1, JOHNSON CITY MEDICAL CENTER - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) THE 13 HOSPITALS ARE COMPRISED OF 7 LICENSED HOSPITALS THAT ARE INCLUDED IN THIS RETURN, 2 HOSPITALS THAT ARE LICENSED UNDER ONE OF THE 7 AND ARE INCLUDED IN THIS RETURN, AND 4 MSHA HOSPITALS THAT FILE SEPARATE RETURNS EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NONPROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO JCMC, THE GROUP CONSISTED OF REPRESENTATIVES FROM THE WASHINGTON COUNTY HEALTH DEPARTMENT, FRONTIER HEALTH, ETSU COLLEGE OF NURSING, ETSU JOHNSON CITY COMMUNITY HEALTH CENTER, ETSU COLLEGE OF PUBLIC HEALTH, WASHINGTON COUNTY COMMISSION, NORTHEAST TENNESSEE REGIONAL HEALTH DEPARTMENT, WASHINGTON COUNTY/JOHNSON CITY EMERGENCY MEDICAL SERVICES, UNITED WAY, PROJECT ACCESS, CHAMBER OF COMMERCE, FAMILIES FREE, CITY OF JOHNSON CITY, AND CENTER ON AGING AND HEALTH EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS THE WASHINGTON COUNTY COMMUNITY BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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

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

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

Form and Line Reference	Explanation
FACILITY 1, JOHNSON CITY MEDICAL CENTER - 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 DUE TO LIMITED RESOURCES, EACH FACILITY PRI ORITIZED FOUR TO FIVE HEALTH PRIORITIES ON WHICH TO FOCUS AND DEVELOP IMPLEMENTATION PLANS TO IMPACT THERE WERE SEVEN COMMON HEALTH PRIORITIES SELECTED BY THE VARIOUS 11 FACILITIE S, BUT NOT ALL FACILITIES SELECTED THE SAME AREAS THE SEVEN ARE OBESITY, SUBSTANCE/PRESCR IPTION DRUG ABUSE, DIABETES, CANCER, HEART DISEASE, SMOKING AND MENTAL HEALTH ALL OF THES E ARE SIGNIFICANT ISSUES FOR ALL 11 FACILITIES, BUT EACH CHOSE TO PRIORITIZE ON A DIFFEREN T SET SO THEY COULD TARGET THEIR EFFORTS AND BE MORE EFFECTIVE WITH LIMITED RESOURCES FOR EXAMPLE, WHILE NEARLY ALL THE FACILITIES IDENTIFIED OBESITY (11 OF 11) AND SUBSTANCE/PRES CRIPTION DRUG ABUSE (10 OF 11), ONLY CERTAIN FACILITIES ELECTED TO FOCUS ON SOME NUMBER OF THE OTHER FIVE COMMON HEALTH PRIORITIES WHILE MENTAL HEALTH IS CLEARLY A SIGNIFICANT ISS UE FOR ALL 11 FACILITIES, ONLY THREE ARE FOCUSED ON IT DUE TO LIMITED RESOURCES THE SAME IS TRUE WITH SMOKING WHERE ONLY 5 OF THE 11 FACILITIES ARE FOCUSED ON IT, BUT IT IS AN ISS UE FOR ALL FACILITIES SIX OF THE 11 FACILITIES SELECTED CANCER, 6 OF THE 11 SELECTED HEAR T DISEASE, AND 9 OF THE 11 CHOSE DIABETES ANOTHER WAY TO STATE THIS IS BY FACILITY FOR E XAMPLE, WHILE CANCER AND MENTAL HEALTH ARE PREVALENT CHALLENGES FOR JCMC'S PRIMARY SERVICE AREA, THE HOSPITAL ELECTED NOT TO FOCUS ON THOSE DUE TO LIMITED TIME, FUNDING, PERSONNEL AND OTHER RESOURCES NEEDED TO EFFECTUATE CHANGE UCMH FELT IT WAS UNABLE TO ADDRESS HEART DISEASE, SMOKING, AND MENTAL HEALTH ISSUES IN ITS PRIMARY SERVICE AREA SOME FACILITIES ID ENTIFIED ISSUES SUCH AS TRANSPORTATION AND EDUCATION AS BARRIERS TO GOOD HEALTH, BUT WERE ALSO UNABLE TO SET ASIDE SUFFICIENT RESOURCES TO MEANINGFULLY IMPACT THOSE CHALLENGES AFT ER THE FACILITIES SELECTED A REASONABLE NUMBER OF HEALTH PRIORITIES THEY FELT THEY COULD A DEQUATELY IMPACT, 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 FOR EACH HOSPITAL THE FACILITI ES CONTINUE TO CONDUCT ACTIVITIES CONSISTENT WITH THEIR RESPECTIVE IMPLEMENTATION PLANS F OR EXAMPLE, A PARTNERSHIP WAS DEVELOPED WITH FEEDING AMERICA OF SOUTHWEST VIRGINIA TO FUND HEALTHY FOOD OPTIONS FOR THE MOBILE FOOD BANK AND PROVIDE NUTRITIONAL EDUCATION TO RECIPI ENTS WHICH ADDRESSES OBESITY AND DIABETES SEVERAL MSHA FACILITIES, INCLUDING JCMC, PARTIC IPATE IN THE MSHA TRIUMPH CANCER NAVIGATOR PROGRAM WHICH HELPS COORDINATE CARE FOR CANCER PATIENTS FREE OF CHARGE TO ALL PATIENTS, REGARDLESS OF WHETHER THEY CHOOSE TO RECEIVE THEI R TREATMENT AT A MSHA FACILITY JCMC PROVIDES A SIGNIFICANT NUMBER OF PUBLIC SERVICE ANNOU NCEMENTS AND PARTNERS WITH LOCAL TELEVISION STATIONS TO INCREASE COMMUNITY AWARENESS ON TH E PREVALENCE OF NEONATAL ABSTI

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

Form and Line Reference	Explanation
FACILITY 1, JOHNSON CITY MEDICAL CENTER - PART V, LINE 11	NENCE SYNDROME, PROVIDE HEALTH EDUCATION ON HEART HEALTH AND CANCER JCMC'S NISWONGER CHIL DREN'S HOSPITAL OFFERED MANY EVENTS THROUGHOUT THE YEAR TO ENCOURAGE ACTIVE PLAY AND HEALT HY LIFESTYLES FOR CHILDREN AND PARENTS JCMC'S FREE CONGESTIVE HEART FAILURE CLINIC HELPS PATIENTS MANAGE THEIR DISEASE AND PATIENTS SEEN IN THE CLINIC HAVE A LOWER HOSPITAL READMI SSION RATE JCMC'S HEALTH RESOURCE CENTER, LOCATED IN THE JOHNSON CITY MALL, OFFERS OUTREA CH PROGRAMS, HEALTH SCREENINGS, HEALTH EDUCATION CLASSES, SUPPORT GROUPS, AND HEALTH MATER IALS TO ADDRESS COMMUNITY MEMBERS' NEEDS

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

Form and Line Reference	Explanation
FACILITY 2, INDIAN PATH MEDICAL CENTER - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) THE 13 HOSPITALS ARE COMPRISED OF 7 LICENSED HOSPITALS THAT ARE INCLUDED IN THIS RETURN, 2 HOSPITALS THAT ARE LICENSED UNDER ONE OF THE 7 AND ARE INCLUDED IN THIS RETURN, AND 4 MSHA HOSPITALS THAT FILE SEPARATE RETURNS EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NONPROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO IPMC, THE GROUP CONSISTED OF REPRESENTATIVES FROM HEALTHY KINGSPORT, KINGSPORT CITY SCHOOLS, UNITED WAY OF GREATER KINGSPORT, SULLIVAN COUNTY HEALTH DEPARTMENT, IPMC HEALTH RESOURCE CENTER, SULLIVAN COUNTY DEPARTMENT OF EDUCATION, KINGSPORT CHAMBER OF COMMERCE, AND KINGSPORT BOARD OF MAYOR AND ALDERMAN EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS IPMC'S SULLIVAN COUNTY COMMUNITY BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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

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FACILITY 2, INDIAN PATH MEDICAL CENTER - 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 DUE TO LIMITED RESOURCES, EACH FACILITY PRI ORITIZED FOUR TO FIVE HEALTH PRIORITIES ON WHICH TO FOCUS AND DEVELOP IMPLEMENTATION PLANS TO IMPACT THERE WERE SEVEN COMMON HEALTH PRIORITIES SELECTED BY THE VARIOUS 11 FACILITIE S, BUT NOT ALL FACILITIES SELECTED THE SAME AREAS THE SEVEN ARE OBESITY, SUBSTANCE/PRESCR IPTION DRUG ABUSE, DIABETES, CANCER, HEART DISEASE, SMOKING AND MENTAL HEALTH ALL OF THES E ARE SIGNIFICANT ISSUES FOR ALL 11 FACILITIES, BUT EACH CHOSE TO PRIORITIZE ON A DIFFEREN T SET SO THEY COULD TARGET THEIR EFFORTS AND BE MORE EFFECTIVE WITH LIMITED RESOURCES FOR EXAMPLE, WHILE NEARLY ALL THE FACILITIES IDENTIFIED OBESITY (11 OF 11) AND SUBSTANCE/PRES CRIPTION DRUG ABUSE (10 OF 11), ONLY CERTAIN FACILITIES ELECTED TO FOCUS ON SOME NUMBER OF THE OTHER FIVE COMMON HEALTH PRIORITIES WHILE MENTAL HEALTH IS CLEARLY A SIGNIFICANT ISS UE FOR ALL 11 FACILITIES, ONLY THREE ARE FOCUSED ON IT DUE TO LIMITED RESOURCES THE SAME IS TRUE WITH SMOKING WHERE ONLY 5 OF THE 11 FACILITIES ARE FOCUSED ON IT, BUT IT IS AN ISS UE FOR ALL FACILITIES SIX OF THE 11 FACILITIES SELECTED CANCER, 6 OF THE 11 SELECTED HEAR T DISEASE, AND 9 OF THE 11 CHOSE DIABETES ANOTHER WAY TO STATE THIS IS BY FACILITY FOR E XAMPLE, WHILE CANCER AND MENTAL HEALTH ARE PREVALENT CHALLENGES FOR JCMC'S PRIMARY SERVICE AREA, THE HOSPITAL ELECTED NOT TO FOCUS ON THOSE DUE TO LIMITED TIME, FUNDING, PERSONNEL AND OTHER RESOURCES NEEDED TO EFFECTUATE CHANGE UCMH FELT IT WAS UNABLE TO ADDRESS HEART DISEASE, SMOKING, AND MENTAL HEALTH ISSUES IN ITS PRIMARY SERVICE AREA SOME FACILITIES ID ENTIFIED ISSUES SUCH AS TRANSPORTATION AND EDUCATION AS BARRIERS TO GOOD HEALTH, BUT WERE ALSO UNABLE TO SET ASIDE SUFFICIENT RESOURCES TO MEANINGFULLY IMPACT THOSE CHALLENGES AFT ER THE FACILITIES SELECTED A REASONABLE NUMBER OF HEALTH PRIORITIES THEY FELT THEY COULD A DEQUATELY IMPACT, 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 FOR EACH HOSPITAL THE FACILITI ES CONTINUE TO CONDUCT ACTIVITIES CONSISTENT WITH THEIR RESPECTIVE IMPLEMENTATION PLANS F OR EXAMPLE, A PARTNERSHIP WAS DEVELOPED WITH FEEDING AMERICA OF SOUTHWEST VIRGINIA TO FUND HEALTHY FOOD OPTIONS FOR THE MOBILE FOOD BANK AND PROVIDE NUTRITIONAL EDUCATION TO RECIPI ENTS WHICH ADDRESSES OBESITY AND DIABETES IPMC HAS BEEN SUPPORTING PHYSICAL ACTIVITY AND SUGAR FREE INITIATIVES AT THE LOCAL BOYS AND GIRLS CLUB TO HELP REDUCE OBESITY IN CHILDREN IPMC PROVIDED A SIGNIFICANT NUMBER OF PUBLIC SERVICE ANNOUNCEMENTS AND PARTNERED WITH LO CAL TELEVISION STATIONS TO INCREASE COMMUNITY AWARENESS AND EDUCATION OF HEALTH ISSUES SUC H AS LUNG CANCER, SMOKING, AND WOMEN'S HEALTH IPMC'S HEALTH RESOURCE CENTER, LOCATED IN T HE KINGSPORT MALL, OFFERS OUTR

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

Form and Line Reference	Explanation
FACILITY 2, INDIAN PATH MEDICAL CENTER - PART V, LINE 11	EACH PROGRAMS, HEALTH SCREENINGS, HEALTH EDUCATION CLASSES, SUPPORT GROUPS, AND HEALTH MAT ERIALS TO ADDRESS COMMUNITY MEMBERS' NEEDS SEVERAL MSHA FACILITIES, INCLUDING IPMC, PARTI CIPATE IN THE MSHA TRIUMPH CANCER NAVIGATOR PROGRAM WHICH HELPS COORDINATE CARE FOR CANCER PATIENTS FREE OF CHARGE TO ALL PATIENTS, REGARDLESS OF WHETHER THEY CHOOSE TO RECEIVE THE IR TREATMENT AT A MSHA FACILITY

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

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Form and Line Reference	Explanation
FACILITY 3, FRANKLIN WOODS COMMUNITY HOSPITAL - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) THE 13 HOSPITALS ARE COMPRISED OF 7 LICENSED HOSPITALS THAT ARE INCLUDED IN THIS RETURN, 2 HOSPITALS THAT ARE LICENSED UNDER ONE OF THE 7 AND ARE INCLUDED IN THIS RETURN, AND 4 MSHA HOSPITALS THAT FILE SEPARATE RETURNS EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NONPROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO FWCH, THE GROUP CONSISTED OF REPRESENTATIVES FROM THE WASHINGTON COUNTY HEALTH DEPARTMENT, FRONTIER HEALTH, ETSU COLLEGE OF NURSING, ETSU JOHNSON CITY COMMUNITY HEALTH CENTER, ETSU COLLEGE OF PUBLIC HEALTH, WASHINGTON COUNTY COMMISSION, NORTHEAST TENNESSEE REGIONAL HEALTH DEPARTMENT, WASHINGTON COUNTY/JOHNSON CITY EMERGENCY MEDICAL SERVICES, UNITED WAY, PROJECT ACCESS, CHAMBER OF COMMERCE, FAMILIES FREE, CITY OF JOHNSON CITY, AND CENTER ON AGING AND HEALTH EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS THE WASHINGTON COUNTY COMMUNITY BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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Form and Line Reference	Explanation
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Form and Line Reference	Explanation
FACILITY 3, FRANKLIN WOODS COMMUNITY HOSPITAL - PART V, LINE 11	H AS COLON CANCER AND SAFETY ISSUES FOR NEWBORNS

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

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FACILITY 4, SYCAMORE SHOALS HOSPITAL - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) THE 13 HOSPITALS ARE COMPRISED OF 7 LICENSED HOSPITALS THAT ARE INCLUDED IN THIS RETURN, 2 HOSPITALS THAT ARE LICENSED UNDER ONE OF THE 7 AND ARE INCLUDED IN THIS RETURN, AND 4 MSHA HOSPITALS THAT FILE SEPARATE RETURNS EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NONPROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO SSH, THE GROUP CONSISTED OF REPRESENTATIVES FROM ELIZABETHTON CITY SCHOOLS, CARTER COUNTY SCHOOLS, UNITED HEALTHCARE, UT-CARTER COUNTY EXTENSION, CENTER ON AGING AND HEALTH, CARTER COUNTY GOVERNOR'S OFFICE, COORDINATED SCHOOL HEALTH, BABE BREASTFEEDING COALITION, PROJECT ACCESS AND CARTER COUNTY HEALTH DEPARTMENT EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS SSH'S CARTER COUNTY COMMUNITY BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

Form and Line Reference	Explanation
FACILITY 4, SYCAMORE SHOALS 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 DUE TO LIMITED RESOURCES, EACH FACILITY PRI ORITIZED FOUR TO FIVE HEALTH PRIORITIES ON WHICH TO FOCUS AND DEVELOP IMPLEMENTATION PLANS TO IMPACT THERE WERE SEVEN COMMON HEALTH PRIORITIES SELECTED BY THE VARIOUS 11 FACILITIE S, BUT NOT ALL FACILITIES SELECTED THE SAME AREAS THE SEVEN ARE OBESITY, SUBSTANCE/PRESCR IPTION DRUG ABUSE, DIABETES, CANCER, HEART DISEASE, SMOKING AND MENTAL HEALTH ALL OF THES E ARE SIGNIFICANT ISSUES FOR ALL 11 FACILITIES, BUT EACH CHOSE TO PRIORITIZE ON A DIFFEREN T SET SO THEY COULD TARGET THEIR EFFORTS AND BE MORE EFFECTIVE WITH LIMITED RESOURCES FOR EXAMPLE, WHILE NEARLY ALL THE FACILITIES IDENTIFIED OBESITY (11 OF 11) AND SUBSTANCE/PRES CRIPTION DRUG ABUSE (10 OF 11), ONLY CERTAIN FACILITIES ELECTED TO FOCUS ON SOME NUMBER OF THE OTHER FIVE COMMON HEALTH PRIORITIES WHILE MENTAL HEALTH IS CLEARLY A SIGNIFICANT ISS UE FOR ALL 11 FACILITIES, ONLY THREE ARE FOCUSED ON IT DUE TO LIMITED RESOURCES THE SAME IS TRUE WITH SMOKING WHERE ONLY 5 OF THE 11 FACILITIES ARE FOCUSED ON IT, BUT IT IS AN ISS UE FOR ALL FACILITIES SIX OF THE 11 FACILITIES SELECTED CANCER, 6 OF THE 11 SELECTED HEAR T DISEASE, AND 9 OF THE 11 CHOSE DIABETES ANOTHER WAY TO STATE THIS IS BY FACILITY FOR E XAMPLE, WHILE CANCER AND MENTAL HEALTH ARE PREVALENT CHALLENGES FOR JCMC'S PRIMARY SERVICE AREA, THE HOSPITAL ELECTED NOT TO FOCUS ON THOSE DUE TO LIMITED TIME, FUNDING, PERSONNEL AND OTHER RESOURCES NEEDED TO EFFECTUATE CHANGE UCMH FELT IT WAS UNABLE TO ADDRESS HEART DISEASE, SMOKING, AND MENTAL HEALTH ISSUES IN ITS PRIMARY SERVICE AREA SOME FACILITIES ID ENTIFIED ISSUES SUCH AS TRANSPORTATION AND EDUCATION AS BARRIERS TO GOOD HEALTH, BUT WERE ALSO UNABLE TO SET ASIDE SUFFICIENT RESOURCES TO MEANINGFULLY IMPACT THOSE CHALLENGES AFT ER THE FACILITIES SELECTED A REASONABLE NUMBER OF HEALTH PRIORITIES THEY FELT THEY COULD A DEQUATELY IMPACT, 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 FOR EACH HOSPITAL THE FACILITI ES CONTINUE TO CONDUCT ACTIVITIES CONSISTENT WITH THEIR RESPECTIVE IMPLEMENTATION PLANS F OR EXAMPLE, A PARTNERSHIP WAS DEVELOPED WITH FEEDING AMERICA OF SOUTHWEST VIRGINIA TO FUND HEALTHY FOOD OPTIONS FOR THE MOBILE FOOD BANK AND PROVIDE NUTRITIONAL EDUCATION TO RECIPI ENTS WHICH ADDRESSES OBESITY AND DIABETES SEVERAL MSHA FACILITIES, INCLUDING SSH, PARTICI PATE IN THE MSHA TRIUMPH CANCER NAVIGATOR PROGRAM WHICH HELPS COORDINATE CARE FOR CANCER P ATIENTS FREE OF CHARGE TO ALL PATIENTS, REGARDLESS OF WHETHER THEY CHOOSE TO RECEIVE THEIR TREATMENT AT A MSHA FACILITY SSH PROVIDED A SIGNIFICANT NUMBER OF PUBLIC SERVICE ANNOUNC EMENTS AND PARTNERED WITH LOCAL TELEVISION STATIONS TO INCREASE COMMUNITY AWARENESS AND ED UCATION OF HEALTH ISSUES SUCH

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

Form and Line Reference	Explanation
FACILITY 4, SYCAMORE SHOALS HOSPITAL - PART V, LINE 11	AS HEART HEALTH AND WOMEN'S HEALTH SSH PROVIDES SUPPORT TO RED LEGACY RECOVERY COUNSELING TO YOUNG WOMEN AND MOTHERS RECOVERING FROM SUBSTANCE ABUSE THE HOSPITAL PARTICIPATED IN ELIZABETHTON CITY SCHOOLS "BACK-2-SCHOOL BASH", A COLLABORATIVE EVENT HELD BEFORE THE NEW SCHOOL YEAR STARTED SSH PROVIDED BACKPACKS FOR THE STUDENTS FILLED WITH SUPPLIES LOCAL B USINESSES AND ORGANIZATIONS, SUCH AS THE CARTER COUNTY HEALTH DEPARTMENT, SPONSORED THE EV ENT THE HEALTH DEPARTMENT SCHEDULED APPOINTMENTS FOR IMMUNIZATIONS, WELLNESS CHECKUPS AND EYE EXAMS KIDS WERE EVEN ABLE TO RECEIVE A FREE HAIR CUT FAMILIES RECEIVED INFORMATION ABOUT NUMEROUS AFTER-SCHOOL PROGRAMS AS WELL AS NUTRITION, HYGIENE AND HEALTHCARE RESOURCE S

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

Form and Line Reference	Explanation
FACILITY 5, RUSSELL COUNTY MEDICAL CENTER - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) THE 13 HOSPITALS ARE COMPRISED OF 7 LICENSED HOSPITALS THAT ARE INCLUDED IN THIS RETURN, 2 HOSPITALS THAT ARE LICENSED UNDER ONE OF THE 7 AND ARE INCLUDED IN THIS RETURN, AND 4 MSHA HOSPITALS THAT FILE SEPARATE RETURNS EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NONPROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO RCMC, THE GROUP CONSISTED OF REPRESENTATIVES FROM THE CUMBERLAND PLATEAU HEALTH DISTRICT, VIRGINIA DEPARTMENT OF HEALTH, DANTE EMERGENCY MEDICAL SERVICES, TOWN OF LEBANON, RUSSELL COUNTY DEPARTMENT OF SOCIAL SERVICES, AND RUSSELL COUNTY YMCA EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS RUSSELL COUNTY MEDICAL CENTER'S BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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

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

Form and Line Reference	Explanation
FACILITY 5, RUSSELL COUNTY MEDICAL CENTER - 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 DUE TO LIMITED RESOURCES, EACH FACILITY PRI ORITIZED FOUR TO FIVE HEALTH PRIORITIES ON WHICH TO FOCUS AND DEVELOP IMPLEMENTATION PLANS TO IMPACT THERE WERE SEVEN COMMON HEALTH PRIORITIES SELECTED BY THE VARIOUS 11 FACILITIE S, BUT NOT ALL FACILITIES SELECTED THE SAME AREAS THE SEVEN ARE OBESITY, SUBSTANCE/PRESCR IPTION DRUG ABUSE, DIABETES, CANCER, HEART DISEASE, SMOKING AND MENTAL HEALTH ALL OF THES E ARE SIGNIFICANT ISSUES FOR ALL 11 FACILITIES, BUT EACH CHOSE TO PRIORITIZE ON A DIFFEREN T SET SO THEY COULD TARGET THEIR EFFORTS AND BE MORE EFFECTIVE WITH LIMITED RESOURCES FOR EXAMPLE, WHILE NEARLY ALL THE FACILITIES IDENTIFIED OBESITY (11 OF 11) AND SUBSTANCE/PRES CRIPTION DRUG ABUSE (10 OF 11), ONLY CERTAIN FACILITIES ELECTED TO FOCUS ON SOME NUMBER OF THE OTHER FIVE COMMON HEALTH PRIORITIES WHILE MENTAL HEALTH IS CLEARLY A SIGNIFICANT ISS UE FOR ALL 11 FACILITIES, ONLY THREE ARE FOCUSED ON IT DUE TO LIMITED RESOURCES THE SAME IS TRUE WITH SMOKING WHERE ONLY 5 OF THE 11 FACILITIES ARE FOCUSED ON IT, BUT IT IS AN ISS UE FOR ALL FACILITIES SIX OF THE 11 FACILITIES SELECTED CANCER, 6 OF THE 11 SELECTED HEAR T DISEASE, AND 9 OF THE 11 CHOSE DIABETES ANOTHER WAY TO STATE THIS IS BY FACILITY FOR E XAMPLE, WHILE CANCER AND MENTAL HEALTH ARE PREVALENT CHALLENGES FOR JCMC'S PRIMARY SERVICE AREA, THE HOSPITAL ELECTED NOT TO FOCUS ON THOSE DUE TO LIMITED TIME, FUNDING, PERSONNEL AND OTHER RESOURCES NEEDED TO EFFECTUATE CHANGE UCMH FELT IT WAS UNABLE TO ADDRESS HEART DISEASE, SMOKING, AND MENTAL HEALTH ISSUES IN ITS PRIMARY SERVICE AREA SOME FACILITIES ID ENTIFIED ISSUES SUCH AS TRANSPORTATION AND EDUCATION AS BARRIERS TO GOOD HEALTH, BUT WERE ALSO UNABLE TO SET ASIDE SUFFICIENT RESOURCES TO MEANINGFULLY IMPACT THOSE CHALLENGES AFT ER THE FACILITIES SELECTED A REASONABLE NUMBER OF HEALTH PRIORITIES THEY FELT THEY COULD A DEQUATELY IMPACT, 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 FOR EACH HOSPITAL THE FACILITI ES CONTINUE TO CONDUCT ACTIVITIES CONSISTENT WITH THEIR RESPECTIVE IMPLEMENTATION PLANS F OR EXAMPLE, A PARTNERSHIP WAS DEVELOPED WITH FEEDING AMERICA OF SOUTHWEST VIRGINIA TO FUND HEALTHY FOOD OPTIONS FOR THE MOBILE FOOD BANK AND PROVIDE NUTRITIONAL EDUCATION TO RECIPI ENTS WHICH ADDRESSES OBESITY AND DIABETES IN RESPONSE TO AN OUTSTANDING NEED IN SOUTHWEST VIRGINIA, RCMC EXPANDED TO INCLUDE A MEDICAL PSYCHIATRIC SERVICE TO CARE FOR PEOPLE SUFFE RING FROM MEDICAL ILLNESS AND MENTAL HEALTH DISORDERS AT THE SAME TIME RCMC SUPPORTED THE RUSSELL COUNTY SCHOOL BACKPACK PROGRAM WHICH PROVIDES HEALTHY FOOD FOR KIDS IN NEED TO HE LP ADDRESS CHILDHOOD OBESITY MSHA FACILITIES, INCLUDING RCMC, PARTICIPATE IN THE MSHA TRI UMPH CANCER NAVIGATOR PROGRAM

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

Form and Line Reference	Explanation
FACILITY 5, RUSSELL COUNTY MEDICAL CENTER - PART V, LINE 11	WHICH HELPS COORDINATE CARE FOR CANCER PATIENTS FREE OF CHARGE TO ALL PATIENTS, REGARDLESS OF WHETHER THEY CHOOSE TO RECEIVE THEIR TREATMENT AT A MSHA FACILITY RCMC PROVIDED A SIG NIFICANT NUMBER OF PUBLIC SERVICE ANNOUNCEMENTS AND PARTNERED WITH LOCAL TELEVISION STATIO NS TO INCREASE COMMUNITY AWARENESS AND EDUCATION OF HEALTH ISSUES SUCH AS WOMEN'S HEALTH, COLON CANCER, LUNG CANCER, ETC DURING FY17 RCMC PROVIDED SPONSORSHIP OF THE RUSSELL CO H IGH SCHOOL DRUG-FREE GRADUATION PROGRAM THE HOSPITAL PROVIDED FINANCIAL SUPPORT AND SUPPL IES TO OTHER NONPROFIT HEALTH ORGANIZATIONS THROUGHOUT THE YEAR

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

Form and Line Reference	Explanation
FACILITY 6, JOHNSON COUNTY COMMUNITY HOSPITAL - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) THE 13 HOSPITALS ARE COMPRISED OF 7 LICENSED HOSPITALS THAT ARE INCLUDED IN THIS RETURN, 2 HOSPITALS THAT ARE LICENSED UNDER ONE OF THE 7 AND ARE INCLUDED IN THIS RETURN, AND 4 MSHA HOSPITALS THAT FILE SEPARATE RETURNS EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NONPROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO JCCH, THE GROUP CONSISTED OF REPRESENTATIVES FROM JOHNSON COUNTY COMMUNITY HOSPITAL, JOHNSON COUNTY HEALTH DEPARTMENT, JOHNSON COUNTY RESCUE AND EMERGENCY MEDICAL SERVICES, ETSU COLLEGE OF NURSING AT MOUNTAIN CITY EXTENDED HOURS, AND JOHNSON COUNTY SCHOOLS EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS JOHNSON COUNTY COMMUNITY HOSPITAL'S BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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

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

Form and Line Reference	Explanation
FACILITY 6, JOHNSON COUNTY COMMUNITY HOSPITAL - PART V, LINE 11	H AS WOMEN'S HEALTH, ISSUES RELATING TO AGING, LUNG CANCER, AND A VARIETY OF OTHER GENERAL HEALTH INFORMATION TOPICS THE HOSPITAL PROVIDED SUPPORT TO THE ACTION COALITION, INC , A N ORGANIZATION THAT FOCUSES ON DRUG AND ALCOHOL PREVENTION

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

Form and Line Reference	Explanation
FACILITY 7, UNICOI COUNTY MEMORIAL HOSPITAL - PART V, LINE 5	MSHA MET WITH TEN FOCUS GROUPS, EACH REPRESENTING ONE OF THE THIRTEEN HOSPITAL FACILITIES LOCATED WITHIN THE CORE COUNTIES OF MSHA FACILITIES (16 COUNTIES) THE 13 HOSPITALS ARE COMPRISED OF 7 LICENSED HOSPITALS THAT ARE INCLUDED IN THIS RETURN, 2 HOSPITALS THAT ARE LICENSED UNDER ONE OF THE 7 AND ARE INCLUDED IN THIS RETURN, AND 4 MSHA HOSPITALS THAT FILE SEPARATE RETURNS EACH GROUP CONSISTED OF PUBLIC HEALTH LEADERS, NURSES, NONPROFIT DIRECTORS, COMMUNITY DEVELOPERS, FAITH BASED LEADERS, PUBLIC OFFICIALS AND SCHOOL REPRESENTATIVES SPECIFIC TO UCMH, THE GROUP CONSISTED OF REPRESENTATIVES FROM THE UNICOI COUNTY CHAMBER OF COMMERCE, BANK OF TENNESSEE, UNICOI COUNTY FAMILY YMCA, KEESECKER/STEEL RAILS, CENTER ON AGING AND HEALTH, UETHDA HEAD START, TELEMON HEAD START, AND UNICOI COUNTY HEALTH DEPARTMENT EACH GROUP RANGED IN ATTENDANCE FROM 5 TO 18 INDIVIDUALS PARTICIPANTS WERE GIVEN SURVEYS TO DETERMINE A COUNTY'S PERCEIVED HEALTH STATUS RATING, AVAILABLE RESOURCES, TOP HEALTH PRIORITIES (DISEASE CONDITIONS, HEALTH BEHAVIORS, AND SOCIOECONOMIC FACTORS), AND SUGGESTIONS FOR IMPROVEMENT OPEN DISCUSSION FOLLOWED THE COLLECTED INFORMATION WAS THEN PAIRED WITH STATISTICAL DATA IN ORDER TO PRIORITIZE HEALTH NEEDS THE FACILITY COMMUNITY BOARDS (SUCH AS THE UNICOI COUNTY COMMUNITY BOARD) WERE PRESENTED THIS INFORMATION AND SHARED THEIR THOUGHTS AS WELL ON THE HEALTH NEEDS TO PRIORITIZE THE SPECIFIC NEEDS FOR EACH COUNTY WERE THEN ADDRESSED IN THE RESPECTIVE FACILITY IMPLEMENTATION PLAN WHICH WAS ADOPTED SEVERAL MONTHS LATER

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

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

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

Form and Line Reference	Explanation
FACILITY 7, UNICOI COUNTY MEMORIAL 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 DUE TO LIMITED RESOURCES, EACH FACILITY PRI ORITIZED FOUR TO FIVE HEALTH PRIORITIES ON WHICH TO FOCUS AND DEVELOP IMPLEMENTATION PLANS TO IMPACT THERE WERE SEVEN COMMON HEALTH PRIORITIES SELECTED BY THE VARIOUS 11 FACILITIE S, BUT NOT ALL FACILITIES SELECTED THE SAME AREAS THE SEVEN ARE OBESITY, SUBSTANCE/PRESCR IPTION DRUG ABUSE, DIABETES, CANCER, HEART DISEASE, SMOKING AND MENTAL HEALTH ALL OF THES E ARE SIGNIFICANT ISSUES FOR ALL 11 FACILITIES, BUT EACH CHOSE TO PRIORITIZE ON A DIFFEREN T SET SO THEY COULD TARGET THEIR EFFORTS AND BE MORE EFFECTIVE WITH LIMITED RESOURCES FOR EXAMPLE, WHILE NEARLY ALL THE FACILITIES IDENTIFIED OBESITY (11 OF 11) AND SUBSTANCE/PRES CRIPTION DRUG ABUSE (10 OF 11), ONLY CERTAIN FACILITIES ELECTED TO FOCUS ON SOME NUMBER OF THE OTHER FIVE COMMON HEALTH PRIORITIES WHILE MENTAL HEALTH IS CLEARLY A SIGNIFICANT ISS UE FOR ALL 11 FACILITIES, ONLY THREE ARE FOCUSED ON IT DUE TO LIMITED RESOURCES THE SAME IS TRUE WITH SMOKING WHERE ONLY 5 OF THE 11 FACILITIES ARE FOCUSED ON IT, BUT IT IS AN ISS UE FOR ALL FACILITIES SIX OF THE 11 FACILITIES SELECTED CANCER, 6 OF THE 11 SELECTED HEAR T DISEASE, AND 9 OF THE 11 CHOSE DIABETES ANOTHER WAY TO STATE THIS IS BY FACILITY FOR E XAMPLE, WHILE CANCER AND MENTAL HEALTH ARE PREVALENT CHALLENGES FOR JCMC'S PRIMARY SERVICE AREA, THE HOSPITAL ELECTED NOT TO FOCUS ON THOSE DUE TO LIMITED TIME, FUNDING, PERSONNEL AND OTHER RESOURCES NEEDED TO EFFECTUATE CHANGE UCMH FELT IT WAS UNABLE TO ADDRESS HEART DISEASE, SMOKING, AND MENTAL HEALTH ISSUES IN ITS PRIMARY SERVICE AREA SOME FACILITIES ID ENTIFIED ISSUES SUCH AS TRANSPORTATION AND EDUCATION AS BARRIERS TO GOOD HEALTH, BUT WERE ALSO UNABLE TO SET ASIDE SUFFICIENT RESOURCES TO MEANINGFULLY IMPACT THOSE CHALLENGES AFT ER THE FACILITIES SELECTED A REASONABLE NUMBER OF HEALTH PRIORITIES THEY FELT THEY COULD A DEQUATELY IMPACT, 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 FOR EACH HOSPITAL THE FACILITI ES CONTINUE TO CONDUCT ACTIVITIES CONSISTENT WITH THEIR RESPECTIVE IMPLEMENTATION PLANS F OR EXAMPLE, A PARTNERSHIP WAS DEVELOPED WITH FEEDING AMERICA OF SOUTHWEST VIRGINIA TO FUND HEALTHY FOOD OPTIONS FOR THE MOBILE FOOD BANK AND PROVIDE NUTRITIONAL EDUCATION TO RECIPI ENTS WHICH ADDRESSES OBESITY AND DIABETES SEVERAL MSHA FACILITIES, INCLUDING UCMH, PARTIC IPATE IN THE MSHA TRIUMPH CANCER NAVIGATOR PROGRAM WHICH HELPS COORDINATE CARE FOR CANCER PATIENTS FREE OF CHARGE TO ALL PATIENTS, REGARDLESS OF WHETHER THEY CHOOSE TO RECEIVE THEI R TREATMENT AT A MSHA FACILITY UCMH PROVIDED A SIGNIFICANT NUMBER OF PUBLIC SERVICE ANNOU NCEMENTS AND PARTNERED WITH LOCAL TELEVISION STATIONS TO INCREASE COMMUNITY AWARENESS AND EDUCATION OF HEALTH ISSUES SUC

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

Form and Line Reference	Explanation
FACILITY 7, UNICOI COUNTY MEMORIAL HOSPITAL - PART V, LINE 11	H AS WOMEN'S HEALTH, HEART HEALTH, LUNG CANCER, AND A VARIETY OF OTHER GENERAL HEALTH INFO RMATION TOPICS HOSPITAL TEAM MEMBERS PROVIDED HEALTH INFORMATION AND EDUCATION AT THE TOW N OF ERWIN APPLE FESTIVAL THE APPLE FESTIVAL IS GOING STRONG AFTER 39 YEARS WITH MORE THA N 110,000 ANNUAL ATTENDEES

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

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

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

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

Name and address	Type of Facility (describe)
JCMC AMBULATORY SURGERY CENTER 400 N STATE OF FRANKLIN ROAD JOHNSON CITY, TN 37604	LICENSED AMBULATORY SURGERY CENTER
MOUNTAIN STATES IMAGING CENTER 301 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604	LICENSED OUTPATIENT DIAGNOSTIC CENTER
INDIAN PATH TRANSITIONAL CARE 2000 BROOKSIDE DRIVE KINGSPORT, TN 37660	LICENSED SKILLED NURSING FACILITY
MEDICAL CNTR HOME CARE-JOHNSON CITY 509 MED TECH PARKWAYSUITE 200 JOHNSON CITY, TN 37604	LICENSED HOME HEALTH AGENCY
MEDICAL CNTR HOME CARE-KINGSPORT 2020 BROOKSIDE DRIVE 28 KINGSPORT, TN 37660	LICENSED HOME HEALTH AGENCY
RUSSELL CO MEDICAL CNTR HOME HLTH 116 FLANNAGAN AVENUE LEBANON, VA 24266	LICENSED HOME HEALTH AGENCY
MEDICAL CENTER HOSPICE 509 MED TECH PARKWAY SUITE 300 JOHNSON CITY, TN 37604	LICENSED HOSPICE AGENCY
JOHNSON COUNTY HOME HEALTH 1987 SOUTH SHADY STREET MOUNTAIN CITY, TN 37683	LICENSED HOME HEALTH AGENCY
RUSSELL COUNTY MEDICAL CNTR HOSPICE 116 FLANNAGAN AVENUE LABANON, VA 24266	LICENSED HOSPICE AGENCY
UNICOI COUNTY LONG TERM CARE 100 GREENWAY CIRCLE UNICOI, TN 37650	LICENSED LONG TERM CARE FACILITY
DICKENSON CO HOME HEALTH & HOSPICE 312 HOSPITAL DRIVE SUITES 1A 1B CLINTWOOD, VA 24228	LICENSED HOME HEALTH AGENCY

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

Part I General Information on Grants and Assistance

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

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

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

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

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

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 19

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

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

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

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

Return Reference	Explanation
SCHEDULE I, PAGE 1, PART I, LINE 2	DONATION REQUESTS THAT WILL BE EXPENSED AT THE CORPORATE DIVISION REQUIRE TWO LEVELS OF APPROVAL, WITH FINAL REVIEW BY MSHA'S PRESIDENT DONATIONS THAT WILL BE EXPENSED BY ONE OF OUR HOSPITALS REQUIRES FINAL APPROVAL BY THE INDIVIDUAL HOSPITAL'S CEO ALL REQUESTS ARE NOW REQUIRED TO BE COMPLETED USING THE ONLINE APPLICATION FORM THE ONLINE FORM PROVIDES CONSISTENCY AMONG APPLICANTS AND GIVES US THE INFORMATION WE NEED IN ORDER TO MAKE A FULLY VETTED FUNDING DECISION SOME OF THE INFORMATION WE REQUIRE FROM APPLICANTS INCLUDES IF THE APPLICANT IS REQUESTING FUNDING FOR A SPECIFIC EVENT OR PROGRAM, THE DATE, LOCATION, AND TIME ARE REQUIRED DESCRIPTION OF THE EVENT/PROGRAM APPLICANTS OTHER SOURCES OF INCOME EVENT/PROGRAM BUDGET HOW THE EVENT/PROGRAM SUPPORTS MSHA'S MISSION WHO WILL BENEFIT FROM OUR CONTRIBUTION WHAT WILL THE EVENT/PROGRAM ACCOMPLISH APPLICANT ORGANIZATION'S MISSION STATEMENT YEAR THE APPLICANT ORGANIZATION WAS FOUNDED NUMBER OF PEOPLE SERVED ANNUALLY BY THE APPLICANT APPLICANT'S WEBSITE TAX STATUS OF THE APPLICANT AND FEDERAL TAXPAYER ID NUMBER WITH FEW EXCEPTIONS, DONATIONS TO NATIONAL ORGANIZATIONS ARE HANDLED AT THE CORPORATE LEVEL, WHICH PREVENTS MULTIPLE CONTRIBUTIONS BEING MADE TO THE SAME NATIONAL ORGANIZATION AND ALLOWS ADDITIONAL CONTRIBUTION DOLLARS TO BE USED FOR REGION-SPECIFIC REQUESTS DONATIONS MADE BY OUR HOSPITALS ARE ALMOST ENTIRELY DIRECTED TO LOCAL NONPROFIT ORGANIZATIONS MSHA'S SOCIAL RESPONSIBILITY COMMITTEE IS COMPRISED OF COMMUNITY LEADERS INCLUDING THE DEAN OF A LOCAL UNIVERSITY, THE PRESIDENT OF A LOCAL COLLEGE, UNITED WAY OF WASHINGTON COUNTY'S PRESIDENT, COMMUNITY VOLUNTEERS, BUSINESS LEADERS, MOUNTAIN STATES FOUNDATION'S PRESIDENT, AND OTHERS COMMITTEE MEMBERS WERE SELECTED SO THAT MEMBERSHIP EXPERTISE INCLUDES PUBLIC HEALTH, HEALTH PROFESSIONS EDUCATION, KNOWLEDGE OF OTHER RESOURCES AVAILABLE TO CHARITABLE ORGANIZATIONS, AND INDIVIDUALS WITH HANDS-ON COMMUNITY VOLUNTEER EXPERIENCE SOME OF THE ROUTINE ACTIVITIES OF THE COMMITTEE DURING QUARTERLY MEETINGS INCLUDE QUARTERLY REVIEW OF THE SOCIAL RESPONSIBILITY SCORECARD, A MEASUREMENT OF ACTUAL ACCOMPLISHMENTS IN THE YEAR COMPARED TO TARGETS SET AT THE BEGINNING OF THE YEAR REVIEW OF CHARITABLE CONTRIBUTION GIVING FOR THE PREVIOUS QUARTER OPPORTUNITY FOR LOCAL TAX EXEMPT ORGANIZATIONS TO PRESENT TO THE COMMITTEE PROGRAMS THEY OFFER, ACHIEVEMENTS, AND FUNDING NEEDS THE COMMITTEE MAY OR MAY NOT RECOMMEND MSHA FUNDING OF PROGRAMS SOMETIMES, MSHA DEPARTMENTS WILL BRING PROPOSALS FOR NEW PROGRAMS TO BENEFIT A SPECIFIC POPULATION, SUCH AS CHILDREN

Additional Data

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

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
AMERICAN CANCER SOCIETY 250 WILLIAMS STREET NW SUITE 400 ATLANTA, GA 30303	13-1788491	501C3	7,525				PROGRAM SUPPORT
AMERICAN HEART ASSOCIATION 208 SUNSET DRIVE JOHNSON CITY, TN 37604	13-5613797	501C3	10,000				PROGRAM SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
AMERICAN RED CROSS OF NE TN 1 PROFESSIONAL PARK STE 14 JOHNSON CITY, TN 37604	53-0196605	501C3	7,180				PROGRAM SUPPORT
APPALACHIAN MOUNTAIN PROJECT ACCESS 809 SOUTH ROAN STREET SUITE 4 JOHNSON CITY, TN 37601	26-2102040	501C3	451,423				HEALTH ACCESS

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
BARTER THEATRE PO BOX 867 ABINGDON, VA 24212	54-6000120	501C3	18,800				SPONSORSHIP
CASA OF NE TENNESSEE PO BOX 1021 JOHNSON CITY, TN 37605	45-0515257	501C3	11,000				PROGRAM SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CHILDREN'S ADVOCACY CTR 1ST DIST PO BOX 827 JOHNSON CITY, TN 37605	62-1765785	501C3	7,150				PROGRAM SUPPORT
CRUMLEY HOUSE BRAIN INJURY REHAB 300 URBANA ROAD LIMESTONE, TN 37681	58-1988511	501C3	6,500				PROGRAM SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
EAST TENNESSEE FOUNDATION 520 W SUMMIT HILL DRIVE STE 1101 KNOXVILLE, TN 37902	62-0807696	501C3	25,000				KINGSPORT CENTENL
EAST TENNESSEE STATE UNIVERSITY PO BOX 70732 JOHNSON CITY, TN 37614	62-6021046	501C3	98,565				HLTH RESEARCH/PHARM

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
FEEDING AMERICA OF SWVA 1025 ELECTRIC ROAD SALEM, VA 24153	54-1939556	501C3	46,000				2 MOBILE PANTRIES
FRIENDS IN NEED HEALTH CENTER 1105 W STONE DRIVE KINGSPORT, TN 37660	62-1541637	501C3	14,000				HEALTH & DENTAL CARE

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
FRONTIER HEALTH FOUNDATION P O BOX 8293 GRAY, TN 37615	46-1432508	501C3	7,800				PROGRAM SUPPORT
KINGSPORT CHAMBER FOUNDATION 151 EAST MAIN STREET KINGSPORT, TN 37660	58-1453565	501C3	51,455				HEALTHY KPT PRGRM

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MILLIGAN COLLEGE PO BOX 189 MILLIGAN COLLEGE, TN 37682	62-0535755	501C3	7,040				HEALTH PROF EDUC
MOUNTAIN STATES FOUNDATION 2335 KNOB CREEK ROAD SUITE 101 JOHNSON CITY, TN 37604	58-1418862	501C3	21,323				LOCAL HLTH PROGRAMS

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
DR ROBERT THOMAS FOUNDATION 742 MIDDLE CREEK RD STE 206 SEVIERVILLE, TN 37862	58-1537582	501C3	10,000				PROGRAM SUPPORT
SUSAN KOMEN BREAST CANCER FOUND PO BOX 5835 KINGSPORT, TN 37663	84-1689067	501C3	25,000				PROGRAM SUPPORT

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
UNITED WAY OF SW VA INC 1096 OLE BERRY DRIVE ABINGDON, VA 24210	54-0718860	501C3	7,260				PROGRAM SUPPORT

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Schedule J (Form 990)

Department of the Treasury Internal Revenue Service

Compensation Information

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items ☐ First-class or charter travel ☐ Housing allowance or residence for personal use ☐ Travel for companions ☐ Payments for business use of personal residence ☐ Tax idemnification and gross-up payments ☐ Health or social club dues or initiation fees ☐ Discretionary spending account ☐ Personal services (e g , maid, chauffeur, chef)			
b	If any of the boxes 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**		No
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**	Yes	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III ☐ Compensation committee ☐ Written employment contract ☐ Independent compensation consultant ☐ Compensation survey or study ☐ Form 990 of other organizations ☐ Approval by the board or compensation committee			
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization			
a	Receive a severance payment or change-of-control payment?	**4a**		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," on line 5a or 5b, describe in Part III			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," on line 6a or 6b, describe in Part III			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		No
8	Were any amounts reported on Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	**9**		

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

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

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

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

Part III Supplemental Information

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

Return Reference	Explanation
SCHEDULE J, PAGE 1, PART I, LINE 1B	BOARD MEMBERS AND TEAM MEMBERS OF MSHA ARE NOT PERMITTED TO TRAVEL FIRST- CLASS WITH THE EXCEPTION OF MSHA'S CEO AS SANCTIONED BY MSHA'S BOARD OF DIRECTORS, MSHA'S CEO IS PERMITTED TO TRAVEL FIRST-CLASS WHEN THE FLIGHT'S DURATION IS GREATER THAN TWO HOURS DUE TO THE LENGTH OF SUCH FLIGHTS, THE BOARD BELIEVES IT IS IN THE BEST INTEREST OF MSHA FOR THE CEO TO TRAVEL FIRST-CLASS CHARTER TRAVEL IS LIMITED TO MSHA BUSINESS TRIPS THAT INCLUDE NUMEROUS TRAVELERS AND WHICH CAN BE JUSTIFIED BASED UPON FINANCIAL AND/OR ESSENTIAL TIME SAVINGS CHARTER FLIGHTS MUST BE APPROVED BY THE CEO PRIOR TO BOOKING THE FLIGHT
SCHEDULE J, PAGE 1, PART I, LINE 4	ALAN LEVINE 0 142,817 0 LYNN KRUTAK 0 48,271 0 MONTY MCLAURIN 0 15,920 0 DAWN TRIMBLE 0 24,072 0 SHANE HILTON 0 17,247 0 LINDA WHITE 0 13,560 0 LEMMIE TAYLOR 0 11,144 0 MORRIS SELIGMAN, M D 0 53,381 0 ANTHONY KECK 0 37,367 0 PAUL MERRYWELL 0 15,920 0 CANDACE JENNINGS 0 265,626 0
SCHEDULE J, PART III	THE FOLLOWING EXECUTIVES LISTED IN SCHEDULE J, PART II PARTICIPATED IN A 457(F) RETIREMENT PLAN PROVIDED BY MOUNTAIN STATES HEALTH ALLIANCE (MSHA) ALAN LEVINE, MORRIS SELIGMAN, LYNN KRUTAK, ANTHONY KECK, DAWN TRIMBLE, SHANE HILTON, MONTY MCLAURIN, LINDA WHITE, LEMMIE TAYLOR, PAUL MERRYWELL, AND CANDACE JENNINGS THE 457(F)PLAN IS A NONQUALIFIED TAX-DEFERRED COMPENSATION PLAN AVAILABLE TO A SELECT GROUP OF KEY EXECUTIVES FOR THE INTENT OF SUPPORTING RETENTION AND TO OFFER A COMPETITIVE TOTAL RETIREMENT PROGRAM ACCOUNT BALANCES HAVE A "SUBSTANTIAL RISK OF FORFEITURE" IN ADDITION TO CREDITOR RISK, SUBSTANTIAL RISK OF FORFEITURE IS CREATED THROUGH DEFAULT RISK IF THE PARTICIPANT'S EMPLOYMENT WITH MSHA IS TERMINATED PRIOR TO AGE 65 HOWEVER, THE 457(F) PLAN CONTAINS A NON-COMPETE PROVISION THAT PROVIDES THE ACCOUNT BALANCE TO BE PAID IN A LUMP SUM AFTER THE EXECUTIVE SATISFIES THE TWO-YEAR NON-COMPETE PERIOD THIS PROVISION APPLIES TO EMPLOYER CONTRIBUTIONS IF THE EXECUTIVE HAS PROVIDED ELIGIBLE SERVICE FOR SIX OR MORE YEARS (ELIGIBLE SERVICE IS OFFICER SERVICE THAT PERMITTED THE EXECUTIVE TO PARTICIPATE IN THE PLAN) THE EXECUTIVE WILL RECEIVE THE ENTIRE ACCOUNT BALANCE IF HE/SHE BECOMES DISABLED, DIES OR IF THE EXECUTIVE TERMINATES FOR "GOOD REASON- OR IS INVOLUNTARILY TERMINATED WITHOUT "GOOD CAUSE" WITHIN A 24-MONTH PERIOD AFTER A CHANGE-OF-CONTROL OCCURS DISTRIBUTIONS FROM THIS PLAN ARE SUBJECT TO FEDERAL, STATE, AND LOCAL TAXES ON THE ENTIRE ACCOUNT BALANCE UPON DISTRIBUTION

Additional Data

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation	(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
1ALAN LEVINE PRESIDENT & CEO	(I)	916,778		48,767	153,217	24,087	1,139,902	26,553
	(II)					-	-	
1MARVIN EICHORNEVP/COO	(I)	558,459		31,936	18,200	24,493	630,141	
	(II)					-	-	
2LYNN KRUTAKEVP/CFO	(I)	456,672		21,992	71,180	18,709	565,606	
	(II)					-	-	
3MONTY MCLAURIN VP/CEO NW MKT	(I)	296,329		269,112	32,670	24,986	620,347	108,669
	(II)					-	-	
4DAWN TRIMBLE VP/CEO WASH CO	(I)	455,286		21,441	40,963	22,372	537,115	
	(II)					-	-	
5SHANE HILTON VP/CFO-MKT OPS	(I)	322,719	12,565	4,103	36,871	24,815	398,236	
	(II)					-	-	
6TONY BENTON VP/COO WASH CO MKT	(I)	290,961		9,411	16,729	23,604	337,981	
	(II)					-	-	
7RICHARD BOONE VP/CFO WASH CO	(I)	282,435		3,628	10,450	18,108	312,836	
	(II)					-	-	
8LINDA WHITE VP & CEO, FWCH/WR	(I)	255,883	6,759	8,243	31,321	20,487	320,101	
	(II)					-	-	
9LEMMIE TAYLOR VP/CEO SE MKT	(I)	207,521		4,030	28,950	21,925	260,279	
	(II)					-	-	
10STEVE SAWYER AVP/CFO NW MKT	(I)	174,936		14,778	9,539	22,803	220,380	
	(II)					-	-	
11MORGAN MAYJCMC CNO	(I)	149,077		3,259	9,288	19,302	180,273	
	(II)					-	-	
12MORRIS SELIGMAN MD EVP & CMO	(I)	505,996		29,278	71,901	19,687	623,915	
	(II)					-	-	
13ANTHONY KECK SVP/CHIEF DEV OFC	(I)	355,385		4,423	50,435	17,964	425,281	
	(II)					-	-	
14CLAY RUNNELS MD VP HOSP PRGM SERV	(I)	352,463		4,425	15,668	24,257	393,886	
	(II)					-	-	
15MARK WILKINSON MD VP/CMO	(I)	349,144		4,414	15,603	24,523	390,761	
	(II)					-	-	
16PAUL MERRYWELLCIO	(I)	300,774		22,559	27,609	19,341	367,533	
	(II)					-	-	
17CANDACE JENNINGS SR VP TN OPERATIONS	(I)			265,626			265,626	265,626
	(II)					-	-	
18DALE CLAYTORE FMR KEY EMPL , VP	(I)	219,484		16,010	13,673	2,197	249,167	
	(II)					-	-	
19PAT NIDAY FMR KEY EMPL , AVP	(I)	159,670		18,896	10,257	18,356	205,531	
	(II)					-	-	

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

Part I Bond Issues

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

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	126,195,000	48,310,000	13,210,000	
2	Amount of bonds legally defeased				173,030,000
3	Total proceeds of issue	195,841,283	206,160,210	125,831,095	185,648,913
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	2,353,905	3,474,644	2,481,706	2,383,533
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	158,517,510		100,727,095	101,295,664
11	Other spent proceeds	34,166,556	202,685,565	22,610,763	81,969,716
12	Other unspent proceeds			11,530	
13	Year of substantial completion	2016		2014	2011

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X		X			X	X	
15	Were the bonds issued as part of an advance refunding issue?		X		X		X	X	
16	Has the final allocation of proceeds been made?	X		X		X		X	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III Private Business Use

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

Part III Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?	X		X		X		X	
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X		X		X	
c	Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶								
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶								
6	Total of lines 4 and 5								
7	Does the bond issue meet the private security or payment test?		X		X		X		X
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?	X		X			X	X	
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of		0 020 %		0 020 %				0 130 %
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2?	X		X				X	
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2?	X		X		X		X	

Part IV Arbitrage

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

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

Return Reference	Explanation
SCHEDULE K - PURPOSE OF ISSUE DESCRIPTION	HLTH & EDU FACIL BD 2011A&B&C&D (PAGE 1 - LINE A) CONSTRUCT AND EQUIP HOSPITAL FACILITIES,INCLUDING REFINANCING TAXABLE DEBT RELATING THERETO, REFUND BONDS ISSUED 12/01/2001, REFINANCING LOANS AND EQUIPMENT LEASES HLTH & EDU FACIL BD 2010A&B (PAGE 1 - LINE B) PARTIAL REFUNDING OF BONDS ISSUED 12/14/2007 (2007A) AND (2007C) AND 2/20/2008 (2008A) HLTH & EDU FACIL BD 2009A&B&C (PAGE 1 - LINE C) CONSTRUCT AND EQUIP HOSPITAL FACILITIES,INCLUDING REFINANCING OF TAXABLE INDEBTEDNESS RELATING THERETO HLTH & EDU FACIL BD 2006A (PAGE 1 - LINE D) CONSTRUCT AND EQUIP HOSPITAL FACILITIES,INCLUDING REFINANCING TAXABLE DEBT RELATING THERETO, AND COST OF INTEREST RATE HEDGE, REFUND BONDS ISSUED 3/28/01, 7/01/03, 7/08/04, 11/23/04, 9/7/05 AND 11/23/05 HLTH & EDU FACIL BD 2012A&B&C (PAGE 2 - LINE A) CONSTRUCT AND EQUIP SURGERY CENTER AT JCMC, CONSTRUCT AND EQUIP HOSPITAL FACILITIES, INCLUDING REFINANCING OF TAXABLE INDEBTEDNESS RELATING THERETO HLTH & EDU FACIL BD 2013A&C&D&E (PAGE 2 - LINE B) CONSTRUCT & EQUIP HOSPITAL FACILITIES, INCLUDING REFINANCING OF TAXABLE INDEBTEDNESS RELATING THERETO, REFUND BONDS ISSUED 2/20/08, 10/19/11 & 9/18/12 HLTH & EDU FACIL BD 2016A (PAGE 2 - LINE C) REFUNDING OF 2006A BOND

Return Reference	Explanation
SCHEDULE K - DATE REBATE COMPUTATION PERFORMED	HLTH & EDU FACIL BD 2011A&B&C&D 04/29/16 HLTH & EDU FACIL BD 2010A&B 02/25/15 HLTH & EDU FACIL BD 2009A&B&C 03/21/14 HLTH & EDU FACIL BD 2006A 03/08/16

Return Reference	Explanation
SCHEDULE K - ADDITIONAL INFORMATION	HLTH & EDU FACIL BD 2016A SCHEDULE K PART VI 1 COMMENT ON SCHEDULE K, PART I, LINES A, B, C, E AND F MOUNTAIN STATES HEALTH ALLIANCE OWNS AND/OR OPERATES HOSPITALS IN A NUMBER OF DIFFERENT LOCATIONS BOTH IN TENNESSEE AND IN VIRGINIA AS A RESULT, MOUNTAIN STATES HE ALTH ALLIANCE MUST UTILIZE CONDUIT GOVERNMENTAL BOND ISSUERS IN A NUMBER OF JURISDICTIONS IN ORDER TO FINANCE IMPROVEMENTS TO ITS HOSPITAL FACILITIES IN 2009, 2010, 2011, 2012 AND 2013, MOUNTAIN STATES HEALTH ALLIANCE WAS THE CONDUIT BORROWER OF TAX-EXEMPT BONDS ISSUED BY MULTIPLE ISSUERS IN TENNESSEE AND VIRGINIA FOR FEDERAL TAX PURPOSES, EVEN THOUGH DIFF ERENT GOVERNMENT ISSUERS WERE INVOLVED, THESE MULTIPLE ISSUES IN EACH YEAR WERE REQUIRED T O BE TREATED, AND WERE TREATED, AS A SINGLE "ISSUE" BECAUSE THEY MET THE SINGLE "ISSUE" TE ST UNDER THE APPLICABLE FEDERAL TAX REGULATIONS THEREFORE, MULTIPLE ISSUERS ARE LISTED UN DER LINES A, B, C, E AND F BECAUSE THE BONDS THAT WERE ISSUED WERE PART OF A SINGLE "ISSUE " FOR FEDERAL TAX PURPOSES 2 COMMENT ON SCHEDULE K, PART II LINE 3 FOR EACH THE LISTED B OND ISSUES DOES NOT MATCH THE APPLICABLE ISSUE PRICE FOR EACH SUCH BOND ISSUE BECAUSE OF I NTEREST EARNINGS EARNED ON THE PROCEEDS OF EACH SERIES OF BONDS 3 COMMENT ON SCHEDULE K, PART II, LINE 9 THROUGH 11 THE INSTRUCTIONS ARE UNCLEAR AS TO WHETHER AMOUNTS USED TO REF INANCE SHORT-TERM TAXABLE LOANS INCURRED TO TEMPORARILY FINANCE ELIGIBLE COSTS SHOULD BE S HOWN AS CAPITAL EXPENDITURES AND WORKING CAPITAL (LINES 9 AND 10) OR AS OTHER SPENT PROCEE DS (LINE 11) BASED UPON A REVIEW OF OTHER 990 FILINGS, IT APPEARS THAT MOST REPORTING ENT ITIES HAVE LISTED THE APPLICATION OF PROCEEDS FOR SUCH PURPOSE UNDER OTHER SPENT PROCEEDS (LINE 11) THIS FILING TAKES THAT APPROACH 4 COMMENT ON SCHEDULE K, PART III, LINE 8C A VERY SMALL AMOUNT OF EQUIPMENT THAT WAS FINANCED OR REFINANCED WITH THE PROCEEDS OF THE BO NDS DESCRIBED IN LINES A, B, D AND F WAS DISPOSED OF DURING THE 2015 FISCAL YEAR NO REMED IAL ACTION WAS REQUIRED PURSUANT TO SECTIONS 1 141-12 AND 1 145-2 OF THE TREASURY REGULATI ONS BECAUSE THE DISPOSITION OF SUCH EQUIPMENT DID NOT RESULT IN THE PRIVATE BUSINESS USE T EST THRESHOLD BEING EXCEEDED THEREFORE, SUCH REGULATIONS WERE INAPPLICABLE HOWEVER, AS A PRECAUTION, AND TO INSURE THAT BOND PROCEEDS WERE ALLOCATED TO ASSETS OWNED BY A 501(C)(3) ORGANIZATION, MOUNTAIN STATES HEALTH ALLIANCE ALLOCATED FROM THE PROCEEDS OF THE SALE OF THE FINANCED EQUIPMENT AND OTHER EQUIPMENT, AN AMOUNT EQUAL TO THE DEPRECIATED BOOK VALUE OF SUCH FINANCED EQUIPMENT TO NEW EQUIPMENT ACQUIRED DURING THE FISCAL YEAR BY MOUNTAIN S TATES HEALTH ALLIANCE 5 COMMENT ON SCHEDULE K, PART IV, LINES 1 AND 2 PRIOR TO JUNE 30, 2016, THE REPORTING DATE OF THE 990, THE ONLY ARBITRAGE REBATE CALCULATIONS THAT WERE REQU IRED RELATED TO THE BONDS DESCRIBED IN LINES A, B, C AND D OF PART I (THE SERIES 2006, 200 9, 2010 AND 2011 BONDS) MOUNTAIN STATES HEALTH ALLIANCE RETAINED A REBATE CALCULATION AGE NT TO CALCULATE WHETHER ANY AR

Return Reference	Explanation
SCHEDULE K - ADDITIONAL INFORMATION	BITRAGE REBATE WAS DUE WITH RESPECT TO THOSE BONDS, AND THERE WAS NEGATIVE ARBITRAGE REBAT E LIABILITY IN A SIGNIFICANT AMOUNT THEREFORE, NO FORM 8038-T WAS REQUIRED TO BE FILED WI TH RESPECT TO THOSE BOND ISSUES

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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

2016

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

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

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

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

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

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

Part II Loans to and/or From Interested Persons.

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

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? 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
(1) DENNIS VONDERFECHT		SPLIT LIFE INSUR LOAN,INCL PR YRS		X	7,205,125	8,295,295		No	Yes		Yes	
(2) MARVIN EICHORN		SPLIT DOLLAR LIFE INSURANCE LOAN		X	1,750,000	2,135,735		No	Yes		Yes	
(3) MARVIN EICHORN		SPLIT DOLLAR LIFE INSURANCE LOAN		X	458,410	561,763		No	Yes		Yes	
(4) MARVIN EICHORN		SPLIT DOLLAR LIFE INSURANCE LOAN		X	304,332	304,332		No	Yes		Yes	
(5) MARVIN EICHORN		SPLIT DOLLAR LIFE INSURANCE LOAN		X	296,183	238,783		No	Yes		Yes	
Total				▶ $		11,535,908						

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
See Additional Data Table					

Part V Supplemental Information

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

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

Additional Data

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

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(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
WORKSPACE INTERIORS INC	VENDOR	369,561	SEE PART V		No
SCOTT PETERS	FAMILY MEMBER	59,063	SEE PART V		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(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
PAULA CLAYTORE	FAMILY MEMBER	233,827	SEE PART V		No
MATTHEW MARTIN	FAMILY MEMBER	28,426	SEE PART V		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(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
CLEM WILKES III	FAMILY MEMBER	165,060	SEE PART V		No

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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

2016

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 1, ITEM C	NISWONGER CHILDREN'S HOSPITAL, FRANKLIN WOODS COMMUNITY HOSPITAL, INDIAN PATH MEDICAL CENTER, SYCAMORE SHOALS HOSPITAL, WOODRIDGE HOSPITAL FOR BEHAVIORAL HEALTH SERVICES, JOHNSON COUNTY COMMUNITY HOSPITAL, RUSSELL COUNTY MEDICAL CENTER, UNICOI COUNTY MEMORIAL HOSPITAL

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 1, ITEM B	MOUNTAIN STATES HEALTH ALLIANCE'S JUNE 30,2017 FORM 990 WAS ORIGINALLY FILED WITHOUT PROGR AM SERVICE ACCOMPLISHMENTS THIS AMENDED FORM 990 HAS PROGRAM SERVICE ACCOMPLISHMENTS ATTA CHED

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 - ORGANIZATION'S MISSION	MOUNTAIN STATES HEALTH ALLIANCE (MSHA) 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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 12C	ANNUALLY, THE CORPORATE AUDIT AND COMPLIANCE DEPARTMENT OF MSHA FORWARDS THE CONFLICT OF I NTEREST POLICY AND DISCLOSURE FORM TO ALL MSHA MANAGEMENT TEAM MEMBERS AND BOARD MEMBERS EMPLOYEES AND BOARD MEMBERS MUST NOTE ANY CONFLICTS OR ATTEST THEY HAVE "NONE", AND RETURN THE FORM TO THE AUDIT AND COMPLIANCE DEPARTMENT ANY NOTED DISCLOSURES ARE FORWARDED TO T HE APPROPRIATE MANAGEMENT OR BOARD PERSONNEL TO EVALUATE AND UTILIZE WHEN A TRANSACTION IN VOLVING A CONFLICTED PERSON ARISES ANY CONFLICTED PERSON SHALL BE EXCLUDED FROM MEETINGS DURING DISCUSSION OF THE MATTER THAT GIVES RISE TO THE POTENTIAL CONFLICT A CONFLICTED BO ARD DIRECTOR WILL NOT VOTE ON THE MATTER THAT GIVES RISE TO THE POTENTIAL CONFLICT IN ADD ITION, IF A CONFLICTED PERSON HAS A FINANCIAL INTEREST IN A TRANSACTION OR ARRANGEMENT THA T MIGHT INVOLVE PERSONAL FINANCIAL GAIN OR LOSS FOR HIM/HER, THE BOARD OR BOARD COMMITTEE MAY APPOINT A NON-INTERESTED PERSON OR COMMITTEE TO INVESTIGATE ALTERNATIVES TO THE PROPOS ED TRANSACTION OR ARRANGEMENT IN ORDER TO APPROVE THE TRANSACTION, THE BOARD OR COMMITTEE MUST FIND BY THE MAJORITY VOTE OF THE BOARD MEMBERS, WITHOUT COUNTING THE VOTE OF A CONFL ICTED PERSON, THAT THE PROPOSED TRANSACTION OR ARRANGEMENT IS IN THE CORPORATION'S BEST IN TEREST AND FOR ITS OWN BENEFIT, THE PROPOSED TRANSACTION IS FAIR AND REASONABLE TO THE COR PORATION, AND, AFTER REASONABLE INVESTIGATION, THE BOARD OR BOARD COMMITTEE HAS DETERMINED THAT THE CORPORATION CANNOT OBTAIN A MORE ADVANTAGEOUS TRANSACTION OR ARRANGEMENT WITH RE ASONABLE EFFORTS UNDER THE CIRCUMSTANCES, THE CONFLICTED PERSON WILL NOT BE PRESENT FOR TH E DISCUSSION OR VOTE REGARDING THE TRANSACTION OR ARRANGEMENT, AND THE TRANSACTION OR ARRA NGEMENT MUST BE APPROVED BY A MAJORITY VOTE OF THE BOARD MEMBERS, NOT INCLUDING ANY CONFLI CTED PERSONS ANY PERSON HAVING A CONFLICT ARISE BETWEEN THE ANNUAL DISTRIBUTION OF THE PO LICY AND DISCLOSURE FORM ARE REQUIRED TO DISCLOSE THE CONFLICT AND WOULD BE DISCIPLINED IN ANY INSTANCE WHERE THEY HAVE NOT DISCLOSED AND ENGAGED IN A CONFLICTED TRANSACTION FAILU RE TO COMPLY WITH MSHA'S CONFLICT OF INTEREST POLICY CONSTITUTES GROUNDS FOR REMOVAL FROM OFFICE, IN THE CASE OF THE GOVERNING BODY, AND, IN THE CASE OF TEAM MEMBERS, TERMINATION O F EMPLOYMENT

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15A	THE EXECUTIVE COMMITTEE SERVES AS THE COMPENSATION COMMITTEE OF MSHA'S BOARD OF DIRECTORS THE COMPENSATION FOR ALAN LEVINE, MSHA'S PRESIDENT AND CEO, WAS REVIEWED AND APPROVED BY THE EXECUTIVE COMMITTEE DURING FY17 DATA OBTAINED BY AN INDEPENDENT, OUTSIDE CONSULTING F IRM WAS USED TO DETERMINE HIS PAY SO THAT IT IS COMPARABLE TO LIKE POSITIONS AT SIMILARLY SITUATED ORGANIZATIONS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15B	THE EXECUTIVE COMMITTEE ALSO REVIEWED AND APPROVED COMPENSATION FOR ALL MSHA OFFICERS AND KEY EMPLOYEES DURING FY17 DATA OBTAINED BY AN INDEPENDENT, OUTSIDE CONSULTING FIRM WAS US ED TO DETERMINE THEIR PAY SO THAT IT IS COMPARABLE TO LIKE POSITIONS AT SIMILARLY SITUATED ORGANIZATIONS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 19	GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE MADE AVAILABLE UPON REQUEST TO APP ROPRIATE PARTIES REQUESTING THEM FINANCIAL STATEMENTS ARE MADE AVAILABLE UPON REQUEST TO APPROPRIATE PARTIES REQUESTING THEM, AND THEY ARE MADE AVAILABLE TO THOSE PARTIES WHO OWN INDEBTEDNESS OF THE COMPANY ON A QUARTERLY BASIS FORM 990, PART VII, OFFICERS, KEY EMPLOY EES, & HIGHEST PAID COMPENSATION CERTAIN EXECUTIVES OF THE ORGANIZATION, SUCH AS THE HEAL TH SYSTEM'S CEO, EVP/CFO, EVP/COO, ETC PROVIDE SERVICES TO SOME OR ALL OF THE ORGANIZATIO NS RELATED TO MSHA

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	PHYSICIAN FEES 27,343,678 0 0 HOSPITAL SUPPORTED CLINICS 34,316,703 0 0 HOSPITAL BASED PRO VIDERS 4,887,120 0 0 DIETARY SERVICES 9,132,684 0 0 CONSULTING SERVICES 0 9,500,631 0 ENVI RONMENTAL SERVICES 8,909,679 0 0 LAUNDRY SERVICES 2,845,582 0 0 COLLECTION SERVICES 0 3,92 9,961 0 RETAIL PHARMACY 652,316 0 0 LABORATORY SERVICES 2,924,068 0 0 CONTRACT LABOR 4,999 ,055 0 0 PATIENT RESOURCE SERVICES 1,337,375 0 0 TRANSCRIPTION SERVICES 0 629,535 0 PHYSIC IAN LOAN FORGIVENESS 886,979 0 0 LITHOTRIPSY 771,909 0 0 ENGINEERING SERVICES 0 1,350,547 0 SKILLED NURSING SERVICES 1,024,300 0 0 HOSPICE 435,339 0 0 OTHER FEES 6,778,591 509,110 18,132 TOTAL 107,245,378 15,919,784 18,132

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	PARTNERSHIP ORDINARY INCOME NOT ON BOOKS 1,081,696 TEMPORARILY RESTRICTED GRANTS -128,812 CHANGE IN FAIR VALUE OF DERIVATIVES -5,570,823 ADDITIONAL PAID IN CAPITAL 181,406 TOTAL -4 ,436,533

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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

2016

Open to Public Inspection

Name of the organization
MOUNTAIN STATES HEALTH ALLIANCE

Employer identification number
62-0476282

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

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

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

See Additional Data Table

(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) Section 512(b)(13) controlled entity? No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) INTEGRATED SOLUTIONS HEALTH NETWORK 509 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604 62-1711997	INVESTMENT	TN	MSHA	EXCLUDED	-737,890	17,619,004		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	MSHA	EXCLUDED	-340,445	-571,741		No			No	
(4) EAST TN AMBULATORY SURGERY CNTR 701 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604 62-1787537	MED SERV	TN	NA					No			No	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1)BLUE RIDGE MEDICAL MANAGEMENT CORP 1021 W OAKLAND AVENUE STE 207 JOHNSON CITY, TN 37604 62-1490616	MED SERV	TN	MSHA	C CORP	131,332,981	225,054,427	100 000 %		No
(2)MEDISERVE MEDICAL EQUIPMENT 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1212286	DME	TN	BRMMC	C CORP	2,819,502	4,977,132	100 000 %		No
(3)MOUNTAIN STATES PROPERTIES 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1845895	PROP MGMT	TN	BRMMC	C CORP	12,713,645	145,039,121	100 000 %		No
(4)MOUNTAIN STATES PHYSICIAN GROUP 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1700412	MED SERV	TN	BRMMC	C CORP	75,663,670	7,011,416	100 000 %		No
(5)COMMUNITY HOME CARE INC 1490 PARK AVENUE NW SUITE B NORTON, VA 24273 54-1453810	DME	VA	NCH	C CORP	218,233	421,162	50 100 %		No
(6)WILSON PHARMACY INC PO BOX 5289 JOHNSON CITY, TN 37604 62-0329587	PHARMACY	TN	BRMMC	C CORP	4,204,295	5,893,887	100 000 %		No
(7)CRESTPOINT HEALTH INSURANCE COMPANY 509 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604 62-0381170	INSURANCE	TN	ISHN	C CORP	22,760,766	12,327,119	99 830 %		No

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

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

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

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

See Additional Data Table

(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)

Additional Data

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) ONE HOSPITAL DRIVE CLINTWOOD, VA 24228 77-0599553	HOSPITAL	VA	501C3	3	NCH		No
(1) 2335 KNOB CREEK ROAD STE 101 JOHNSON CITY, TN 37604 58-1418862	FUNDRAISER	TN	501C3	12A	MSHA		No
(2) 400 N STATE OF FRANKLIN ROAD JOHNSON CITY, TN 37604 58-1418345	SUPPORT	TN	501C3	12A	MSHA		No
(3) 245 MEDICAL PARK DRIVE MARION, VA 24354 54-0794913	HOSPITAL	VA	501C3	3	MSHA		No
(4) 100 15TH STREET NW NORTON, VA 24273 54-0566029	HOSPITAL	VA	501C3	3	NA		No
(5) 16000 JOHNSTON MEMORIAL DRIVE ABINGDON, VA 24211 54-0544705	HOSPITAL	VA	501C3	3	NA		No
(6) 16000 JOHNSTON MEMORIAL DRIVE ABINGDON, VA 24211 20-5485346	MED SERV	VA	501C3	12A	JMH		No
(7) 1021 W OAKLAND AVENUE STE 207 JOHNSON CITY, TN 37604 80-0592504	MED SERV	VA	501C3	12A	NA		No
(8) 211 COMMERCE ST STE 800 NASHVILLE, TN 372011817 61-1771290	SUPP ORG	TN	501C3	12B	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
(1) BLUE RIDGE MEDICAL MANAGEMENT CORP 1021 W OAKLAND AVENUE STE 207 JOHNSON CITY, TN 37604 62-1490616	MED SERV	TN	MSHA	C CORP	131,332,981	225,054,427	100 000 %		No
(1) MEDISERVE MEDICAL EQUIPMENT 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1212286	DME	TN	BRMMC	C CORP	2,819,502	4,977,132	100 000 %		No
(2) MOUNTAIN STATES PROPERTIES 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1845895	PROP MGMT	TN	BRMMC	C CORP	12,713,645	145,039,121	100 000 %		No
(3) MOUNTAIN STATES PHYSICIAN GROUP 1021 W OAKLAND AVENUE SUITE 207 JOHNSON CITY, TN 37604 62-1700412	MED SERV	TN	BRMMC	C CORP	75,663,670	7,011,416	100 000 %		No
(4) COMMUNITY HOME CARE INC 1490 PARK AVENUE NW SUITE B NORTON, VA 24273 54-1453810	DME	VA	NCH	C CORP	218,233	421,162	50 100 %		No
(5) WILSON PHARMACY INC PO BOX 5289 JOHNSON CITY, TN 37604 62-0329587	PHARMACY	TN	BRMMC	C CORP	4,204,295	5,893,887	100 000 %		No
(6) CRESTPOINT HEALTH INSURANCE COMPANY 509 MED TECH PARKWAY SUITE 100 JOHNSON CITY, TN 37604 62-0381170	INSURANCE	TN	ISHN	C CORP	22,760,766	12,327,119	99 830 %		No

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

	(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(1)	APP	L	146,280	
(1)	BLUE RIDGE MEDICAL MANAGEMENT	A	455,329	
(2)	BLUE RIDGE MEDICAL MANAGEMENT	G	1,324,523	
(3)	BLUE RIDGE MEDICAL MANAGEMENT	L	8,188,053	
(4)	BLUE RIDGE MEDICAL MANAGEMENT CORP	M	43,122,504	
(5)	BLUE RIDGE MEDICAL MANAGEMENT CORP	O	743,713	
(6)	BLUE RIDGE MEDICAL MANAGEMENT CORP	P	267,686	
(7)	BLUE RIDGE MEDICAL MANAGEMENT CORP	Q	35,217,305	
(8)	BLUE RIDGE MEDICAL MANAGMENT CORP	S	177,514	
(9)	DICKENSON COMMUNITY HOSPITAL	L	1,144,642	
(10)	DICKENSON COMMUNITY HOSPITAL	Q	669,985	
(11)	HEALTHPLUS	A	53,922	
(12)	HEALTHPLUS	L	76,463	
(13)	HEALTHPLUS	M	359,277	
(14)	HEALTHPLUS	O	371,390	
(15)	HEALTHPLUS	Q	18,190,481	
(16)	ISHN	A	121,900	
(17)	ISHN	D	500,000	
(18)	ISHN	L	169,895	
(19)	ISHN	M	135,390	
(20)	ISHN	P	927,911	
(21)	ISHN	Q	3,957,302	
(22)	JOHNSTON MEMORIAL HOSPITAL	L	13,451,405	
(23)	JOHNSTON MEMORIAL HOSPITAL	P	59,103	
(24)	JOHNSTON MEMORIAL HOSPITAL	R	116,326	

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

	(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(26)	MEDISERVE	G	70,980	
(1)	MEDISERVE	K	172,438	
(2)	MEDISERVE	L	264,263	
(3)	MEDISERVE	Q	3,445,977	
(4)	MOUNTAIN STATES FOUNDATION	C	1,300,186	
(5)	MOUNTAIN STATES PROPERTIES	K	2,140,000	
(6)	MOUNTAIN STATES PROPERTIES	M	254,756	
(7)	MOUNTAIN STATES PROPERTIES	O	510,550	
(8)	MOUNTAIN STATES PROPERTIES	Q	5,685,343	
(9)	MSHA AUXILIARY	C	119,111	
(10)	MSHA AUXILIARY	P	80,459	
(11)	MSHA AUXILIARY	Q	1,352,471	
(12)	NORTON COMMUNITY HOSPITAL	D	20,708,048	
(13)	NORTON COMMUNITY HOSPITAL	L	6,352,308	
(14)	NORTON COMMUNITY HOSPITAL	O	122,905	
(15)	NORTON COMMUNITY HOSPITAL	P	216,254	
(16)	NORTON COMMUNITY HOSPITAL	Q	24,257,133	
(17)	NORTON COMMUNITY HOSPITAL	R	463,530	
(18)	SMYTH COUNTY COMMUNITY HOSPITAL	D	15,558,742	
(19)	SMYTH COUNTY COMMUNITY HOSPITAL	L	4,908,872	
(20)	SMYTH COUNTY COMMUNITY HOSPITAL	Q	12,435,212	